ROSEMEAD SCHOOL DISTRICT
3907 ROSEMEAD BLVD., ROSEMEAD, CA 91770
TEL: (626) 312-2900 FAX: (626) 312-2913

Scan to Enroll



2026-2027 ENROLLMENT OPENS 2-10-2026

YOUR KIDS DESERVE THE BEST EDUCATION

Why Rosemead School District?

- Rigorous Academics
- 21st Century Learning Environment
- Engaging STEAM & Arts instruction
- Mandarin Dual Language Immersion Program (Kinder-6th Grade)
- 7 Habits Leader In Me Lighthouse Schools (leaderinme.com)
- Instrumental Music Program (4th-8th Grades)
- PBIS Platinum Schools (pbis.org)
- New Elementary Playground Structures
- Middle School Electives & Clubs
- Advancement Via Individual Determination (AVID)
- Elevo Expanded Learning (elevolearning.com)
- After School Programs:
  - → Childcare
  - → Soccer
  - → Chess Club
  - → Cooking Classes
  - → Enrichment Program

Transitional Kindergarten (TK)/Kindergarten Registration Dates

Tues., February 10th - Janson Elementary
Wed., February 11th - Shuey Elementary
Thurs., February 12th - Encinita Elementary
Fri., February 13th - Savannah Elementary

Encinita Elementary

Janson Elementary

Muscatel Middle

Savannah Elementary

Shuey Elementary

Register https://bit.ly/RSDPreRegistrationForm

(626) 312-2900 registration@rosemead.k12.ca.us https://www.rosemead.k12.ca.us/



ENCINITA ELEMENTARY MANDARIN DLI PROGRAM 2026-2027

K-6TH GRADE

1st-6th grade applicants will be scheduled for an exam*

2026-2027 DLI INTEREST FORM

https://bit.ly/490l0Ai

(626) 312-290000 x213
crivera@rosemead.k12.ca.us

3907 Rosemead Blvd.
Rosemead, CA 91770
Phone: 626-312-2900
Fax: 626-312-2906

PHILIP D'AGOSTINO, Ed.D, Superintendent of Schools

BOARD OF TRUSTEES
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February, 2026

Dear Parent(s)/Guardian:

In order to enroll your child in the Rosemead School District, you must first register online and then bring the following items to your school of residence:

A. Proof of age (Birth Certificate or Passport)

B. Proof of Residency (**Current** Gas, Landline Telephone, Electric, Trash, Cable or Water bill with one of the student's parent's name on it). If you do not have a bill in your name you will need to obtain address verification from your home school.

C. Immunization Record (refer to the *Required Immunizations For School Entry* form)

These immunization requirements apply to new admissions and transfers for all grades, including transitional kindergarten:

FOR NEW TK/KINDERS (and some grade 1 students) all appropriate immunizations (as listed above) are needed PLUS:

1. Dental Health Evaluation Form needs to be completed DURING Kindergarten. NOT required to be done BEFORE Entry.

WAIVERS:
If a parent wishes to sign **waivers on ANY requirements** please ask that they speak to the district school nurse.

You may pick up the registration information at your school of residency and go online to enroll at our website: http://www.rosemead.k12.ca.us to register your child. You must enroll your child at your school of residency or your enrollment package will be invalid.

If you have any questions, please feel free to contact the Special Education & Student Support Services Office at (626) 312-2900 or email at registration@rosemead.k12.ca.us.

Sincerely,

Hoori Chalian

Hoori Chalian
Coordinator
Special Education & Student Support Services

Parents/Guardians – Are Your Kids Ready for School?

Required Immunizations For School Entry

CDPH California Department of Public Health

Please bring your child's immunization records with you at the time of registration. You may view and print a digital copy of your child's California vaccine record at: **MyVaccineRecord.CDPH.CA.gov**

Students Entering Transitional Kindergarten or Kindergarten Need Records of:

- ☐ **Diphtheria, Tetanus, and Pertussis (DTaP, DTP, Tdap or Td) — 5 doses**
  4 doses OK if one was given on or after 4th birthday;
  3 doses OK if one was given on or after 7th birthday.
- ☐ **Polio (IPV or OPV) — 4 doses**
  3 doses OK if one was given on or after 4th birthday. Oral polio vaccine (OPV) doses given on or after April 1, 2016, do not count.
- ☐ **Hepatitis B — 3 doses**
- ☐ **Measles, Mumps, and Rubella (MMR) — 2 doses**
  Both doses must be given on or after 1st birthday.
- ☐ **Varicella (Chickenpox) — 2 doses**

New and Transfer Students Entering TK/K-12th Grade Need Records of:

- ☐ **All immunizations listed above**
  For 7th-12th graders: at least 1 dose of pertussis-containing vaccine is required on or after 7th birthday. Hepatitis B vaccine is required for any grade, except for entry into 7th grade.

Students Starting 7th Grade Need Records of:

- ☐ **Tetanus, Diphtheria, and Pertussis (Tdap) —1 dose**

What other immunizations should I ask my health care provider about?

When you visit your health care provider for back-to-school immunizations, make sure to also ask about other vaccines that help keep your child healthy, including **hepatitis A, COVID-19, and the annual flu vaccine**. Preteens and teens should also get the **human papillomavirus (HPV) vaccine** to protect against certain cancers and **meningococcal vaccines**.

Learn more about vaccines your child needs and **where to get immunized** at **GetImmunizedCA.org**.

County of Los Angeles Public Health
Tuberculosis Control Program

Pediatric Tuberculosis (TB) Risk Assessment

This tool is used to identify asymptomatic **children** for latent TB infection (LTBI) testing.

Check appropriate risk factor boxes below based on patient response.
Refer to pediatrician for LTBI testing (skin or blood test), if any of the 3 boxes below are checked.
If a LTBI test result is positive, and active TB disease is ruled out, LTBI treatment is recommended.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the California Adult Tuberculosis Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-US born persons ≥2 years old

☐ **Immunosuppression,** current or planned

- HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥2 mg/kg/day, or ≥15 mg/day for ≥2 weeks) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease at any time

- The Centers for Disease Control and Prevention indicates that the investigation of contacts and treatment of infected contacts is an important component of the U.S. strategy for TB elimination.

- Re-testing should only be done in persons who previously tested negative and have new risk factors since the last risk assessment.
  If initial negative screening test occurred prior to 6 months of age, repeat testing should occur at age 6 months or older.
- For children with TB symptoms or abnormal chest x-ray consistent with active TB disease →Evaluate for active TB disease *with a chest x- ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing.*
- *A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.*
- Do not treat for LTBI until active TB disease has been excluded.

See the **Pediatric TB Risk Assessment User Guide** below for more detailed information about this tool.

Provider: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

(Place sticker here if applicable)

For the most current version, go to the PEDIATRIC TB RISK ASSESSMENT at: http://publichealth.lacounty.gov/tb/TBTesting.htm

Tuberculosis Clearance Form

This satisfies requirements in the California Education Code, and the California Health and Safety Code.

Certificate of Completion of Tuberculosis Risk Assessment and/or Examination

Date of TB risk assessment and/or examination:_____month/____day/_____year

First and Last Name of the patient assessed and/or examined: _____

Date of Birth:_____month/____day/_____year

The patient named above has submitted to a pediatric tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has had a TB skin test (TST) or TB blood test (IGRA), and chest x-ray (CXR) if indicated, and upon exam determined to be free of infectious tuberculosis. The patient is cleared to attend school.

Please print, place label or stamp with Health Care Provider information below:

_____

Name of Health Care Provider Completing the TB Risk Assessment and/or Examination

_____

Health Care Provider Signature

_____

Facility Name and Address

In order to protect the privacy of individuals, all information regarding this assessment is considered confidential. The facility and the Los Angeles County Department of Public Health cannot release the name(s) of any ill person(s).

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ORAL HEALTH NOTIFICATION LETTER

Dear Parent or Guardian:

To make sure your child is ready for school, California law, *Education Code* Section 49452.8, now requires that your child have an oral health assessment (dental check-up) by May 31 in either kindergarten or first grade, whichever is his or her first year in public school. Assessments that have happened within the 12 months before your child enters school also meet this requirement. The law specifies that the assessment must be done by a licensed dentist or other licensed or registered dental health professional.

Take the attached Oral Health Assessment/Waiver Request form to the dental office, as it will be needed for your child's check-up. If you cannot take your child for this required assessment, please indicate the reason for this in Section 3 of the form. You can get more copies of the necessary form at your child's school or online from the California Department of Education's Web site at http://www.cde.ca.gov/ls/he/hn/. California law requires schools to maintain the privacy of students' health information. Your child's identity will not be associated with any report produced as a result of this requirement.

The following resources will help you find a dentist and complete this requirement for your child:

1. Medi-Cal/Denti-Cal's toll-free number or Web site can help you to find a dentist who takes Denti-Cal: 1-800-322-6384; http://www.denti-cal.ca.gov. For help enrolling your child in Medi-Cal/Denti-Cal, contact your local social service agency at (fill in appropriate local contact information, available at http://www.denti-cal.ca.gov/WSI/Bene.jsp?fname=ProvReferral.)

2. Healthy Families' toll-free number or Web site can help you to find a dentist who takes Healthy Families insurance or to find out if your child can enroll in the program: 1-800-880-5305 or http://www.benefitscal.com/.

3. For additional resources that may be helpful, contact your local public health department at (fill in appropriate local contact information, available at http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx).

Remember, your child is not healthy and ready for school if he or she has poor dental health! Here is important advice to help your child stay healthy:

- Take your child to the dentist twice a year.
- Choose healthy foods for the entire family. Fresh foods are usually the healthiest foods.
- Brush teeth at least twice a day with toothpaste that contains fluoride.

- Limit candy and sweet drinks, such as punch or soda. Sweet drinks and candy contain a lot of sugar, which causes cavities and replaces important nutrients in your child's diet. Sweet drinks and candy also contribute to weight problems, which may lead to other diseases, such as diabetes. The less candy and sweet drinks, the better!

Baby teeth are very important. They are not just teeth that will fall out. Children need their teeth to eat properly, talk, smile, and feel good about themselves. Children with cavities may have difficulty eating, stop smiling, and have problems paying attention and learning at school. Tooth decay is an infection that does not heal and can be painful if left without treatment. If cavities are not treated, children can become sick enough to require emergency room treatment, and their adult teeth may be permanently damaged.

Many things influence a child's progress and success in school, including health. Children must be healthy to learn, and children with cavities are not healthy. Cavities are preventable, but they affect more children than any other chronic disease.

If you have questions about the new oral health assessment requirement, please contact the Student Support Services office at (626) 312-2900 or email at registration@rosemead.k12.ca.us.

Sincerely,

Hoori Chalian

Hoori Chalian
Coordinator
Special Education & Student Support Services

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) says every child must have a dental check-up (assessment) by May 31st of his/her first year in public school. A California licensed dental professional must do the check-up and fill out Section 2 of this form. If your child had a dental check-up in the last 12 months, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out the separate Waiver of Oral Health Assessment Requirement Form.

This assessment will let you know if there are any dental problems that need attention by a dentist. This assessment will also be used to evaluate our oral health programs. Children need good oral health to speak with confidence, express themselves, be healthy and, ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of California's children.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's Birth Date: MM – DD – YYYY
Address:			Apt.:
City:			ZIP Code:
School Name:	Teacher:	Grade:	Year child starts kindergarten: Y Y Y Y
Parent/Guardian First Name:	Parent/Guardian Last Name:		Child's Gender: ☐ Male ☐ Female

Child's Race/Ethnicity:	☐ White	☐ Native American
	☐ Black/African American	☐ Multi-racial
	☐ Hispanic/Latino	☐ Native Hawaiian/Pacific Islander
	☐ Asian	☐ Unknown
	☐ Other (please specify)	

Continued on Next Page

Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box.

Assessment Date: MM – DD – YYYY	Untreated Decay (Visible Decay Present) ☐Yes ☐No	*Caries Experience (Visible decay and/or fillings present) ☐Yes ☐No

Treatment Urgency:

☐ **No obvious problem found**

☐ **Early dental care recommended** (caries without pain or infection; or child would benefit from sealants or further evaluation)

☐ **Urgent care needed** (pain, infection, swelling or soft tissue lesions)

Licensed Dental Professional Signature	***CA License Number***	MM – DD – YYYY ***Date***

*Check "Yes" for Caries experience if there is presence of untreated decay or fillings
Check "No" for Caries experience if there is no untreated decay and no fillings

Section 3: Follow-up to Urgent Care (Filled out by entity responsible for follow up)

Parent notified that child has urgent dental care need on:	MM – DD – YYYY
A follow-up appointment for this child has been scheduled for:	MM – DD – YYYY
Did child receive needed treatment?	☐ **Yes** ☐ **No** (If no, entity responsible for follow-up will be encouraged to check back in with parent) ☐ **I don't know**

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school.

Return this form to the school *no later than* May 31st of your child's first school year.

Original to be kept in child's school record.

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTH DATE—Month/Day/Year

ADDRESS—Number, Street	City	ZIP code	SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	_____/_____/_____
Physical Examination	_____/_____/_____
Dental Assessment	_____/_____/_____
Nutritional Assessment	_____/_____/_____
Developmental Assessment	_____/_____/_____
Vision Screening	_____/_____/_____
Audiometric (hearing) Screening	_____/_____/_____
TB Risk Assessment and Test, if indicated	_____/_____/_____
Blood Test (for anemia)	_____/_____/_____
Urine Test	_____/_____/_____
Blood Lead Test	_____/_____/_____
Other	_____/_____/_____

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER (e.g., TB Test, if indicated)					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER *(optional)* *and* RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

☐ Examination shows no condition of concern to school program activities.

☐ Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: *(please explain)*

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

☐ Please check this box if you ***do not*** want the health examiner to fill out Part III.

Signature of parent or guardian — Date

Name, address, and telephone number of health examiner

Signature of health examiner — Date

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.

Rosemead School District
Special Education & Student Support Services
3907 Rosemead Blvd.
Rosemead, CA 91770

☎ (626) 312-2900
🖷 (626) 312-2913
🌐 www.rosemead.k12.ca.us

Health Centers (Public/Private/Free) for Physical Exams & Immunizations & Other Needs for School

*** Call ahead to all providers for further details regarding services. Clinic hours and eligibility are subject to change ***

Community Health Alliance of Pasadena – Lincoln
2055 Lincoln Ave., Pasadena, CA 91103 (626) 398-6300. **Appointment needed please contact the center**. Site Hours: Monday through Friday, 8:00am to 5:00pm; Saturday, 9:00am to 1:00pm. Website: www.chapcare.org Services: Immunizations, Physical exams and Dental Care.

East Valley Community Health Center / various locations in LA county
4368 Santa Anita Ave., El Monte, CA 91731 (855) 535-5545 Website: https://www.evchc.org/ **Appointment preferred, but walk-ins accepted.** Open Mon, Wed, Fri 9:00am-5pm and Tues, Thurs 1:00pm-7:00pm. The clinic helps you with enrollment with different programs to qualify for free or low-cost vaccines (*no inquiries on immigration status. No insurance necessary.)

Monrovia Public Health Center (a Los Angeles County Public Health Center)
330 Maple Ave., Monrovia, CA 91016 (626) 256-1600
A public health center primarily used for the services of free immunizations and TB test. Call for hours of service. Parent must bring child's vaccine record. Vaccines offered by appointment only, on Tuesdays only from 8am-10:30am and 12:30-3:30 pm please call to schedule appointment.

Tzu Chi Buddhist Clinic
1000 S. Garfield Ave., Alhambra, CA 91801 (626) 281-3383
This is a free clinic (adult and child), dental clinic, and Vaccinations. Eligibility is income based, Offers CHDP exams and free immunizations for children. Tuesdays only from 1:15pm-5pm appointment needed. Languages spoken: English, Spanish, Cantonese, Mandarin and Vietnamese.

AltaMed Health Services
10454 Valley Blvd. #B, El Monte, CA 91731 (626) 453-8466
Sliding Scale based income, qualifying applicants can apply for CHDP a state-run program to help children obtain free or low-cost Physicals and Immunizations the clinic assists in determining eligibility. Also takes most insurance plans. Appointments needed.

Chinatown Service Center (CSC) Health Center
320 S. Garfield Ave. #118, Alhambra, CA 91801 (213) 808-1700
This center offers Free and low-cost Health programs for low-income individuals with no insurance. Monday-Friday from 8:30am- 5:00pm. Appointments needed Languages spoken: English, Spanish, Chinese, Vietnamese. The Clinic offers health exams (adult and Pediatric) Vaccinations, TB test, dental care and Behavioral health.

Herald Christian Health Center
923 S. San Gabriel Blvd., San Gabriel, CA 91776 (626) 286-8700
The Clinic is mandated to serve the community (all ethnicities, faiths) The clinic will assist in determining eligibility for CHDP program for free/low-cost exams and vaccines. **Appointments preferred, but not required walk-in's accepted.**

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BEFORE SCHOOL CARE AND AFTERSCHOOL PROGRAMS

Before School Care

The Rosemead School District offers before-school care at all elementary school sites, beginning at 7:00 a.m. This program is available for a quarterly fee. Parents may enroll their child in before-school care starting **July 1, 2026**. Detailed enrollment information will be available on the Rosemead School District website.

Late Start Days

Late Start Days are provided at all Rosemead School District campuses, with **18 Late Start Days** scheduled throughout the year. This program is offered at no cost to families, but students must be enrolled to participate.

Parents can enroll their children during the district's Welcome Back to School Fairs or by accessing the enrollment link on the Rosemead School District website.

After School Programs

ASES (After School Education and Safety Program)
The ASES Program operates at **Encinita Elementary, Janson Elementary, Muscatel Middle, Savannah Elementary, & Shuey Elementary** and is provided at no cost to families. Students must attend the full program daily, which runs until **6:00 p.m.**

Participants benefit from:

- Homework assistance
- Enrichment activities
- Structured physical activities
- A healthy light supper

Enrollment Process:

- **Enrollment Information Release:** April 27, 2026
- **Enrollment Period:** May 11 – May 22, 2026

Information on how to enroll will be distributed to school sites and will also be available on the Rosemead School District website starting **April 27, 2026**.

For more details and updates, please visit the Rosemead School District, Child Development Department website: https://www.rosemead.k12.ca.us/domain/41 or call (626) 312-2900.

Sincerely,

Deborah Lawrence

Deborah Lawrence
Coordinator
Child Development Department

3907 Rosemead Blvd.
Rosemead, CA 91770
Phone: 626-312-2900
Fax: 626-312-2906

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INTRA-DISTRICT TRANSFER GUIDELINES

An Intra-District transfer may be granted for a student to attend a school in the Rosemead School District (RSD) other than the RSD School of Residence. However, you must enroll at your school of residence until class sizes are determined.

The Intra-District transfer request period is open all year long, starting on February 1st for the next school year. Transfers may be issued at any time for the school year. The application can be downloaded from this website: https://www.rosemead.k12.ca.us/Page/824

Information regarding the specific reasons may be obtained from Special Education & Student Support Services at (626) 312-2900 or registration@rosemead.k12.ca.us.

POLICY

- Permits do not carry transportation privileges.
- Parents are expected to ensure your student is on time and in school for the full school day every day.

APPLICATION INSTRUCTIONS

1. An RSD inter-district permit application must be completed on-line. Paper applications will not be accepted. You can submit a request by visiting our website at: https://www.rosemead.k12.ca.us/Page/824
2. You must enroll at your school of residence until it's been determined there is space available at the requested school.
3. Upon administrative approval at the requested school, you will receive an email confirmation.

ADDITIONAL INFORMATION

Students Must:

- Maintain satisfactory school attendance/report to school/class on-time every day.
- Make continuous progress toward grade level standards (elementary) and/or maintain a minimum 2.0 GPA with no D or F grades (secondary).
- Seek help from teachers and counselors and attend tutoring when having academic difficulties or in danger of receiving a grade of *D* or *F* (Secondary).
- Comply with all classroom and school rules and policies.
- Demonstrate appropriate citizenship and behavior in the classroom and on campus - no Report Card with multiple "1s" for Skills for Success on Achievement Report (elementary) or multiple "Unsatisfactory" citizenship grades (secondary).
- 6. Comply with all conditions of the RSD Discipline Policy (parent/guardian signature on file).

Parent Must:

- Provide adequate transportation so the student can maintain satisfactory school attendance/report to class on time and is picked up from school on time.

- Ensure that your student attends school.
- Call the Attendance Office before 9:30 a.m. on the day of the absence to inform the school of the reason for the absence--or provide a note explaining the reason for the absence on the day of the return.
- Excuse a student only for valid reasons. Requests for absence other than for illness or emergencies are strongly discouraged. Parents should plan family vacations during regular school vacation times.
- Provide a time and place for quiet study time for completion of homework and study assignments.
- Provide school officials with accurate and true information.
- Cooperate with school and district officials and maintain a positive working relationship.
- Attend parent conferences when requested.
- Insist your student complies with the school dress code.

PERMIT CANCELLATION

Permits may be cancelled, revoked, or denied renewal for the following reasons:

- Issued in error
- Falsified information or documentation
- Any change to the permit criteria
- Truancy
- Infractions of school rules and regulations
- Failure to make satisfactory academic progress
- The student is dropped off or picked up is beyond regular school hours including before and after school programs.

Rosemead School District
Nutrition & Wellness
3907 Rosemead Blvd.
Rosemead, CA 91770

☎ (626) 312-2900
(626) 312-2913
www.rosemead.k12.ca.us

Universal Benefits Application
Rosemead School District

This application may qualify your child for benefits such as Summer EBT/SUN Bucks, internet access, school transportation, and more. Inquire with your child's school district to learn what benefits may be available to them. Completing this application will not impact your student's ability to receive school meals at no cost. The U.S. Department of Homeland Security and U.S. Citizenship and Immigration Services do not consider health, food, and housing services as part of the public charge determination. Therefore, submitting this application will not hurt an individual's immigration status.

Note: A non-household member may be designated as the authorized representative for application processing purposes if they have difficulty completing the application process.

Complete, sign, and return this application to: **Rosemead School District**
Nutrition & Wellness
3907 Rosemead Blvd., Suite 150
Rosemead, CA 91770

1. List **all students** living with you that are attending school using the exact spelling as listed in their school records. If the student is experiencing homelessness, indicate this by placing an "x" in the "homeless" box. Include any personal income received by the student and make an "x" in the correct box for how often it is received.

Student's Last Name	Student's First Name	MI	Homeless	Date of Birth	School	Grade	Student Income	Weekly	Bi-weekly	2 X Month	Monthly
			☐				$	☐	☐	☐	☐
			☐				$	☐	☐	☐	☐
			☐				$	☐	☐	☐	☐
			☐				$	☐	☐	☐	☐
			☐				$	☐	☐	☐	☐

If any Household Members (including yourself) currently participate in one or more of the following assistance programs, please write in a case number. If no, go to Step 3.
☐ **CalFresh** ☐ **CalWORKs/ Temporary Assistance for Needy Families (TANF)**

☐ **Food Distribution Program on Indian Reservations (FDPIR)**

Case Number: _____

2. **List the names of all other household members - Enter income (in whole dollars) and check how often it is received. If a household member does not receive income, write 0. If you enter 0 or leave the income sections blank, you are promising there is no income to report.**

Report Income: Earnings from Work (before any deductions) and Public Assistance/Child Support/Alimony

Names of all other household members (do not include students listed above)	Earnings from work (before any deductions)	Weekly	Bi-weekly	2 X Month	Monthly	Public Assistance/ Child Support/ Alimony	Weekly	Bi-weekly	2 X Month	Monthly
	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐

Report Income Continued: Pensions/Retirement/Social Security (SSI) and Any Other Income Not Already Listed

Names of all other household members (Continued From Above)	Pensions/ Retirement/ Social Security (SSI)	Weekly	Bi-weekly	2 X Month	Monthly	Any Other Income Not Already Listed	Weekly	Bi-weekly	2 X Month	Monthly
	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐

3. **Total Household Members** (include all people living in your household): ☐
(Total entered must equal number of household members listed above, a second application may be required if number of household members exceeds empty fields)

4. **Contact Information & Signature – Complete, sign, and return this application to above address:**
I certify (promise) that all information on this application is true, that all income is reported, and that my household does not receive Summer EBT benefits through a different State or Indian Tribal Organization (if applicable). I understand that this information is given in connection with the receipt

of federal or state benefits and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose these benefits, and I may be prosecuted under applicable State and Federal laws.

Printed Name of Adult Household Member	**Adult Household Member Signature**	
Mailing Address	**City, State & Zip Code**	
Email Address	**Daytime Phone Number**	**Date**

5. **Children's Racial and Ethnic Identities (Optional) – We are required to ask for information about your child(ren)'s race and ethnicity. This information is important and helps make sure we are fully serving our community. Responding to this section is optional and does not affect your child(ren)'s eligibility for free & reduced-price meals or SUN Bucks.**

   Mark one or more racial identities: ☐ American Indian or Alaska Native ☐ Asian ☐ Black, or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

   Mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Child Nutrition Eligibility: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot determine eligibility for benefits through the Richard B. Russel National School Lunch Act. The Richard B. Russell National School Lunch Act requires that we use information from this application to determine who qualifies for Summer EBT benefits. We can only approve complete forms. We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefits to your household. Inspectors and law enforcement may also use your information to make sure that program rules are met. Some children qualify for benefits without an application. Please contact your State or ITO to get benefits for a foster child, and children who are homeless, migrant, or runaway.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint web page at

https://www.usda.gov/about-usda/general-information/staff-offices/office-assistant-secretary-civil-rights/how-file-program-discrimination-complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights,
1400 Independence Avenue
SW, Mail Stop 9410
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

USDA is an equal opportunity provider, employer, and lender.

Rosemead School District
Nutrition & Wellness

Non-Discrimination Statement: The Rosemead School District prohibits discrimination, intimidation, harassment (including sexual harassment) or bullying based on a person's actual or perceived ancestry, color, disability, ethnicity, gender, gender expression, gender identity, immigration status, marital status, national origin, parental status, pregnancy status, race, sex, sexual orientation, or association with a person or group with one or more of these actual or perceived characteristics.

School Use Only – Do Not Write Below This Line

Annual Income Conversion: Weekly x 52; Bi-Weekly x 26; Twice per month x 24; Monthly x 12.
(Do not convert to annual income unless household reports multiple pay frequencies).

If the "Homeless" box is checked, refer to the student(s) records in CALPADS to verify the homeless record(s).

If there is no record of homelessness in CALPADS, refer the household to your LEA's Homeless Liaison to verify their status.

Local Education Agency Approval: ☐ CalFresh/CalWORKs/FDPIR ☐ Homeless ☐ Income Household

Total Household Size: ☐ Total Household Income: $ ☐

☐ Weekly ☐ Bi-Weekly ☐ Twice Per Month ☐ Monthly ☐ Annual

Application Approved For: ☐ Free Eligible ☐ Reduced-Priced Eligible

Application Denied Because: ☐ Income Over Allowed Amount ☐ Incomplete/Missing Information

☐ Other: _____

Date Notice Sent: _____

Signature of Approving Official: _____ Date: _____

3907 Rosemead Blvd.
Rosemead, CA 91770
Phone: 626-312-2900
Fax: 626-312-2906

PHILIP D'AGOSTINO, Ed.D, Superintendent of Schools

BOARD OF TRUSTEES
Nancy Armenta
Diane Benitez
Ronald Esquivel
Veronica Peña
John Quintanilla

STUDENTS WITH FOOD ALLERGIES OR INTOLERANCES

If your child has a food allergy or intolerance, please do the following:

- ☐ Have a licensed physician, physician assistant, or nurse practitioner complete and sign the attached **Medical Statement to Request Special Meals and/or Accommodations**
- ☐ Return the completed Medical Statement form to the school office, cafeteria, or Nutrition Services office

Question? Please call Nutrition Services at (626) 312-2900, ext. 254.

ESTUDIANTES CON ALERGIAS O INTOLERANCIAS ALIMENTARIAS

Si su hijo tiene una alergia o intolerancia a los alimentos, haga lo siguiente:

- ☐ Pídale a un médico, asistente médico o enfermera practicante con licencia que complete y firme la Declaración médica adjunta para solicitar comidas especiales y / o adaptaciones
- ☐ Regrese el formulario de Declaración Médica completado a la oficina de la escuela, a la cafetería o a la oficina de Servicios de Nutrición

¿Pregunta? Llame a Servicios de Nutrición al (626) 312-2900, ext. 254.

HỌC SINH CÓ DI ỨNG HOẶC KHÔNG DUNG NẠP THỰC PHẨM

Nếu học sinh có dị ứng hoặc không dung nạp thực phẩm, xin tuân thủ các điều sau đây:

- ☐ Yêu cầu bác sĩ được cấp phép, y sĩ, hoặc y tá thực hành điền và ký vào **Giấy Giám Định Y Khoa Đề Nghị Đồ Ăn và/hoặc Điều Chỉnh Đặc Biệt**
- ☐ Nộp lại Giấy Giám Định Y Khoa cho văn phòng nhà trường, nhà ăn, hoặc văn phòng Bộ Phận Dịch Vụ Dinh Dưỡng

Nếu quý vị có bất cứ câu hỏi hoặc thắc mắc nào, xin vui lòng gọi điện cho Bộ Phận Dinh Dưỡng, theo số (626) 312-2900, ext. 254.

學生對食物過敏或不能忍受

假如貴子弟有食物過敏或不能忍受某些食物，請執行下列事項：

- ☐ 讓有 執照的醫生，醫生助理，或執業護士 填妥並簽署 **健康聲明書以要求特殊的餐飲和/或調適**。
- ☐ 交回填妥的表格給學校辦公室，餐廳，或營養服務部

任何疑問請打電話給營養服務部,(626) 312-2900, ext. 254.

Medical Statement to Request Special Meals and/or Accommodations

Medical Statement Form		
1. School	**2. Site Name**	**3. Site Phone Number**
4. Name of Child		**5. Age or Date of Birth**
6. Name of Parent/Guardian		**7. Phone Number**
8. Description of Child's Physical or Mental Impairment Affected:		
9. Explanation of Diet Prescription and/or Accommodation:		
10. Indicate Food Texture for Above Child: ☐ **Regular** ☐ **Chopped** ☐ **Ground** ☐ **Pureed**		
11. Adaptive Equipment to be Used:		
12. Foods to be Omitted and Appropriate Substitutions:		
Foods to Be Omitted	**Suggested Substitutions**	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
13. Signature of Registered Dietitian (RD) or State Licensed Healthcare Professional*		
14. Printed Name	**15. Phone Number**	**16. Date**

*In California, effective April 1, 2025, RDs are permitted to complete and sign a written medical statement for school meal modifications due to a disability. The CDE also permits the following state licensed healthcare professionals to complete and sign a written medical statement for a disability: licensed physicians, physician assistants, and nurse practitioners.

*This form is also considered valid with a certified digital signature.

The information on this form is required to reflect the current medical and/or nutritional needs of the child.

Instructions

1. **School**: Print the name of the school that is providing the form to the parent/guardian.
2. **Site**: Print the name of the site where meals will be served.
3. **Site Phone Number**: Print the phone number of site where meal will be served.
4. **Name of Child**: Print the name of the child to whom the information pertains.
5. **Age of Child**: Print the age of the child. For infants, please use date of birth.
6. **Name of Parent/Guardian**: Print the name of the person requesting the child's medical statement.
7. **Phone Number**: Print the phone number of parent/guardian.
8. **Description of Child's Physical or Mental Impairment Affected**: Describe how the physical or mental impairment restricts the child's diet.
9. **Explanation of Diet Prescription and/or Accommodation**: Describe a specific diet or accommodation that has been prescribed by the RD or state licensed healthcare professional.
10. **Indicate Texture**: If the child does not need any modification, check "Regular".
11. **Adaptive Equipment to be Used**: Describe specific equipment required to assist the child with dining (e.g., sippy cup, large handled spoon, wheelchair accessible furniture, etc.).
12. **Foods to be Omitted**: List specific foods that must be omitted.
    Suggested Substitutions: List specific foods to include in the diet.
13. **Signature of RD or State Licensed Healthcare Professional**: Signature of RD or state licensed healthcare professional requesting the special meal or accommodation.
14. **Printed Name**: Print name of RD or state licensed healthcare professional.
15. **Phone Number**: Phone number of RD or state licensed healthcare professional.
16. **Date**: Date RD or state licensed healthcare professional signed the form.

Definitions

Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

Physical or mental impairment means, any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine; or any mental or psychological disorder such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disability.

Physical or mental impairment includes, but is not limited to, contagious and noncontagious diseases and conditions such as the following: orthopedic, visual, speech, and hearing impairments, and cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disability, emotional illness, dyslexia and other specific learning disabilities, Attention Deficit Hyperactivity Disorder, Human Immunodeficiency Virus infection (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, writing, communicating, interacting with others, and working; and the operation of a major bodily function.

Major bodily function includes*,* the operation and functions of the immune system, special sense organs and skin, normal cell growth, and digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive systems. The operation of a major bodily function includes the operation of an individual organ within a body system.

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf (PDF), from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail:
   U.S. Department of Agriculture Office of the
   Assistant Secretary for Civil Rights 1400
   Independence Avenue, SW
   Washington, D.C. 20250-9410;

2. fax:
   833-256-1665 or 202-690-7442; or

3. email:
   program.intake@usda.gov

   This institution is an equal opportunity provider.

Open to ages 3-4

PRESCHOOL REGISTRATION 2026-2027

ROSEMEAD SCHOOL DISTRICT OFFERS BOTH FULL AND PART TIME DAY PROGRAMS FOR 3 AND 4 YEAR OLD CHILDREN (CHILD MUST TURN 3 BY SEPT. 1, 2026)







WHEN: Begins April 21, 2026

TIME: 8:30am – 3:30pm
Translators will be on site to help from 8:30am – 12:30pm.

LOCATION: 3907 Rosemead Blvd., Rosemead, CA 91770

Please bring the following documents to determine if your family is eligible for the State Preschool Programs:

- Child's birth certificate and siblings' birth certificates
- Proof of family income (pay stubs from the month prior to the application date)
- Immunization record (yellow card)
- Proof of address
- Child Development Services and Eligibility Certificate Form CD9600 (will be provided during enrollment)

Completing the CD9600 application does not guarantee enrollment in the State Preschool Program. You will be notified within 30 days of completing the CD9600 of your eligiblity status.

Contact us now for more details
(626) 312-2900, ext. 235

New enrollment at
https://www.rosemead.k12.ca.us/