SANTA CRUZ CITY SCHOOLS
ENROLLMENT FORM
Grades 1st – 5th

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	Birth Date
			☐ M ☐ F	/ /

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.

	Asian:		Native Hawaiian or other Pacific Islander:
☐ American Indian or Alaska Native	☐ Chinese	☐ Laotian	☐ Hawaiian
☐ Black or African American	☐ Japanese	☐ Cambodian	☐ Guamanian
☐ White: Hispanic or Latino	☐ Korean	☐ Filipino	☐ Samoan
☐ White: Not Hispanic or Latino	☐ Vietnamese	☐ Hmong	☐ Tahitian
	☐ Asian Indian	☐ Other Asian	☐ Other Pacific Islander

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:

Continued on the other side →

SANTA CRUZ CITY SCHOOLS
ENROLLMENT FORM

Primary Household Contact Information

Home Address

Number	Street Name	Apt. Number	City	Zip code

Is this a permanent, regular and adequate nighttime residence? ☐ Yes ☐ 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
☐					

Primary Household Number: ( ) ☐ Home phone ☐ 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)

☐ Primary Residence	☐ Primary Residence ☐ Secondary Residence
Name:	Name:
Relationship: ☐ Mother ☐ Father ☐ Other:	Relationship: ☐ Mother ☐ Father ☐ Other:
Does the student live with this Parent/Guardian? ☐ Yes ☐ No	Does the student live with this Parent/Guardian? ☐ Yes ☐ 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? ☐ Yes ☐ No
Employer:	Primary Contact Number: ( )
Preferred Language: ☐ English ☐ Spanish ☐ Other:	Secondary Contact Number: ( )
Highest Education Level	E-mail Address:
☐ Not a High School Graduate ☐ High School Graduate	Employer:
☐ Some College ☐ College Graduate ☐ Graduate School	Preferred Language: ☐ English ☐ Spanish ☐ Other:
Are there custody arrangements? ☐ Yes ☐ No	Highest Education Level
If yes, please provide documentation or specify verbal agreement: _____	☐ Not a High School Graduate ☐ High School Graduate
	☐ Some College ☐ College Graduate ☐ 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
			☐ M ☐ F	/ /	

Parent/Guardian Information ☐ Change of Information	Parent/Guardian Information ☐ Change of Information
Name:	Name:
Relationship: ☐ Mother ☐ Father ☐ Other:	Relationship: ☐ Mother ☐ Father ☐ 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: ☐ English ☐ Spanish ☐ Other:	Preferred Language: ☐ English ☐ Spanish ☐ Other:
Does the student live with this Parent/Guardian? ☐ Yes ☐ No	Does the student live with this Parent/Guardian? ☐ Yes ☐ No
Are there custody arrangements? ☐ Yes ☐ No	Are there custody arrangements? ☐ Yes ☐ 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: / /

SANTA CRUZ CITY SCHOOLS **HOME LANGUAGE SURVEY**
Encuesta de idioma del hogar

Date: _____ **School** _____
Fecha Escuela
School Year (año escolar) _____

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/County** (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.

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? _____

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.

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

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. 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 Estado 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? _____

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 ingles. Ud. recibirá una carta con los resultados y la recomendación del programa en que se ubicara a su hijo.

¿Usted prefiere comunicación de la escuela en: ☐ Ingles ☐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**_____

405 Old San Jose Road, Soquel, California 95073 | (831) 429-3410 | www.sccs.santacruz.k12.ca.us

Kris Munro *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)
5 DPT (4 doses if 4th dose given on or after 4th birthday)
2 MMR (both doses must be given on or after 1st birthday)
3 Hepatitis B
1 Varicella or documentation of Chickenpox disease

Rev. 1/10/2017

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: □ Male □ Female
Parent/Guardian Name:	Child's race/ethnicity: □ White □ Black/African American □ Hispanic/Latino □ Asian □ Native American □ Multi-racial □ Other_____ □ Native Hawaiian/Pacific Islander □ Unknown		

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

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

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

_____ _____ _____

Licensed Dental Professional Signature ***CA License Number*** ***Date***

Section 3: Waiver of Oral Health Assessment Requirement

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

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

□ I am unable to find a dental office that will take my child's dental insurance plan.
My child's dental insurance plan is:

□ Medi-Cal/Denti-Cal □ Healthy Families □ Healthy Kids □ Other _____ □ None

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

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

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

If asking to be excused from this requirement: ▶ _____

Signature of parent or guardian ***Date***

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

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

State of California—Health and Human Services Agency
Primary Care and Family Health Division

Department of Health Services
Children's Medical Services Branch
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	BIRTHDATE—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
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.

State of California—Health and Human Services Agency
Primary Care and Family Health Division

Department of Health Services
Children's Medical Services Branch
Child Health and Disability Prevention (CHDP) Program

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.

Westlake Elementary School
New Student Information Sheet

Welcome to Westlake Elementary School! So we can become better acquainted with your child, we ask that you take the time to answer the following questions:

Child's Name _____ Entering Grade _____

1. What subjects and school activities motivate and interest your child?

   _____
   _____
   _____
   _____

2. What kind of classroom environment do you think best fits your child? That is, what types of things motivate him/her and what style of classroom discipline do you support for your child?

   _____
   _____
   _____
   _____

3. What are the main goals and objectives that you would like to see your child attain while attending Westlake?

   _____
   _____
   _____
   _____

4. Please list some of the academic strengths and weaknesses of your child that you feel we should take into consideration.

   Strengths: _____
   _____
   _____

   Weaknesses: _____
   _____
   _____

Over...

5. Has your child ever been retained? If so, at what grade level?

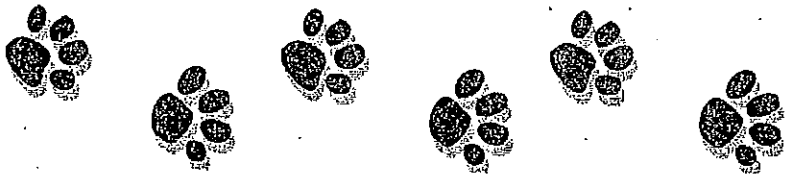
6. Are there any behavioral or adjustment problems that your child has had in the past? (conflicts with other children or teachers?)

7. Does your child play a musical instrument? If so, what instrument(s)?

8. Does your child have any health problems? If so, please describe.

9. Has your child been involved in any special program outside the regular classroom? (Speech, RSP Reading, RSP Math, Special Education, etc.)

10. Is there any other information about your child that you feel is important for us to know?



Westlake Elementary School
1000 High St.
Santa Cruz, CA 95060
831-429-3878 fax: 831-429-3835

REQUEST FOR RECORDS

Date: _____

Name of Student: _____

Date of Birth: _____ Grade Level: _____

Name and address of last school: _____

_____

_____

Please include all records including **health files and immunization records, RSP files, IEP (complete or in progress), formal test scores and any other existing files or reports.**

In accordance with the Family Education Rights and Privacy Act, I authorize the release of my child's records, including confidential records, to the school listed above. I understand that I have the right to examine these records upon written request.

_____ _____

Signature of parent, guardian or student over 18. Date