New Student Enrollment Checklist
2020 - 2021

We are happy you will be joining the Learning By Design community! Please feel free to reach out to us with any questions and return this enrollment packet as soon as possible. **The first day of school is August 18, 2020.** We look forward to seeing you then!

The following documents are required for enrollment. All documents must be returned.

General Information

- ☐ New Student Enrollment Form
- ☐ Student Emergency and Medical Card
- ☐ Health History Form
- ☐ Parent / Legal Guardian Publicity Authorization and Release

Verification of Parent/Guardian Identity (*one of the following*)

- ☐ Current Driver's License or CA ID Card
- ☐ Company / Work ID
- ☐ Passport
- ☐ Government Issued ID with Photo

Verification of Student Date of Birth (*one of the following*)

- ☐ Birth Certificate or Passport (original required)
- ☐ Adoption Papers / Court Documents
- ☐ Hospital Record
- ☐ Foster Placement Papers (if applicable)

Health and Wellness Verification

- ☐ Physical Examination for:
  - ETK / Kindergarten Students - Needs to be less than 1 year prior to entering school
  - First Grade Students - Needs to be less than 18 months prior to first-grade entry
  - Students entering from out of the country
- ☐ Verification of Immunizations (Bring immunization record at time of enrollment)

  The following immunizations are required for school enrollment.
  - Polio Vaccine
  - DTP: Diphtheria, Tetanus, Pertussis Vaccine
  - Varicella (Doctor documented disease history)
  - Hepatitis B Vaccine
  - MMR: Measles, Mumps, Rubella Vaccine
- ☐ Oral Health Information Form for TK / Kindergarten only
- ☐ Health Examination for School Entry Form

2019-2020 Application for Free and Reduced Price Meals

Proof of Residency - Must be in the Parent/Guardian's Name

- Must be dated within the past 60 days. Included below is a list of acceptable documents:
  - ☐ Electric Bill
  - ☐ Water Bill
  - ☐ Utility Bill
  - ☐ Mortgage Statement
  - ☐ Gas Bill
  - ☐ Trash Bill
  - ☐ Property Tax Bill
  - ☐ Lease/Rental Agreement

Additional Documentation (if applicable)

- ☐ Prior School Records
  - Most recent Report Card or Transcript if the student attended school prior to enrollment at LBD
- ☐ Student Individualized Education Plan (IEP) and/or Student's Section 504 Plan
- ☐ Medical Statement to Request Special Meals and/or Accommodations Form
- ☐ Court Papers, Foster Placement, Restraining Orders

Enrollment Form
2020-2021 School Year

Instructions: Please print using black or blue ink. If you have any questions, please ask for assistance.

1. STUDENT INFORMATION (Please write name EXACTLY as it appears on the birth verification)

Legal Last Name	Legal First Name	Middle Name	Grade

Home Address	Apt/Unit	City	Zip Code

Gender: ☐ Male ☐ Female	Home Phone ( )	Date of Birth / /	Place of Birth

1. PLEASE INDICATE STUDENT'S ETHNICITY (CHECK ONE)
Student is of Hispanic origin? ☐ Yes ☐ No

2. PLEASE INDICATE STUDENT'S RACE (CHECK ALL THAT APPLY)
☐ African American or Black ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hawaiian ☐ Hmong ☐ Japanese
☐ American Indian or Alaska Native ☐ Korean ☐ Laotian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Tahitian ☐ Vietnamese ☐ White

RESIDENTIAL STATUS:
☐ Single Family Permanent Residence (House, Apartment, Condo, Mobile Home) ☐ Hotels/Motels ☐ Temporarily Doubled Up
☐ Temporary Shelters ☐ Temporarily Unsheltered ☐Other _____

2. FAMILY INFORMATION

Parent/Legal Guardian

Last Name	First Name

Home Address (if different than student)

Home Phone ( )	Cell Phone ( )

Work Telephone ( ) Ext.	Email Address

Relationship to Student	Lives with Student ☐ Yes ☐ No

Highest Level of Education (CHECK ONE)
☐ Not a High School Graduate ☐ High School Graduate
☐ Some College or Associate's Degree ☐ College Graduate
☐ Graduate School ☐ Decline to State

Is an Armed Forces member, on active duty or serve on full-time National Guard Duty? ☐ Yes ☐ No

Parent/Legal Guardian

Last Name	First Name

Home Address (if different than student)

Home Phone ( )	Cell Phone ( )

Work Telephone ( ) Ext.	Email Address

Relationship to Student	Lives with Student ☐ Yes ☐ No

Highest Level of Education (CHECK ONE)
☐ Not a High School Graduate ☐ High School Graduate
☐ Some College or Associate's Degree ☐ College Graduate
☐ Graduate School ☐ Decline to State

Is an Armed Forces member, on active duty or serve on full-time National Guard Duty? ☐ Yes ☐ No

Home Correspondence Language – In which language do you wish to receive written communications from the school?
☐ English ☐ Spanish ☐ Other: _____

3. HOME LANGUAGE SURVEY

Which language did the student learn when he/she first began to talk?	
Which language does the student most frequently use at home?	
Which language do you use most frequently to speak to this student?	
Which language is most often used by the adults at home?	
Has this student received any formal English language instruction?	☐ Yes ☐ No

4. STUDENT EDUCATIONAL INFORMATION

Special Services	
A. Was this student receiving special education services at his/her previous school?	☐ Yes ☐ No
B. Did this student have an Individualized Education Program (IEP) at his/her previous school?	☐ Yes ☐ No
If YES, please provide a copy of the IEP.	
C. Did this student have a Section 504 Plan at his/her previous school?	☐ Yes ☐ No
If YES, please provide a copy of the Section 504 Plan.	

D. Does this student have difficulties that interfere with his/her ability to go to school or to learn?	☐ Yes ☐ No
E. Has this student been identified for gifted and talented educational services (GATE)?	☐ Yes ☐ No

Previous School Information		
Has this student previously attended this school?	☐ Yes ☐ No	If yes, when? / /
Date of first U.S. school enrollment?	Grade	Date
Date of first California school enrollment?	Grade	Date

Please list last two schools the student attended (include preschool, if applicable):

School Name	City/State	Dates attended:	Which grade level(s)?

Is this student currently under an expulsion order? If yes, please provide name of the school district:	☐ Yes ☐ No

5. ADDITIONAL HOUSEHOLD INFORMATION

Are there any court orders regarding legal custody, physical custody, educational rights or restricted contact with this child? If yes, please provide copy of the court order.	☐ Yes ☐ No

Does student live with Foster Family? ☐ Yes ☐ No Children's Social Worker (CSW):

If yes, ☐ Relative Caregiver ☐ Non-Relative Caregiver

If yes, please provide Notification of Placement Status Form Telephone Number: ( ) ext.

Complete these three rows if student's address is a licensed children's institution/family foster agency/group home/adult residential facility

_____ Facility Name _____ Facility Type _____ License Number _____ Contact Person

_____ Facility Telephone Number _____ Alternate Telephone Number _____ Facility Address: Number Street Apt./Unit City Zip Code

_____ Children's Social Worker (CSW) _____ Telephone Number and Extension

Does the student have any relatives who are all or part American Indian or Alaskan Native?	☐ Yes ☐ No
Has the student's parent or legal guardian worked in one or more of the following industries in the last three years: agriculture, dairy, fishery, food process/packing, or livestock?	☐ Yes ☐ No

6. ADDITIONAL SCHOOL AGED CHILDREN LIVING IN HOUSEHOLD WITH SAME PARENT(S)/LEGAL GUARDIAN(S)

Last Name, First Name	Birth Date / /	Current School
Last Name, First Name	Birth Date / /	Current School
Last Name, First Name	Birth Date / /	Current School
Last Name, First Name	Birth Date / /	Current School

7. EMERGENCY CONTACT INFORMATION (Other than Parent/Legal Guardian authorized to pick up child. Must be 18 years of age or older)

1.Legal Name	Home Phone	Work Phone	Cell Phone
Relationship to Student	Address		
2. Legal Name	Home Phone	Work Phone	Cell Phone
Relationship to Student	Address		
3. Legal Name	Home Phone	Work Phone	Cell Phone
Relationship to Student	Address		

8. SIGNATURE

I verify that the information in this document is true and correct to the best of my knowledge.

PRINT NAME	SIGNATURE	DATE / /

RELATIONSHIP TO STUDENT: ☐ Parent ☐ Legal Guardian ☐ Other _____

Health History Form
2020 - 2021

Student Information

First Name: _____ Middle Name: _____ Last Name: _____

Gender: ▢ Female ▢ Male Date of Birth: ____/____/____ Grade Level: _____ Home Language: _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____ Blood type: _____

Allergies

Does your child have any significant allergies? ▢ Yes ▢ No

If yes, list allergies, symptoms of allergic reaction, and treatment below:

_____

_____

_____

_____

Does your child have an EPIPen, EPIPen Jr. or Auvi - Q prescribed to treat the allergy? ▢ Yes ▢ No
(If yes, please contact the school before the first day of school to prepare an emergency action plan)

Daily Medications

Please note: All prescription medications to be given at school must be delivered by the parent to the school in a prescription bottle with the students' name and dosage clearly marked on the bottle.

Does your child take daily medications at home? ▢ Yes ▢ No

Does your child require medication to be given at school? ▢ Yes ▢ No If yes, list the current medications:

Name of Medication: _____ Time Given: _____

Reason Given: _____

Name of Medication: _____ Time Given: _____

Reason Given: _____

Does your child require any special medical procedures or emergency treatments during school hours? ▢ Yes ▢ No If yes, please describe: _____

Please note: All medical procedures or treatments required at school must have a doctor's medical order on file with the school before any procedures/treatments can be performed.

Medical History

Does your child have any of the following medical conditions? Check all that apply:

▢ ADD/ADHD	▢ Diabetes	▢ Hearing Impaired
▢ ASD (Autism)	▢ Eating Disorder	▢ Heart Condition
▢ Asthma	▢ Emotional Concerns	▢ Migraines
▢ Blood Disease	▢ Genetic/Congenital	▢ Seizures
▢ Bowel Bladder	▢ Glasses/Contacts	▢ Sleep Disorder
▢ Cancer	▢ Head Injury/Concussion	▢ Other: _____

List any recent hospitalization or treatments and explain (please include dates):

_____

_____

Activity Restrictions

Does your child have any restrictions for physical activities? ▢ Yes ▢ No
If yes, a written note from your physician for the current school year, stating the restrictions is required and needs to be updated yearly.

Emergency Care

This information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health and safety of the student. In case of an emergency, if the school is not able to contact me, I give permission to take the student to the nearest hospital or appropriate facility for medical attention. This medical information may be shared with school personnel, EMTs, and hospital personnel as needed. If it is necessary to contact an ambulance, it will be the responsibility of the parent/guardian to pay for this service. I understand a copy of this information will be sent with my child to the hospital. If I cannot be reached by telephone in the event of an emergency involving: _____ (Student's Name), please send my child to _____ or any available medical service.

This information is current and correct; I understand that it is my responsibility as the parent/guardian to notify the school of new or existing health concerns or any changes in contact information. I understand that this health history form must be updated every school year.

Parent / Legal Guardian Signature: _____ Date: _____

Printed Parent / Legal Guardian Name: _____

LOS ANGELES UNIFIED SCHOOL DISTRICT
STUDENT EMERGENCY INFORMATION FORM

Parent Information: Please fill out completely and sign where indicated. In a major emergency, it is school district policy to retain students at school for their safety. This form will be used by the school staff when students are released to go home. Please complete electronically or print clearly and return completed form to school.

STUDENT'S LAST NAME	FIRST NAME	M.I.

BIRTH DATE	☐ MALE ☐ FEMALE	GRADE	HOME LANGUAGE

STUDENT'S HOME ADDRESS -- NUMBER	STREET	APT #	CITY	ZIP CODE
MAILING ADDRESS -- NUMBER (IF DIFFERENT FROM ABOVE)	STREET	APT #	CITY	ZIP CODE

PARENT'S / LEGAL GUARDIAN'S LAST NAME	FIRST NAME	RELATIONSHIP TO STUDENT	LIVES WITH? ☐ Yes ☐ No
WORK ADDRESS -- NUMBER	**STREET**	**CITY**	**ZIP CODE**

CONTACT NUMBERS		Indicate which phone to call for each message type:*				EMAIL ADDRESS:
HOME		EMERGENCY	☐ Home	☐ Cell	☐ Work	
CELL		ATTENDANCE	☐ Home	☐ Cell	☐ Work	
WORK		GENERAL INFO	☐ Home	☐ Cell	☐ Work	
TEXT		☐ I authorize receiving text messages and understand that I am responsible for all text related charges.				

PARENT'S / LEGAL GUARDIAN'S LAST NAME	FIRST NAME	RELATIONSHIP TO STUDENT	LIVES WITH? ☐ Yes ☐ No
WORK ADDRESS -- NUMBER	**STREET**	**CITY**	**ZIP CODE**

CONTACT NUMBERS		Indicate which phone to call for each message type:*				EMAIL ADDRESS:
HOME		EMERGENCY	☐ Home	☐ Cell	☐ Work	
CELL		ATTENDANCE	☐ Home	☐ Cell	☐ Work	
WORK		GENERAL INFO	☐ Home	☐ Cell	☐ Work	
TEXT		☐ I authorize receiving text messages and understand that I am responsible for all text related charges.				

To the principal: In case you are unable to reach me during any emergency, you are authorized to contact and, if necessary, release my child to any of the following:

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE
NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE
NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE

List any other family members attending this school:

LAST NAME	FIRST NAME	HOME ROOM	GRADE	RELATIONSHIP
LAST NAME	FIRST NAME	HOME ROOM	GRADE	RELATIONSHIP

MILITARY CONNECTED FAMILY: In efforts to provide resources and support to military connected students and their families, please respond to the following:	Immediate family member in the military (Active Duty, Guard, Reserve, or Veteran): ☐YES ☐NO Relationship to Student: _____	Currently Deployed: ☐YES ☐NO Military Branch: _____ Status: ☐Active Duty; ☐Guard; ☐Reserve; ☐Veteran; ☐Deceased

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

The undersigned, as parent/legal guardian of, _____ a minor,
(Print name of the student here)

hereby authorizes the principal or designee, into whose care the student has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to the student upon the advice of any licensed physician and/or dentist. It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the Los Angeles Unified School District ("District") to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary. This authorization is given in accordance with Section 49407 of the California Education Code, and shall remain effective until revoked in writing and delivered to the District. I understand that the District, its officers and its employees assume no liability of any nature in relation to the transportation of the student. I further understand that all costs of paramedic transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my sole responsibility as the student's parent/guardian.

HEALTH ALERTS -- ***List any medical condition which restricts physical activity or requires special attention. Include conditions such as asthma and allergies such as peanut and bee stings. If none, please indicate "none".***

DOES THE STUDENT HAVE HEALTH INSURANCE? (Check One) ☐ YES ☐ NO* **If "Yes":** ☐ Private Health Insurance ☐ Medi-Cal ☐ Healthy Families

MEDI-CAL / HEALTHY FAMILIES ID Number:

1. PRIVATE HEALTH INSURANCE NAME	GROUP NO.	2. PRIVATE HEALTH INSURANCE NAME (If covered under more than one plan)	GROUP NO.
NAME OF DOCTOR / MEDICAL OFFICE		**PHONE NUMBER OF DOCTOR / MEDICAL OFFICE**	

*If the student currently does not have health insurance, information on free or low-cost health care programs is available by calling the District's toll-free HELPLINE 1(866)742-2273.

MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS:	
MY CHILD CURRENTLY TAKES THE FOLLOWING MEDICATIONS:	

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THIS FORM AND DO HEREBY GIVE MY AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT, AND THAT ALL OF THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND CORRECT.

X **DATE**

SIGNATURE OF: (CHECK ONE) ☐ PARENT ☐ LEGAL GUARDIAN CAREGIVER (AFFIDAVIT)

* Selected telephone number must be a direct dial number (no extensions).

Revised January 2014

STUDENT'S LAST NAME

FIRST NAME

MIDDLE INITIAL

Parent / Legal Guardian Publicity Authorization and Release
2020 - 2021

Dear Parent/Guardian:

Learning By Design Charter School requests your permission to reproduce through printed, audio, visual, or electronic means activities in which your pupil has participated in his/her education program. Your authorization will enable us to use specially prepared materials to (1) train teachers and/or (2) increase public awareness and promote continuation and improvement of education programs through the use of mass media, displays, brochures, websites, etc.

Name of Student: _____ Date of Birth: _____

Name of Parent: _____

a. I, as a parent or guardian of the above named student, fully authorize and grant Learning By Design Charter School and its authorized representatives, the right to print, photograph, record, and edit as desired, the biographical information, name, image, likeness, and/or voice of the above named pupil on audio, video, film, slide, or any other electronic and printed formats, currently developed, (known as “Recordings”), for the purposes stated or related to the above.

b. I understand and agree that use of such Recordings will be without any compensation to the pupil or the pupil’s parent or guardian.

c. I understand and agree that Learning By Design Charter School and/or its authorized representatives shall have the exclusive right, title, and interest, including copyright, of the Recordings.

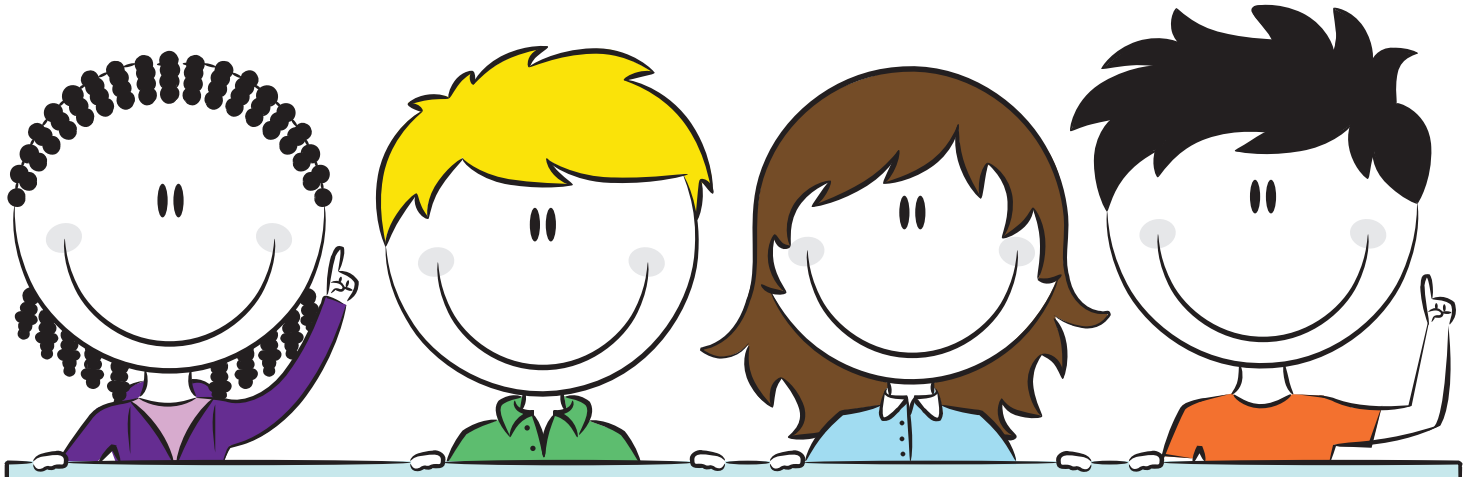
d. I understand and agree that Learning By Design Charter School and/or its authorized representatives shall have the unlimited right to use the Recordings for any purposes stated or related to the above.

e. I hereby release and hold harmless Learning By Design Charter School and its authorized representatives from any and all actions, claims, damages, costs, or expenses, including attorney’s fees, brought by the pupil and/or parent or guardian which relate to or arise out of any use of these Recordings as specified above.

My signature indicates that I have read and understand the release and I agree to accept its provisions.

Signature of Parent/Guardian: _____ Date: _____

No Shots? No Records? No School.



Children will not be enrolled unless an immunization record is presented and immunizations are up-to-date.*

**If your child is unimmunized due to medical reasons, please notify us.*

Go to **ShotsForSchool.org** to access information about immunization requirements, an interactive school look-up tool, implementation materials for schools, and educational materials for parents. ShotsforSchool.org

IMM-1167 (5-16)

CALIFORNIA IMMUNIZATION REQUIREMENTS FOR

K – 12TH GRADE (including transitional kindergarten)

GRADE	NUMBER OF DOSES REQUIRED OF EACH IMMUNIZATION[1, 2, 3]				
K-12 Admission	4 Polio[4]	5 DTaP[5]	3 Hep B[6]	2 MMR[7]	2 Varicella
(7th-12th)[8]	K-12 doses	+ 1 Tdap			
7th Grade Advancement[9,10]		1 Tdap[8]			2 Varicella[10]

1. Requirements for K-12 admission also apply to transfer pupils.
2. Combination vaccines (e.g., MMRV) meet the requirements for individual component vaccines. Doses of DTP count towards the DTaP requirement.
3. Any vaccine administered four or fewer days prior to the minimum required age is valid.
4. Three doses of polio vaccine meet the requirement if one dose was given on or after the 4th birthday.
5. Four doses of DTaP meet the requirement if at least one dose was given on or after the 4th birthday. Three doses meet the requirement if at least one dose of Tdap, DTaP, or DTP vaccine was given on or after the 7th birthday (also meets the 7th-12th grade Tdap requirement. See fn. 8.)
6. For 7th grade admission, refer to Health and Safety Code section 120335, subdivision (c).
7. Two doses of measles, two doses of mumps, and one dose of rubella vaccine meet the requirement, separately or combined. Only doses administered on or after the 1st birthday meet the requirement.
8. For 7th-12th graders, at least one dose of pertussis-containing vaccine is required on or after the 7th birthday.
9. For children in ungraded schools, pupils 12 years and older are subject to the 7th grade advancement requirements.
10. The varicella requirement for seventh grade advancement expires after June 30, 2025.

DTaP/Tdap = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine
Hep B = hepatitis B vaccine
MMR = measles, mumps, and rubella vaccine
Varicella = chickenpox vaccine

INSTRUCTIONS:

California schools are required to check immunization records for all new student admissions at TK /Kindergarten through 12th grade and all students advancing to 7th grade before entry. Students entering 7th grade who had a personal beliefs exemption on file must meet the requirements for TK/K-12 and 7th grade. See shotsforschool.org for more information.

UNCONDITIONALLY ADMIT a pupil whose parent or guardian has provided documentation of any of the following for each immunization required for the pupil's age or grade as defined in table above:

- Receipt of immunization.
- A permanent medical exemption in accordance with 17 CCR section 6051.
- A personal beliefs exemption (filed in CA prior to 2016) in accordance with Health and Safety Code section 120335; this is valid until enrollment in the next grade span, typically at TK/K or 7th grade.

CONDITIONALLY ADMIT any pupil who lacks documentation for unconditional admission if the pupil has:

- Commenced receiving doses of all the vaccines required for the pupil's grade (table above) and is not currently due for any doses at the time of admission (as determined by intervals listed in Conditional Admission Schedule, column entitled "EXCLUDE IF NOT GIVEN BY"), or
- A temporary medical exemption from some or all required immunizations (17 CCR section 6050).

CONDITIONAL ADMISSION SCHEDULE FOR GRADES K-12

Before admission a child must obtain the first dose of each required vaccine and any subsequent doses that are due because the period of time allowed before exclusion has elapsed.

DOSE	EARLIEST DOSE MAY BE GIVEN	EXCLUDE IF NOT GIVEN BY
Polio #2	4 weeks after 1st dose	8 weeks after 1st dose
Polio #3[1]	4 weeks after 2nd dose	12 months after 2nd dose
Polio #4[1]	6 months after 3rd dose	12 months after 3rd dose
DTaP #2	4 weeks after 1st dose	8 weeks after 1st dose
DTaP #3[2]	4 weeks after 2nd dose	8 weeks after 2nd dose
DTaP #4	6 months after 3rd dose	12 months after 3rd dose
DTaP #5	6 months after 4th dose	12 months after 4th dose
Hep B #2	4 weeks after 1st dose	8 weeks after 1st dose
Hep B #3	8 weeks after 2nd dose and at least 4 months after 1st dose	12 months after 2nd dose
MMR #2	4 weeks after 1st dose	4 months after 1st dose
Varicella #2	Age less than 13 years: 3 months after 1st dose	4 months after 1st dose
	Age 13 years and older: 4 weeks after 1st dose	8 weeks after 1st dose

1. Three doses of polio vaccine meet the requirement if one dose was given on or after the fourth birthday. If polio #3 is the final required dose, polio #3 should be given at least six months after polio #2.
2. If DTaP #3 is the final required dose, DTaP #3 should be given at least six months after DTaP #2, and pupils should be excluded if not given by 12 months after second dose. Three doses meet the requirement if at least one dose of Tdap, DTaP, or DTP vaccine was given on or after the seventh birthday. One or two doses of Td vaccine given on or after the seventh birthday count towards the requirement.

Continued attendance after conditional admission is contingent upon documentation of receipt of the remaining required immunizations. The school shall:

- review records of any pupil admitted conditionally to a school at least every 30 days from the date of admission,
- inform the parent or guardian of the remaining required vaccine doses until all required immunizations are received or an exemption is filed, and
- update the immunization information in the pupil's record.

For a pupil **transferring** from another school in the United States whose immunization record has not been received by the new school at the time of admission, the school may admit the child for up to 30 school days. If the immunization record has not been received at the end of this period, the school shall exclude the pupil until the parent or guardian provides documentation of compliance with the requirements.

Questions?

See the California Immunization Handbook at ShotsForSchool.org

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.

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 31st 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 Website 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 Website 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, available at http://www.denti-cal.ca.gov/WSI/Bene.jsp?fname=ProvReferral.

2. Healthy Families' toll-free number or Website 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: 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 your child's school and speak to the School Operations Manager.

Sincerely,

Charla Harris
Executive Director

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31st 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: □ Male □ Female
Parent/Guardian Name:	Child's race/ethnicity: □ White □ Black/African American □ Hispanic/Latino □ Asian □ Native American □ Multi-racial □ Other_____ □ Native Hawaiian/Pacific Islander □ 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) □ Yes □ No	Visible Decay 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*** ***Date***

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 31st of your child's first school year.
Original to be kept in child's school record.