

WILMAR UNION SCHOOL DISTRICT
WILSON SCHOOL
STUDENT REGISTRATION INFORMATION (Grades K-6)

Student's Legal Name:

(Last) _____ (First) _____ (Middle) _____

Other Name by which student is known: _____

Address _____ Apt. # _____ Grade _____ Sex (circle one) M/F

City _____ Zip Code _____ Telephone _____

Birth date ___/___/___ Birthplace _____ Date of Entry _____

Previous School Attended _____ Address _____

Name of Father/Legal Guardian _____ Occupation _____

Employer _____ Daytime phone _____ Cell Phone _____

Name of Mother/Legal Guardian _____ Occupation _____

Employer _____ Daytime Phone _____ Cell Phone _____

Other Guardian _____ Relationship _____ Occupation _____

Employer _____ Daytime Phone _____ Cell Phone _____

Student Lives With: Father ___ Mother ___ Step Parent ___ Legal Guardian ___ Other ___

Are parents separated? Yes ___ No ___ If Yes, may other parent pick up child at school? Yes ___ No ___ *

*(SUPPORTIVE LEGAL DOCUMENT REQUIRED) LEGAL CUSTODY PAPERS ON FILE _____

Brothers/Sisters (living at home)	Date of Birth	Age	If school age, name of school
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Name _____	_____	_____	_____
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Name _____	_____	_____	_____
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Name _____	_____	_____	_____
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If more than 3 children living at home, please attach a separate sheet.

SPECIAL PROGRAMS

Does your son/daughter receive Special Education services? Yes _____ No _____

If yes, please specify _____

FOR OFFICE USE ONLY			
Placement: Date _____	Grade _____	Room No. _____	Teacher _____
		Class List _____	Computer _____
Cum Folder Req. _____	Rec. _____	INTERDISTRICT ATTENDANCE: District _____ Approval Date _____	
Verification of Residency _____	Verification of Birth date _____	Verified By: _____	

WILMAR UNION SCHOOL DISTRICT
STATE MANDATED COMPLIANCE INFORMATION

Student's Legal Name:

(Last) _____ (First) _____ (Middle) _____

Birth date _____ Grade _____ Gender (circle one) M F

I. Parent Education level: Check one response that best applies for each parent:

Father:

Not a high school graduate College graduate

High School graduate Grad school

Some college

Mother:

Not a high school graduate College graduate

High School graduate Grad school

Some college

II. Primary Ethnicity: Check the group with which student most closely identifies. (Check only one)

American Indian or Alaskan

Asian/Asian American*

Black/African American

Filipino/Filipino American

Hispanic/Latino

Pacific Islander*

White (not of Hispanic origin)

Declined to state

*If Asian or Pacific Islander is marked, check all that apply:

Chinese

Korean

Asian Indian

Hawaiian

Guamanian

Tahitian

Japanese

Vietnamese

Laotian

Samoan

Cambodian

Other Asian or Pacific Islander

III. Home Language Survey

The California Education code requires schools to determine the language(s) spoken at home by each student.

This information is essential in order to provide meaningful instruction for all students.

1. Which language did your child learn when he/she first began to talk? _____

2. What language does your son or daughter use most frequently at home? _____

3. What language do you use most frequently to speak to your son or daughter? _____

4. What language is most often spoken by the adults at home? _____

Circle the entry grade from which this student has been continuously enrolled in this school.

Grade K Grade 1 Grade 2 Grade 3 Grade 4 Grade 5 Grade 6

Parent Signature: _____ Date: _____

Sonoma County Office of Education
STUDENT HEALTH HISTORY

Date: ___/___/___ School: _____

Student's Name: _____ Sex: M F

Birthdate: _____ Teacher: _____

Parent/Guardian: _____

Address: _____
Street Apt. City Zip

Telephone: (Home) _____ (Work) _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING:

Chicken pox Tuberculosis Diabetes
 Asthma Allergies Stinging Insect Allergy
 Heart Problems Behavior Problems Convulsion, seizure
 Frequent colds Recurring ear infections Eye problems Movement limitation
 Recent illness, hospitalization, surgery or other physical condition which limits your child's physical activity at school

Please provide additional information for any of the above conditions checked: _____

ALL MEDICATION SENT TO SCHOOL MUST BE IN THE PRESCRIPTION CONTAINER WITH A CURRENT DATE

Does your child require medication while at school? yes no

If yes, Please complete an "Authorization for Administration of Medication" (obtain form from the school secretary)

Please indicate:

Medication _____ Dosage _____ Hour(s) given _____

Medication _____ Dosage _____ Hour(s) given _____

Date of last physical exam: ___/___/___ Doctor _____

Date of last dental exam: ___/___/___ Dentist _____

Does your child wear glasses? Yes No

Does your child have any medical condition which might require care while at school or which might restrict his/her physical activity, such as in contact sports? (Please describe)

Information obtained from this health history may be included on a confidential health conditions list, if appropriate. For more information/concerns, please contact the school nurse.

PARENT SIGNATURE/DATE

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 _____ State _____ 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/DTaP/DTaP (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.

Oral Health Assessment Form

California law, *Education Code* Section 49452.8, now requires that your child have an oral health assessment *before* May 31 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:	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"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown		

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: _____

If requesting to be excused from this requirement: v _____

Signature of parent or guardian

Date

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.

Return this form to the school *before* May 31 - Original to be retained in child's school record.