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 _____
Last First

Occupation _____ Daytime phone _____ Cell phone _____ Email _____

Name of Other Legal Guardian _____ Employer _____
Last First

Occupation _____ Daytime phone _____ Cell phone _____ Email _____

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. 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 _____

OFFICE USE ONLY	**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**	

Print Reset

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: _____ (Street Address), _____ (City) _____ (Zip Code) Primary Phone: _____ Secondary Phone: _____

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.

Condition	Limitations	Medications/Dosage	Under Physician's Care
☐ Allergies, Food/Other (List) Epi Pen ☐ Yes ☐ No			☐ Yes ☐ No
☐ Asthma			☐ Yes ☐ No
☐ Bee Sting Allergy: Epi Pen ☐ Yes ☐ No			☐ Yes ☐ No
☐ Heart Condition			☐ Yes ☐ No
☐ Diabetes			☐ Yes ☐ No
☐ Kidney Disease			☐ Yes ☐ No
☐ Epilepsy/Seizure: Type _____			☐ Yes ☐ No
☐ Frequent or Severe Headache			☐ Yes ☐ No
☐ Depression/Anxiety Disorder (circle one)			☐ Yes ☐ No
☐ Other physical/mental condition:			☐ Yes ☐ 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 vie 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
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 (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) says every child must have a dental check-up (assessment) by May 31st of his/her first year in public school. A California licensed dental professional must do the check-up and fill out Section 2 of this form. If your child had a dental check-up in the last 12 months, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out the separate Waiver of Oral Health Assessment Requirement Form.

This assessment will let you know if there are any dental problems that need attention by a dentist. This assessment will also be used to evaluate our oral health programs. Children need good oral health to speak with confidence, express themselves, be healthy and, ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of California's children.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's Birth Date: MM – DD – YYYY
Address:			Apt.:
City:			ZIP Code:
School Name:	Teacher:	Grade:	Year child starts kindergarten: Y Y Y Y
Parent/Guardian First Name:	Parent/Guardian Last Name:		Child's Gender: ☐ Male ☐ Female

Child's Race/Ethnicity:		
	☐ White	☐ Native American
	☐ Black/African American	☐ Multi-racial
	☐ Hispanic/Latino	☐ Native Hawaiian/Pacific Islander
	☐ Asian	☐ Unknown
	☐ Other (please specify)	

Continued on Next Page

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: MM – DD – YYYY	Untreated Decay (Visible Decay Present) ☐Yes ☐No	*Caries Experience (Visible decay and/or fillings 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)

_____	_____	MM – DD – YYYY _____
Licensed Dental Professional Signature	***CA License Number***	***Date***

*Check "Yes" for Caries experience if there is presence of untreated decay or fillings
Check "No" for Caries experience if there is no untreated decay and no fillings

Section 3: Follow-up to Urgent Care (Filled out by entity responsible for follow up)

Parent notified that child has urgent dental care need on:	MM – DD – YYYY
A follow-up appointment for this child has been scheduled for:	MM – DD – YYYY

Did child receive needed treatment?

◯ **Yes**

◯ **No** (If no, entity responsible for follow-up will be encouraged to check back in with parent)

◯ **I don't know**

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 31st of your child's first school year.

Original to be kept in child's school record.

WILSON ELEMENTARY SCHOOL

3775 Bodega Avenue Petaluma, CA 94952 707-765-4340

Wilmar Union District

Type 1 Diabetes Information Sheet

Pursuant to California Education Code Section 49452.6, type 1 diabetes informational materials are to be provided to the parent or guardian of a pupil when the pupil is first enrolled in elementary school.

Type 1 diabetes in children is an autoimmune disease that can be fatal if untreated, and the guidance provided in this information sheet is intended to raise awareness about this disease.

What is Type 1 Diabetes?

- The body turns the carbohydrates in bodies into glucose (blood sugar), which is the basic fuel for the body's cells
- The pancreas makes insulin. Insulin is a hormone that moves glucose from the blood into the body's cells.
- In type 1 diabetes, the body's pancreas stops making insulin, and the levels of glucose in the blood rise.
- Over time the glucose levels in the blood may become dangerously high. When this happens, it is called "hyperglycemia".
- If left untreated, hyperglycemia can result in diabetic ketoacidosis (DKA), which is a life-threatening complication of diabetes.
- Type 1 Diabetes usually develops in children and young adults but can occur at any age.

Risk factors Associated with Type 1 Diabetes

- Researchers do not completely understand why some people develop type 1 diabetes.
- Having a family history of type 1 diabetes can increase the likelihood of developing type 1 diabetes.
- Other risk factors may include environmental triggers, such as viruses.
- Type 1 diabetes is not caused by diet or lifestyle choices.

Warning Signs and Symptoms Associated with Type 1 Diabetes

Warning signs and symptoms may develop quickly, in weeks or months. If your child displays the warning signs below, contact your child's health care provider to determine if screening your child for type 1 diabetes is appropriate:

- Increased thirst
- Unexplained weight loss
- Feeling very tired
- Blurred vision
- Very dry skin
- Slow healing of sores or cuts
- Increased hunger, even after eating
- Moodiness, restlessness, irritability or behavior changes
- Increased urination, including bed-wetting after toilet training

DKA is a complication of untreated type 1 diabetes, and is a medical emergency. Symptoms include:

- Fruity breath
- Dry/flushed skin
- Nausea
- Vomiting

Student Residency Questionnaire
Wilmar Union School District
Wilson Elementary School

Grade: _____
Data Entry Complete: _____

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: _____

Where is the student presently living? (*Check one box, complete information)*

☐ **Shelter** *(emergency, family, youth, domestic violence, etc.)*
Name of Shelter: _____
Address: _____
Contact Phone #: _____

☐ **Doubled-up** *(living with friends or relatives)*
Name of Friend or Relative: _____
Address: _____
Contact Phone #: _____

☐ **Hotel/Motel**
Name: _____
Address: _____
Contact Phone #: _____

☐ **Unsheltered** *(e.g. cars or other vehicle, parks, campgrounds, abandoned buildings, substandard housing, etc.)*

If the answer to Question #2 above is YES, please (√) the Supplies/Services Requested

_____ School supplies or other related costs
_____ Free breakfast and lunch
_____ Free PE uniform (middle/high school)
_____ Referral for counseling services for student
_____ Assistance for referrals to shelters, financial help, medical assistance, food, and clothing
_____ Free summer school tuition
_____ Referral Guide of Community Resources to include medical/vision
_____ After-school tutoring
_____ Free after-school care at participating schools (elementary), space limited
_____ Assistance w/college applications and financial aid (12th grade only)
_____ Free graduation cap and gown (12th grade only)

Questions regarding this questionnaire may be directed to the Wilson School office, at 707-765-4340.