

# RIDGECREST CHARTER SCHOOL ENROLLMENT DOCUMENTS

Congratulations on your student being accepted to attend RCS for the 2018 – 2019 school year.

In order for your student to attend class on the first day of school, August 13<sup>th</sup> 2018, the attached enrollment packet **MUST** be completed and turned into the front office. Office hours for the summer are 8 am to 12 pm. You may call the school at 760-375-1010 with any questions or concerns.

**1. Parents/ Guardians MUST complete the entire packet for grade placement ( 1-8) and you must remit the following: No Exceptions**

- A current immunization record.
- Report card or transcript from previous school.
- Copy of current IEP and psychological report if applicable.
- Copy of 504 Plan if applicable.
- Custody agreement if one is in place for your student.

**2. KINDERGARTEN STUDENTS ONLY**

- Please bring in your student's Birth Certificate for proof of age.
- Please bring in a current immunization record.
- Students **MUST** have a physical for Kindergarten entry completed. The form is attached.
- The **ORAL** Health Assessment Form attached is due to the school by **MAY 31<sup>st</sup> of your students first year in school. (not due before school starts).** You may bring it in during the year after visiting the dentist.

Your student will be enrolled in a class for the 2018- 2019 school year only after all the above documentation has been received and processed by the school. Your student will not be enrolled and will not start school without the above documentation.

Please contact the school office with any questions or concerns about documentation necessary for school enrollment.

SCHOOL

[Empty box]

GRADE

Has your student ever attended [ ] before?  Yes  No  
[ ] attended: \_\_\_\_\_ Year attended: \_\_\_\_\_

PLEASE PRINT - STUDENT'S LEGAL NAME

Legal Last Name      Legal First Name      Legal Middle Name      Other Legal Name (if applicable)

Male     Female    Birth date:    [ ]    [ ]    [ ]  
Month    Day    Year

Parent/Guardian First Name      Last Name      Home Phone      Work Phone  
[ ]    [ ]    [ ]    [ ]

Parent/Guardian First Name      Last Name      Home Phone      Work Phone  
[ ]    [ ]    [ ]    [ ]

Mailing Address      Apt#    City      State    Zip

Residence Address (house # & street name if different)      Apt #    City      State    Zip

WHAT IS YOUR CHILD'S ETHNICITY? (Please check one)

Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)       Not Hispanic or Latino

WHAT IS YOUR CHILD'S RACE? (Please 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.

- American Indian or Alaskan Native (100)  
(Persons having origins in any of the original people of North, Central or South America)
- Laotian (206)
- Tahitian (304)
- Chinese (201)
- Cambodian (207)
- Other Pacific Islander (399)
- Japanese (202)
- Hmong (208)
- Filipino/Filipino American (400)
- Korean (203)
- Other Asian (299)
- African American or Black (600)
- Vietnamese (204)
- Hawaiian (301)
- White (700) (Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East)
- Asian Indian (205)
- Guamanian (302)
- Samoan (303)

PARENT EDUCATION - Check the response that describes the education level of the most educated parent.

- Graduate Degree or Higher (5)
- College Graduate (4)
- Some College or Associate's Degree (3)
- High School Graduate (2)
- Not a High School Graduate (1)

Date student first attended school in the U.S.

Month      Day      Year

Date student first attended school in California

Month      Day      Year

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

U.S. Citizen (at birth):     Yes     No

**HOME LANGUAGE SURVEY: Indicate only one language (most frequently used) per line:**

1. What language/dialect does your son/daughter most frequently use at home? \_\_\_\_\_
2. Which language/dialect did your son/daughter learn when he/she first began to talk? \_\_\_\_\_
3. What language/dialect do you most frequently speak to your child? \_\_\_\_\_
4. Has your child ever been given the CELDT Test (Calif English Language Development Test)?  Yes  No  I don't know

In which language do you wish to receive written communications from the school?  English  Spanish

**Residence – where is your child/family currently living? (federally mandated by NCLB) – Please check appropriate box:**

- In a single family permanent residence (house, apartment, condo, mobile home)  In a motel/hotel (110)
- Temporarily doubled-up (sharing housing with other families/individuals due to economic hardship or loss) (120)  Unsheltered (car/campsite) (130)
- In a shelter or transitional housing program (100)

**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:  Joint Custody  Sole Custody  Guardian

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

1.  Father  Step Father/Guardian (check one) **Full Name:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Daytime Phone # ( \_\_\_\_ )** \_\_\_\_\_

2.  Mother  Step Mother/Guardian (check one) **Full Name:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Daytime Phone # ( \_\_\_\_ )** \_\_\_\_\_

**PLEASE LIST OTHER CHILDREN LIVING AT HOME:**

First and Last Name	Relationship	School	Grade	Date of birth

**MOST RECENT SCHOOL ATTENDED:**

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

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: _____	Enroll Date: Enter Date: _____	Cumulative record requested: _____	Copies to: PSS _____ EL Office _____ Special Ed _____	Grade Placement Verification: _____
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**PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THE FORM (REV 2/10)**



## STUDENT RECORDS RELEASE FORM

I hereby authorize the following school district to request records from the school/facility my child previously attended.

Name of Student: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Sending School: \_\_\_\_\_  
 (Last School Student Attended) (Address)

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Last Grade Completed: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

*(For School Use Only)*

Information to be sent to the attention of: **Gayle Pietrangelo**

Receiving School: **Ridgecrest Charter School, 325 S Downs, Ridgecrest, CA 93555**

Phone: (760) 375-1010 Fax (760) 375-7766

Please include all items checked below that apply to the student.

- |  |  |
|--|--|
| <input type="checkbox"/> Transfer Card   | <input type="checkbox"/> Child Study Records |
| <input type="checkbox"/> Academic Record ( <i>Report Card/Transcript</i> )<br>(Report Card/Transcript) | <input type="checkbox"/> Health Record       |
| <input type="checkbox"/> Attendance Record   | <input type="checkbox"/> Discipline Records  |
| <input type="checkbox"/> Standardized Test Scores  | <input type="checkbox"/> IEP, 504, SST, RTI  |
|  | <input type="checkbox"/> CELDT               |

Thank you for your cooperation in this regard. It is greatly appreciated.



RIDGECREST CHARTER SCHOOL  
325 S. Downs, Ridgecrest, California 93555  
(760) 375-1010 Fax (760) 375-7766

### Special Education Verification Form

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

Date of Birth: \_\_\_\_\_

Grade: \_\_\_\_\_

Student was enrolled in a special education program and has an Individualized Education

Plan (IEP). Yes                      No

Student has a 504 Accommodation Plan. Yes                      No

Parent or guardian provided a current copy of IEP and/or 504 Accommodation Plan.

Yes                      No

Previous School of Attendance

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

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

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

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

<p><b>For office use only</b></p> <p>Date of Request: _____ School Personnel: _____</p>
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## Parent Release Form for Media Recording

I, the undersigned, do hereby grant or deny permission to Ridgecrest Charter School to use the image of my child, \_\_\_\_\_, while he/she is engaged in school-related activities in Facebook, Instagram, website and/or local media coverage of school activities.

- Deny permission to use my child's image at all.
- Grant permission to use my child's image.

Parent/Guardian  
signature \_\_\_\_\_

Date \_\_\_\_\_

*Ridgecrest Charter School*  
325 S. Downs St.  
Ridgecrest, Ca 93555  
(760)375-1010

*If you have questions, contact Dr. Steve Martinez at 760-375-101 ext.1022*

**RIDGECREST CHARTER SCHOOL**

**STUDENTS NAME;** \_\_\_\_\_

**As part of the new accountability requirements under the Every Student Succeeds Act (ESSA), the U.S. Department of Education is requiring school districts nationwide to identify students who are armed forces family members.**

**Is either parent/guardian on ACTIVE duty in the US armed forces:  Army,  Navy,  Air Force,  Marine Corps or  Coast Guard or on full-time  National Guard Duty?  YES  NO**

**Please return this form to your child's teacher on the first day of school. You may also drop the form off to the school during summer during the hours of 7-3.**

**Thank you,**

**RCS**



RIDGECREST CHARTER SCHOOL  
325 S. Downs, Ridgecrest, California 93555  
(760) 375-1010 Fax (760) 375-7766

**RE: Updated Medication Forms for the 2018-2019 School Year**

Dear Parents and Guardians,

Medication forms, available in the school office, are to be used in the event your student needs to be administered any form of medication during the school day including over the counter medication such as Tylenol and cough drops.

Over the counter medication must be brought to the school office by the parent or guardian in an unopened package along with the completed authorization form. Unused medication must be picked up at the end of the school year by the parent. A log will be kept on the administration of over the counter medicine.

Prescription medication must be brought to the school office by a parent or guardian along with the authorization form completed by the physician prescribing the medication and also completed by the parent/guardian. A log will be kept on the administration of prescription medicine.

**NO MEDICATION will be administered by school staff until these forms have been completed. All medication left after last school year has been discarded.**

Staff cannot administer any type of medication including cough drops without a medication form on file in the school office.

**IF YOUR STUDENT HAD MEDICATION IN THE PRIOR SCHOOL YEAR PLEASE BE ADVISED THAT A NEW FORM MUST BE COMPLETED AND NEW MEDICATION MUST BE BROUGHT INTO THE SCHOOL FOR THE 2018-2019 SCHOOL YEAR.**

In the event you have any questions please contact the school office.

Gayle Pietrangelo  
RCS Administration



# RIDGECREST CHARTER SCHOOL EMERGENCY INFORMATION CARD

School Year \_\_\_\_\_

**STUDENT LEGAL NAME:**

LAST \_\_\_\_\_

Teacher: FIRST \_\_\_\_\_ Grade: \_\_\_\_\_ MIDDLE \_\_\_\_\_ Birthdate: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mother/Guardian Name: \_\_\_\_\_

Address \_\_\_\_\_ Cell Number \_\_\_\_\_ Work Number \_\_\_\_\_  
(If different than student) Can the school call this? \_\_\_

Email Address for Correspondence: \_\_\_\_\_

Father/Guardian Name: \_\_\_\_\_

Address \_\_\_\_\_ Cell Number \_\_\_\_\_ Work Number \_\_\_\_\_  
(If different than student) Can the school call this? \_\_\_

Email Address for Correspondence: \_\_\_\_\_

In case of illness or emergency I want the school to first contact: Please put a 1 or 2 next to contact Mom/Guardian \_\_\_ at \_\_\_\_\_ Dad/Guardian \_\_\_ at \_\_\_\_\_

Please list in order, (contact 1, contact, 2 etc.) of the people who will assume care of you child if you cannot be reached in case of illness or emergency.

1. _____ Name _____ Phone# _____	2. _____ Name _____ Phone# _____
3. _____ Name _____ Phone# _____	4. _____ Name _____ Phone# _____

**Health Problems or Disability the school should be aware of: (Check all that apply)**

<input type="checkbox"/> Diagnosed ADD or ADHD	<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Right ___ Left ___
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema/Skin Trouble	<input type="checkbox"/> Known Vision Loss	<input type="checkbox"/> Right ___ Left ___
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Wears Contact Lens	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Wears Glasses	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> History of Fractures	<input type="checkbox"/> For close work ___ Distance Only ___ At all time	
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> History of Hospitalization	<input type="checkbox"/> Color Vision Deficiency	
<input type="checkbox"/> Frequent Nosebleeds	<input type="checkbox"/> History of Surgery	<input type="checkbox"/> Known Hearing Loss	
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Physical Limitations (explain below) _____	<input type="checkbox"/> History of ear Problem	
<input type="checkbox"/> Seizure Disorder	_____		
<input type="checkbox"/> Chicken Pox	_____		
Other or further details above _____			
Allergies (check all that apply) _____			
<input type="checkbox"/> Animals	<input type="checkbox"/> Drugs	<input type="checkbox"/> Food	<input type="checkbox"/> Plants
<input type="checkbox"/> Bee Stings	<input type="checkbox"/> Insects	Other _____ List specific item(s) student is allergic to: _____	
Describe allergic reaction and /or treatment: _____			
CURRENT MEDICATION(s) ___ No ___ Yes ___ Epi-Pen _____			

**EMERGENCY MEDICAL AUTHORIZATION**  
I am/we are the parent/guardian of the above named student. In case I am/we are unable to be reached during any emergency, I/we hereby authorize a representative of the school, pursuant to the provisions of Family Code Section 6910, to act as any agent to consent to the giving of any medical, dental, hospital or surgical care to the above named student. In the event that I cannot be reached, I authorize the school to contact the physician indicated below and follow his/her instructions. If it is not possible to contact the physician, the school may make whatever arrangements seem necessary. Please be advised that you are responsible to pick up a sick student within 60 minutes of the first notification. The school is not equipped to take care of students for an extended period of time.

**Please see reverse side and sign the form before returning to your child's teacher**

**In the event that medication MUST be taken during school hours, please contact the school office for forms and procedures.**

**Please initial \_\_\_\_\_**

**This list of emergency contacts is an emergency list ONLY. The intent of this list is that it is used in the event of an emergency; sickness, school closure for example, and we are unable to reach YOU as the parent/guardian.**

**Please be advised that your student WILL NOT be released to people on this list for reasons of medical appointments, lunch date or to be picked up before the school day ends without your written authorization and must be over the age of 18.**

**Please initial \_\_\_\_\_**

**The school utilizes an automated system to notify parents of absences and upcoming events.**

**Please listen to the voicemail BEFORE calling the school office.**

**Please initial \_\_\_\_\_**

**I/We have reviewed this two page document and to the best of my/our knowledge, the information contained herein is true and complete. The undersigned declares under penalty of perjury that they are the parents or legal guardians of the above-named student and grant the above authorizations.**

**I agree to notify the school in writing when any information I have supplied on the release has changed.**

**Signature of Parent/Guardian**

**Date**

\_\_\_\_\_

\_\_\_\_\_

**Kindergarten Students ONLY**



# Grades K-12

**INSTRUCTIONS** Use this guide as a quick reference to help you determine whether children seeking admission to your school meet California's school immunization requirements. For the actual laws, see Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380; California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, Sections 6000-6075. If you have any questions, call the Immunization Coordinator at your local health department.

**IMMUNIZATION REQUIREMENTS** To enter into public and private elementary and secondary schools (grades kindergarten through 12), children under age 18 years must have immunizations.

VACCINE	REQUIRED DOSES
Polio	4 doses at any age, but... 3 doses meet requirement for ages 4-6 years if at least one was given on or after the 4th birthday <sup>1</sup> ; 3 doses meet requirement for ages 7-17 years if at least one was given on or after the 2nd birthday. <sup>1</sup>
Diphtheria, Tetanus, and Pertussis	Age 6 years and under: DTP, DTaP or any combination of DTP or DTaP with DT (diphtheria and tetanus) 5 doses at any age, but... 4 doses meet requirements for ages 4-6 years if at least one was on or after the 4th birthday. <sup>1</sup> Age 7 years and older: Tdap, Td, or DTP, DTaP or any combination of these 4 doses at any age, but... 3 doses meet requirement for ages 7-17 years if at least one was on or after the 2nd birthday. <sup>1</sup> If last dose was given before the 2nd birthday, one more (Tdap) dose is required.
Measles, Mumps, Rubella (MMR)	Kindergarten: 2 doses <sup>2</sup> both on or after 1st birthday. <sup>1</sup> 7th grade: 2 doses <sup>2</sup> both on or after 1st birthday. <sup>1</sup> Grades 1-6 and 8-12: 1 dose on or after 1st birthday. <sup>1</sup>
Hepatitis B <sup>3</sup>	Kindergarten: 3 doses at any age
Varicella	1 dose <sup>4, 6</sup>
Tdap Booster (Tetanus, reduced diphtheria, and pertussis)	7th grade: 1 dose on or after 7th birthday. <sup>5, 7</sup>

- <sup>1</sup> Receipt of a dose up to (and including) 4 days before the birthday will satisfy the school entry immunization requirement.
- <sup>2</sup> Two doses of measles-containing vaccine required. One dose of mumps and rubella-containing vaccine required; mumps vaccine is not required for children 7 years of age and older.
- <sup>3</sup> Not required for 7th grade.
- <sup>4</sup> Physician-documented varicella (chickenpox) disease history or immunity meets the varicella requirement.
- <sup>5</sup> Tdap, DTaP, or DTP given on or after 7th birthday will meet the requirement. Td does not meet the requirement.
- <sup>6</sup> 2 dose varicella requirement for ages 13-17 years applies to transfer students who were not admitted to a California school before July 1, 2001.
- <sup>7</sup> 8th-12th grade students transferring from outside of California must meet the requirement.

**EXEMPTIONS** The law allows parents/guardians to choose an exemption from immunization requirements based on their personal beliefs or medical conditions. For children with medical exemptions, the physician's written statement should be submitted. Schools should maintain an up-to-date list of pupils with exemptions, so they can be excluded quickly if an outbreak occurs.

**NOT MEETING REQUIREMENTS** Refer pupils who do not meet these State requirements to their physician or local health department. Give families a written notice indicating which doses are lacking.

**CONDITIONAL ADMISSIONS** Children who lack one or more required vaccine doses that are not currently due may be admitted on condition that they receive the remaining doses when due (Title 17, CCR Section 6035).

## HEALTH REQUIREMENTS FOR KINDERGARTEN/FIRST GRADE SCHOOL ENTRY

Children beginning school for the first time must show proof that they have received a health examination and immunizations, before they can attend school\*.

Each school will ask that the attached, "REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY" be brought to school, completed and signed by a doctor.

### THE HEALTH EXAMINATION:

Must be obtained no earlier than six months before entering kindergarten or eighteen months before entering first grade.

Must include the following services:

- A health and development history
- A complete physical history
- An examination of teeth and gums
- A vision test - other tests if needed
- A hearing test
- Urine and blood screening test
- A tuberculosis skin test

\*If any of the health requirements are contrary to the parents religious or personal beliefs, a special form can be obtained from the school to request exemption.

### THE IMMUNIZATIONS:

Must include immunizations against measles, mumps and rubella, given four days before or after the first birthday; against diphtheria, tetanus and whooping cough (DPT/DTaP/DT/Td); against polio (IPV); against Hepatitis B (Hep B), and against chickenpox (varicella) or health care provider documented varicella disease. (See the attached sheet for more information).

### HOW AND WHERE TO GET SERVICES:

If your child is on Medi-Cal or your family income is lower than 200% of the Federal Poverty Level, your child may be eligible for a **FREE EXAMINATION AND IMMUNIZATIONS**.

The child must go to one of the **CHDP PROGRAM CERTIFIED PHYSICIANS OR CLINICS** listed in this packet to get a free exam. If you have Medi-Cal, call your Primary Care Physician for an appointment.

If your child is not eligible for a free examination, call your family doctor, pediatrician, or **USUAL SOURCE OF MEDICAL CARE**. (The usual fee will be charged.)

If your child is not eligible for a free examination but still needs more immunizations and you cannot afford them, call the **STANISLAUS COUNTY HEALTH SERVICES AGENCY** at (209) 558-7700 to ask about immunization clinics.

### IF YOU HAVE ANY QUESTIONS ABOUT SCHOOL ENTRY REQUIREMENTS:

Call your school district office for more information about your district's requirements.

Call the Health Department's CHDP Program if you need more information About health examinations or are unable to Obtain an examination for your child:

English - (209) 558-8860

Spanish - (209) 558-4806

# REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

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

## PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

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

ADDRESS—Number, Street  City  ZIP code  SCHOOL

## PART II TO BE FILLED OUT BY HEALTH EXAMINER

### HEALTH EXAMINATION

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

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	/ /
Physical Examination	/ /
Dental Assessment	/ /
Nutritional Assessment	/ /
Developmental Assessment	/ /
Vision Screening	/ /
Audiometric (hearing) Screening	/ /
TB Risk Assessment and Test, if indicated	/ /
Blood Test (for anemia)	/ /
Urine Test	/ /
Blood Lead Test	/ /
Other	/ /

### IMMUNIZATION RECORD

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

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DTP/DTP/DTTd (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 (e.g., TB Test, if indicated)					
OTHER					

## PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER (optional)

### 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)*

## and RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

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.*

### 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)
<div style="display: flex; justify-content: space-between; margin-top: 10px;"> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span><i>Licensed Dental Professional Signature</i></span> <span><i>CA License Number</i></span> <span><i>Date</i></span> </div>			

#### 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.*