

# Registration Information

## 2012-2013

- Kindergarten Enrollment begins Wednesday, February 1, 2012
- Packets will be available for pick up on Thursday January 26<sup>th</sup>.

### The following documents will be required to register

#### PLEASE PROVIDE THE ORIGINAL AND A PHOTOCOPY OF THE FOLLOWING:

##### Parent's Picture Identification

- Current Driver's License **or**
- Current California State ID card **or**
- Valid Consulate Issued Picture ID

##### Verification of Residency within the Moreland School District

- Closing Escrow Agreement or Mortgage Statement **or**
- Lease/Rental Agreement

##### **AND**

- Current PG & E bill **or**
- Current Water bill **or**
- Current cable/Direct TV bill **or**
- Vehicle Registration

##### Verification of Student's Age

- Original birth certificate
- Immunization Record (must be up to date at time of registration)  
**AND Mantoux (PPD) skin test given and read after August 2011 to register for 2012-2013 school year.**

The CHDP and Oral Health forms do not need to be turned in to register. However, they must be turned in before school starts August 20, 2012.

**ONLY completed packets will be accepted at the Enrollment Center - 1850 Fallbrook Avenue (Community Ctr office)**  
**Hours: Monday through Thursday 8:30 a.m. to 4:00 p.m.**  
Closed for Lunch 1:00-2:00 p.m.

**MORELAND SCHOOL DISTRICT**  
**Kindergarten**  
**ENROLLMENT CHECKLIST**

Student Name: \_\_\_\_\_ Grade: Kindergarten

**COMPLETE THE FOLLOWING FORMS:**

1. \_\_\_\_\_ Moreland School District Cumulative Record Folder (**in pencil only**) (only the side where student's name is listed).
2. \_\_\_\_\_ Student Registration
3. \_\_\_\_\_ Ethnicity (on the Back)
4. \_\_\_\_\_ Health/Medical Information Form (both sides)
5. \_\_\_\_\_ Informal Primary Language Survey
6. \_\_\_\_\_ Yellow CHDP Health Exam (due during Kindergarten school year)
7. \_\_\_\_\_ Oral Health Assessment (due during Kindergarten school year)

To complete to the Registration process (see below)

**PLEASE PROVIDE THE ORIGINAL AND A PHOTOCOPY OF THE FOLLOWING:**

8. \_\_\_\_\_ Parent's Picture Identification
  - Current Driver's License **or**
  - Current California State ID card **or**
  - Valid Consulate Issued Picture ID
  
9. \_\_\_\_\_ Verification of Residency within the Moreland School District
  - Mortgage Statement **or**
  - Lease/Rental Agreement

**AND**

  - Current PG & E bill **or**
  - Current Water bill **or**
  - Current cable/Direct TV bill **or**
  - Vehicle Registration (**not** Title Certificate)
  
10. \_\_\_\_\_ Verification of Student's Age
  - Original birth certificate
  
11. \_\_\_\_\_ Immunization Record **and**
  
12. \_\_\_\_\_ Mantoux (PPD) skin test
  - Incoming Kindergarten students **must present** written evidence of a Mantoux (**PPD**) skin test **given and read** within the last **12months to register.**

Student # \_\_\_\_\_  
School Year \_\_\_\_\_

# MORELAND SCHOOL DISTRICT Student Enrollment Form

**K 1 2 3 4 5 6 7 8**  
Grade – Circle One

## Student Information

Legal Last Name \_\_\_\_\_ Legal First Name \_\_\_\_\_ M.I. \_\_\_\_\_ **Male Female**  
Circle One \_\_\_\_\_ Date of Birth MM/DD/YR \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone \_\_\_\_\_ Home or Cell \_\_\_\_\_

Sibling(s) \_\_\_\_\_ Place of Birth \_\_\_\_\_  
Name(s)/school/grade \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

**MOTHER-** First Name \_\_\_\_\_ Last \_\_\_\_\_ Father  Step Parent  Foster Parent  Legal Guardian

**Highest level of education completed:**  
 Did not graduate High School  College Graduate  
 Graduated High School  Post Graduate Degree  
 Attended Some College

**Highest level of education completed:**  
 Did not graduate High School  College Graduate  
 Graduated High School  Post Graduate Degree  
 Attended Some College

Cell Number \_\_\_\_\_ Email address \_\_\_\_\_

Cell Number \_\_\_\_\_ Email address \_\_\_\_\_

Address if different than Student \_\_\_\_\_

Address if different than Student \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

## Student's Educational History

Previous School Attended \_\_\_\_\_ Grade Level \_\_\_\_\_

Has your child ever been retained?  No  Yes If yes, at what grade? \_\_\_\_\_

Has your child ever been expelled from a school district?  No  Yes If yes, which district? \_\_\_\_\_

Has your child ever attended school in the Moreland School District?  No  Yes  
If yes, last date of attendance in MSD \_\_\_\_\_ Name of School \_\_\_\_\_

### Has your child received any of these special services listed below?

Special Education Programs: \_\_\_\_\_ Resource Program \_\_\_\_\_ Special Day Class \_\_\_\_\_ Speech Services \_\_\_\_\_  
If you checked any above program please attach current IEP.

Regular Education Programs: \_\_\_\_\_ ELL (English Lang. Learners) \_\_\_\_\_ GATE \_\_\_\_\_ Section 504 (attach plan)

### Home Language Survey (Answer ALL Questions)

List only ONE language for each question below.

1. What language did this student learn when first beginning to talk? \_\_\_\_\_ If Chinese:  Cantonese  Mandarin

2. What language do you use most frequently to speak to this student? \_\_\_\_\_

3. What language does this student most frequently use at home? \_\_\_\_\_

4. What language is most often spoken by the adults at home? \_\_\_\_\_

If a language other than English is listed in questions 1-4 above, the student will be required to take an CELDT Test, unless you provide us with CELDT test scores or Proof of re-designation to Fully English Proficient (FEP) status.

**I have read, understand and verify that all information submitted is correct.**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

For office use only:

Date/Time received \_\_\_\_\_ Home School \_\_\_\_\_ Staff Initials: \_\_\_\_\_

Inter \_\_\_\_\_ Intra \_\_\_\_\_ School requested \_\_\_\_\_ School Assigned \_\_\_\_\_

Moreland School District

All California public schools are required to report race and ethnicity data for staff and students. The following information is confidential. No student name or other identifiers will be used for reporting purposes.

**ETHNICITY/RACE FORM**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**COMPLETE BOTH ETHNICITY & RACE SECTIONS**

<b>Ethnicity</b> Is student Hispanic or Latino? ( <i>Select only one</i> ) _____ No, not Hispanic or Latino _____ Yes, Hispanic or Latino
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The above part of the question is about ethnicity, not race. No matter what you selected above, **continue to answer the following** by marking one or more boxes to indicate what you consider your race to be.

<b>Race</b> What is the race of this student ( <i>Select one or more</i> ): _____ American Indian or Alaska Native (100) _____ Asian Indian (205) _____ Black or African American (600) _____ Cambodian (207) _____ Chinese (201) _____ Filipino (400) _____ Guamanian (302) _____ Hawaiian (301) _____ Hmong (156) _____ Japanese (202) _____ Korean (203) _____ Laotian (206) _____ Other Asian (299) _____ Other Pacific Islander (399) _____ Samoan (303) _____ Tahitian (304) _____ Vietnamese (204) _____ White/Caucasian (700)
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California Public School Information

1. What month, day and year did/will your child first attend a public school in CA? Month \_\_\_\_ Day \_\_\_\_ Yr \_\_\_\_
2. If your child was **NOT** born in the United States, please answer questions #3 and #4.
3. When did your child first enter the United States? Month \_\_\_\_ Day \_\_\_\_ Yr \_\_\_\_
4. When did your child first attend school in the United States Month \_\_\_\_ Day \_\_\_\_ Yr \_\_\_\_

# MORELAND SCHOOL DISTRICT

## HEALTH INFORMATION FORM

Parent/Guardian: Please complete and return this form in order to provide information for our health records and to assist in planning your child's school program. Legislation (California Education Code 49480) requires that the parent/guardian of any student notify the school of any medication being taken by the child on a regular basis. Thank you

### BOTH SIDES MUST BE FILLED OUT & RETURNED WITH REGISTRATION

STUDENT'S NAME \_\_\_\_\_  
Last First Middle  
 \_\_\_\_\_  
School Grade Date of Birth

ADDRESS \_\_\_\_\_  
Street City Zip

PARENT/GUARDIAN \_\_\_\_\_ HOME TELEPHONE # \_\_\_\_\_

EMAIL \_\_\_\_\_ WORK # \_\_\_\_\_ CELL# \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_ HOME TELEPHONE # \_\_\_\_\_

EMAIL \_\_\_\_\_ WORK # \_\_\_\_\_ CELL# \_\_\_\_\_

ADDRESS \_\_\_\_\_  
 (if different than above) Street City Zip

BROTHERS	AGES	SISTERS	AGES
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DOCTOR \_\_\_\_\_  
Name Address Telephone #

DENTIST \_\_\_\_\_  
Name Address Telephone #

### Has your child had any health condition related to the following?

- |  |  |  |   |  |   |
|--|--|--|---|--|---|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> ADD/ADHD            | <input type="checkbox"/> Serious Illness  |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Seizure         | <input type="checkbox"/> Hyperglycemia         | <input type="checkbox"/> Mumps            | <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Serious Injury   |
| <input type="checkbox"/> Sinus Infections    | <input type="checkbox"/> Febrile Seizure | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> German Measles   | <input type="checkbox"/> Depression          | <input type="checkbox"/> Operation        |
| <input type="checkbox"/> Ear Infections      | <input type="checkbox"/> Migraines       | <input type="checkbox"/> Heart/Valve Condition | <input type="checkbox"/> Red Measles      | <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Gastrointestinal |
| <input type="checkbox"/> Frequent Colds      | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Scarlet Fever    | <input type="checkbox"/> Mental Health       | <input type="checkbox"/> Special Diet     |
| <input type="checkbox"/> Nosebleeds          | <input type="checkbox"/> Brain Tumor     | <input type="checkbox"/> Cancer/Leukemia       | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Cerebral Palsy      | <input type="checkbox"/> Kidney/Bladder   |
| <input type="checkbox"/> Premature Birth     | <input type="checkbox"/> Meningitis      | <input type="checkbox"/> Blood Disorder        | <input type="checkbox"/> Eczema           | <input type="checkbox"/> Spina Bifida        | <input type="checkbox"/> Joint Pain       |
| <input type="checkbox"/> Birth Complications | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Physical Disability   | <input type="checkbox"/> Skin Sensitivity | <input type="checkbox"/> Muscular Dystrophy  | <input type="checkbox"/> Tires Easily     |

If YES, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Does your child have health insurance? Yes  No  Name of insurance program \_\_\_\_\_

Does your child have dental insurance? Yes  No  Does your child have vision insurance? Yes  No

## Health Information Continued

Does your child have any other health problems the school should be aware of? Yes  No

If YES, please explain: \_\_\_\_\_

Should your child's activities be limited in any way? Yes  No

If YES, please explain: \_\_\_\_\_

Does your child have **Allergies** to any of the following?

- Food            Yes  No  Please specify: \_\_\_\_\_
- Bee/Insect    Yes  No  Please specify: \_\_\_\_\_
- Drug            Yes  No  Please specify: \_\_\_\_\_
- Latex            Yes  No  Please specify: \_\_\_\_\_
- Seasonal        Yes  No  Please specify: \_\_\_\_\_
- Other            Yes  No  Please specify: \_\_\_\_\_

**Does your child need Medication? If medication is needed at school, a permission form must be completed and signed by both the physician and parent/guardian, and medication/supplies must be in the original container.**

Epi Pen    Yes  No  / Benadryl    Yes  No  / Albuterol Inhaler    Yes  No  / Glucagon    Yes  No   
 Other      Yes  No  Please specify: \_\_\_\_\_

**\*\*\*PLEASE SUPPLY YOUR CHILD'S MEDICATION WITH PERMIT TO TAKE MEDICATION FORM TO THE SCHOOL, IF YOUR CHILD NEEDS MEDICATION AT SCHOOL.\*\*\***

**Is your child on a continuing medication regimen?**

\_\_\_\_\_ My child **is not** on a continuing medication regimen.

\_\_\_\_\_ My child **is** on a continuing medication regimen.

Medication: \_\_\_\_\_

Condition: \_\_\_\_\_

Physician: \_\_\_\_\_ Telephone # \_\_\_\_\_

Address: \_\_\_\_\_ Fax # \_\_\_\_\_

Vision / Hearing	YES	NO	PLEASE EXPLAIN
Vision Problems			
Wears Glasses / Contacts			
Hearing Difficulties			
Wears Hearing Aid			

OTHER IMPORTANT HEALTH INFORMATION: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

**Please fill out both sides of this form**

# Moreland School District

## K-8 Informal Primary Language Survey

### California Public School Information

<b>Student Name:</b>	<b>Person Completing This Survey:</b>
<b>Student Birth Date:</b>	<b>Signature of Person Completing this form:</b>
<b>Primary Language:</b>	<b>School:</b>
<b>Grade:</b>	<b>Date Completed:</b>

**To be completed by parent/guardian.**

The purpose of this survey is to find out how well your child knows his/her home language.

1. Has your child attended school in another country?  
 No \_\_\_\_\_  
 Yes \_\_\_\_\_ Country \_\_\_\_\_ # of months \_\_\_\_\_ or # of Years \_\_\_\_\_
  
2. How many years has he/she attended school in the United States?  
 \_\_\_\_\_ Years
  
3. How well can your child **understand** the home language?  
 Very well \_\_\_\_\_  
 Limited \_\_\_\_\_  
 None \_\_\_\_\_
  
4. How well can your child **speak** the home language?  
 Very well \_\_\_\_\_  
 Limited \_\_\_\_\_  
 None \_\_\_\_\_
  
5. How well can your child **read** in his/her home language?  
 Very well \_\_\_\_\_ (appropriate for age)  
 Limited \_\_\_\_\_ (not as well as other students of the same age)  
 None \_\_\_\_\_
  
6. How well can your child **write** in his/her home language?  
 Very well \_\_\_\_\_ (appropriate for age)  
 Limited \_\_\_\_\_ (not as well as other students of the same age)  
 None \_\_\_\_\_

<b>Completed Primary Language Survey Should Remain In Student's Enrollment Folder</b>
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# Parents of Children In or Entering School or Child Care



**REFERENCE** Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380; California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, Sections 6000-6075

**WHY YOUR CHILD NEEDS SHOTS** The California School Immunization Law requires that children be up-to-date on their immunizations (shots) to attend school or child care. Diseases like chickenpox, measles, and whooping cough spread quickly, so children need to be protected before they enter. Most children need booster shots before starting kindergarten. 7th grade entry requirements went into effect July 1, 1999. A varicella (chickenpox) requirement for kindergarten entry and child care attendance went into effect July 1, 2001.

**WHAT YOU WILL NEED AT REGISTRATION** You will need your child's Immunization Record. It must show the date your child was given each required shot. If you do not have an Immunization Record or your child has not received all required shots, call your doctor or local health department now for an appointment.



**THESE ARE THE SHOTS THAT ARE REQUIRED** Review your child's Immunization Record to make sure you have a date for each shot required.

Vaccine	NUMBER OF IMMUNIZATIONS REQUIRED TO ENTER, BY AGE OF CHILD							
	Child Care					School		
	2-3 months	4-5 months	6-14 months	15-17 months	18+ months	4-6 years	7-17 years	7th grade
Polio (OPV/IPV)	1	2	2	3	3	4 <sup>a</sup>	4 <sup>b</sup>	
DTP/DTaP	1	2	3	3	4	5 <sup>a</sup>	3 <sup>b</sup>	
Td Booster								[1 <sup>c</sup> ]
MMR				1 <sup>d</sup>	1 <sup>d</sup>	2 <sup>e</sup>	1 <sup>e</sup>	2 <sup>e</sup>
Hepatitis B	1	2	2	2	3	3		3 <sup>f</sup>
Hib	1	2	2	1 <sup>d</sup>	1 <sup>d</sup>			
Varicella					1 <sup>g</sup>	1 <sup>g</sup>	1-2 <sup>h</sup>	

<sup>a</sup> This number includes kindergarten boosters. If your child is 4-6 years old, entry requirements are met with only 3 polio and 4 DTPs if at least one polio and one DTP dose were after your child's fourth birthday.

<sup>b</sup> For children 7-17 years old, entry requirements are met with only 3 polio and 3 DTP or DT/Td if at least one polio and DTP or DT/Td were after your child's 2nd birthday. For students age 7 years and older, pertussis immunization is not required.

<sup>c</sup> A Td booster is recommended but not required.

<sup>d</sup> One dose must be on or after the 1st birthday regardless of any doses received earlier. The Hib requirement applies only to child care children under age 4 years and 6 months.

<sup>e</sup> One dose on or after the first birthday is required for grades 1-6 and 8-12. Mumps immunization is not required for students age 7 years and older.

<sup>f</sup> Two doses of the 2-dose hepatitis B vaccine formulation along with provider documentation that the 2-dose hepatitis B vaccine formulation was used for both doses and both doses were received at age 11-15 years will also fulfill this requirement.

<sup>g</sup> If your child had chickenpox disease, ask your doctor to note it on the immunization record to meet the requirement.

<sup>h</sup> Required for children not enrolled in California schools before July 1, 2001. 1 dose required for grades K-12. For children 13-17 years old, 2 doses are needed if vaccine received after 13th birthday.

If your child's record is missing some doses, please contact your doctor or clinic now to obtain the full immunization record or any doses needed. If your child recently received immunizations and needs an immunization later in the year, he/she can be allowed to attend, provided you get the remaining doses when they become due.

Your child may be exempted from some or all immunizations by a doctor because of a medical condition. Your child may be exempted by you because of your personal or religious beliefs. Ask your school or child care provider for details.

## TB/TUBERCULIN SKIN TEST REQUIREMENTS

### TB/Tuberculosis Mandate Requirements:

The requirement applies to the following students entering a public or private school in Santa Clara County beginning October 1, 1995 and later. This requirement is mandated by the Santa Clara County Public Health Department.

#### 1) Kindergarten entrants:

All new and transfer students who register for kindergarten must present written evidence of a Mantoux (PPD) skin test or Interferon Gamma Release Assay (IGRA) given within twelve months prior to first school entrance or transfer. (Multiple puncture (Tine) tests are not acceptable.)

#### 2) Grades one through twelve:

All new students and students transferring from outside Santa Clara County must present written evidence of a Mantoux (PPD) skin test or Interferon Gamma Release Assay (IGRA) given within twelve months prior to school entrance. (Multiple puncture (Tine) tests are not acceptable.)

### What is Required?

Documentation requirements of the Mantoux (PPD) test must include the following:

- Date the test was given and date it was read
- The result of the reading in millimeters of induration
- Signature of the physician or designee

Documentation requirements of the Interferon Gamma Release Assay (IGRA) Blood Test must include the following:

- Original or copy of lab report
- Providers may attach IGRA results to yellow California immunization card, as there is no current place to record the IGRA.
- \*TB Risk Factor Assessment Form must be completed for an indeterminate IGRA result.

### Positive readings:

If a student has a positive reading of 10 millimeters or greater, the student will need to have a chest x-ray within 20 days of the TB test. The student may be conditionally admitted pending results of the chest x-ray and completion of TB Sign and Symptom Form. If the student has had a previous positive result, the x-ray must have been done in the United States within the past 6 months. The x-ray must be read and certified by a physician documenting that the student has a normal chest x-ray and is free of communicable tuberculosis.

Students treated with INH (minimum of 6 months of treatment) are required to provide documentation of treatment for school records, including dosage of INH; date started and date completed. A repeat chest x-ray is not required. Students presenting evidence of completion of INH are automatically considered to be free of communicable tuberculosis.

TB	Type*	Date given	Date read	mm indur	Impression
SKIN TESTS	<input type="checkbox"/> PPD-Mantoux	/ /	/ /		<input type="checkbox"/> Pos
	<input type="checkbox"/> Other	/ /	/ /		<input type="checkbox"/> Neg
	<input type="checkbox"/> PPD-Mantoux	/ /	/ /		<input type="checkbox"/> Pos
	<input type="checkbox"/> Other	/ /	/ /		<input type="checkbox"/> Neg

\*If required for school entry, must be Mantoux unless exception granted by local health department.

## REPORT OF HEALTH EXAMINATION FOR FIRST GRADE

To protect the health of children, California law requires students to have a health examination eighteen months prior to entering first grade. The examination can be given up to six months before entering Kindergarten, but not before March 1<sup>st</sup> of that year.

It is recommended that students have a health examination when visiting the doctor for immunizations before starting Kindergarten.

## 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	/ /
Tuberculin Test (Mantoux/PPD)	/ /
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/DT/DT/d (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					
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)

TB SKIN TESTS	Type*	Date given	Date read	mm indur	Impression
	<input type="checkbox"/> PPD-Mantoux	/	/		<input type="checkbox"/> Pos
	<input type="checkbox"/> Other	/	/		<input type="checkbox"/> Neg
	<input type="checkbox"/> PPD-Mantoux	/	/		<input type="checkbox"/> Pos
	<input type="checkbox"/> Other	/	/		<input type="checkbox"/> Neg

\*If required for school entry, must be Mantoux unless exception granted by local health department.

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 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 their 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 starts 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 <u>Present:</u> <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)
<div style="display: flex; justify-content: space-between; margin-top: 10px;"> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span><b>Licensed Dental Professional Signature</b></span> <span><b>CA License Number</b></span> <span><b>Date</b></span> </div>			

### **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.*