Berryessa Union School District
1376 Piedmont Road * San Jose, CA 95132 * 408-923-1800

2015-2016 Student Enrollment
New Students Entering Transitional Kindergarten, and Kindergarten through 8th grade

2015-2016 Registration packets are also available on the district web page (www.berryessa.k12.ca.us)

To enroll your student, you must attend the below date that corresponds to your child's resident home school family, and bring a *completed* registration packet **

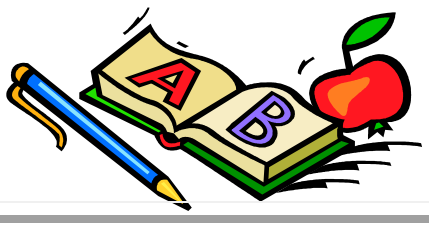
Transitional Kindergarten and Kindergarten through 8th grade will be held on the following evenings:

	Date	Time	Place
Morrill Family Schools: (Morrill, Brooktree, Laneview & Northwood)	March 5 (Thursday)	3:30 -7:00 p.m.	District Office
Piedmont Family Schools: (Piedmont, Noble, Summerdale, Toyon & Vinci Park)	March 12 (Thursday)	3:30 -7:00 p.m.	District Office
Sierramont Family Schools: (Sierramont, Cherrywood, Majestic Way & Ruskin)	March 19 (Thursday)	3:30 -7:00 p.m.	District Office
All School Families *(If you were unable to attend or complete your registration during your school's family evening registration date)*	March 26 (Thursday)	4:00 p.m. – 6:00 p.m.	District Office

Incomplete packets will not be accepted and you will be required to return at one of the below dates to finalize the registration. All required vaccines and tests must be given and properly recorded for age by a doctor or clinic.

All School Families	Date	Time	Place
	March 30 to June 26	9:00 a.m. - 1:00 p.m.	Resident Home School
	June 29 to Aug 13 (**Monday -Thursday only**)	**9:00 a.m. - 2:00 p.m. only**	District Office
	Beginning August 17 (Monday)	9:00 a.m. - 1:00 p.m.	Resident Home School

** Please read the "PARENT CHECKLIST" page of the student enrollment packet very carefully in order to ensure that you bring all necessary documents to successfully complete the registration process.

Brooktree Elementary School 1781 Olivetree Drive San Jose, CA 95131 (408) 923-1910	**Noble Elementary School** 3466 Grossmont Drive San Jose, CA 95132 (408) 923-1935	**Summerdale Elementary School** 1100 Summerdale Drive San Jose, CA 95132 (408) 923-1960
Cherrywood Elementary School 2550 Greengate Drive San Jose, CA 95132 (408) 923-1915	**Northwood Elementary School** 2760 East Trimble Road San Jose, CA 95132 (408) 923-1940	**Toyon Elementary School** 995 Bard Street San Jose, CA 95127 (408) 923-1965
Laneview Elementary School 2095 Warmwood Lane San Jose, CA 95132 (408) 923-1920	**Piedmont Middle School** 955 Piedmont Road San Jose, CA 95132 (408) 923-1945	**Vinci Park Elementary School** 1311 Vinci Park Way San Jose, CA 95131 (408) 923-1970
Majestic Way Elementary School 1855 Majestic Way San Jose, CA 95132 (408) 923-1925	**Ruskin Elementary School** 1401 Turlock Lane San Jose, CA 95132 (408) 923-1950	
Morrill Middle School 1970 Morrill Avenue San Jose, CA 95132 (408) 923-1930	**Sierramont Middle School** 3155 Kimlee Drive San Jose, CA 95132 (408) 923-1955	

BERRYESSA UNION SCHOOL DISTRICT
1376 Piedmont Road ◆ San Jose, CA 95132

Visit our website for additional information: www.berryessa.k12.ca.us

2015 – 2016 PARENT CHECKLIST

NOTE: A parent or legal guardian is required to sign the enrollment papers. It is essential for you to bring a Valid Driver's License or Valid Identification Card with you when you enroll your child. **A driver's license will not be accepted as proof of residence.** P. O. Boxes are not accepted as a residence address. It is NOT necessary for your child to be present at time of enrollment.

The following documents are required to enroll your child for school. Please bring all required documents at time of enrollment, and use this checklist to assist you in making sure all information is complete. You may contact your neighborhood school if assistance is needed in completing any of these forms.

☐ 1. Berryessa Union School District Residence Verification *(check one)*
- ☐ Homeowners - Your Proof of Ownership **AND** one other document as listed on next page.
- ☐ Renters - Your Lease/Rental Agreement **AND** one other document as listed on next page.
- ☐ All Others (*Caregiver's Affidavit* or *Family Affidavit*) – Please ask school or district for this form (not included with packet). Note: For *Family Affidavit*, Parent/Guardian registering the student(s) must provide two (2) pieces of mail with their name and current address on it (government papers such as; tax papers, state assistance verification; and a bill such as cell phone, credit card, medical, insurance**). These Affidavit forms are required to be renewed annually and families may expect a verification visit/check from district staff.**

☐ 2. **Original** Child's Age Verification Document **and 1 copy**

☐ 3. **Original** Child's Yellow Immunization Card **and 1 copy**

Card must be updated by doctor or clinic with all required vaccines and tests properly recorded for age. Please see Health Requirements attached in packet.

Documentation of TB screening assessment by student's health care provider

☐ 4. Enrollment Forms, 2 pages

If your child has an IEP or 504 Plan, you must provide a current copy with your registration packet, so that your child can be appropriately placed.

Please provide a current copy of your child's state testing results if you have it available.

☐ 5. Understanding School Assignment Form

☐ 6. Student Media Release Form

☐ 7. Oral Health Assessment/Waiver Request Form (Kindergarten and 1st grade only).

☐ 8. Report of Health Examination for School Entry (preferred for Kindergarten, required for 1st grade). Please see INSTRUCTIONS FOR ENROLLMENT, item #3.

☐ 9. Medical Statement to Request Special Meals and/or Accommodations (to be completed if child has a food allergy/intolerance)

☐ 10. SCC Public Health Department, TB Risk Assessment for School Entry

☐ 11. Parent/Guardian Valid Driver's License or Valid Identification Card

INSTRUCTIONS FOR ENROLLMENT

1. **RESIDENCE VERIFICATION**:

If you own	If you rent
<u>One</u> *of the following documents in parent's name, showing residency property address where the student physically resides.* ***P.O. Boxes are not accepted as a residence address.***	
Deed of Trust, Grant Deed, Property Tax Bill (or payment receipt), Mortgage Statement, Escrow Letter, Tax Assessment Card	Current Lease or Rental Agreement (or payment receipt)
<u>and one</u> *of the following documents in parent's name showing residency property address*	
Current PG&E Bill, Utility Service Contract (or statement/payment receipt), Pay Stub, W-2 Form, Voter Registration, valid CA Vehicle Registration, correspondence from a Government agency.	

All others you must provide:

When a student and his/her parents/guardians reside with a party who lives within the Berryessa Union School District's boundaries (rent a room, share a home, live with relative) a Family Affidavit must be completed. Parent/Guardian registering the student(s) must provide two (2) pieces of mail with their name and current address on it (government papers such as; tax papers, state assistance verification; a bill such as cell phone, credit card, medical insurance).

When only the student resides with a party (not the student's parents) who lives within the Berryessa Union School District's boundaries, a Caregiver's Affidavit must be completed.

Both of these affidavits require that the residence be on a full-time basis, Monday through Thursday and are required to be renewed annually.

Owner/Renter signing Family Affidavit must provide residence verification as stated above.

If, at any time, a question is raised about a student's residence, the District will undertake an investigation of the student's actual residence. If it is found that the situation is not as stated by the parents/guardians, the student will be **immediately un-enrolled** and then must enroll at their appropriate school or home district. (AR 5101.1) Berryessa Union School District reserves the right to verify residence. It is the policy of the Berryessa Union School District that all new students registering in the district and students who change their residence while attending school in the district provide proof of residence within the boundaries of the Berryessa Union School District (BUSD).

2. **AGE VERIFICATION:**

One of the following <u>ORIGINAL</u> official documents and <u>ONE PHOTOCOPY</u> must be brought for enrollment: (Ed. Code, Section 48000) containing the student's first and last name, date of birth, and gender.

Certified Birth Certificate (PREFERRED), Baptism Record, Passport (Visa's are **not** acceptable), Hospital Record, School Transcript

California Law and Board Policy permit the enrollment in kindergarten of those children who will be 5 years old on/or before **September 1** of the current school year (Ed. Code, § 48000). Children entering Berryessa schools from another country will be assigned to their age appropriate grade level. If your child is transferring from another school, you may bring age verification from his/her previous school.

If your child will turn 5 years old between September 2 and December 2, he/she is eligible to enroll in the Transitional Kindergarten program. The availability of this program is dependent on state funding.

3. **CALIFORNIA SCHOOL IMMUNIZATION RECORDS:**

   REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY: (preferred for Kindergarten, required for 1st grade)

   California state law requires children to have a health examination and submit a completed REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY (yellow form in this packet) 18 months prior to entering first grade. The examination can be given up to six months before entering kindergarten, but NOT BEFORE March 1st of this year in order to satisfy the 1st grade requirement. We recommend that parents submit the completed yellow form as part of the kindergarten registration packet. **However, if your child received their exam prior to March 1st of this year, they will need to have another health exam prior to entering first grade. Please be sure to submit the yellow form to your child's school office prior to your child beginning the 1st grade.**

   Yellow Immunization Card and ONE PHOTOCOPY

   If your child is enrolling from a previous school in California, a verified copy of the "California School Immunization Record Form" may be brought from the previous school for enrollment.

   Documentation of TB screening assessment by student's health care provider

4. **ENROLLMENT FORMS**, 2 pages: This form must be completed in English.
   It is important that all information is printed or typed. If your child attended another school prior to enrolling in the Berryessa Union School District, be sure to include all previous school information so we may request your child's past school records.

   (If your child has an IEP or 504 Plan, you must provide a current copy with your registration packet, so that your child can be appropriately placed.)

5. **UNDERSTANDING SCHOOL ASSIGNMENT FORM**

6. **STUDENT MEDIA RELEASE FORM**

7 **ORAL HEALTH ASSESSMENT/WAIVER REQUEST FORM** (Kindergarten and 1st grade only).

8. **REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY** (yellow) (preferred for Kindergarten, required for 1st grade)

9. **MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS** (green) (to be completed if child has a food allergy/intolerance)

10. **SCC Public Health Department, TB Risk Assessment for School Entry**

ATTENDANCE POLICY (GENERAL STATEMENT)
On-time daily attendance is a critical part for student achievement and academic success. Berryessa Union School District adheres to strict attendance policies. Parents/Guardians are encouraged to schedule their vacation/trips around the school calendar. During the first week of school, you will be receiving a detailed Attendance Agreement defining excused and unexcused absences and Berryessa attendance policy.

Schools of Choice
Parents in the Berryessa Union School District may select to have their child attend a school other than their designated neighborhood school, if space is available, through a transfer process. "Request For Interdistrict Attendance Permit" (transfer request) forms are available at the District Office and at school offices throughout the district. This request allows students to attend a school outside of the Berryessa Union School District.

ADDITIONAL DOCUMENTATION CAN AND MAY BE REQUESTED: MEETING ALL OF THE ABOVE REQUIREMENTS MAY NOT SATISFY THE DISTRICT'S REASONABLE DOUBT REGARDING A STUDENT'S AGE, PARENT/GUARDIAN STATUS OR RESIDENCY.

Berryessa Union School District, 1376 Piedmont Rd, San Jose, CA 95132

STUDENT ENROLLMENT FORM

PLEASE PRINT - ALL AREAS MUST BE COMPLETE

STUDENT/FAMILY INFORMATION

First Day of Attendance: _____ **OFFICE USE ONLY**
Neighborhood School: _____
Teacher: _____ Date Received: _____
Student ID: _____ Time Received: _____

_____ _____ _____ _____
Student's Legal Last Name | Legal First Name | Legal Middle Name | Other Name Used

Social Security #: _____ - _____ - _____ Male _____ Female _____ Entering Grade: _____

_____ _____ _____ - _____ _____
Student's Home Address | City | Zip Code | Home Phone Number

Student Date of Birth _____/_____/_____ (Month Day Year)
Student Place of Birth: _____ (City) _____ (State) _____ (Country)
Student Date of Entry into United States: _____/_____/_____ (**Month Day Year**)

OFFICE USE ONLY: Birth Verification
☐ Birth Certificate
☐ Baptism Record
☐ Hospital Record
☐ Passport
☐ School Transcript

☐ Father/ ☐ Guardian – Relationship to Student: _____ Student lives with Father/Guardian? ☐ Yes ☐ No

_____ _____ _____ _____
Last Name | First Name | Cell Phone Number | E-mail Address

_____ _____ _____ - _____ _____
Home Address (if different from student) | City | Zip Code | Home Phone Number

☐ Not High School Grad ☐ High School Grad ☐ Some College and/or 1-2 yrs Community College ☐ 4 yr College Grad ☐ Grad School/Post Grad

☐ Mother/ ☐ Guardian – Relationship to Student: _____ Student lives with Mother/Guardian? ☐ Yes ☐ No

_____ _____ _____ _____
Last Name | First Name | Cell Phone Number | E-mail Address

_____ _____ _____ - _____ _____
Home Address (if different from student) | City | Zip Code | Home Phone Number

☐ Not High School Grad ☐ High School Grad ☐ Some College and/or 1-2 yrs Community College ☐ 4 yr College Grad ☐ Grad School/Post Grad

SPECIAL PROGRAMS: Has your child received assistance from or participated in any of the following programs:
☐ Gifted and Talented Education (GATE) ☐ Language/Speech/Hearing (LSH) ☐ Resource Specialist Program (RSP) ☐ 504 Plan
☐ Individual Education Plan (IEP)* ☐ Modified/Adaptive Physical Ed ☐ Special Day Class (SDC) ☐ Retained in Grade: ____
* Must provide copy of current IEP or 504 Plan

PREVIOUS SCHOOL/PRESCHOOL INFORMATION: Last Day of Attendance: _____/_____/_____

_____ _____ _____ _____ _____ _____ _____
Previous School Attended | School District | School Address | City | State | Zip Code | Phone Number

Is student Hispanic or Latino? (Must select one) ☐No, not Hispanic or Latino ☐Yes, Hispanic or Latino

Please indicate your primary race/ethnicity by marking only one "P".
Indicate as many other race/ethnicity as appropriate by indicating with an "X".

__**American Indian or Alaska Native** __**Black or African American** __**White**
Asian: __Chinese __Japanese __Korean __Vietnamese __Asian Indian __Laotian __Cambodian __Filipino __Other Asian
Native Hawaiian or Other Pacific Islander: __Hawaiian __ Guamanian __Samoan __Tahitian __Other Pacific Islander

HOME LANGUAGE SURVEY: What other language would you like written correspondence in? ☐ Chinese ☐ Spanish ☐ Vietnamese

What language did student learn when first beginning to talk? _____
What language do you use most frequently to speak to student? _____
What language does student most frequently use at home? _____ ⇨ IF CHINESE, PLEASE SPECIFY
What language is most often spoken by the adults at home? _____ WHICH DIALECT: _____

MOBILITY: (Required for State Testing Reports)
What grade did/will your child first attend THIS SCHOOL in Berryessa Union School District (Grades TK-8)? Grade:_____
What grade did/will your child first attend BERRYESSA UNION SCHOOL DISTRICT (Grades TK-8)? Grade:_____
What date did/will your child first attend a PRIVATE OR PUBLIC SCHOOL in CALIFORNIA (Grades TK-8)? Month____Day____Year _____
What date did/will your child attend a PRIVATE OR PUBLIC SCHOOL in the UNITED STATES (Grades TK-8)?Month____Day____Year _____

Student's Last Name: _____ First: _____ DOB: _____

HEALTH INFORMATION:

Health Care Provider: _____ Group #: _____
Student's Doctor Name: _____ Phone: _____
Student's Dentist Name: _____ Phone: _____

Does your child require corrective lenses? ☐ Yes ☐ No
Does your child have a health condition? ☐ Yes ☐ No (If any boxes are checked, please explain below)

☐ Allergies - life threatening ☐ Hearing Problems ☐ Orthopedic Condition
☐ Asthma ☐ Heart Problems ☐ Other Significant Health Concerns
☐ Diabetes ☐ Limited Physical Activity ☐ Seizure Disorder
☐ Neurological Condition ☐ Vision Problems - Eye disease such as glaucoma, cataracts, color blindness, other (please explain below)

Please explain: _____
_____
_____

* FOOD ALLERGIES REQUIRE GREEN FORM (attached to packet) **"MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS"**

Does your child take medication on a regular basis? ☐ Yes ☐ No Is it required during school day? ☐ Yes* ☐ No

If yes, list medication(s): _____ _____
* If medication is taken during school hours, please see school office for the **"PERMIT TO TAKE MEDICATION IN SCHOOL"** form (or print one from our district website). This form must be renewed annually.

Father/ Guardian Work Phone: _____ Company Name: _____ Occupation: _____

Mother/Guardian Work Phone: _____ Company Name: _____ Occupation: _____

EMERGENCY CONTACT:

DO NOT LIST PARENTS/GUARDIANS WHO ARE LISTED ON THE FRONT OF THIS FORM:
In case of my child's illness, injury or the event of a major disaster (e.g., earthquake, flood) and the school is unable to reach me, I give my consent to call or release my child to any of the following persons listed below.

Name	Address, City	Telephone	Relationship to Student

OTHER CHILDREN LIVING IN THE HOME, AGES 1 DAY TO 20 YRS OLD:

Name	Gender	Birth Date	Grade	School	Relationship to Student

RESIDENT VALIDATION:

I verify that my child meets the school resident requirements established by Berryessa Union School District. I have substantiated this requirement by providing the requested documentation. I understand that if it is found that the student is not living at the residence as stated and/or falsification of information, my child will immediately be enrolled at the appropriate district school or home district. If I change my residence while attending school in the district, I will be required to provide proof of residence within the boundaries of the Berryessa Union School District. I hereby certify that the STUDENT/FAMILY INFORMATION provided on pages 1 and 2 is accurate and I understand that intentionally giving false information is considered to be fraudulent.

I, the (parent or legal guardian) of this child, certify that all information on this enrollment form is true and correct.

Parent/Guardian Signature: _____ Date: _____

OFFICE USE ONLY: E/R Identified: ☐ P : ☐ S : ☐ O

Residence verified by: _____ School Year: 2015-2016

Resident verification: _____ **AND** _____
(List what was shown) (List what was shown)

Valid ID: (check one) ☐ Driver's License OR ☐ Identification Card

Berryessa Union School District
Health Requirements

Vaccine	Required Dose
Polio (IPV, DTaP-HepB-IPV (Pediarix), DTaP-IPV/Hib (Pentecel), DTaP-IPV (Kinrix)	4 doses at any age, but 3 doses meet requirements for ages 4-6 yrs if at least one dose was given on or after the 4th birthday*; 3 doses meet requirements for ages 7-17 yrs if at least one dose was given on or after 2nd birthday.*
Diphtheria, Tetanus, and Pertussis (DTP, DTaP, DT)	
Age 6 yrs and under DTP, DTaP or any combination of DTP or DTaP with DT	5 doses at any age, but 4 doses meet requirements for ages 4-6 if at least one dose was given on or after 4th birthday. *
Age 7 years and older Tdap, Td, DT or DTP, DTaP or any combination of these.	4 does at any age, but 3 doses meet requirements for ages 7-17. yrs if at least one dose was given on or after 2nd birthday. * If last dose was given before the 2nd birthday, one more (Td) dose is required.
Pertussis (Tdap**, Whooping Cough)	
7th Gr	1 dose of Tdap on or after 7th birthday.
Measles, Mumps, Rubella (MMR, MMRV)	
TK/Kindergarten	2 doses*** both on or after 1st birthday*
7th Gr	2 doses*** both on or after 1st birthday*
Grades 1-6 and 8-12	1 dose must be on or after 1st birthday*
Hepatitis B	
TK/Kindergarten	3 doses at any age
Varicella (Chickenpox) (VAR, MMRV)	
TK/Kindergarten	1 dose****
Out-of-state entrants (Grades 1-12)	I dose for children under 13 yrs; 2 doses are needed if immunized on or after 13th birthday. ****
TB Screening	
TK-8th Grade	Documentation of TB Risk Assessment by student's health care provider, within one year prior to registration or first day of school. A TST or other TB test will be ordered by student's health care provider if deemed necessary, based on the TB screening assessment.

(*) Receipt of the dose up to (and including) 4 days before the birthday will satisfy the school entry immunization requirement.
(**) "Tdap" = Tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine.
(***) Two doses of measles containing vaccine required. One dose of mumps and rubella containing vaccine required.
(****) Physician documented varicella (chickenpox) disease history or immunity meets the varicella requirement.

IMMUNIZATION SERVICES

Immunization Services in Santa Clara County

Santa Clara County PUBLIC HEALTH
Immunization Education and Planning Program

SCHOOL HEALTH CENTERS

- Franklin McKinley School Center
  645 Wool Creek Dr., San Jose, CA 95112
  1.408.283.6051
- Gilroy Neighborhood Health Clinic
  7861 Murray Avenue, Gilroy CA 95020
  1.408.842.1017
- Overfelt Neighborhood Health Clinic
  1835 Cunningham Ave., San Jose, CA 95122
  1.408.347.5988
- San Jose High Neighborhood Health Clinic
  1149 E. Julian St., Bldg. H, San Jose, CA 95116
  1.408.535-6001
- Washington Neighborhood Health Clinic
  100 Oak St., San Jose, CA 95110
  1.408.295.0980

MAYVIEW COMMUNITY HEALTH CENTERS

- Mayview Community Health Center
  270 Grant Ave., Palo Alto, CA 94306
  1.650.327.8717
- Mayview Community Health Center
  900 Miramonte Ave. 2nd floor, Mtn. View, CA 94040
  1.650.965-3323
- Mayview Community Health Center
  785 Morse Ave., Sunnyvale, CA 94085
  1.408.746.0455

PLANNED PARENTHOOD CLINICS

Main number for all Planned Parenthood Clinics
Call Center: 1.877.855.7526

- Planned Parenthood, Blossom Hill
  5440 Thornwood Dr., #G, San Jose, CA 95123
- Planned Parenthood, Mountain View
  225 San Antonio Rd., Mtn. View, CA 94040
- Planned Parenthood, San Jose
  1691 The Alameda, San Jose, CA 95126
- Mar Monte Community Clinic
  2470 Alvin Ave., #60, San Jose, CA 95121

GARDNER FAMILY HEALTH NETWORK

- Alviso Health Center
  1621 Gold St., Alviso, CA 95002
  1.408.935.3949
- CompreCare Health Center
  3030 Alum Rock Ave., San Jose, CA 95127
  1.408.272.6300
- Gardner Health Center
  195 E. Virginia St., San Jose, CA 95112
  1.408.998.8815
- Gardner South County Health Center
  7526 Monterey St., Gilroy, CA 95020
  1.408.848.9400
- St. James Health Center
  55 E. Julian St., San Jose, CA 95112
  1.408.918.2600
- Gardner Downtown Health Center
  725 E. Santa Clara St., #10, San Jose, CA 95112
  1.408.794.0500

COMMUNITY CLINICS/HEALTH CENTERS

- Asian Americans for Community Involvement
  2400 Moorpark Ave., #319, San Jose, CA 95128
  1.408.975.2763
- Indian Health Center
  1333 Meridian Ave., San Jose, CA 95125
  1.408.445.3400
- Indian Health Center – Silver Creek site
  1642 E Capitol Expy., San Jose, CA 95121
  1.408.445.3400 x200
- San Jose Foothill Family Community Clinic
  2880 Story Rd., San Jose, CA 95127
  1.408.729.1643
- Foothill Family Clinic
  1066 South White Rd., #170, San Jose, CA 95127
  1.408.729.9700
- Montpelier Clinic
  2380 Montpelier Dr., #200, San Jose, CA 95116
  1.408.254.1800

To see if your child is eligible for free or low cost children's health insurance, please call:

- Children's Health Initiative
  888.244.5222
- Child Health & Disability Prevention Program
  408.937.2250
- Medi-Cal Eligibility
  877.962.3633
- Santa Clara Valley Health & Hospital System Valley Connection
  888.334.1000

Santa Clara County
Child Health & Disability Prevention

CHDP Program

Health exams at no charge for eligible children and youth

Child Health & Disability Prevention Program
Public Health Department
Santa Clara Valley Health & Hospital System

Regular health exams can:

- Help children and youth stay healthy
- Identify health problems early and refer for treatment as needed

A health problem found and treated at an early age is easier to correct and can reduce or prevent serious problems for the child or youth later in life.

Children and youth are eligible if they are:

- On Medi-Cal and 0 – 21 years old,
  or
- Low/moderate income* and 0 – 19 years old

* Children and youth may be able to receive temporary Medi-Cal for up to 60 days through CHDP Gateway.

Types of CHDP Exams:

- Well-baby and well-child exams
- Preschool/Head Start exams
- 1st grade exams
- School exams
- Sport or camp physicals
- Teen physicals

All CHDP exams include:

- A developmental and health history
- Head-to-toe physical inspection
- Height & weight check, growth assessment
- Nutritional assessment
- Hearing and vision screening
- Oral health screening (does not replace dental exam)
- Immunizations as needed
- Blood and urine tests
- Tuberculosis screening
- Answers to your questions and an explanation of the results of the health exam

If the tests indicate a need for further diagnosis and treatment, it is important to follow the health provider's recommendations.

For more information, call 1 (800) 689-6669

Berryessa Union School District

UNDERSTANDING SCHOOL ASSIGNMENT FORM

I understand that my child, _____is not guaranteed enrollment in his/her designated school of attendance*. If there is no space available in his/her designated school, my child will be assigned to an overload school in the district. **If space is available, your child will be invited back the following school year.**

Enrollment to your child's designated school of attendance is determined by the date and time in which enrollment documents were submitted and considered complete during central registration.

I understand that if a grade at my child's designated school of attendance reaches capacity, the student(s) selected to be assigned to another District school will be determined on a "last in*, first out" basis.

I understand that if my child does not attend class on the first day of school he/she may lose placement in the class/school and may be assigned to another school within the District.

Printed Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Grade: _____ Birthdate: _____

Name of School: _____ Student Id: _____

* Designated School of Attendance is defined as:
A school designated by the District for your specific residence area.

* LAST IN is defined by:
The date and time the completed enrollment packet is received by the School/District.

Berryessa Union School District

STUDENT MEDIA RELEASE FORM

Dear Parents/Guardians,

Berryessa Union School District is proud of the many accomplishments of our students and staff. Often, such accomplishments draw the attention of newspaper, television stations, or other media who visit our schools to photograph, videotape, and/or interview students and staff during various activities. In addition, we often use pictures of our students in Berryessa Union School District's publications and the district's website. For your child's privacy, we must know whether or not you want your child to be photographed, videotaped, or interviewed by the news media, or for the district's publications.

Please check appropriate box:

☐ **I *DO* GIVE PERMISSION** for my child to be photographed, videotaped, or interviewed by the news media for any reason and for the Berryessa Union School District to use my child's photograph or words in district publications.

☐ **I *DO NOT* GIVE PERMISSION** for my child to be photographed, videotaped, or interviewed by the news media for any reason. Nor do I give my permission for the Berryessa Union School District to use my child's photograph or words in district publications. Note: I understand this media release refusal does not apply to classroom displays or yearbooks.

Printed Student Name: _____

Parent/Guardian Signature: _____ Date: _____

Grade: _____ Birthdate: _____

Name of School: _____ Student Id: _____

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

Information on the Oral Health Assessment/Waiver Request Form

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.dhs.ca.gov/mcs/medi-Calhome/CountyListing1.htm.)

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 http://www.dhs.ca.gov/mcs/medi-Calhome/CountyListing1.htm)

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.

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. SCHOOL/AGENCY	2. SITE	3. SITE TELEPHONE NUMBER

4. NAME OF PARTICIPANT	5. AGE OR DATE OF BIRTH

6. NAME OF PARENT OR GUARDIAN	7. TELEPHONE NUMBER

8. CHECK ONE:

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to definitions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A licensed physician must sign this form.**

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, or registered nurse must sign this form.**

9. DISABILITY OR MEDICAL CONDITION REQUIRING A SPECIAL MEAL OR ACCOMMODATION:

10. IF PARTICIPANT HAS A DISABILITY, PROVIDE A BRIEF DESCRIPTION OF PARTICIPANT'S MAJOR LIFE ACTIVITY AFFECTED BY THE DISABILITY:

11. DIET PRESCRIPTION AND/OR ACCOMMODATION: ***(PLEASE DESCRIBE IN DETAIL TO ENSURE PROPER IMPLEMENTATION)***

12. INDICATE TEXTURE:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

13. FOODS TO BE OMITTED AND SUBSTITUTIONS: ***(PLEASE LIST SPECIFIC FOODS TO BE OMITTED AND SUGGESTED SUBSTITUTIONS. YOU MAY ATTACH A SHEET WITH ADDITIONAL INFORMATION)***

A. Foods To Be Omitted	B. Suggested Substitutions

14. ADAPTIVE EQUIPMENT:

15. SIGNATURE OF PREPARER*	16. PRINTED NAME	17. TELEPHONE NUMBER	18. DATE

19. SIGNATURE OF MEDICAL AUTHORITY*	20. PRINTED NAME	21. TELEPHONE NUMBER	22. DATE

*** Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or registered nurse must sign the form.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

Please return to:
Berryessa Union School District
Attn: Child Nutrition Services Dept
1376 Piedmont Road
San Jose, CA 95132

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

INSTRUCTIONS

1. **School/Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served (e.g., school site, child care center, community center, etc.)
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
5. **Age of Participant:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Telephone Number:** Print the telephone number of parent or guardian.
8. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
9. **Disability or Medical Condition Requiring a Special Meal or Accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.)
10. **If Participant has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition affects disability. For example: "Allergy to peanuts causes a life-threatening reaction."
11. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician, or describe diet modification requested for a non-disabling condition. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
12. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
13. **A. Foods to Be Omitted:** List specific foods that must be omitted. For example, the "exclude fluid milk."
    B. Suggested Substitutions: List specific foods to include in the diet. For example, "calcium fortified juice."
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. (Examples may include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.)
15 **Signature of Preparer:** Signature of person completing form.
16. **Printed Name:** Print name of person completing form.
17. **Telephone Number:** Telephone number of person completing form.
18. **Date:** Date preparer signed form.
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
20. **Printed Name:** Print name of medical authority.
21. **Telephone Number:** Telephone number of medical authority.
22. **Date:** Date medical authority signed form.

DEFINITIONS*:

"A Person with a Disability" is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

"Physical or mental impairment" means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Major life activities" are functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

"Has a record of such an impairment" is defined as having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

(*Citations from Section 504 of the Rehabilitation Act of 1973)

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.

Child's Name: _____ **Birthdate:** _____ **Male/Female** **School:** _____
Last, First **month/day/year**

Address_____ **Phone:** _____ **Grade:** _____
Street **City** **Zip**

Santa Clara County Public Health Department
TB Risk Assessment for School Entry

This form must be completed by a licensed health professional and returned to the child's school.

1. Was your child born in Africa, Asia, Latin America, or Eastern Europe?	❑ **Yes** ❑ **No**
2. Has your child traveled to a country with a high TB rate* (for more than a week)?	❑ **Yes** ❑ **No**
3. Has your child been exposed to anyone with tuberculosis (TB) disease?	❑ **Yes** ❑ **No**
4. Has a family member or someone your child has been in contact with had a positive TB test or received medications for TB?	❑ **Yes** ❑ **No**
5. Was a parent, household member or someone your child has been in close contact with, born in or traveled to a country with a high TB rate?*	❑ **Yes** ❑ **No**
6. Has another risk factor for TB (i.e. one of those listed on the back of this page)?	❑ **Yes** ❑ **No**

***** This includes countries in Africa, Asia, Latin America or Eastern Europe. For travel, the risk of TB exposure is higher if a child stayed with friends or family members for a cumulative total of 1 week or more.

If YES, to any of the above, the child has an increased risk of TB infection and should have a TST/ IGRA.

All children with a positive TST/IGRA result must have a medical evaluation, including a chest X-ray. Treatment for latent TB infection should be initiated if the chest X-ray is normal and there are no signs of active TB. If testing was done, please attach or enter results below.

Tuberculin Skin Test (TST/Mantoux/PPD) Date given: Date read:	Induration _____ mm Impression: ❑ Negative ❑ Positive
Interferon Gamma Release Assay (IGRA) Date:	Impression: ❑ Negative ❑ Positive ❑ Indeterminate
Chest X-Ray (**required with positive TST or IGRA**) Date:	Impression: ❑ Normal ❑ Abnormal finding
☐ LTBI treatment (Rx & start date): ☐ Contraindications to INH or rifampin for LTBI	☐ Prior TB/LTBI treatment (Rx & duration): ☐ Offered but refused LTBI treatment

Providers, please check one of the boxes below and sign:

☐ Child has no TB symptoms, none of the above or other risk factors for TB and does not require a TB test.

☐ Child has a risk factor, has been evaluated for TB and is free of active TB disease.

_____ _____
Health Provider Signature, Title **Date**

Name/Title of Health Provider:

Facility/Address:

Phone number: **Fax number:**

County of Santa Clara
Public Health Department

Tuberculosis Prevention & Control Program
976 Lenzen Avenue, Suite 1700
San José, CA 95126
408.885.2440

Risk Factors for Tuberculosis (TB) in Children

- Have clinical evidence or symptoms of TB
- Have a family member or contacts with history of confirmed or suspected TB
- Are in foreign-born families from TB endemic countries (including countries in Africa, Asia, Latin America or Eastern Europe)
- Travel to countries with high rate of TB
- Contact with individual(s) with a positive TB test
- Abnormalities on chest X-ray suggestive of TB
- Adopted from any high-risk area or live in out-of-home placements
- Live with an adult who has been incarcerated in the last five years
- Live among or frequently exposed to individuals who are homeless, migrant farm workers, residents of nursing homes, or users of street drugs
- Drink raw milk or eat unpasteurized cheese (i.e. queso fresco or unpasteurized cheese)
- Have, or are suspected to have, HIV infection or live with an adult with HIV seropositivity. See below for testing methods in children with HIV or other immunocompromised conditions.

Testing Methods

A Mantoux tuberculin skin test (TST) or an Interferon Gamma Release Assay (IGRA) (for children aged 4 and older) should be used to test those at increased risk. A TST of ≥10mm is considered positive. If a child has had contact with someone with active TB (yes to question 3 on reverse) then TST ≥5mm is considered positive.

Screening should be performed by CXR in addition to a TST/IGRA (consider doing both) and symptom review in HIV infected or suspected HIV, other immunocompromised conditions or if a child is taking immunosuppressive medications such as prednisone or TNF-alpha antagonists.

Referral, Treatment, and Follow-up of Children with Positive TB Tests

- All children with a positive TST or IGRA result should have a medical evaluation, including a chest X-ray.
- Report any confirmed or suspected case of TB disease to the TB Control Program within 1 day, including any child with an abnormal chest X-ray.
- If TB disease is not found, treat children and adolescents with a positive TST or IGRA for latent TB infection (LTBI).
- Isoniazid (INH) is the drug of choice for the treatment of LTBI in children and adolescents. The length of treatment is 9 months with daily dosing: 10-15mg/kg (maximum 300 mg).
- For management and treatment guidelines for TB or LTBI, go to: www.cdc.gov/tb or contact the TB Control Program at (408) 885-4214.

References

American Academy of Pediatrics, Committee on Infectious Diseases. Tuberculosis. In L.K. Pickering (Ed.), 2009 *Red Book: Report of the Committee on Infectious Diseases*. 27th ed. El Grove Vilage, IL: American Academy of Pediatrics, 2009:680-701.

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Pediatric Tuberculosis Collaborative Group. Targeted Tuberculin Skin Testing and Treatment of Latent Tuberculosis Infection in Children and Adolescents. *Pediatrics* 2004; 114 (14):1175-1201.

Pang J, Teeter LD, Katz DJ, et al. Epidemiology of Tuberculosis in Young Children in the United States. Pediatrics, 2014:494-504.