

# MILLER CREEK SCHOOL DISTRICT STUDENT REGISTRATION

GRADE

Student Last Name:

► Has your student ever attended a Miller Creek public school before?  Yes  No

PLEASE PRINT – STUDENT’S LEGAL NAME

Legal First Name	Legal Middle Name	Legal Last Name	Other Legal Name (if applicable)
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Male  Female  
 Non-Binary

Birth date:

Month	Day	Year
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Parent/Guardian First Name	Last Name	Home Phone ( ) ( )	Work Phone ( ) ( )
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E-mail Address: \_\_\_\_\_

Parent/Guardian First Name	Last Name	Home Phone ( ) ( )	Work Phone ( ) ( )
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E-mail Address: \_\_\_\_\_

Residence Address (house # & street name)	Apt #	City	State	Zip
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Mailing Address (IF DIFFERENT from above)	Apt #	City	State	Zip
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First Name:

**WHAT IS YOUR CHILD’S ETHNICITY? (Must check one):**  Hispanic or Latino  Not Hispanic or Latino

**WHAT IS YOUR CHILD’S RACE? (Can check up to five racial categories)**

*The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be.*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> American Indian or Alaskan Native(100) | <input type="checkbox"/> Laotian (206)     | <input type="checkbox"/> Samoan (303)                     |
| <input type="checkbox"/> Chinese (201)                          | <input type="checkbox"/> Cambodian (207)   | <input type="checkbox"/> Tahitian (304)                   |
| <input type="checkbox"/> Japanese (202)                         | <input type="checkbox"/> Hmong (208)       | <input type="checkbox"/> Other Pacific Islander (399)     |
| <input type="checkbox"/> Korean (203)                           | <input type="checkbox"/> Other Asian (299) | <input type="checkbox"/> Filipino/Filipino American (400) |
| <input type="checkbox"/> Vietnamese (204)                       | <input type="checkbox"/> Hawaiian (301)    | <input type="checkbox"/> African American or Black (600)  |
| <input type="checkbox"/> Asian Indian (205)                     | <input type="checkbox"/> Guamanian (302)   | <input type="checkbox"/> White (700)                      |

Permanent/Local ID:

**PARENT EDUCATION** – Check the response that describes the education level of the **most educated parent** and which parent with whom the student lives.  Mother  Father

- Graduate Degree or Higher (10)
- College Graduate (11)
- Some College or Associate’s Degree (12)
- High School Graduate (13)
- Not a High School Graduate (14)

Date first attended school <u>in the U.S.</u>		
Month	Day	Year
Date first attended school <u>in California</u>		
Month	Day	Year

**BIRTHPLACE:** City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

**PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THE FORM**

**Parent/Guardianship Information (with whom the student lives) – check all that apply**

Father  Mother  Both  Step-Father  Step-Mother  Guardian  Foster/Group Home  Other \_\_\_\_\_  
 Is the above (checked) person(s) the student’s LEGAL guardian?  Yes  No If No, please complete a “Caregiver Affidavit”  
 If there is a legal custody agreement regarding this student, please check one and attach a copy:  
 Joint Custody  Sole Custody  Guardian

**PLEASE COMPLETE INFORMATION BELOW FOR PARENT(S)/GUARDIAN WITH WHOM THE STUDENT LIVES:**

1.  Parent  Guardian (check one) Full Name: \_\_\_\_\_  
 Employer: \_\_\_\_\_ City: \_\_\_\_\_ Daytime Phone # ( \_\_\_\_ ) \_\_\_\_\_

2.  Parent  Guardian (check one) Full Name: \_\_\_\_\_  
 Employer: \_\_\_\_\_ City: \_\_\_\_\_ Daytime Phone # ( \_\_\_\_ ) \_\_\_\_\_

**DUPLICATE MAILING** – If divorced/separated & joint custody allows duplicate mailing/information to be given to other parent, Please include their name, address, and phone number:

Full Name: \_\_\_\_\_ Phone #: ( \_\_\_\_ ) \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

**MOST RECENT SCHOOLS ATTENDED/MOBILITY:**

	School	Address/City/State/Zip	Grade(s)	Date(s)
Recent				
Previous				

Are there psychological or confidential reports available from your child’s former school?  Yes  No  
 Has your child been suspended?  Yes  No Has your child ever been expelled?  Yes  No  
 What special services has your child received? **(please check all boxes that apply)**  
**Special Education:**  Resource (RSP)  Special Day Class (SDC)  Speech/Language  
**Other:**  Gifted (GATE)  Remedial Math  Remedial Reading  Counseling  English Language Development  504  
 Help to Improve Attendance/ Behavior  Retained  
 Other (Specify) \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

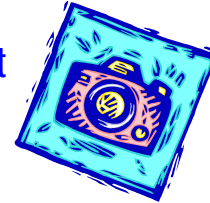
**BELOW FOR SCHOOL USE ONLY**

Proof of Birth: Type: _____ Verified by: _____	Proof of Residence: Type: _____ Verified by: _____	Proof of Immunization: Type: _____ Verified by: _____	Entry Reason:	Enroll Date:	Assigned Grade:	Permanent ID:
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**PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THE FORM**

**\*\*NOTE: Please give this form to your child's preschool.**

Transition to Kindergarten – Child Snapshot



**Dear Early Childhood Teacher:**

In order to assist with this child's transition into Kindergarten, please complete this information about the child and send it to the Miller Creek School District at 380 Nova Albion Way, San Rafael, CA 94903. This ECE teacher information will be passed on to the child's new Kindergarten teacher.

**ECE Teacher Completing Form**

ECE Teacher Completing Form:

\_\_\_\_\_

Name Phone number Name of ECE Program Date

**Child's Information**

1. Child's Name

\_\_\_\_\_

First Middle Last Name

2. Child's date of birth

\_\_\_\_/\_\_\_\_/\_\_\_\_

Month Day Year

**Child's Social Emotional Development**

3. Are there other children that this child should not be placed with?

Yes  No  Don't Know

Other Child's Name: \_\_\_\_\_

Other Child's Name: \_\_\_\_\_

4. At school, does this child play mostly alone, with others, or both?

Mostly alone  Mostly with others  Both

5. How often is this child able to... (check one)	Most of the time	Some of the time	Never
a. Sit attentively for 10-15 minutes for large group or circle time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Cooperate with and share with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Follow the classroom routine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Make a choice and engage in the selected activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Ask the teacher for help?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Follow two step directions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Please describe any areas in which this child needs help (e.g. toileting, classroom behavior)?

\_\_\_\_\_

7. Please describe strategies or accommodations that work well for this child:

\_\_\_\_\_

**Cognitive and Physical Development**

8. Can this child identify letters?

 None  Few  Many  All  Don't Know

9. Does this child show developmentally appropriate fine motor skills (for example, use scissors, grip pencil, etc.)?

 Yes  No  Don't Know

10. Can this child recognize numbers 1-10?

 None  Few  Many  All  Don't Know

11. Can this child write symbols to create meaning?

 Yes  No  Don't Know

12. Can this child read?

 Yes  No  Don't Know**Language Development**

13. Language(s) this child speaks:

At home \_\_\_\_\_

At school \_\_\_\_\_

14. How often does this child communicate clearly?

 Most of the time  Some of the time  Never

15. How often does this child use sentences to communicate?

 Most of the time  Some of the time  Never**Special Needs**16. Does this child have an Individual Education Plan (IEP)?  Yes  No  Don't Know

17. What services has this child received?

18. Please describe this child's learning style.

**Special Interests/Strengths**

19. Please describe this child's favorite activities.

20. Please describe this child's strengths.

21. What would you like another teacher to know about this child? (For example, family situation, personality, behavior, living arrangements, etc.)

**Please return the Teacher form to the child's school of attendance. Thank you!****Mary E. Silveira Elementary**  
375 Blackstone Drive  
San Rafael, CA 94903**Vallecito Elementary**  
50 Nova Albion Way  
San Rafael, CA 94903**Lucas Valley Elementary**  
1175 Idylberry Road San  
Rafael, CA 94903

# Lucas Valley School New Parent Questionnaire

Child's Name \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Right or Left handed \_\_\_\_\_

Names and ages of siblings \_\_\_\_\_  
\_\_\_\_\_

Birth order: \_\_\_\_\_ oldest \_\_\_\_\_ youngest \_\_\_\_\_ middle \_\_\_\_\_ only child \_\_\_\_\_ twin

Language/s spoken in child's home \_\_\_\_\_

Does your child have: (if yes please explain) \_\_\_\_\_

difficulties with speech \_\_\_\_\_

health problems or allergies \_\_\_\_\_

difficulty regulating emotions \_\_\_\_\_

vision and/or hearing problems \_\_\_\_\_

learning difficulties \_\_\_\_\_

behavior problems \_\_\_\_\_

an I.E.P. \_\_\_\_\_

other \_\_\_\_\_

Is your child taking any medications? Please explain \_\_\_\_\_  
\_\_\_\_\_

Is your child afraid of anything? \_\_\_\_\_

What responsibilities does your child have at home? \_\_\_\_\_  
\_\_\_\_\_

What behavioral strategies do you use at home (ie. sticker chart, time out)? \_\_\_\_\_

\_\_\_\_\_

What time does your child go to bed? \_\_\_\_\_

What is your bedtime routine? \_\_\_\_\_

\_\_\_\_\_

How much TV and/or video games does your child watch? \_\_\_\_\_

How much time do you read with your child? \_\_\_\_\_

Who reads to your child? And in what language? \_\_\_\_\_

What are your child's strengths or talents? \_\_\_\_\_

What are your child's hobbies? \_\_\_\_\_

What are your child's personal qualities? \_\_\_\_\_

Do you have any health/safety concerns? \_\_\_\_\_

Are there any issues that could affect attendance or learning? \_\_\_\_\_

\_\_\_\_\_

The most important thing you should know about my child is \_\_\_\_\_

\_\_\_\_\_

Is there anything else you would like us to know about your child? \_\_\_\_\_

\_\_\_\_\_

How would you like to be involved in your child's school experience? Check as many as you like:

\_\_\_\_\_ classroom volunteer

\_\_\_\_\_ drive on field trips

\_\_\_\_\_ room parent

\_\_\_\_\_ garden helper

\_\_\_\_\_ do projects at home

\_\_\_\_\_ other (describe) \_\_\_\_\_

# NEW

## TRANSITIONAL KINDERGARTEN & KINDERGARTEN QUESTIONNAIRE & PLACEMENT

CHILD'S NAME: \_\_\_\_\_ CALLED BY: \_\_\_\_\_ M\_\_\_\_F\_\_\_\_  
(LAST) (FIRST)

Placement in Family (1st of 3, 2nd of 4, etc.) \_\_\_\_\_ Birthdate: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ Work Ph. \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ Work Ph. \_\_\_\_\_

Parents: \_\_\_\_\_ Natural \_\_\_\_\_ Adoptive \_\_\_\_\_ Foster

### PRESCHOOL/DAY CARE EXPERIENCE:

Name of Institution	Number of Years	Number of Days (per week)	Number of Hours (per day)

Day Care Plans  Yes  No WHERE? \_\_\_\_\_

Bussing Plans  Yes  No WHERE? \_\_\_\_\_

Please provide the following information:

1. Languages spoken in the home: \_\_\_\_\_

2. Age your child began to talk: \_\_\_\_\_

3. Special Health Information (vision, hearing, allergies, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. Handedness: Right \_\_\_\_\_ Left \_\_\_\_\_ Ambidextrous \_\_\_\_\_

5. Describe your child's behavior: \_\_\_\_\_

\_\_\_\_\_

6. Further information to help us better know your child (interests, experiences, social skills, etc.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_





## HOME LANGUAGE SURVEY

Name of Student: \_\_\_\_\_  
(Surname / Family Name) (First Given Name) (Second Given Name)

Date of Birth: \_\_\_\_\_ Site: \_\_\_\_\_ Enrollment Grade: \_\_\_\_\_

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### Directions to Parents and Guardians:

The California *Education Code* contains legal requirements which direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with these requirements. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered. If an error is made completing this home language survey, you may request correction before your student's English proficiency is assessed.

1. Which language did your child learn when he/she first began to talk? \_\_\_\_\_
2. Which language does your child most frequently speak at home? \_\_\_\_\_
3. Which language do you (the parents or guardians) most frequently use when speaking with your child? \_\_\_\_\_
4. Which language is most often spoken by adults in the home? (parents, guardians, grandparents, or any other adults) \_\_\_\_\_

Please sign and date this form in the spaces provided below, then return this form to your child's teacher. Thank you for your cooperation.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date



July 2022

## Oral Health Notification Letter

Dear Parent or Guardian:

Having a healthy mouth helps your child do well in school. To make sure your child is ready for school, California law *Education Code* Section 49452.8, requires that your child have an oral health assessment or dental check-up in his or her first year in public school (kindergarten or first grade). Every child needs an oral health assessment from a licensed dentist or other licensed or registered dental health professional, and a completed Oral Health Assessment form (attached to this letter) to meet this requirement.

If your child has not had an oral health assessment in the past 12 months, they will need one before May 31. Take the attached form to your child's dentist to complete, if your child had an oral health assessment or dental check-up in the past 12 months. The following information will help you find a dentist:

1. You can call the Medi-Cal Telephone Service Center at 1-800-322-6384 or visit [Smile California - Find a Dentist \(https://smilecalifornia.org/find-a-dentist/\)](https://smilecalifornia.org/find-a-dentist/) to find a dentist that accepts Medi-Cal. For help enrolling your child in Medi-Cal, you can apply by mail, go in person to your local Social Services office, or online at [Apply for Medi-Cal. \(https://www.dhcs.ca.gov/services/medi-cal/pages/applyformedi-cal.aspx\)](https://www.dhcs.ca.gov/services/medi-cal/pages/applyformedi-cal.aspx)
2. For additional resources that may be helpful, contact your local public health department, click [Apply for Health Coverage \(https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx\)](https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx) to find yours.

When you take your child to the dentist, bring the attached form to be completed.

If you cannot take your child for an oral health assessment, please fill out the separate Waiver of Oral Health Assessment Requirement form, and return the form.

Please return the form to (insert school-specific information to return form). Your child's identity will not be in any report. Schools keep students' health information private. You can get more copies of the form at your child's school or on-line from the [California Department of Education. \(https://www.cde.ca.gov/ls/he/hn/oralhealth.asp\)](https://www.cde.ca.gov/ls/he/hn/oralhealth.asp)



We want your child to be healthy and ready for school! Even though they fall out, baby teeth are very important. Children need healthy baby teeth to eat, talk, smile, and feel good about themselves. Children with cavities may have pain, difficulty eating, stop smiling, and have problems paying attention and learning at school.

Here is important advice to help your child stay healthy:

- Take your child to the dentist. Dental check-ups can help keep your child's mouth healthy and pain free.
- Choose healthy foods for the entire family, like fresh fruits and vegetables.
- Brush teeth at least twice a day with toothpaste that contains fluoride.
- Limit candy and sweet drinks like punch, juice or soda. Sweet drinks and candy contain a lot of sugar, which causes cavities and leaves less room for your child to have healthy foods and drinks. Sweet drinks and candy can also cause weight problems, which may lead to other diseases, such as diabetes. Give your child healthy choices like water, milk, and fruit instead.

If you have questions about the new oral health assessment requirement, please contact the school district office at (415) 492-3700.

Thank you!

Sincerely,

Becky Rosales  
District Superintendent

**Oral Health Assessment/Waiver Request Form**

California law, *Education Code* Section 49452.8, now requires that your child have an oral health assessment **by May 31st** in kindergarten or first grade, whichever is his or her first year of public school. The law specifies that the assessment must be performed by a licensed dentist or other licensed or registered dental health professional. Oral health assessments that have happened within the 12 months before your child enters school also meet this requirement. If you cannot take your child for this assessment, you may be excused from this requirement by filling out Section 3 of this form.

**Section 1**

**To be completed by the 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 Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:			

**Section 2**

**Oral Health Data Collection**

**To be completed by the dental professional conducting the assessment**

Assessment Date:	<u>Visible caries and/or fillings present:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Visible caries present:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Treatment Urgency:</u> <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended <input type="checkbox"/> Urgent care needed
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\_\_\_\_\_  
*Dental professional's signature*

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

**Section 3**

**Waiver of Oral Health Assessment Requirement**

**To be completed by a parent or guardian requesting to be excused from this requirement**

I request that my child be excused from the oral health assessment requirement for the following reason: (Please check the box that best describes the reason.)

- I am unable to find a dental office that will take my child's insurance plan.  
My child is covered by the following insurance plan:  
 Medi-Cal/Denti-Cal    Healthy Families    Healthy Kids    None  
 Other \_\_\_\_\_

- I cannot afford an oral health assessment for my child.
- I do not wish my child to receive an oral health assessment.

Optional: other reasons my child could not get an oral health assessment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**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. If you have any questions about this requirement, please contact your school office.**

\_\_\_\_\_  
*Signature of parent or guardian*

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

Grade	Number of Doses Required of Each Immunization <sup>1, 2, 3</sup>				
<b>K-12 Admission</b>	<b>4 Polio<sup>4</sup></b>	<b>5 DTaP<sup>5</sup></b>	<b>3 Hep B<sup>6</sup></b>	<b>2 MMR<sup>7</sup></b>	<b>2 Varicella</b>
<b>(7th-12th)<sup>8</sup></b>	<b>K-12 doses</b>	<b>+ 1 Tdap</b>			
<b>7th Grade Advancement<sup>9,10</sup></b>		<b>1 Tdap<sup>8</sup></b>			<b>2 Varicella<sup>10</sup></b>

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

DTaP/Tdap = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine

Hep B = hepatitis B vaccine

MMR = measles, mumps, and rubella vaccine

Varicella = chickenpox vaccine

### Instructions:

California schools are required to check immunization records for all new student admissions at TK / Kindergarten through 12th grade and all students advancing to 7th grade before entry. See [shotsforschool.org](https://shotsforschool.org) for more information.

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

- Receipt of immunization.
- A permanent medical exemption.\*

**Conditionally Admit** any pupil who lacks documentation for unconditional admission if the pupil has:

- Commenced receiving doses of all the vaccines required for the pupil's grade (table above) and is not currently due for any doses at the time of admission (as determined by intervals listed in the Conditional Admission Schedule, column entitled "Exclude If Not Given By"), or
- A temporary medical exemption from some or all required immunizations.\*

## Conditional Admission Schedule for Grades K-12

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

Dose	Earliest Dose May Be Given	Exclude If Not Given By
<b>Polio #2</b>	4 weeks after 1st dose	8 weeks after 1st dose
<b>Polio #3<sup>1</sup></b>	4 weeks after 2nd dose	12 months after 2nd dose
<b>Polio #4<sup>1</sup></b>	6 months after 3rd dose	12 months after 3rd dose
<b>DTaP #2</b>	4 weeks after 1st dose	8 weeks after 1st dose
<b>DTaP #3<sup>2</sup></b>	4 weeks after 2nd dose	8 weeks after 2nd dose
<b>DTaP #4</b>	6 months after 3rd dose	12 months after 3rd dose
<b>DTaP #5</b>	6 months after 4th dose	12 months after 4th dose
<b>Hep B #2</b>	4 weeks after 1st dose	8 weeks after 1st dose
<b>Hep B #3</b>	8 weeks after 2nd dose and at least 4 months after 1st dose	12 months after 2nd dose
<b>MMR #2</b>	4 weeks after 1st dose	4 months after 1st dose
<b>Varicella #2</b>	Age less than 13 years: 3 months after 1st dose	4 months after 1st dose
<b>Varicella #2</b>	Age 13 years and older: 4 weeks after 1st dose	8 weeks after 1st dose

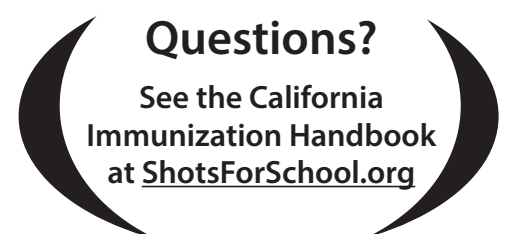
1. Three doses of polio vaccine meet the requirement if one dose was given on or after the fourth birthday. If polio #3 is the final required dose, polio #3 should be given at least six months after polio #2.
2. If DTaP #3 is the final required dose, DTaP #3 should be given at least six months after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

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

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

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

\* In accordance with 17 CCR sections 6050-6051 and Health and Safety Code sections 120370-120372.





# Marin County Report of Health Examination for School Entry

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ Medi-Cal # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_ Phone \_\_\_\_\_

Reason for referral if other than pre-school physical: \_\_\_\_\_ School Nurse \_\_\_\_\_ Phone \_\_\_\_\_

**HEALTH EXAMINATION MUST INCLUDE AREAS NOTED IN BOLD.** (Please check if done and note results as appropriate)

**Date of Exam:** \_\_\_\_\_ Is child  New?  Established to your care?

		<b>Follow-Up / Referral</b>	
		Please indicate who will follow-up	
		<b>HEALTH PROVIDER</b>	<b>SCHOOL NURSE</b>
<input type="checkbox"/> <b>Health and Developmental History</b>			
<input type="checkbox"/> <b>Nutritional Assessment</b>	Height _____ Weight _____ B/P _____		
<input type="checkbox"/> <b>Physical Examination</b>	Dental Assessment <input type="checkbox"/> Normal <input type="checkbox"/> Possible caries <b>DENTAL</b>		
<input type="checkbox"/> <b>Blood Test for Anemia</b>	Blood Test for Lead: <input type="checkbox"/> No <input type="checkbox"/> Yes Result: _____		
<input type="checkbox"/> <b>Urine Test</b>	Exposure to second hand smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes		

**Vision Testing:** Acuity Test Used:  Snellen  Titmus **VISION**

Right: 20/ \_\_\_\_\_ Left: 20/ \_\_\_\_\_ Eye muscle testing:  Normal  Abnormal

Referred?  Yes  No Student should wear glasses:  Yes  No

**Audiometry Screening** **AUDIO**

Tympanograms (Optional)

	1000	2000	3000	4000
<b>Right</b>				
<b>Left</b>				

Right \_\_\_\_\_ Left \_\_\_\_\_

Referred?  Yes  No

Comments: \_\_\_\_\_

**ADDITIONAL INFORMATION FROM HEALTH EXAMINER:** **OTHER**

Does this child have any conditions that might concern the school?  No  Yes

If yes, explain condition(s) and recommendations for follow-up: \_\_\_\_\_

Are there any restrictions from physical activities?  No  Yes

If yes, explain \_\_\_\_\_

Does this child take any medication(s)?  No  Yes If yes, explain \_\_\_\_\_

*(If child must take medication at school, please request and complete a medication form.)*

Stamp or print examiner's name, address, phone number

\_\_\_\_\_  
Examiner's Signature

**TB skin test (PPD) required for school entry unless BCG given within past 12 mos.**

Date given \_\_\_/\_\_\_/\_\_\_ Date read \_\_\_/\_\_\_/\_\_\_

Induration \_\_\_\_\_ mm  Negative  Positive

Chest X-Ray required If positive

Date \_\_\_/\_\_\_/\_\_\_  Normal  Abnormal

## Immunization Dates

<b>Polio (OPV or IPV)</b>					
<b>DTP / DTaP</b>					
<b>DT / Td</b>					
<b>HIB Meningitis</b>					
<b>MMR</b>					
<b>Hepatitis B</b>					
<b>Varicella</b>					
<b>Other</b>					

If any required immunizations were not given, list reason: \_\_\_\_\_

\_\_\_\_\_ Exemption expiration date \_\_\_/\_\_\_/\_\_\_

MILLER CREEK SCHOOL DISTRICT

STUDENT HEALTH APPRAISAL (K-8)

Your child's learning depends upon good health. Please complete the following to assist school Health Services.

Name \_\_\_\_\_ Birth date \_\_\_\_\_ School \_\_\_\_\_

Grade \_\_\_\_\_ Teacher/Rm \_\_\_\_\_ Home Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Mother's phone during day \_\_\_\_\_

Father's Name \_\_\_\_\_ Father's phone during day \_\_\_\_\_

Last Physical Exam: Date \_\_\_\_\_ Dr. \_\_\_\_\_ Last Dental Exam: Date \_\_\_\_\_ Dr. \_\_\_\_\_

DOES YOUR CHILD HAVE?

- ADD/ADHD No Yes Specify
Allergies No Yes Specify
Anorexia/Bulimia No Yes Specify
Asthma No Yes Mild/Moderate/Severe (check one) Trigger: Inhaler?
Bee Sting/Insect Allergy No Yes Local Reaction Generalized Reaction Medication needed?
Blood Disorder No Yes Specify
Cancer No Yes Specify
Depression No Yes Specify
Diabetes No Yes Takes Insulin No Yes
Ear Infections No Yes Date of last ear infection List period(s) of chronic ear infection
Epilepsy or Seizures No Yes Date of last seizure
Heart Condition No Yes Specify
Kidney Disease No Yes Specify
Migraines No Yes Specify
Orthopedic Problem No Yes Specify
Social/Emotional Problem No Yes Specify
Speech Problem No Yes Specify
Ulcers No Yes Specify
Other No Yes Specify

HAS YOUR CHILD HAD?

- Serious Illness/Injury No Yes Specify type and date
Surgery (Operations) No Yes Specify type and date

DOES YOUR CHILD HAVE?

- Trouble seeing close work? No Yes
Trouble seeing at distance? No Yes
Trouble hearing? No Yes

DOES YOUR CHILD?

- Wears glasses? No Yes Last vision exam date
Wears contacts? No Yes Last vision exam date
Wears hearing aid? No Yes Last exam date

Does your child have a condition which prevents participation in regular PE (running push-ups, wrestling, contact sports, etc.)? No Yes Specify

Does your child have any medical or physical restrictions? No Yes Specify

Does he/she take daily medications? No Yes Specify
Required at school? No Yes Specify

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_



**ADDRESS VERIFICATION INSTRUCTIONS**

**Residency verification paperwork must be submitted:**

- Before a new student is registered
- Any time a student's address changes
- At the beginning of every school year
- Prior to participation in extracurricular activities (upon request)
- Before a change between levels (such as elementary to middle school )

**RESIDENCY REQUIREMENTS**

*Unless otherwise permitted by law:*

- Students **MUST** reside within the specific school's attendance area or have an approved Intradistrict or Interdistrict Transfer on file with the Miller Creek Elementary School District. The school will require 4 proofs of residency for **ALL** students. All proofs must have same name and address.
- Proof of Residency - Parents or guardians must provide proof that they live within the school's attendance area.
- Any change of address that results in a change of school attendance boundaries must be approved at the district office. If a school is at capacity, students will be placed on a waiting list or may attend the school located in the prior attendance area on an approved intradistrict transfer agreement. (5111.1) See table below for requirements (Ed Code 48204.1)

<b>1. Parent's/Guardian's Picture I.D.</b> <i>One of the following with the parent or guardian name:</i>	<b>2. Residency Verification</b> <i>One of the following original documents with parent or guardian name:</i>	<b>3. Residency Documentation</b> <i>Two of the following original documents (no more than one from any section) with parent or guardian name:</i>
Current CA State Driver's License <i>(must show current address)</i>	Current mortgage payment dated within the past 60 days or real estate document verifying change (e.g., sale or purchase)	A W2 form dated within the year or a Payroll Stub/Checks dated within the last month
Current CA State I.D. Card <i>(must show current address)</i>	State or Federal Tax Return *filed within the past 12 months with W-2 forms attached. Business returns do not meet residency requirements	Government Forms *I.D. or communication from a government agency (e.g., voter registration)
Military I.D./Orders <i>(must show current address)</i>	Property Tax Bill *Parent's name and property address indicating home owner's exemption—most recent billing period	Current PG&E or Cable bill dated within the past 60 days <i>(no water, cell phone or garbage will be accepted)</i>
	Management Company Rental/Lease Current agreement or last two month's receipts *Must include: Parent's name, student's name, address, manager's/owner's name and phone number. (This will be verified by a phone call from the school.)	Bank or credit card statement dated within the past 60 days or valid vehicle registration with current address

**CAREGIVER AFFIDAVITS or DECLARATION of RESIDENCY AFFIDAVITS**

*(Must be approved/renewed every year)*

Caregiver affidavits are applied for through the Miller Creek School District: (415) 492-3700

Students qualify as District residents if they reside **FULL-TIME** in the home of a caregiving adult living within District boundaries. Declaration of Residency affidavits may be obtained at the school office. Both affidavits require district office approval.

This caregiving adult or "Declaration of Residency" adult must provide residency verification as outlined above. "Full-time" residency is defined as:

- The student's primary residence is that of the caregiving adult or "Declaration of Residency" adult and
- The student resides in the home of the caregiving adult or "Declaration of Residency" adult 24 hours a day, seven days a week, and during periods of vacation and/or holidays.

**NOTICE REGARDING FRAUDULENT ENROLLMENT**

Attention All MCSD Families

Any student enrolled in the Miller Creek Elementary School District under fraudulent conditions may have enrollment terminated immediately upon discovery of fraud.

Fraudulent Enrollment is defined as enrolling or attempting to enroll using false information or withholding true information about where you live.

This includes families who:

- ⇒ Claim residence within the MCSD boundaries or within specific school attendance area boundaries, but are living outside of the boundaries
- ⇒ Acquire and produce fraudulent documents to claim MCSD residency
- ⇒ Once resided within the MCSD boundaries, moved, and do not inform the school of the change of address
- ⇒ Claim to live with another family within the District and fraudulently sign a Residency or Caregiver Affidavit
- ⇒ Use any other method to falsely claim residence within MCSD or within a specific school attendance boundary.

I have read the above notice, understand the consequences of fraudulent enrollment, and agree to MCSD residency requirements.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Print Parent Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Name

For District Use Only	
Photo I.D. _____	Initial _____
C.D.L. # _____	
*****	
Description Documentation #1 _____	Initial _____
*****	
Description Documentation #2 _____	Initial _____
*****	
Description Documentation #3 _____	Initial _____