Biggs - Richvale Elementary Schools

NEW STUDENT REGISTRATION

FORMS YOU WILL NEED FOR REGISTRATION INCLUDE:

1. **REGISTRATION FORM:** See attached.
2. **HOME LANGUAGE SURVEY:** See attached form.
3. **CUM REQUEST FORM:** See attached form.
4. **VERIFICATION OF ADDRESS:** A current Government issued document; or a PG&E bill or a City of Biggs bill with you current address and name listed on the form.
5. **BIRTH CERTIFICATE:** Birth Certification for the child who will be attending our school.
6. **IMMUNIZATION RECORDS**: Proof of immunization shots. Note: ALL immunizations must be completed before we can enroll your child.
7. **FIELD TRIP PERMISSION CONSENT TO TRANSPORT AND TREAT** – Field Trip / Excursion form.
8. ***(K & 1st Grade ONLY)*** **REPORT OF HEALTH EXAM:** See attached. Signed by a doctor.
9. ***(7th – 12th Grades ONLY)*** **TDAPP shot** (Whooping Cough)
10. ***IF you live in our bus route, YOU must call our Bus Dispatcher, Monica, at 624-0733.***

BIGGS – RICHVALE ELEMENTARY SCHOOLS

REGISTRATION FORM

☐ Check this box IF address and/or phone is different from last year

(Please type or print clearly all information requested on both sides of this form)

☐ Intra / Inter on file: ☐ Restraining Order on file: **OFFICE USE ONLY** First Enrolled in District: _____ Enrollment Date: _____

☐ Address Verification: ☐ Immunization Verification: ☐ Birth date Verification: Drop Date: _____

Transfer from School: _____ Home Language Survey _____ Date Records Received: _____

Address: _____

School: **Biggs / Richvale Elementary Schools** Grade: _____ Teacher: _____ Student I.D.# _____

Student Name: _____ _____ _____
First Middle Last

MAILING Address: _____ PO Box # _____ **STREET** Address _____ Apt. # _____

City: _____ Zip Code: _____ Home phone # _____

Birth date: ____/____/____ Place of Birth: _____/_____/_____ Sex: _____
Mo. Day Year City State County M/F

Entry Date to USA: ____/____/____ Student's Social Security Number: _____

WHAT IS YOUR CHILD'S ETHNICITY? (Please check one) ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Primary Race (Please check one):

◯ American Indian or Alaskan Native ◯ Cambodian ◯ Guamanian ◯ Japanese ◯ Other Asian ◯ Tahitian
◯ Other Pacific Islander ◯ Chinese ◯ Vietnamese ◯ Korean ◯ Hawaiian ◯ Asian Indian
◯ Black/African American ◯ Filipino ◯ Hmong ◯ Laotian ◯ Samoan ◯ White

Secondary Race (Please check one):

◯ American Indian or Alaskan Native ◯ Cambodian ◯ Guamanian ◯ Japanese ◯ Other Asian ◯ Tahitian
◯ Other Pacific Islander ◯ Chinese ◯ Vietnamese ◯ Korean ◯ Hawaiian ◯ Asian Indian
◯ Black/African American ◯ Filipino ◯ Hmong ◯ Laotian ◯ Samoan ◯ White

NAME OF PERSON(S) WITH WHOM STUDENT LIVES (Parent or Legal Guardian):

(1 - Name) _____
Relationship: _____
STREET Address: _____
City: _____ Zip: _____
HOME phone: _____ Cell: _____
Employer: _____
City: _____ Zip: _____
Work phone _____
Email: _____

(2 - Name) _____
Relationship: _____
STREET Address: _____
City: _____ Zip: _____
HOME phone: _____ Cell: _____
Employer: _____
City: _____ Zip: _____
Work phone _____
Email: _____

Names of Brothers and Sisters:	**M/F**	**School**	**Birth date**
			____/____/____
			____/____/____
			____/____/____

Babysitter: _____ Phone # _____
First Last

◯ **Student is currently under expulsion.** Effective Dates: _____

Student previously enrolled in **Special Education?** ◯ Yes ◯ No Speech? ◯ Yes ◯ No

Student previously identified **504?** ◯ Yes ◯ No

Contacts: ***IMPORTANT! Contacts Listed Below Are Authorized To Pick Up Your Student***

1. _____ _____ _____ _____
Name | Relationship to child | Home phone | Cell phone

2. _____ _____ _____ _____
Name | Relationship to child | Home phone | Cell phone

3. _____ _____ _____ _____
Name | Relationship to child | Home phone | Cell phone

Health / Medical / Consent information:

*In the event of an EMERGENCY involving my child, I authorize Biggs Unified School District staff to arrange for any necessary emergency medical/surgical treatment or procedure on my behalf. _____ **(parent/guardian signature)**

If emergency contacts are NOT available, ALL emergencies will be transported to any Hospital Emergency. (The district/school does not assume responsibility for medical expenses.)

Name of Doctor: _____ Doctor Office phone # _____

Please note any specific health problems: _____

Please list medications taken, if any: _____

Allergic to Foods? ◯ Yes ◯ No If no, what foods? _____

Allergic to Drugs? ◯ Yes ◯ No If no, what drugs? _____

Allergic to Bee Stings? ◯ Yes ◯ No EpiPen Req'd? Yes No Explain: _____

Surgeries? ◯ Yes ◯ No Explain: _____

Serious Illnesses? ◯ Yes ◯ No Explain: _____

Physical Limitations? ◯ Yes ◯ No Explain: _____

Wears Glasses/Contacts? ◯ Yes ◯ No Worn ◯ All the time ◯ Reading ◯ Distance

Hearing Problems? ◯ Yes ◯ No Explain: _____

PLEASE NOTE: State law requires that all students have a completed immunization record upon registering at any school.

Parents' Highest Level of Education: ◯ Not a high school graduate ◯ High school graduate ◯ Some college (includes AA Degree) ◯ College Graduate ◯ Graduate School or Post Graduate training ◯ Decline to state or unknown

Publication and Media Release:

◯ Yes, my child may be interviewed or photographed for publication, media outlets, websites and school publications.

◯ No, my child may not be interviewed or photographed for non school publication.

If available, in what language do you prefer communications from the school be sent?

◯ English ◯ Spanish

Discipline Policy & Legal Notifications Handbook

I have received and understand it is my responsibility to read the Discipline Policy & Legal Notifications Handbook, which includes the Internet Policy.

Date: _____ Signature of Parent or Legal Guardian (REQUIRED): _____

Biggs - Richvale Elementary Schools

BIGGS UNIFIED SCHOOL DISTRICT
300 B Street, Biggs, California 95917
(530) 868-5870 Ext 221
Fax (530) 868-5137

A Culture of Learning and Success!

REQUEST FOR TRANSFER OF EDUCATIONAL RECORDS

STUDENT: _____
(Last Name) (First Name) (Middle Name)

BIRTH DATE: _____ GRADE _____ TODAY'S DATE: _____

LAST SCHOOL ATTENDED: _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

TELEPHONE: _____ FAX #: _____

Please fax Birth Certificate and Immunization records ASAP!!
Include the SSID # _____ (or print in Aeries STU2 page)

In addition, please send ALL student records, cum folders, psychological reports, health histories, confidential records, and CELDT Test to:

Biggs Elementary School
300 B Street
Biggs, CA 95917

_____ _____
School Personnel Parent/Guardian Signature

My child _____ was participating in, or receiving the following services at their previous school:

_____ Special Education – Special Day Class (SDC)
_____ Special Education _ Resource Specialist Program (RSP)
_____ Speech/Language Specialist Program
_____ Migrant Education
_____ Other, specify: _____

Has your child been suspended or expelled? _____ yes _____ no

BIGGS UNIFIED SCHOOL DISTRICT
HOME LANGUAGE SURVEY
ENGLISH VERSION

Name of Student: _____ _____ _____
Surname / Last Name First Given Name Second Given Name

School: _____ Age: ____ Grade Level: _____ Teacher Name: _____

Directions to Parents and Guardians:

The *California Education Code* contains legal requirements which direct schools to determine the language(s) spoken in the home of each student. 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 this legal requirement. 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.

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) _____

Has your student attended another school in the United States? Yes No If yes, please complete the following information:
Name of school: _____ City, State: _____ Dates attended: _____

Has your student attended school in another country? Yes No If yes, please complete the following information:
Name of school: _____ City, State: _____ Dates attended: _____

Has your student attended school in California? Yes No If yes, please complete the following information:
Name of school: _____ City, State: _____ Dates attended: _____

Please sign and date this form in the spaces provided below, then return this form to the school office. Thank you for your cooperation.

_____ _____
Signature of Parent or Guardian Date

Form JLS, Revised October 2005
California Department of Education
Gpm 11-4-2011

BIGGS UNIFIED SCHOOL DISTRICT
CUESTIONARIO DEL IDIOMA EN EL HOGAR
VERSIÓN EN ESPAÑOL

Nombre del estudiante: _____ _____ _____
Apellido Primer nombre Segundo nombre

Escuela: _____ Edad: ____ Grado: _____ *Nombre del maestro:* _____

Direcciones para los Padres o Tutores

El código de educación de California contiene requerimientos legales los cuales dicta a las escuelas a determiner el idioma(s) que se habla en el hogar de cada estudiante . Esta información es fundamental para que la escuela provea servicios y programas de instrucción adecuados.

Como padres o tutores, su cooperacion es requerida para cumplir con este requerimiento legal. Por favor responda a cada una de las cuatro preguntas enlistadas abajo lo mas correcto possible. Para cada pregunta, escriba el nombre(s) del idioma(s) que aplica en el espacio proveido. Por favor no deje ninguna pregunta sin contester.

1. ¿Que idioma aprendio su hijo cuando el/ella comenzsó a hablar? _____
2. ¿Que idioma su hijo/a habla mas frecuentemente en el hogar? _____
3. ¿Que idoma usted (los padres o tutores) usa mas frecuentemente cuando habla con su hijo/a? _____
4. ¿Que idioma es el mas hablado por los adultos en el hogar? (padres, tutores, abuelos, o cualquier otro adulto) _____

Su estudiante ha atendido otra escuela en Estados Unidos? Si No Si si, por favor complete la siguiente información:
Nombre de la escuela: _____ Ciudad, Estado: _____ Fechas que atendió: _____

Su estudiante ha atendido la escuela en otro pais? Si No Si si, por favor complete la siguiente información:
Nombre de la escuela: _____ Ciudad, Estado: _____ Fechas que atendió: _____

Su estudiante ha atendido escuela en California? Si No Si si, por favor complete la siguiente información:
Nombre de la escuela: _____ Ciudad: _____ Fechas que atendió: _____

Por favor de firmar y regresar esta forma a la oficina. Gracias por su coperacion.

_____ _____
Firma del Padre o Tutor Fecha

Form JLS, Revised October 2005
California Department of Education
Ggm 11-4-2011

Absence Verification

PARENTS

Please post this on your refrigerator or bulletin board
...or ...
Copy and download the data on your phone!

Dear Parent:

When your child is absent from school for any reason, it is VERY important to report the absence to us.

To verify an absence, please call one of our Secretaries at Biggs Elementary School at 868-5870 ext 221 or 223.

If email is easier, please email us at gmeeker@biggs.org or vazevedo@biggs.org and state your child's name and reason.

If your child has been ill and has **missed 3 or more days from school** in the school year, you MUST provide a note from your Doctor. You MUST:

- bring the note to the front office
- ....OR ....
- Have the Doctor fax a note to 868-5137

Thank you!!

Biggs & Richvale Elementary Schools
Secretaries, Georgianne Meeker & Vicky Azevedo

Verificación de Ausencia

PADRES

Por favor peguen esto en su refrigerador o en sus notas
...o ...
Copie y tenga esta informacion en su telefono!

Estimados padres :
Cuando su niño falte a la escuela por cualquier razón, es muy importante reportar la ausencia a nosotros.

Para verificar una falta, por favor llame a uno de nuestras Secretarias de la Escuela Primaria Biggs al 868-5870 ext 221 o 223 . Si su idioma es Español se puede comunicar con Cecilia Garcia quien esta en la oficina de las 9:30 a las 10:20 a.m.

Si el correo electrónico es más fácil, por favor envíenos un email a gmeeker@biggs.org o vazevedo@biggs.org o cgarcia@biggs.org e indicar el nombre y la razón de su hijo.

Si su hijo ha estado enfermo y ha **perdido 3 o más días de la escuela** en el año escolar , debe proporcionar una nota de su doctor . **Usted debe**:

- llevar la nota a la oficina
- ....O ....
- Pedrirle al Dr. que mande una nota por fax al 868-5137

Gracias !!

Biggs y Richvale Escuelas Primarias
Secretarios, Georgianne Meeker y Vicky Azevedo

State of California—Health and Human Services Agency

Department of Health Care Services
Child Health and Disability Prevention (CHDP) Program

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

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

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTH DATE—Month/Day/Year

ADDRESS—Number, Street	City	ZIP code	SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

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

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

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

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

CHDP website: www.dhcs.ca.gov/services/chdp

INFORME DEL EXAMEN DE SALUD PARA EL INGRESO A LA ESCUELA

Para proteger la salud de los niños, la ley de California exige que antes de ingresar a la escuela todos los niños tengan un examen médico de salud. Por favor, pidale al examinador salud que llene este informe y entregelo a la escuela—este informe sera archivado por la escuela en forma confidencial.

PARTE I PARA SER LLENADO POR EL PADRE/LA MADRE O EL GUARDIÁN

NOMBRE DEL NIÑO/NIÑA—Apellido	Primer Nombre	Segundo Nombre	FECHA DE NACIMIENTO—Mes/Día/Año

DOMICILIO—Número y Calle	Ciudad	Zona Postal	Escuela

PARTE II PARA SER LLENADO POR EL EXAMINADOR DE SALUD

EXAMEN DE SALUD

AVISO: Todas las pruebas y evaluaciones excepto el análisis de sangre para el plomo deben ser hechas después de la edad de 4 años y 3 meses.

PRUEBAS Y EVALUACIONES REQUERIDAS	FECHA(mm/dd/aa)
Historia de Salud	/ /
Examen Físico	/ /
Evaluación de Dientes	/ /
Evaluación de Nutrición	/ /
Evaluación del Desarrollo	/ /
Pruebas Visuales	/ /
Pruebas con Audiómetro (auditivas)	/ /
Pruebas con Tuberculina (Mantoux/PPD)	/ /
Análisis de Sangre (para anemia)	/ /
Análisis de Orina	/ /
Análisis de Sangre para el plomo	/ /
Otra	/ /

REGISTRO DE INMUNIZACIONES

Aviso al Examinador: Por favor dé a la familia, una vez completado, o a la fecha, el Registro de Inmunización de California e papel amarillo.

Aviso a la Escuela: Por favor apunte las fechas de inmunización sobre el Registro de Inmunización de la escuela de Californ en papel azul.

VACUNA	FECHA EN QUE CADA DOSIS FUE DADA				
	Primero	Segundo	Tercero	Quarto	Quinto
POLIO (OPV o IPV)					
DTaP/DTP/DT/Td (difteria, tétano y [acellular] pertusis [tos ferina]) O (tétano y difteria solamente)					
MMR (sarampión, paperas, rubéola)					
HIB MENINGITIS (Hemófilo, Tipo B) (Requerida para centros de cuidado para niños y centros preescolares solamente)					
HEPATITIS B					
VARICELLA (Viruelas locas)					
OTRA					
OTRA					

PARTE III INFORMACIÓN ADICIONAL DEL EXAMINADOR DE SALUD *(optional)*

RESULTADOS Y RECOMENDACIONES

Llene esta parte si el padre/la madre o el guardián ha firmado el consentimiento para divulgar (distribuir) la información de salud de su niño/niña.

☐ El examen reveló que no hay condiciones que conciernen las actividades de los programas escolares.

☐ Las condiciones encontradas en el examen o después de una evaluación posterior que son de importancia para la actividad escolar o física son: (por favor explique)

y

PERMISO PARA DIVULGAR (DISTRIBUIR) EL INFORME DE SALUD

Yo le doy permiso al examinador de salud para que comparta con la escuela la información adicior de este examen como es explicado en la Parte III.

☐ Por favor marque esta caja si Ud. no desea que el examinador llene la Parte III.

Firma del padre/madre o guardián — Fecha

Nombre, domicilo, y teléfono del examinador

Firma del examinador de salud — Fecha

Si su niño o niña no puede obtener el examen de salud llame al Programa de Salud para la Prevención de Incapacidades de Niños y Jovenes (Child Health and Disability Prevention Program) en su departamento de salud local. Si Ud. no desea que su niño(a) tenga un examen de salud, puede firmar la orden (PM 171 B), formulario que se consigue en la escuela de su niño(a).

CHDP website: www.dhcs.ca.gov/services/chdp

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May15 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: ☐ Male ☐ Female
Parent/Guardian Name:	Child's race/ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Multi-racial ☐ Other_____ ☐ Native Hawaiian/Pacific Islander ☐ Unknown		

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

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

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

Section 3: Waiver of Oral Health Assessment Requirement

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

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

☐ I am unable to find a dental office that will take my child's dental insurance plan.
My child's dental insurance plan is:
☐ Medi-Cal/Denti-Cal ☐ Healthy Families ☐ Healthy Kids ☐ Other _____ ☐ None

☐ I cannot afford a dental check-up for my child.

☐ I do not want my child to receive a dental check-up.

Optional: other reasons my child could not get a dental check-up: _____

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

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

Return this form to the school ***no later than*** **May 15** of your child's first school year.
Original to be kept in child's school record.

Formulario de evaluación de la salud bucal

La ley de California (Sección 49452.8 del *Código de Educación*) exige que su hijo se haga un chequeo dental antes del 31 de mayo de su primer año en una escuela pública. Un profesional de la salud dental matriculado de California que trabaje dentro de su área de especialización debe realizar el chequeo y completar la Sección 2 de este formulario. Si su hijo tuvo un chequeo dental en los 12 meses anteriores al comienzo del año escolar, pídale a su dentista que complete la Sección 2. Si no puede conseguir un chequeo dental para su hijo, complete la Sección 3.

Sección 1. Información del menor (debe ser completada por el padre, la madre o el tutor)

Primer nombre del menor:	Apellido:	Inicial del segundo nombre:	Fecha de nacimiento del menor:
Domicilio:			Dpto.:
Ciudad:			Código postal:
Nombre de la escuela:	Maestro:	Grado:	Sexo del menor: ☐ Masculino ☐ Femenino
Nombre del padre/madre/tutor:	Raza/origen étnico del menor: ☐ Blanco ☐ Negro/Afroamericano ☐ Hispano/Latino ☐ Asiático ☐ Indio nativo americano ☐ Multirracial ☐ Otro_____ ☐ Nativo de Hawai/islas del Pacífico ☐ Desconocido		

Sección 2. Información de salud dental: debe ser completada por un profesional de la salud dental matriculado de California

[Oral Health Data (To be completed by a California licensed dental professional)]

NOTA IMPORTANTE: Considere cada casilla por separado. Marque cada casilla.
[IMPORTANT NOTE: Consider each box separately. Mark each box.]

Fecha de la evaluación: *[Assessment Date:]*	Incidencia de caries *[Caries Experience]* (Caries visibles y/o empastes presentes) *(Visible decay and/or fillings present)]* ☐ Sí *[Yes]* ☐ No *[No]*	Caries visibles presentes: *[Visible Decay Present:]* ☐ Sí *[Yes]* ☐ No *[No]*	Urgencia de tratamiento: *[Treatment Urgency:]* ☐ Ningún problema obvio *[No obvious problem found]* ☐ Se recomienda atención dental temprana (caries sin dolor o infección o el niño se beneficiará del sellador dental o de una evaluación adicional) *[Early dental care recommended (Caries without pain or infection or child would benefit from sealants or further evaluation)]* ☐ Se necesita atención urgente (dolor, infección, inflamación o lesiones del tejido blando) *[Urgent care needed (pain, infection, swelling or soft tissue lesions)]*

_____	_____	_____
Firma del profesional de salud dental matriculado *[Licensed Dental Professional Signature*	***Número de matrícula de CA*** *CA License Number*	***Fecha*** *Date]*

Sección 3. Exención del requisito de evaluación de salud dental

Debe ser completado por el padre, la madre o el tutor que solicita que su hijo/a sea eximido de este requisito.

Solicito que mi hijo sea eximido de este chequeo dental porque: (marque la casilla que describa el motivo)

- ☐ No puedo encontrar un consultorio dental que acepte el plan de seguro dental de mi hijo.
  El plan de seguro dental de mi hijo es:
  - ☐ Medi-Cal/Denti-Cal ☐ Healthy Families ☐ Healthy Kids ☐ Otro _____ ☐ Ninguno
- ☐ No puedo pagar el chequeo dental de mi hijo.
- ☐ No quiero que a mi hijo se le haga un chequeo dental.

Opcional: otras razones por las cuales mi hijo no pudo obtener un chequeo dental: _____

Si pide ser eximido de este requisito: ▶ _____

Firma del padre, madre o tutor *Fecha*

La ley establece que las escuelas mantengan la privacidad de la información médica de los estudiantes. El nombre de su hijo no formará parte de ningún informe que se realice como resultado de esta ley. Esta información sólo puede ser utilizada para fines relacionados con la salud de su hijo. Si tiene alguna pregunta, comuníquese con la escuela.

Regrese este formulario a la escuela *antes* del 31 de mayo del primer año escolar de su hijo.
El original de este formulario será guardado en el registro escolar del menor.

[NOTE TO LOCAL EDUCATIONAL AGENCIES (LEAS): As a form of assistance to LEAs, the California Department of Education (CDE) offers this translation free of charge. Because there can be variations in translation, the CDE recommends that LEAs confer with local translators to determine any need for additions or modifications, including the addition of local contact information or local data, or modifications in language to suit the needs of specific language groups in the local community. If you have comments or questions regarding the translation, please e-mail the Clearinghouse for Multilingual Documents (CMD) at cmd@cde.ca.gov.]

PERMISSION FOR FIELD TRIP/EXCURSION
CONSENT TO TRANSPORT AND TREAT

Field Trips and Activities

THIS FORM MAY NOT BE ALTERED IN ANY WAY

Permission for Field Trip/Excursion

_____ has my permission to participate in the activities listed below. I fully understand the following:

1. Participation in these activities is voluntary;
2. I may revoke this permission at any time by notifying the school district in writing; and
3. Revocation is not effective until receipt is acknowledged by the school district.
4. "All persons making the field trip or excursion shall be deemed to have waived all claims against the district or the State of California for any injury, accident, illness, or death occurring during or by reason of the field trip or excursion." (California Education Code, Section 35330)
5. The field trip / excursion may include but not be limited to:

a. museums	d. public / private businesses	g. _____
b. concerts / plays	e. environmental trips	h. _____
c. libraries	f. parks	i. _____

Consent to Transport

In accordance with California Education Code Section 35350, my signature below gives permission to transport (if applicable).

Consent to Treat

In the event of illness or injury, I hereby consent to whatever X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physicians and/or dentist and performed by or under the supervision of a member of the medical staff of the hospital, facility or office furnishing medical and/or dental services.

Initial all appropriate boxes below and provide additional information where necessary.

_____ There are no special problems that the staff should be aware of and no medications are to be administered on the trip.

_____ The following medication(s) is/are to be administered on the trip: _____.
A physician's written instructions on dispensing must be attached to this form. All prescriptions, excepting those which must be kept on the student's person for emergency use, must kept and distributed by the staff.

_____ My student has a special medical problem of which staff should be made aware. A description of that problem is attached to this form.

_____ No blood transfusions or blood products are to be given.

I fully understand that my student is to abide by all rules and regulations of conduct during the trip. Any violation of these rules and regulations may result in the school contacting me to arrange transportation home for my student at my full expense.

_____ _____
Signature of Parent or Legal guardian *Date*

_____ _____
Address where parent will be during field trip *Phone where parent can be reached during field trip*

_____ _____
Parent's/Guardian's Health Insurance Company / MEDI-CAL *Policy number*