

# STUDENT REGISTRATION INFORMATION (Grades TK-6)

## Wilmar Union School District / Wilson Elementary School



Date \_\_\_\_\_

School Year 20\_\_\_\_ - 20\_\_\_\_

Student's Legal Name \_\_\_\_\_ Grade \_\_\_\_\_  
Last First Middle

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male Female Non Binary Primary phone \_\_\_\_\_  
MM / DD / YYYY

Mailing Address \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Address \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of Father/Legal Guardian \_\_\_\_\_ Employer \_\_\_\_\_  
Last First

Occupation \_\_\_\_\_ Daytime phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email \_\_\_\_\_

Name of Mother/Legal Guardian \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Daytime phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email \_\_\_\_\_  
Last First

Name of Other Legal Guardian \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Daytime phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email \_\_\_\_\_  
Last First

**STUDENT LIVES WITH (Check all that apply):** Father Mother Stepfather Stepmother Grandfather Grandmother Uncle Aunt

Legal Guardian(s) Other Conditions: \_\_\_\_\_

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

**(SUPPORTIVE LEGAL DOCUMENT REQUIRED) LEGAL CUSTODY PAPERS ON FILE** \_\_\_\_\_

2nd Mailing Address \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Brothers/sisters (living at home)*	Date of Birth	Age	If school age, name of school
Name _____	_____	_____	_____
Name _____	_____	_____	_____
Name _____	_____	_____	_____

\*If more than 3 children living at home, please attach a separate sheet.

Previous School Attended \_\_\_\_\_  
Name of School Street Address City State Zip Code

Is your student currently under an expulsion order at another district or being recommended for expulsion? Yes No

### SPECIAL PROGRAMS & SPECIAL EDUCATION

Does your son/daughter have an IEP, 504 plan, or receive speech services? Yes No If yes, please specify and attach IEP or 504 \_\_\_\_\_

Has your son/daughter been identified as a Gifted and Talented Education (GATE) student? Yes No

Any special health considerations or allergies (please indicate if an EpiPen is prescribed) \_\_\_\_\_



**STATE MANDATED COMPLIANCE INFORMATION**  
**Wilmar Union School District / Wilson Elementary School**

Student's Legal Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Last First Middle

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

**Father/guardian:**

- Not a high school graduate
- High school graduate
- Some college
- College graduate
- Grad school/past grad training
- Decline to state or unknown

**Mother/guardian:**

- Not a high school graduate
- High school graduate
- Some college
- College graduate
- Grad school/past grad training
- Decline to state or unknown

**II. Ethnicity: Is your student Hispanic or Latino? (Choose only one)**

- Yes, Hispanic or Latino. (This includes all persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)
- No, not Hispanic or Latino.

**III. Race: What is your student's race? (Mark any that apply.)**

American Indian or Alaskan Native (A person having origins in any of the original peoples of North and South America, including Central America, AND who maintains tribal affiliation or community attachment.)

- Black/African American
- White (A person having origins in any of the original peoples of Europe, the Middle East or North Africa.)
- Asian Indian
- Cambodian
- Chinese
- Hmong
- Japanese
- Korean
- Laotian
- Vietnamese
- Other Asian
- Filipino/Filipino
- American Guamanian
- Hawaiian
- Samoan
- Tahitian
- Other Pacific Islander

**IV. 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. Name the language most often spoken by the adults at home. \_\_\_\_\_

- In what language do you wish the school to communicate with you? **English** **Spanish** (Please check only one)
- Is at least one parent/guardian of this student active in the United States Armed forces? Yes No

I declare under penalty of perjury (under the laws of the United States of America) that the foregoing is true and correct.

Signature of parent/guardian filling out this form \_\_\_\_\_ Date \_\_\_\_\_

<b>OFFICE USE ONLY</b>	Verification of Residency _____	Verified by _____	
	Verification of Birthdate _____	Verified by _____	
	Interdistrict Permit Needed? Y ___ N ___	Intradistrict Permit Needed? Y ___ N ___	Permanent ID Number _____
Placement: _____		Verified by _____	

# Wilmar Union School District / Wilson Elementary School

## STUDENT EMERGENCY/TREATMENT FORM

Please PRINT information ◊ Return to School Office

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Student Cell # (optional): \_\_\_\_\_ Grade: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_  
Street Address City Zip Code

Mother's Name: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Student lives with:  Both Parents  Mother  Father  Step-Parent  Legal Guardian  Other/Explain: \_\_\_\_\_

In case of illness or emergency, list the names & contact information for 3 people to whom we can release your child, :

1. Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

2. Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

3. Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Student's Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Permission to Contact Doctor:  Yes  No

Health Insurance Carrier: \_\_\_\_\_ Insurance #: \_\_\_\_\_

### HEALTH INVENTORY

In order to provide the best educational program for your child, the school would appreciate you providing the following health information.

Please check which of the following conditions your child has and whether he/she is still under care of a physician for this condition.

<u>Condition</u>	<u>Limitations</u>	<u>Medications/Dosage</u>	<u>Under Physician's Care</u>
<input type="checkbox"/> Allergies, Food/Other (List) Epi Pen <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Asthma	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bee Sting Allergy: Epi Pen <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Heart Condition	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Diabetes	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Kidney Disease	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Epilepsy/Seizure: Type _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Frequent or Severe Headache	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Depression/Anxiety Disorder (circle one)	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other physical/mental condition: _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Does your child have any condition, which could be a school emergency?  Yes  No Explain: \_\_\_\_\_

Is your child presently taking any medicine not listed above?  Yes  No Explain: \_\_\_\_\_

Name of Medicine : \_\_\_\_\_ Time of day medicine is taken: \_\_\_\_\_

I/We the undersigned, parent(s) of the above, a minor, do hereby authorize the principal or designee as agent for the undersigned to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act, whether such a diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of their best judgment may deem advisable.

This authorization shall remain effective until the end of the current school year, unless revoked in writing delivered to said agent(s).

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

# PARENTS' GUIDE TO IMMUNIZATIONS REQUIRED FOR SCHOOL ENTRY



Starting July 1, 2019

## Students Admitted at TK/K-12 Need:

- **Diphtheria, Tetanus, and Pertussis (DTaP, DTP, Tdap, or Td) — 5 doses**  
(4 doses OK if one was given on or after 4th birthday.  
3 doses OK if one was given on or after 7th birthday.)  
For 7th-12th graders, at least 1 dose of pertussis-containing vaccine is required on or after 7th birthday.
- **Polio (OPV or IPV) — 4 doses**  
(3 doses OK if one was given on or after 4th birthday)
- **Hepatitis B — 3 doses**  
(Not required for 7th grade entry)
- **Measles, Mumps, and Rubella (MMR) — 2 doses**  
(Both given on or after 1st birthday)
- **Varicella (Chickenpox) — 2 doses**

These immunization requirements apply to new admissions and transfers for all grades, including transitional kindergarten.

## Students Starting 7th Grade Need:

- **Tetanus, Diphtheria, Pertussis (Tdap) — 1 dose**  
(Whooping cough booster usually given at 11 years and up)
- **Varicella (Chickenpox) — 2 doses**  
(Usually given at ages 12 months and 4-6 years)

In addition, the TK/K-12 immunization requirements apply to 7th graders who:

- previously had a valid personal beliefs exemption filed before 2016 upon entry between TK/Kindergarten and 6th grade
- are new admissions

## Records:

California schools are required to check immunization records for all new student admissions at TK/Kindergarten through 12th grade and all students advancing to 7th grade before entry. Parents must show their child's Immunization Record as proof of immunization.

## 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
<b>POLIO</b> (OPV or IPV)					
<b>DtaP/DTP/DT/Td</b> (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
<b>MMR</b> (measles, mumps, and rubella)					
<b>HIB MENINGITIS</b> (Haemophilus Influenzae B) (Required for child care/preschool only)					
<b>HEPATITIS B</b>					
<b>VARICELLA</b> (Chickenpox)					
OTHER (e.g., TB Test, if indicated)					
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) 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.*

**Student Residency Questionnaire**  
**Wilmar Union School District**  
**Wilson Elementary School**

Grade: _____ Data Entry Complete: _____
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This questionnaire is intended to address the McKinney-Vento Homeless Education Assistance Improvement Act. The *confidential* answers to this questionnaire help determine the services the student may be eligible to receive.

1. Student's Name: \_\_\_\_\_  Male  Female  Non-Binary  
*Please Print Full Name*

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Contact Phone #: \_\_\_\_\_

2. Is your address a temporary arrangement? \_\_\_\_ Yes \_\_\_\_ No  
***If the answer is yes, please complete the remaining sections of this form.***

3. Is this temporary living arrangement due to loss of housing and/or economic hardship?  
 Loss of Housing  Economic Hardship

4. Parent/Guardian Name(s): \_\_\_\_\_  
*Please Print Full Name*

Relationship to Student (i.e., mother, father, grandparent, uncle, aunt, friend): \_\_\_\_\_

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

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

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

<p>Where is the student presently living? (<i>Check one box, complete information</i>)</p> <p><input type="checkbox"/> <b>Shelter</b> (<i>emergency, family, youth, domestic violence, etc.</i>)          Name of Shelter: _____          Address: _____          Contact Phone #: _____</p> <p><input type="checkbox"/> <b>Doubled-up</b> (<i>living with friends or relatives</i>)          Name of Friend or Relative: _____          Address: _____          Contact Phone #: _____</p> <p><input type="checkbox"/> <b>Hotel/Motel</b>          Name: _____          Address: _____          Contact Phone #: _____</p> <p><input type="checkbox"/> <b>Unsheltered</b> (<i>e.g. cars or other vehicle, parks, campgrounds, abandoned buildings, substandard housing, etc.</i>)</p>	<p><b>If the answer to Question #2 above is YES, please (✓) the Supplies/Services Requested</b></p> <p>_____ School supplies or other related costs</p> <p>_____ Free breakfast and lunch</p> <p>_____ Free PE uniform (middle/high school)</p> <p>_____ Referral for counseling services for student</p> <p>_____ Assistance for referrals to shelters, financial help, medical assistance, food, and clothing</p> <p>_____ Free summer school tuition</p> <p>_____ Referral Guide of Community Resources to include medical/vision</p> <p>_____ After-school tutoring</p> <p>_____ Free after-school care at participating schools (elementary), space limited</p> <p>_____ Assistance w/college applications and financial aid (12<sup>th</sup> grade only)</p> <p>_____ Free graduation cap and gown (12<sup>th</sup> grade only)</p>
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