



**SANTA CRUZ CITY SCHOOLS
ENROLLMENT FORM**

School of Enrollment:

Student ID Number:

Please provide the student's information as it appears on their Birth Certificate

Last Name	First Name	Middle Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date / /
Birthplace: City	State	Country		

The following are Federal and State Requirements

Student Ethnicity: Hispanic or Latino or Not Hispanic or Latino

Student Race: (Check all that apply. You must select at least one)

The above question is about Ethnicity, not Race. No matter what you selected above, please also answer the following by marking one or more boxes to indicate what you consider your race to be.

<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White: Hispanic or Latino <input type="checkbox"/> White: Not Hispanic or Latino	Asian: <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hmong <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Asian	Native Hawaiian or other Pacific Islander: <input type="checkbox"/> Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Tahitian <input type="checkbox"/> Other Pacific Islander
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Program Participation (Check all that apply)

Is the student in foster care? Yes No If yes, please provide placement documentation.

GATE 504 Accommodation Plan (please provide the most recent copy) Migrant

Special Education: Date of last IEP: Speech (please attach a copy of current IEP)

Has the student ever been referred to the School Attendance Review Board (SARB)? Yes No

Has the student ever been referred to a school disciplinary meeting? Yes No

Enrollment History

Prior grade completed:	Enrolling in grade:
Original entry date in US schools	____/____/____ Month Day Year
Original entry date in California schools	____/____/____ Month Day Year
Original entry date in this district	____/____/____ Month Day Year

Has the student ever been retained? Yes No If yes, list grade repeated:

Previous Schools Attended

School Name:	School Name:
Address:	Address:
City, State, Zip Code:	City, State, Zip Code:
Phone: ()	Phone: ()
Fax: ()	Fax: ()
Dates Attended:	Dates Attended:



**SANTA CRUZ CITY SCHOOLS
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Primary Household Contact Information					
Home Address					
Number	Street Name	Apt. Number	City	Zip code	
Is this a permanent, regular and adequate nighttime residence? <input type="checkbox"/> Yes <input type="checkbox"/> No (Not a motel, campground, shelter or living with friends or family out of necessity, not by choice)					
Mailing Address (if different from the home address)					
P.O. Box	Number	Street Name	Apt. Number	City	Zip Code
<input type="checkbox"/>					
Primary Household Number: ()			<input type="checkbox"/> Home phone <input type="checkbox"/> Cell Phone		
Student Contact Number: ()			Student E-mail Address:		
Parent/Guardian Information (Complete one section for each adult. If you are a legal guardian, please attach documentation)					
<input type="checkbox"/> Primary Residence			<input type="checkbox"/> Primary Residence <input type="checkbox"/> Secondary Residence		
Name:			Name:		
Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other:			Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other:		
Does the student live with this Parent/Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No			Does the student live with this Parent/Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Contact Number: ()			Home Address (if different than student's primary residence):		
Secondary Contact Number: ()					
E-mail Address:			Does this person request duplicate mailings? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer:			Primary Contact Number: ()		
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:			Secondary Contact Number: ()		
Highest Education Level			E-mail Address:		
<input type="checkbox"/> Not a High School Graduate <input type="checkbox"/> High School Graduate			Employer:		
<input type="checkbox"/> Some College <input type="checkbox"/> College Graduate <input type="checkbox"/> Graduate School			Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		
Are there custody arrangements? <input type="checkbox"/> Yes <input type="checkbox"/> No			Highest Education Level		
If yes, please provide documentation or specify verbal agreement: _____			<input type="checkbox"/> Not a High School Graduate <input type="checkbox"/> High School Graduate		
			<input type="checkbox"/> Some College <input type="checkbox"/> College Graduate <input type="checkbox"/> Graduate School		
List all children living at home					
Name		School		Grade Level	
Is there anything else you would like us to know about your student? _____					
Please notify the school immediately of any change in the above information.					
Parent/Guardian Signature:				Date: / /	



SANTA CRUZ CITY SCHOOLS
STUDENT EMERGENCY INFORMATION

Teacher:	Room:
Emergency Phone Number: ()	

Student's Last Name	First Name	M.I.	Gender	Birth Date	Grade
			<input type="checkbox"/> M <input type="checkbox"/> F	/ /	

Parent/Guardian Information	Parent/Guardian Information
<input type="checkbox"/> Change of Information	<input type="checkbox"/> Change of Information
Name:	Name:
Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other:	Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other:
Home Address: _____	Home Address: _____
Primary Contact Number: ()	Primary Contact Number: ()
Secondary Contact Number: ()	Secondary Contact Number: ()
E-mail Address:	E-mail Address:
Employer:	Employer:
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:
Does the student live with this Parent/Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the student live with this Parent/Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are there custody arrangements? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are there custody arrangements? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide documentation or specify verbal agreement: _____	If yes, please provide documentation or specify verbal agreement: _____

List siblings currently attending any Santa Cruz City School		
Name	School	Grade Level

Emergency Contacts		
If we are unable to reach you, we must have 3 local contact persons who you authorize to pick up your student from school if: your student is ill, needs medical attention or must be evacuated due to a natural disaster.		
Name	Relationship	Contact Number

Health Information			
Primary Doctor	Phone Number	Dentist	Phone Number
	()		()

Does your student currently have Medical Insurance? Yes No Insurance Carrier: _____

If not, would you like information about free/low-cost health insurance? Yes No

In case of an emergency (serious illness or injury), when I cannot be reached, I hereby authorize SCCS personnel to obligate me for services of a local doctor/hospital for my student.

Please notify the school immediately of any change in the above information.

Parent/Guardian Signature: _____	Date: / /
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Name of Student: _____ **Age** _____ **Birth date** _____ **Grade** _____

(Nombre del Estudiante): **Last** (Apellido) **First** (Primer Nombre) **Middle** (Segundo Nombre) (Edad) (Fecha de Nacimiento) (Grado)

Birthplace: _____ **Last School Attended:** _____

(Lugar de Nacimiento): **City** (Ciudad) **State/Country** (Estado/País) (última escuela que asistió): **Name** (Nombre) **City/State/Country** (Ciudad/Estado/País)

A Home Language Survey (HLS) is used to determine a student's primary language and is on file for each student in the District, including Migrant, Special Education and continuation school enrollees. Your assistance in providing accurate information is requested.
Please answer all the questions and sign below.

Una encuesta de idioma del hogar es usada para determinar el primer idioma y está archivada para cada estudiante en el distrito, incluyendo estudiantes inscritos como migrantes o en Educación Especial. Se solicita su ayuda en proveer la información correcta.
Por favor conteste todas las preguntas y firme abajo.

1. Which language did your child learn when he/she first began to speak? _____
2. What language do you use most frequently to speak to your child? _____
3. What language does your child most frequently use at home? _____
4. Name the language most often spoken by the adults at home. _____
5. What year and in what state did your child enroll in a school in the USA for the first time? _____
6. Have you moved within the past 3 years, even for a short time? _____
7. Did you move so that you or a member of our family could find work in agriculture? _____

1. Cuando su hijo empezó a hablar. ¿cuál idioma aprendió primero? _____
2. Cuando usted habla con su hijo. ¿Qué idioma usa con más frecuencia? _____
3. En casa. ¿Qué idioma habla su hijo con más frecuencia? _____
4. Mencione el idioma que hablan los adultos con más frecuencia en la casa. _____
5. ¿En qué año y en qué estado inscribió a su hijo por primera vez en una escuela de los Estados Unidos? _____
6. ¿Se ha mudado de domicilio durante los últimos 3 años aunque sea por un período corto? _____
7. ¿Se mudó para que usted o algún miembro de su familia obtuviera trabajo en la agricultura? _____

Each student whose home language is other than English as determined on this form will be assessed in English listening, speaking, reading and writing. You will receive a letter with your child's results and program placement recommendation.

Cada estudiante para quien su idioma del hogar es diferente al inglés por determinación de este formulario será evaluado en escuchar, hablar, leer y escribir en inglés. Ud. recibirá una carta con los resultados y la recomendación del programa en que se ubicará a su hijo.

Do you prefer communication from your school in: English Spanish ?

¿Usted prefiere comunicación de la escuela en: Inglés Español?

Parent/Guardian Signature: _____ Address: _____ Phone: _____

Firma De Padre/Tutores _____ Domicilio _____ Teléfono _____

CA Ed Code S52164.1(a) Distribution: **Original Student's Cum** Copy to: **Curriculum, Intervention, and Assessment**

2017-2018
Santa Cruz City Schools
Student Health History

Student's Last Name _____ First _____ Initial _____ Birthdate _____ Grade _____ M F

Doctor: _____ Dentist: _____ Medical Insurance Provider _____

1. CHECK THIS BOX IF STUDENT HAS NO KNOWN HEALTH PROBLEMS & SIGN BELOW.

2. Check boxes below that apply to your student and sign below.

- *Diabetes** Type 1 Type 2 Medications? Oral Injection Pump Given at school? Yes No
Name of medication? _____ MD's Name/Phone# _____
- *Allergic Reactions** To what? _____ Hives /rash? Yes No
Difficulty breathing? Yes No Has EpiPen? Yes No
MD's Name/Phone# _____
- * Seizure Disorder** Date of last seizure? _____ Requires Medication? Yes No
Name of Medication? _____ MD's Name/ Phone# _____
- Orthopedic conditions** Any physical limitations? _____
Wheelchair? Corrective shoes/braces? Crutches?
- Asthma** Requires medication/ inhaler? Yes No Name of medication _____
Given at school? Yes No MD's Name/ Phone# _____
- Heart Problems** Diagnosis: _____ MD's Name/Phone# _____
Medications ? Yes No Physical Restrictions Yes No
- Mental Health** Anxiety, Depression PTSD
Diagnosis: _____ Under care? Yes No
Medications: _____ MD/Therapist Name/Phone# _____
- ADHD** Requires medication Yes No Name of medication _____
Given at school? Yes No MD's Name/Phone # _____
- Hospitalizations** Explain: _____
- Taking medication?** For what condition? _____ Name of medication _____
Given at school? Yes No MD Name/Phone# _____
- Vision Problems** Wears glasses? Contacts? Reading only? All the time? Date of last exam _____
- Hearing Problems** Permanent Hearing Loss? Hearing aid? Left Right Both Date of last exam _____

Please list other important health or behavior information: _____

These conditions require a Health Care Plan. Note: Any of the above conditions may require a Health Care Plan. All forms can be obtained from the School Health Office

Parent Name _____ **Parent signature** _____
Date _____ **Best phone number to reach parent** _____



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Superintendent of
Schools

Molly Parks
Assistant Superintendent
Human Resources

Patrick Gaffney
Assistant
Superintendent
Business Services

Frank Wells
Assistant Superintendent
Educational Services

K-5th Grade School Entry Requirements – Health

Dear Parent or Guardian:

As your child prepares to enter school, it is also the time to take a look at your child's health. About 10% of children entering school have a health problem that is unknown to their parents. Below are the health requirements that California law requires for school entry.

1. Health Examination Requirement (CHDP) Child Health and Disability Program

A thorough health examination is required for all children entering school. This health check-up may be completed any time from 18 months before entering first grade to 90 days (and no later) after starting first grade. The "**Report of Health Check-up for School Entry**" form must be completed and signed by your child's doctor and returned to the school health office. In order to save time parents, are urged to have their child examined before starting kindergarten since immunization boosters are needed at this time.

NOTE: All children who are eligible for Medi-Cal are eligible for this health check-up at no cost. Some children are eligible to receive a CHDP health check-up at no cost to their family, depending on the family's size and income. If you want to find out if your child is eligible, call the Santa Cruz County Health Services Agency (**CHDP**) at **(831) 763-8100**.

2. Oral Health Examination: 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. The following resources will help you find a dentist and complete this requirement for your child:

- 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 (831) 454-4165.
- For additional resources that may be helpful, contact the local public health department at (831) 454-4000.

3. Immunization Requirements

At registration, you will need an **immunization record** showing that your child has received all the required immunizations to enroll, or a Medical Exemption letter from your child's doctor.

4 Polio (3 doses if 3rd dose given on or after 4th birthday)

3 Hepatitis B

5 DPT (4 doses if 4th dose given on or after 4th birthday)

1 Varicella or documentation of Chickenpox disease

2 MMR (both doses must be given on or after 1st birthday)

Board of Trustees

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Oral Health Assessment Form

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

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

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

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

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

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

Section 3: Waiver of Oral Health Assessment Requirement

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

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

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

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

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

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

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	ZIP Code	SCHOOL	BIRTHDATE—Month/Day/Year
ADDRESS—Number/Street	City				

PART II TO BE FILLED OUT BY HEALTH EXAMINER

IMMUNIZATION RECORD

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

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).

REQUIRED TESTS/EVALUATIONS	DATE
Health History	
Physical Examination	
Dental Assessment	
Nutritional Assessment	
Developmental Assessment	
Vision Screening	
Audiometric (hearing) Screening	
Tuberculin Test (Mantoux/PPD)	
Blood Test (for anemia)	
Urine Test	
Blood Lead Test	
Other	

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DTaP/DT/DTT/d (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER (optional)

and RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

- Fill out if patient or guardian has signed the release of health information.
- Examination shows no condition of concern to school program activities.
- Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: (please explain)

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.

WAIVER OF HEALTH EXAMINATION FOR SCHOOL ENTRY

CHILD'S NAME—Last	First	Middle	BIRTH DATE—Month/Day/Year	
ADDRESS—Number/Street	City	ZIP Code	SCHOOL	Teacher

PARENT OR GUARDIAN:

Please fill out this form if you want to excuse your child from the health examination required by California law for school entry. **SIGN AND RETURN THIS FORM TO THE SCHOOL** where it will be maintained as confidential information.

NOTE: SIGNING THIS WAIVER **DOES NOT** EXCUSE YOUR CHILD FROM RECEIVING THE IMMUNIZATIONS REQUIRED BY CALIFORNIA LAW FOR CHILDREN IN SCHOOL. ALSO, SIGNING THIS WAIVER WILL NOT DENY YOUR CHILD THE VISION AND HEARING TESTS DONE BY THE SCHOOL.

I have been informed about the health examination recommended by health professionals and required by state law. I have been informed about where my child can receive a health examination and about the income levels for receiving it at no cost to me.

Please check one of the following:

- I choose not to have my child receive a health examination as a part of the school entry requirement.
- I would like my child to receive a health examination, but I am unable to obtain it.

Reason (see Health and Safety Code, Section 124085):

Signature of parent or guardian

Date

INQUIRE AT THE SCHOOL OFFICE OR YOUR LOCAL HEALTH DEPARTMENT IF YOU WANT MORE INFORMATION.