

Kindergarten Intake Checklist

Name _____ Date _____

_____ Birth Certificate _____ DOB must be on or before September 1, 2009
For Kindergarten

_____ DOB must be before December 2, 2009
For Transitional Kindergarten

_____ Proof of Address

_____ Registration Form

_____ Pink Enrollment Card

_____ White Emergency Card (signed and filled out)

_____ Physical Exam (needs to be done after February 1, 2014)
(needs to be signed by parent and physician)

_____ Dental Exam (needs to be done after July 2013)
(needs to be signed by parent and dentist)

_____ Copy of Current Immunization Records (must have Dr. signature, stamp, or clinic stamp)

Immunization Requirements

_____ Polio 4 doses, but 3 if last dose was on or after 4th birthday

_____ DPT 5 doses, but 4 if last dose was on or after 4th birthday

_____ MMR 2 doses of measles & at least 1 dose of mumps & rubella
(both after the 1st birthday)

_____ Hep B 3 doses (series)

_____ Varicella 1 dose or must have had disease verified by doctor

Bellevue Union School District

STUDENT REGISTRATION FORM

Page 1 of 2

Enrollment Date: _____ *School Use Only* School Year: 2014 - 2015

School Site: *SCHOOL USE ONLY* Student ID No: *SCHOOL USE ONLY* GRADE *SCHOOL USE ONLY*

Teacher Assignment: *SCHOOL USE ONLY* Registration Date: _____ Birth Certificate Verified: _____

STUDENT'S NAME: _____
 Last Name First Name MI

LEGAL NAME: _____
 Last Name First Name GRADE

BIRTH DATE: _____ **GENDER:** Male Female **PHONE:** _____
 MONTH DAY YEAR

HOME ADDRESS: _____
 Street City State Zip Code

BIRTH PLACE: _____ **DATE FIRST ATTENDED U.S. SCHOOL** _____
 City State Country MONTH DAY YEAR

PARENT EDUCATION: Check the response that describes the education level of the *most educated parent*.
 Graduate Degree or Higher (10) College Graduate (11) Some College or AA Degree (12)
 High School Graduate (14) Not a High School Graduate (14)

DATE FIRST ATTENDED IN CALIFORNIA _____
 MONTH DAY YEAR

STUDENT'S ETHNICITY (Please check one): Hispanic or Latino NOT Hispanic or Latino

STUDENT'S RACE (Please check up to five racial categories):
Student's Ethnicity is about ethnicity, not race. No matter what you selected under student's ethnicity, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be.

American Indian or Alaskan Native (100) Vietnamese (204) Hmong (208) Somoan (303)
 Chinese (201) Asian Indian (205) Other Asian (208) Tahitian (304)
 Japanese (202) Hawaiian (301) Other Pacific Islander (399)
 Korean (203) Cambodian (207) Guamanian (302) African American or Black (600)
 White (700)

HOME LANGUAGE SURVEY:
 1. What language/dialect does your son/daughter most frequently speak at home? _____
 2. What language/dialect did your son/daughter learn when he/she first began to talk? _____
 3. What language/dialect do you most frequently speak to your child? _____
 4. Has your child ever been given the CELDT Test (Calif English Language Development Test)? Yes No I don't know

SPECIAL SERVICES Please check any services your child has received.
 Special Education Remedial Reading and/or Math English Language Learner/ESL SARB-Attendance Review Board
 504 Resource (RSP) Speech Counseling
 Gifted (GATE) Other (please specify): _____

RESIDENCE: Please check the appropriate box - where your child/family are currently living. (Federally mandated by NCLB)
 In a single family permanent residence (house, apartment, condo, mobile home) In a Motel/Hotel (09)
 Doubled-up (sharing housing with other families/individuals due to economic hardship or loss) (11)
 Unsheltered (car/campsite) (12) In a shelter or transitional housing program (10)
 Other (15) (please specify) _____

LAST SCHOOL ATTENDED:
 Name: _____ Grade(s): _____ Date(s): _____
 Address: _____ City: _____ State: _____ Zip: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Bellevue Union School District

STUDENT REGISTRATION FORM

Page 2 of 2

Enrollment Date: _____ <i>School Use Only</i>		School Year: 2014 - 2015
School Site: <i>SCHOOL USE ONLY</i>	Student ID No: <i>SCHOOL USE ONLY</i>	GRADE <i>SCHOOL USE ONLY</i>
Teacher Assignment: <i>SCHOOL USE ONLY</i>	Registration Date:	Birth Certificate Verified:

STUDENT'S NAME:			
	Last Name	First Name	MI

PARENT/GUARDIANSHIP INFORMATION (with whom the student lives) - check all that apply Other _____

Father Mother Both Step-Mother Step-Father Guardian Foster/Group Home

Is the above checked person(s) the student's LEGAL guardian?

Yes No If NO, please complete a "Caregiver Affidavit".

If there is a legal custody agreement regarding this student, please check one:

Joint Custody Sole Custody Guardian

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR PARENT(S)/GUARDIAN WITH WHOM THE STUDENT LIVES

1 Father Step-Father Guardian
Name: _____ Employer: _____ Phone: _____

2 Mother Step-Mother Guardian
Name: _____ Employer: _____ Phone: _____

HEALTH INFORMATION / EMERGENCY CONTACT INFORMATION

Please check all the following conditions that your child has had and if they are under medical care or taking medication.

If yes, does the medication need to be dispensed at school. Yes No

<input type="checkbox"/> Bee Sting	Epi-Pen	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Asthma	Inhaler	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Diabetes	Insulin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Vision/Hearing	Glasses	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Allergies _____			
<input type="checkbox"/> Other _____			

Physician's Name: _____ Phone: _____

Address _____ Medi-Cal: Yes No

I give my permission to consult my family Physician in case of accident or sudden illness at the discretion of school authorities. I give my permission for the school to transport my child in case of emergency.

Parent signature _____ Date _____

Emergency contact:

1. Name/Relationship _____ Phone _____

2. Name/Relationship _____ Phone _____

3. Childcare provider: _____ Phone _____

PROOF OF RESIDENCY: California Education Code requires proof of residency in any District within which you are registered.

The following proof has been provided upon registration:

Rent Receipt PG&E Bill Phone Bill Water Bill Other _____

Purchase of Property Contract

My signature indicates that I have read and understand the registration form. It also certifies that the information on this form is true and correct. My signature affirms that the child resides with me at this address (affirmed by PG&E bill, recent bill with my name). I understand that any change of residency information (address, telephone number, guardianship) must be reported to the school, examined and verified within 30 days of change. Falsification of information will be grounds for invalidating the student's enrollment.

PARENT/GUARDIAN SIGNATURE:	DATE:
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**Bellevue Union School District
Student Emergency Form**

Teacher _____ Rm. _____

Student Name: _____ Home Phone: _____

Address: _____
Last First Middle Initial Birthdate: ____ / ____ / ____ Sex: M F

Parents: _____ Step Foster Guardian

Mother's Work _____ Work Phone _____ Cell Phone _____

Father's Work _____ Work Phone _____ Cell Phone _____

Student Lives with: ____ Father ____ Mother ____ Legal Guardian ____ Other

Primary Language Eng Span Other _____

Legal Documents on File yes no Date: _____ Type of Document _____

Emergency Contact:
1. Name/Relationship _____ Phone: _____

2. Name/Relationship _____ Phone: _____

3. Name/Relationship _____ Phone: _____

Permission to transport Student

We, the undersigned (parent/guardian) of _____, do hereby grant permission for the
student's name

Bellevue Union School District in Sonoma, CA to transport the above named student to and from school sponsored events including but not limited to study trips, athletic and social events.

Parent/Guardian Signature: _____ Date: _____

Family Health Care

Physicians Name: _____ Phone: _____

Medi-Cal: Yes no

Address: _____

I give my permission to consult my family physician in case of accident or sudden illness at the discretion of school authorities.

I give my permisison for the school to transport my child in case of emergency.

Parent Signature: _____ Date: _____

Please check all of the following conditions that your child has had and if they are under mefical care or taking medication. If yes, doe sthe medication need to be dispensed at school.

- | | | | |
|--|---------|------------------------------|-----------------------------|
| <input type="checkbox"/> Bee Sting | Epi-Pen | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Asthma | Inhaler | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Diabetes | Insulin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Vision/Hearing | Glasses | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Allergies _____ | | | |
| <input type="checkbox"/> Other _____ | | | |

If you are not the legal guardian of the student attending _____ School in the Bellevue Union school Distric

our district needs a statement from the legal guardian for educational and medical services. I, _____

am the legal guardian of _____, and all paperwork regarding guardianship has been provided to the

school office. I give permission to _____ to make educational and medical decisions from

_____ to _____
Date Date

BELLEVUE UNION SCHOOL DISTRICT FAMILY ENROLLMENT CARD

FAMILY NAME _____ FATHER'S NAME _____ MOTHER'S NAME _____

HOME ADDRESS _____ TELEPHONE NUMBER _____

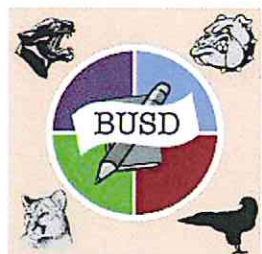
FATHER'S EMPLOYER _____ TELEPHONE _____

MOTHER'S EMPLOYER _____ TELEPHONE _____

CHILDREN ATTENDING IN BELLEVUE SCHOOL DISTRICT

NAME	BIRTHPLACE	DATE OF		SEX	GRADE	RM NO	BUS NO
		BIRTH					

DATE _____ SIGNATURE OF PARENT _____



BELLEVUE UNION SCHOOL DISTRICT

3150 Education Drive

Santa Rosa, CA 95407-7723

Phone: 707-542-5197 – Fax: 707-542-6127

www.bellevueusd.org

SCHOOLS:

Bellevue

Kawana Academy
of Arts and Sciences

Meadow View

Taylor Mountain

Alicia Henderson

Ph.D.

Superintendent

BOARD OF

TRUSTEES

Yvonne Kennedy

Carole Montoya

Kathleen Mullins

Lisa Reyes

Sharon Ligon

MISSION

The mission of the Bellevue Union School District is to maximize the potential of each student. We as a community do this through collaborative, responsive, and reflective practice.

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 Human Services Dept. 520 Mendocino Ave. P.O. Box 1539 Santa Rosa, CA 95402 (707) 565-5206 (800) 354-1277
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.healthyfamilies.ca.gov/hfhome.asp>.
3. For additional resources that may be helpful, contact the local public health department at (fill in appropriate local contact information, available at Human Services Dept. 520 Mendocino Ave. P.O. Box 1539 Santa Rosa, CA 95402 (707) 565-5206 (800) 354-1277

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 school.

Sincerely,

A handwritten signature in black ink that reads "Alicia Henderson". The signature is written in a cursive, flowing style.

Alicia Henderson, Ph.D.
District Superintendent

Attachment

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31 of his/her first year in public school. A California licensed dental professional operating within his scope of practice must perform the check-up and fill out Section 2 of this form. If your child had a dental check-up in the 12 months before he/she started school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

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

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:	Child's race/ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other _____ <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown		

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:	Caries Experience (Visible decay and/or fillings present) <input type="checkbox"/> Yes <input type="checkbox"/> No	Visible Decay Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Urgency: <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) <input type="checkbox"/> Urgent care needed (pain, infection, swelling or soft tissue lesions)
_____ <i>Licensed Dental Professional Signature</i>		_____ <i>CA License Number</i>	
		_____ <i>Date</i>	

Section 3: Waiver of Oral Health Assessment Requirement

To be filled out by parent or guardian asking to be excused from this requirement

Please excuse my child from the dental check-up because: (Check the box that best describes the reason)

- I am unable to find a dental office that will take my child's dental insurance plan.
My child's dental insurance plan is:
 Medi-Cal/Denti-Cal Healthy Families Healthy Kids Other _____ None
 - I cannot afford a dental check-up for my child.
 - I do not want my child to receive a dental check-up.
- Optional: other reasons my child could not get a dental check-up: _____

If asking to be excused from this requirement: ► _____
Signature of parent or guardian
Date

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 31 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.