

*Every Child Has The Right To A Free Public Education*

2020-2021 Student Enrollment Information

New Students Entering Transitional Kindergarten, and Kindergarten through 8<sup>th</sup> grade



The first day of school is Monday, August 17, 2020

Due to space availability, students who do not attend class on this date, will risk being dropped from enrollment\* and/or overloaded to another elementary school.

\*Students who are dropped from enrollment, will be required to repeat the entire enrollment process over again to be reenrolled.

Enrollment for the 2020-2021 school year, will begin in mid-February. Parents may enroll their child to our district on-line (www.berryessa.k12.ca.us), or by printing and completing an enrollment packet, which is also available on our district web page (www.berryessa.k12.ca.us).

To enroll your child, you must attend the below date that corresponds to your child’s resident home school family, and bring either your on-line confirmation or a completed registration packet and provide the proper required documents to finalize the enrollment process.\*\*

Please note, your child does not need to attend when you finalize your enrollment.

Currently enrolled Berryessa students in grades TK, and 5th, do not need to re-enroll for Kindergarten and 6<sup>th</sup> grade. Students will automatically attend their resident elementary/middle school.

New student enrollment for TK and Kindergarten through 8<sup>th</sup> grade will be held on the following days:

Early Opportunities for Enrollment

	<u>Date</u>	<u>Time</u>	<u>Place</u>
<b>Piedmont Family Schools:</b> (Piedmont, Noble, Summerdale, Toyon & Vinci Park)	March 16 (Monday)	10:00 a.m. - 6:00 p.m.	District Office
<b>Sierramont Family Schools:</b> (Sierramont, Cherrywood, Majestic Way & Ruskin)	March 17 (Tuesday)	10:00 a.m. - 6:00 p.m.	District Office
<b>Morrill Family Schools:</b> (Morrill, Brooktree, Laneview & Northwood)	March 18 (Wednesday)	10:00 a.m. - 6:00 p.m.	District Office
<b>All Schools who missed the above dates/times.</b>	March 19 (Thursday)	10:00 a.m. - 4:00 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

<u>Date</u>	<u>Time</u>	<u>Place</u>
March 23 - June 19, 2020	9 a.m. - 1 p.m.	Resident Home School
June 22 - Aug 6 (Monday -Thursday only)	<b>9 a.m. - 1 p.m. ONLY</b>	District Office (9 a.m. – 1 p.m. ONLY)
Beginning August 10, 2020	9 a.m. - 1 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.

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



Pathway to the Future

## BERRYESSA UNION SCHOOL DISTRICT

1376 Piedmont Road ♦ San Jose, CA 95132

Visit our website for additional information: [www.berryessa.k12.ca.us](http://www.berryessa.k12.ca.us)

### 2020 – 2021 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 For Family Affidavit (located in this packet on the back of Residency Declaration), 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). **The Family Affidavit (Part 4 of the Residency Declaration form) is required to be renewed annually and families may expect a verification visit/check from district staff.**
- 2. **Original** Child's Age Verification Documentation **and 1 copy** (Birth Certificate preferred).
- 3. **Original** Child's Immunization Record from Health Care Provider **and 1 copy**

Record must be updated by doctor or clinic with all required vaccines and tests properly recorded for age. Please see *Parents' Guide to Immunizations* attached in packet. Documentation of TB screening assessment by student's health care provider
- 4. Residency Declaration (and Part 4 Family Affidavit section on backside, if required)
- 5. 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.
- 6. Home Language Survey
- 7. Understanding School Assignment Form
- 8. Student Media Release Form
- 9. Student Use of Technology Acknowledgement Form
- 10. Oral Health Assessment/Waiver Request Form (TK, Kindergarten and 1<sup>st</sup> grade only).
- 11. Report of Health Examination for School Entry (preferred for Kindergarten, required for 1<sup>st</sup> grade). Please see INSTRUCTIONS FOR ENROLLMENT, item #3.
- 12. Medical Statement to Request Special Meals and/or Accommodations (to be completed if child has a food allergy/intolerance)
- 13. SCC Public Health Department, TB Risk Assessment for School Entry
- 14. Parent/Guardian Valid Driver's License or Valid Identification Card

# INSTRUCTIONS FOR ENROLLMENT

## 1. RESIDENCE VERIFICATION:

If you own	If you rent
<p><b><u>One</u></b> of the following documents in parent's name, showing residency property address where the student physically resides.  <b><i>P.O. Boxes are not accepted as a residence address.</i></b></p>	
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)
<p><b><u>and one</u></b> of the following documents in parent's name showing residency property address</p>	
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 ORIGINAL official documents and ONE PHOTOCOPY 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 1<sup>st</sup> 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 1<sup>st</sup> 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 1<sup>st</sup> 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 1<sup>st</sup> grade.**

Original Child's Immunization Record from Health Care Provider **and 1 Copy**

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. **RESIDENCY DECLARATION** (and Part 4 Family Affidavit section on backside, if required)

5. **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.)

6. **HOME LANGUAGE SURVEY**

7. **UNDERSTANDING SCHOOL ASSIGNMENT FORM**

8. **STUDENT MEDIA RELEASE FORM**

9. **STUDENT USE OF TECHNOLOGY ACKNOWLEDGEMENT FORM**

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

11. **REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY** (yellow) (preferred for Kindergarten, required for 1<sup>st</sup> grade)

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

13. **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.**



Pathway to the Future

2020-2021

RESIDENCY DECLARATION

BERRYESSA UNION SCHOOL DISTRICT, 1376 Piedmont Rd, San Jose, CA 95132

THIS FORM MUST BE COMPLETED, SIGNED AND SUBMITTED WITH PROOF OF RESIDENCY

PART 1: STUDENT AND PARENT/LEGAL GUARDIAN INFORMATION

Student's Last Name Student's First Name Grade Birth Date Age M/F

Parent/Legal Guardian's Last Name Parent/Guardian's First Name Parent/Legal Guardian's Home Phone/Cell Phone

Parent/Legal Guardian's Current Street Address Apartment # City State Zip

How long has the student lived full time at the above listed address?

Type of Dwelling in which Family Resides:

- Single Family (house, condo, mobile home, etc) (200) Foster Family/Kinship (210) Doubled-Up (120) Motel/Hotel (110) Shelter/Transitional Housing Program (100) Unsheltered (car/campsite) (130) Other

PART 2: ADDITIONAL ADDRESS HISTORY

Please provide the previous address you or your student have lived, if less than 3 years at current address

Previous Street Address Apartment # City/Country if not in USA State Zip

Please provide the address of other property you (or spouse) currently own, rent, or lease in the U.S.

Street Address of additional location Apartment # City State Zip

PART 3: DECLARATION OF UNDERSTANDING

Initial next to each statement to indicate your understanding

- California Education Code (Section 48200) and District Administrative Regulation 5111 require that a student be enrolled in and attend the school that is within the district in which the student's parent(s) or legal guardian(s) reside(s). My Student resides with me full time (or legally mandated residency of 50% or more) at the address listed above, which is my full time primary residence. I agree to notify the District, within 15 calendar days, if the student or I, move. Berryessa Union School District will actively investigate all cases where it has reason to believe false information has been provided on this statement or to any school/district official. I understand that home visitation and/or residency verification is part of a periodic process when residency is established in the Berryessa Union School District. I also understand that the District staff may verify residency status, which may include home visits and investigations. The District may refer cases in which false information has been provided to the County District Attorney for further action and/or file civil action to recover damages incurred as a result of providing false information. Persons who provide or solicit false information are subject to criminal prosecution for perjury, which is punishable by fine and/or prison (up to 4 years) and may be found civilly liable for fraud, negligent misrepresentation, or negligence. [Civil Code § 1709] [Family Code § 6552; Penal Code § 118 and 126] I am aware and understand that should this statement be found to be false, I could be held liable for the expense of education for my student at a cost based on the state's revenue limit per school year. In the event investigations that reveal that students have enrolled on the basis of providing false information, they will be dropped from enrollment and required to transfer to his/her resident school.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. In accordance with State Compliance I have attached the required documentation as proof of residence for enrollment.

Signature of Parent/Legal Guardian Date Daytime Telephone

OFFICE USE ONLY

List what was shown (1) List what was shown (2) Mail verified by: Date

## REQUIRED DOCUMENTS FOR PROOF OF RESIDENCY VERIFICATION

<i>If you own</i>	<i>If you rent</i>
<p><b>One</b> of the following documents in parent's name, showing residency property address where the student physically resides.  <b>P.O. Boxes are not accepted as a residence address.</b></p>	
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)
<p><b>and one</b> of the following documents in parent's name showing residency property address</p>	
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.	

**PART 4: (FAMILY AFFIDAVIT) TO BE COMPLETED BY OWNER/LANDLORD IF LIVING WITH ANOTHER FAMILY**

*Initial next to each statement below to indicate your understanding and provide Proof of Residency documents in owner/landlord's name*

\_\_\_\_\_  
 Student's Last Name                      Student's First Name                      Grade                      Birth Date                      Age                      M/F

\_\_\_\_\_  
 Parent/Legal Guardian's Last Name                      Parent/Guardian's First Name                      Parent/Legal Guardian's Home Phone/Cell Phone

\_\_\_\_\_  
 Parent/Legal Guardian's Current Street Address                      Apartment #                      City                      State                      Zip

The above named occupants live full-time in a residence owned/leased by me. I understand that if this student/family are not actually living with me (*or living in the residence owned/leased by me*) at this address on a full-time basis, the enrollment of this student in the Berryessa Union School District will cease. I hereby agree to notify school officials immediately if there is any change of address for the student(s) living in my residence. I have provided proof of my residence at time of enrollment/renewal (or change of address) within the Berryessa Union School District boundaries.

**One** of the following documents in property owner's name, showing residency property address, such as:  
 Deed of Trust, Grant Deed, Property Tax Bill (or payment receipt), Mortgage Statement, Escrow Letter, Tax Assessment Card, Current Lease or Rental Agreement that must state able to sublet.

**And one** of the following documents in property owner's name, showing residency property address, such as:  
 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.

***I understand intentionally giving false information is considered fraudulent and falsification of information will be justification for student(s) being withdrawn from school. Berryessa Union School District reserves the right to verify residence. Families may expect a verification visit/check from district staff.***

\_\_\_\_\_ I am the Owner/Landlord of the property at the above residence.

\_\_\_\_\_ I attest that the student and parent listed above, reside at the above residence.

**I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.**

\_\_\_\_\_  
 Owner/Landlord Name (*please print*)

\_\_\_\_\_  
 Signature of Owner/Landlord

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Daytime Telephone

**PARENT/GUARDIAN REGISTERING THE STUDENT MUST PROVIDE TWO PIECES OF MAIL WITH THEIR NAME AND CURRENT ADDRESS ON IT, SUCH AS: VEHICLE REGISTRATION, INCOME TAX PAPERS, STATE ASSISTANCE VERIFICATION, PAY STUB, W-2, CELL PHONE BILL, CREDIT CARD STATEMENT, MEDICAL INSURANCE.**

OFFICE USE ONLY

\_\_\_\_\_  
 List what was shown (1)

\_\_\_\_\_  
 List what was shown (2)

\_\_\_\_\_  
 Mail verified by:

\_\_\_\_\_  
 Date

**STUDENT ENROLLMENT FORM**

**PLEASE PRINT - ALL AREAS MUST BE COMPLETE**

**STUDENT/FAMILY INFORMATION**

First Day of Attendance: _____	<b>OFFICE USE ONLY</b>
Neighborhood School: _____	
Teacher: _____	Date Received: _____
Student ID: _____	Time Received: _____

\_\_\_\_\_  
Student's Legal Last Name      Legal First Name      Legal Middle Name      Other Name Used

\_\_\_\_\_  
Student's Home Address      City      Zip Code      Home Phone Number      Grade: \_\_\_\_\_

Student Date of Birth      Student Place of Birth:      Male \_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month    Day    Year    City      State      Country      Female \_\_\_\_\_

<b>OFFICE USE ONLY:</b> Birth Verification <input type="checkbox"/> B. C. <input type="checkbox"/> P <input type="checkbox"/> B. R. <input type="checkbox"/> H. R. <input type="checkbox"/> S. T.
--

**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/PostGrad

**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/PostGrad

**TYPE OF DWELLING** (*federally mandated*)

- Single Family (house, condo, mobile home, etc) (200)     Shelter/Transitional Housing Program (100)
- Temporarily Doubled-Up (120)     Foster Family/Kinship (210)
- Motel/Hotel (110)     Unsheltered (car/campsite) (130)     Other \_\_\_\_\_

**SPECIAL PROGRAMS:** Has your child received assistance from or participated in any of the following programs:  
 Language/Speech/Hearing (LSH)       Resource Specialist Program (RSP)       504 Plan     Special Day Class (SDC)  
 Individual Education Plan (IEP)\*       Modified/Adaptive Physical Ed       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  
Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

**Please indicate your primary race/ethnicity by marking only one "P".**  
**Indicate as many other race/ethnicity as appropriate by indicating with an "X". Must select at least one.**  
\_\_\_ 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

**What other language would you like written correspondence in?**     English     Chinese     Spanish     Vietnamese

**MOBILITY:** (Required for State Testing Reports)      **PLEASE NOTE:** The below questions do not pertain to Preschool  
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 (Grds 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
- Asthma
- Diabetes
- Hearing Problems
- Heart Problems
- Limited Physical Activity
- Neurological Condition
- Orthopedic Condition
- Other Significant Health Concerns
- Seizure Disorder
- Vision Problems - Eye disease such as glaucoma, cataracts, color blindness, other (please explain below)

Please explain: \_\_\_\_\_  
 \_\_\_\_\_

**\* FOOD ALLERGIES REQUIRE 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.

<u>Name</u>	<u>Address, City</u>	<u>Telephone</u>	<u>Relationship to Student</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

<u>Name</u>	<u>Gender</u>	<u>Birth Date</u>	<u>Grade</u>	<u>School</u>	<u>Relationship to Student</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**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: 2020-2021

Resident verification: \_\_\_\_\_ AND \_\_\_\_\_  
 (List what was shown) (List what was shown)

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





# PARENTS' GUIDE TO IMMUNIZATIONS REQUIRED FOR SCHOOL ENTRY



Starting July 1, 2019

## Students Admitted at TK/K-12 Need:

- **Diphtheria, Tetanus, and Pertussis (DTaP, DTP, Tdap, or Td) — 5 doses**  
(4 doses OK if one was given on or after 4th birthday.  
3 doses OK if one was given on or after 7th birthday.)  
For 7th-12th graders, at least 1 dose of pertussis-containing vaccine is required on or after 7th birthday.
- **Polio (OPV or IPV) — 4 doses**  
(3 doses OK if one was given on or after 4th birthday)
- **Hepatitis B — 3 doses**  
(Not required for 7th grade entry)
- **Measles, Mumps, and Rubella (MMR) — 2 doses**  
(Both given on or after 1st birthday)
- **Varicella (Chickenpox) — 2 doses**

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

## Students Starting 7th Grade Need:

- **Tetanus, Diphtheria, Pertussis (Tdap) — 1 dose**  
(Whooping cough booster usually given at 11 years and up)
- **Varicella (Chickenpox) — 2 doses**  
(Usually given at ages 12 months and 4-6 years)

In addition, the TK/K-12 immunization requirements apply to 7th graders who:

- previously had a valid personal beliefs exemption filed before 2016 upon entry between TK/Kindergarten and 6th grade
- are new admissions

## Records:

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. Parents must show their child's Immunization Record as proof of immunization.

# 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 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. 2<sup>nd</sup> 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

Call center for all Planned Parenthood clinics:  
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 Rose Garden**  
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
- **Foothill Community Health Center, Gilroy Clinic**  
9460 No Name Uno, Suite 110, Gilroy CA 95020  
1.408.729.9700
- **Foothill Community Health Center, Family Clinic**  
1066 South White Rd., #170, San Jose, CA 95127  
1.408.729.9700
- **Foothill Community Health Center, Montpelier Clinic**  
2380 Montpelier Dr., #200, San Jose, CA 95116  
1.408.254.1800
- **Foothill Community Health Center, Story Clinic**  
2880 Story Rd., San Jose, CA 95127  
1.408.729-9700
- **Indian Health Center, Meridian**  
1333 Meridian Ave., San Jose, CA 95125  
1.408.445.3400
- **Indian Health Center, SilverCreek**  
1642 E Capitol Expy., San Jose, CA 95121  
1.408.445.3400 x200

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

- **Children's Health Initiative**  
1.888.244.5222
- **Child Health & Disability Prevention Program**  
1.408.937.2250
- **Medi-Cal Eligibility**  
1.877.962.3633
- **Santa Clara Valley Health & Hospital System  
Valley Connection**  
1.888.334.1000

# The **ABCs** of Health Coverage for **ALL** Kids

**HEALTHY  
KIDS MAKE  
BETTER  
LEARNERS.**

**ALL CHILDREN,  
regardless of  
immigration status,  
are eligible for  
Medi-Cal coverage.**

Health coverage and care are an important part of making sure children and youth succeed in school and life. As of May 16, 2016, health coverage through Medi-Cal is available to all undocumented children under 19 years old, whose families meet the income requirements. For example, all children in a family of four that has a monthly income of \$5,387 will qualify for coverage.

## **A** Apply any time of the year

You can enroll in Medi-Cal any time of the year. You can apply over the phone, through a mail-in application, or in person at your local county human services office or local clinic. Get help finding a clinic at [www.localclinic.net](http://www.localclinic.net) or by calling (855) 899-7587.

## **B** Bring what you need

When you apply for Medi-Cal, bring as many of the following items as you can:

- ▶ **Proof of Identity** (any passport or photo ID)
- ▶ **Proof of Income** (current pay stub or bank statement)
- ▶ **Proof of Residency** (telephone or electric bill)
- ▶ **Medi-Cal cards of other family members**, if applicable

\* Not all items are needed to enroll; more examples are accepted.

## **C** Coverage and care are free or low cost

Medi-Cal is free for children whose household meets certain income requirements. Other families, depending on their income, may have a small monthly fee. For all children, Medi-Cal coverage opens the door to free preventive care and treatment, including medical, vision, dental, and mental health services. Getting regular preventive care, like checkups and screenings, makes it possible to identify and treat health problems before they become more serious conditions.

### **IMMIGRANT FAMILIES**

can enroll their children in Medi-Cal without worrying how personal information, including their immigration status, will be shared. Personal information is safe and protected and will NOT be shared with immigration officials or used for immigration enforcement purposes. Medi-Cal will only use personal information to check eligibility status for health coverage.



**HEALTH  
CARE  
FOR ALL  
FAMILIES**

A PROJECT OF THE CHILDREN'S PARTNERSHIP



FOR MORE INFORMATION GO TO:

[www.allinforhealth.org/health4allkids](http://www.allinforhealth.org/health4allkids)

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# PUNTOS PRINCIPALES

## relacionados con la cobertura médica de **TODOS** los niños

**LOS NIÑOS SANOS APRENDEN MEJOR.**

**TODOS los niños, sin importar su estatus migratorio, son elegibles para cobertura con Medi-Cal.**

La cobertura médica y el cuidado médico son importantes para asegurarse que los niños y los jóvenes tengan éxito en la escuela y en la vida. A partir del 16 de mayo de 2016, la cobertura médica a través de Medi-Cal está disponible para todos los niños indocumentados menores de 19 años cuyas familias cumplan con los requisitos de ingreso. Por ejemplo, todos los niños en una familia de cuatro personas que tenga un ingreso mensual de \$5,387 calificarán para cobertura médica.



### Solicite en cualquier época del año

Usted puede inscribirse en Medi-Cal en cualquier época del año. Puede solicitar por teléfono, a través de una solicitud por correo, o en persona en la oficina local de servicios sociales del condado. Obtenga ayuda para encontrar una clínica en el siguiente sitio web [www.clinicalocal.net](http://www.clinicalocal.net) o llamando al (855) 899-7587.



### Traiga lo que se necesita

Cuando solicite Medi-Cal traiga, de los siguientes documentos, los más que pueda:

- ▶ **Comprobante de identidad** (cualquier pasaporte o identificación con fotografía)
- ▶ **Comprobante de ingreso** (talón de cheque o comprobante de cuenta de banco más reciente)
- ▶ **Comprobante de residencia** (recibo de teléfono o luz)
- ▶ **Tarjetas de Medi-Cal de otros miembros de la familia** (según aplique)

\* No todos los documentos anteriores se necesitan para inscribirse; se aceptan más ejemplos.



### La cobertura médica y el cuidado médico son gratuitos o de bajo costo

Medi-Cal es gratuito para niños cuyas familias cumplen con ciertos requisitos de ingreso. Otras familias, dependiendo de su ingreso, pueden tener una pequeña cuota mensual. Para todos los niños, la cobertura con Medi-Cal abre las puertas a cuidado médico preventivo y tratamiento gratuitos, incluyendo cuidado médico, de visión, dental y servicios de salud mental. El obtener cuidado médico preventivo regularmente, como revisiones y visitas médicas rutinarias, hace posible el identificar y tratar problemas de salud antes de que se conviertan en condiciones más serias.

### LAS FAMILIAS INMIGRANTES

pueden inscribir a sus hijos en Medi-Cal sin preocuparse por cómo se utilizará su información personal, tal como su estatus migratorio. Los datos personales están seguros y protegidos y NO se compartirán con oficiales de inmigración; tampoco se utilizarán para propósitos de inmigración. Medi-Cal únicamente utilizará su información personal para verificar su elegibilidad para cobertura médica.



**Asegúrate, para el bienestar de tu familia**

UN PROYECTO DE "THE CHILDREN'S PARTNERSHIP"



PARA MÁS INFORMACIÓN VISITE:

[www.allinforhealth.org/health4allninos](http://www.allinforhealth.org/health4allninos)

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## What Does CHDP Offer?

The CHDP program helps to prevent or find health problems through regular, no cost, health check-ups. A check-up includes:

- Health and developmental history
- Physical exam
- Needed shots
- Oral health screening and routine referral to a dentist starting by age 1
- Nutrition screening
- Behavioral screening
- Vision screening
- Hearing screening
- Health information
- Lab tests, which may include: anemia, lead, tuberculosis, and other problems, as needed
- Referral to Women, Infants, and Children (WIC) program for children up to age 5

## Other Services

If further health services are needed, we will help you find them, including:

- Dentists that accept Denti-Cal for the care of your child's teeth
- Medical specialists, as needed
- Mental and behavioral health services, as needed

Diagnosis and treatment can be paid for as long as your child has Medi-Cal.

## Information

For more information about CHDP, transportation options, or for help setting up an appointment, contact your local CHDP office.

You can find your local CHDP office by visiting the California Department of Health Care Services website at: [www.dhcs.ca.gov/services/chdp](http://www.dhcs.ca.gov/services/chdp)

***Regular health check-ups keep your child healthy.***

***Health check-ups can also find and treat problems before they become serious.***



Edmund G. Brown, Jr.  
Governor, State of California

PUB 183 (English, 9/15)

## English

### Child Health and Disability Prevention (CHDP) Program

## Medical and Dental Health Check-Ups



# FREE

For Babies, Children, and Youth  
Under age 21 with Full Scope Medi-Cal or  
Under Age 19 with Low Family Income.  
No Documentation Required



## Why Get Health Check-Ups?

Health check-ups are important for all children and youth. Health check-ups are a time to:

- Find and address medical, dental, mental, and behavioral health problems
- Get needed shots
- Ask your doctor questions

Health check-ups can also be used for foster care, sports, camp, or school entry, as needed.

### Babies and Toddlers Birth Through 3 Years

Regular check-ups can keep your baby happy and healthy. You can find out about your baby's growth, weight, and health, and needed shots are given. At 1 year and 2 years, your baby should be tested for lead. A test for anemia is also given. Your child should see a dentist at least once a year starting by age 1.



### Dental

Please contact your local CHDP office for assistance to find a Dentist who accepts Denti-Cal. CHDP may also assist with appointment scheduling and transportation if necessary.

### School Children 4 Through 12 Years

It is important to make sure your child is healthy and ready for school. State laws require children to be up to date on their shots and get a health check-up.

School children will also get vision and hearing screenings. If your child has not had a lead test before, he/she should have one by age 6 or before. Your child should see a dentist at least once a year.



### Vision & Hearing

The local CHDP office can provide assistance to obtain vision and hearing services if medically necessary.

## Who is Eligible?

Children and youth up to age 21 who are eligible for Medi-Cal. Children and youth under age 19 with family incomes less than or equal to 200% Federal Income Guidelines are also eligible. Proof of residence and income is not required.

### Teens and Young Adults 13 Through 20 Years

Teens need health check-ups too! This is a chance to make sure your teen is growing and developing well. It is also a time for you or your teen to ask the doctor any questions. Extra health check-ups can be given for sports and camp physicals. Your child should see a dentist at least once a year.



### Mental Health, Autism and Behavioral Services

Contact the local CHDP office for assistance to access these services.



Pathway to the Future

## 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.*

PLEASE COMPLETE OTHER SIDE





Pathway to the Future

## 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: \_\_\_\_\_

PLEASE COMPLETE OTHER SIDE

## STUDENT USE OF TECHNOLOGY

### ACCEPTABLE USE AGREEMENT AND RELEASE OF DISTRICT FROM LIABILITY (STUDENTS)

The Berryessa Union School District authorizes students to use technology owned or otherwise provided by the district as necessary for instructional purposes. The use of district technology is a privilege permitted at the district's discretion and is subject to the conditions and restrictions set forth in applicable Board policies, administrative regulations, and this Acceptable Use Agreement. The district reserves the right to suspend access at any time, without notice, for any reason.

The district expects all students to use technology responsibly in order to avoid potential problems and liability. The district may place reasonable restrictions on the sites, material, and/or information that students may access through the system.

Each student who is authorized to use district technology and his/her parent/guardian shall sign this Acceptable Use Agreement as an indication that they have read and understand the agreement.

#### Definitions

*District technology* includes, but is not limited to, computers, the district's computer network including servers and wireless computer networking technology (wi-fi), the Internet, email, USB drives, wireless access points (routers), tablet computers, smartphones and smart devices, telephones, cellular telephones, personal digital assistants, pagers, MP3 players, wearable technology, any wireless communication device including emergency radios, and/or future technological innovations, whether accessed on or off site or through district- owned or personally owned equipment or devices.

#### Student Obligations and Responsibilities

Students are expected to use district technology safely, responsibly, and for educational purposes only. The student in whose name district technology is issued is responsible for its proper use at all times. Students shall not share their assigned online services account information, passwords, or other information used for identification and authorization purposes, and shall use the system only under the account to which they have been assigned.

Students are prohibited from using district technology for improper purposes, including, but not limited to, use of district technology to:

1. Access, post, display, or otherwise use material that is discriminatory, libelous, defamatory, obscene, sexually explicit, or disruptive
2. Bully, harass, intimidate, or threaten other students, staff, or other individuals ("cyberbullying")
3. Disclose, use, or disseminate personal identification information (such as name, address, telephone number, Social Security number, or other personal information) of another student, staff member, or other person with the intent to threaten, intimidate, harass, or ridicule that person
4. Infringe on copyright, license, trademark, patent, or other intellectual property rights

5. Intentionally disrupt or harm district technology or other district operations (such as destroying district equipment, placing a virus on district computers, adding or removing a computer program without permission from a teacher or other district personnel, changing settings on shared computers)
6. Install unauthorized software
7. "Hack" into the system to manipulate data of the district or other users
8. Engage in or promote any practice that is unethical or violates any law or Board policy, administrative regulation, or district practice

**Privacy**

Since the use of district technology is intended for educational purposes, students shall not have any expectation of privacy in any use of district technology.

The district reserves the right to monitor and record all use of district technology, including, but not limited to, access to the Internet or social media, communications sent or received from district technology, or other uses. Such monitoring/recording may occur at any time without prior notice for any legal purposes including, but not limited to, record retention and distribution and/or investigation of improper, illegal, or prohibited activity. Students should be aware that, in most instances, their use of district technology (such as web searches and emails) cannot be erased or deleted.

All passwords created for or used on any district technology are the sole property of the district. The creation or use of a password by a student on district technology does not create a reasonable expectation of privacy.

**Personally Owned Devices**

If a student uses a personally owned device to access district technology, he/she shall abide by all applicable Board policies, administrative regulations, and this Acceptable Use Agreement. Any such use of a personally owned device may subject the contents of the device and any communications sent or received on the device to disclosure pursuant to a lawful subpoena or public records request.

**Reporting**

If a student becomes aware of any security problem (such as any compromise of the confidentiality of any login or account information) or misuse of district technology, he/she shall immediately report such information to the teacher or other district personnel.

**Consequences for Violation**

Violations of the law, Board policy, or this agreement may result in revocation of a student's access to district technology and/or discipline, up to and including suspension or expulsion. In addition, violations of the law, Board policy, or this agreement may be reported to law enforcement agencies as appropriate.

**Student Acknowledgment**

I have received, read, understand, and agree to abide by this Acceptable Use Agreement and other applicable laws and district policies and regulations governing the use of district technology. I understand that there is no expectation of privacy when using district technology. I further understand that any violation may result in loss of user privileges, disciplinary action, and/or appropriate legal action.

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
(Please print)

School: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent or Legal Guardian Acknowledgment**

If the student is under 18 years of age, a parent/guardian must also read and sign the agreement.

As the parent/guardian of the above-named student, I have read, understand, and agree that my child shall comply with the terms of the Acceptable Use Agreement. By signing this Agreement, I give permission for my child to use district technology and/or to access the school's computer network and the Internet. I understand that, despite the district's best efforts, it is impossible for the school to restrict access to all offensive and controversial materials. I agree to release from liability, indemnify, and hold harmless the school, district, and district personnel against all claims, damages, and costs that may result from my child's use of district technology or the failure of any technology protection measures used by the district. Further, I accept full responsibility for supervision of my child's use of his/her access account if and when such access is not in the school setting.

Name: \_\_\_\_\_  
(Please print)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\*\* Should you wish to opt your child out of this technology agreement, it will be necessary for the parent or guardian to meet with the site principal for further clarification and discussion on how this choice would impact your child's access to the curriculum.**

### Oral Health Assessment Form

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

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

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

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

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

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

#### Section 3: Waiver of Oral Health Assessment Requirement

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

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

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

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

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

**Return this form to the school *no later than May 31* of your child's first school year.**  
*Original to be kept in child's school record.*

# 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											
<p>8. CHECK ONE:</p> <p><input type="checkbox"/> Participant has a disability or a medical condition and <i>requires</i> 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. <b>A licensed physician must sign this form.</b></p> <p><input type="checkbox"/> 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. <b>A licensed physician, physician's assistant, or registered nurse must sign this form.</b></p>													
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: <i>(PLEASE DESCRIBE IN DETAIL TO ENSURE PROPER IMPLEMENTATION)</i>													
<p>12. INDICATE TEXTURE:</p> <p style="text-align: center;"> <input type="checkbox"/> Regular                      <input type="checkbox"/> Chopped                      <input type="checkbox"/> Ground                      <input type="checkbox"/> Pureed         </p>													
<p>13. FOODS TO BE OMITTED AND SUBSTITUTIONS: <i>(PLEASE LIST SPECIFIC FOODS TO BE OMITTED AND SUGGESTED SUBSTITUTIONS. YOU MAY ATTACH A SHEET WITH ADDITIONAL INFORMATION)</i></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center; border: none;"><b>A. Foods To Be Omitted</b></td> <td style="width: 50%; text-align: center; border: none;"><b>B. Suggested Substitutions</b></td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> </table>				<b>A. Foods To Be Omitted</b>	<b>B. Suggested Substitutions</b>	_____	_____	_____	_____	_____	_____	_____	_____
<b>A. Foods To Be Omitted</b>	<b>B. Suggested Substitutions</b>												
_____	_____												
_____	_____												
_____	_____												
_____	_____												
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.

In accordance with Federal law and U.S. Department of Agriculture policy, this agency is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410, or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

**Please return to:**  
**Child Nutrition Services Department**  
**951 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
<b>POLIO</b> (OPV or IPV)					
<b>DtaP/DTP/DT/Td</b> (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
<b>MMR</b> (measles, mumps, and rubella)					
<b>HIB MENINGITIS</b> (Haemophilus Influenzae B) (Required for child care/preschool only)					
<b>HEPATITIS B</b>					
<b>VARICELLA</b> (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 Tuberculosis (TB) Risk Assessment for School Entry

**This form must be completed by a U.S. licensed primary care provider and returned to the child's school.**

1. Was your child born in, or has your child resided in or traveled to (for more than one week) a country with an elevated TB rate?\*  Yes  No
2. Has your child been exposed to anyone with TB disease?  Yes  No
3. Has a family member had a positive TB test or received medications for TB?  Yes  No
4. Was a parent, household member, or visitor who stayed in the child's home for >1 week, born in a country with an elevated TB rate?\*  Yes  No
5. Is your child immunosuppressed [e.g. due to HIV infection, organ transplant, treatment with TNF-alpha inhibitor or high-dose systemic steroids (e.g. prednisone ≥ 15 mg/day for ≥ 2 weeks)]?  Yes  No

\*Most countries other than the U.S., Canada, Australia, New Zealand, or a country in western or northern Europe. This does not include tourist travel for <1 month (i.e. travel that does not involve visiting family or friends, or involve significant contact with the local population).

If **YES**, to any of the above questions, the child has an increased risk of TB and should have a TB blood test (IGRA, i.e. QuantiFERON or T-SPOT.TB) or a tuberculin skin test (TST) unless there is either 1) a documented prior positive IGRA or TST performed in the U.S. or 2) no new risk factors since last documented negative IGRA (performed at age ≥2 years in the U.S.) or TST (performed at age ≥6 months in the U.S.).

**All children with a current or prior positive IGRA/TST result must have a medical evaluation, including a chest x-ray (CXR; posterior-anterior and lateral for children <5 years old is recommended). CXR is not required for children with documented prior treatment for TB disease, documented prior treatment for latent TB infection, or BCG-vaccinated children who have a positive TST and negative IGRA. If there are no symptoms or signs of TB disease and the CXR is normal, the child should be treated for latent TB infection (LTBI) to prevent progression to TB disease.**

**Enter test results for all children with a positive risk assessment:**

Interferon Gamma Release Assay (IGRA) Date: _____	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate
Tuberculin Skin Test (TST/Mantoux/PPD) Date placed: _____ Date read: _____	Induration _____ mm Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Chest X-Ray Date: _____ Impression: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
LTBI Treatment Start Date: _____ <input type="checkbox"/> Rifampin daily - 4 months <input type="checkbox"/> Isoniazid/rifapentine - weekly X 12 weeks <input type="checkbox"/> Isoniazid daily - 9 months <input type="checkbox"/> Other: _____	<input type="checkbox"/> Prior TB/LTBI treatment (Rx & duration): _____ <input type="checkbox"/> Treatment medically contraindicated: _____ <input type="checkbox"/> Declined against medical advice
Please check one of the boxes below and sign: <input type="checkbox"/> Child has no TB symptoms, no risk factors for TB, and does not require a TB test. <input type="checkbox"/> Child has a risk factor, has been evaluated for TB and is free of active TB disease. <input type="checkbox"/> Child has no new risk factors since last negative IGRA/TST and no TB symptoms.	
_____ Health Care Provider Signature, Title <span style="float: right;">Date</span>	

**Name/Title of Health Provider:**

**Facility/Address:**

**Phone number:**

# County of Santa Clara

## Public Health Department

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



### Testing Methods

An Interferon Gamma Release Assay (IGRA, i.e. QuantiFERON or T-SPOT.TB) or Mantoux tuberculin skin test (TST) should be used to test those at increased risk. An IGRA can be used in all children  $\geq 2$  years old and is preferred in BCG-vaccinated children to avoid a false positive TST result. A TST of  $\geq 10$ mm induration is considered positive. If a child has had contact with someone with active TB disease (yes to question 2 on reverse), or the child is immunosuppressed, then TST  $\geq 5$  mm is considered positive. If a BCG-vaccinated child has a positive TST, and an IGRA is subsequently performed and is negative, testing is considered negative unless the child was exposed to someone with TB disease or is immunosuppressed. For immunosuppressed children, screening should be performed by CXR in addition to a TST/IGRA (consider doing both) and symptom review.

### Evaluation of Children with Positive TB Tests

- All children with a positive IGRA/TST result must have a medical evaluation, including a CXR (posterior-anterior and lateral is recommended for children  $<5$  years old). A CXR is not required for a positive TST with negative IGRA in a BCG-vaccinated child, or if the child has documentation of prior treatment for TB disease or treatment for latent TB infection.
- For children with TB symptoms (e.g. cough for  $>2-3$  weeks, shortness of breath, hemoptysis, fever, weight loss, night sweats) or an abnormal CXR consistent with active TB disease, report to the County of Santa Clara Public Health Department TB Program within one day. The child will need to be evaluated for TB disease with sputum AFB smears/cultures and nucleic acid amplification testing. A negative TST or IGRA does not rule out active TB disease in a patient with symptoms or signs of TB disease. The child cannot enter school unless active TB disease has been excluded or treatment has been initiated.
- If there are no symptoms or signs of TB disease and the CXR is normal, the child should be treated for latent TB infection (LTBI). Do not treat for LTBI until active TB disease has been excluded.
- Short-course regimens (rifampin daily for four months or 12-dose weekly isoniazid/rifapentine) are preferred (except in persons for whom there is a contraindication, such as a drug interaction or contact to a person with drug-resistant TB) due to similar efficacy and higher treatment completion rates as compared with 9 months of daily isoniazid

### Treatment Regimens for Latent TB Infection

- Rifampin 15 - 20 mg/kg (max. 600 mg) daily for 4 months
- 12-dose Weekly Isoniazid/Rifapentine (3HP) Regimen:
  - Isoniazid
    - 2-11 years old: 25 mg/kg rounded up to nearest 50 or 100 mg (max. 900 mg)
    - $\geq 12$  years old: 15 mg/kg rounded up to nearest 50 or 100 mg (max. 900 mg)
  - Rifapentine
    - 10.0-14.0 kg: 300 mg
    - 14.1-25.0 kg: 450 mg
    - 25.1-32.0 kg: 600 mg
    - 32.1-50.0 kg: 750 mg
    - $>50$  kg: 900 mg
  - Vitamin B6 50 mg weekly
- Isoniazid 10 mg/kg (range, 10-15 mg/kg; max. 300 mg) daily for 9 months. Recommended pyridoxine dosage is 25 mg for school-aged children (or 1-2 mg/kg/day).

For additional information: [www.sccphd.org/tb](http://www.sccphd.org/tb) or contact the TB Control Program at (408) 885-2440.