TO REGISTER YOUR CHILD FOR KINDERGARTEN.... PLEASE BRING:

1.) A Birth Certificate

2.) A Current Immunization Record

3.) Proof of Residency

Your child ***will not*** be allowed to start Kindergarten without these items.

*In the fall, you will need to provide an Oral Health Assessment and proof of a CHDP/Wellness Exam.

KEEPING STUDENTS AND STAFF HEALTHY

One of the goals at school is to keep students and staff healthy. Listed below are some recommendations for parents of children in school to decrease the spread of illness. If your child is ill, please keep him/her home. If your child has a contagious condition, please make sure there is a note from a physician, or clearance from the nurse at school, before he/she returns to school.

Reasons to keep your child at home:

- Continuous cough
- Fever during the night or the morning before school
- Vomiting during the night or the morning before school
- Red eyes with a crusty discharge
- Unexplained rash
- Head lice and/or nits (eggs). The child will usually have a persistent itchy scalp.

Please take your child to a physician if he/she has:

- A high fever or one that lasts for more than 24 hours
- Red eyes with a crusty discharge
- An unexplained rash
- An illness that doesn't go away
- A cough that doesn't go away

To help prevent illness, please provide your child with adequate rest, warm clothing, fluids, nutritious meals, and proper shoes on wet or snowy days. Remember the importance of eating breakfast and good hand-washing.

This information is provided by the Lassen County Office of Education.
(3/00)

JANESVILLE UNION ELEMENTARY SCHOOL DISTRICT

Janesville Union School
464-555 Main Street, PO Box 280
Janesville, CA 96114
(530) 253-3551 (School Office)
(530) 253-3660 (District Office)
(530) 253-3891 (FAX)

www.janesvilleschool.org

CLASS	TIME	LUNCH
Kindergarten	8:15 – 2:20	11:35-11:55
1st Grade	8:15 – 2:20	11:20-12:05
2nd Grade	8:15 – 2:20	11:25-12:05
3rd Grade	8:15 – 2:20	11:30-12:10
4th Grade	8:15 – 2:25	11:45-12:25
5th Grade	8:15 – 2:25	11:55-12:35
6th Grade	8:15 – 2:25	12:00-12:40
7th/8th Grades	8:15 – 2:25	12:15-12:55

MINIMUM DAY DISMISSAL TIMES:

Kindergarten – Grade 3	12:40
Grades 4 – 8	12:45

Lunch is served on minimum days.

Meal Prices:

Breakfast:	$1.75
Student lunch:	$2.85
Guest breakfast:	$2.25
Guest lunch:	$3.35
Milk:	$ .40

Free and reduced price breakfast and lunch are available to those who qualify.

Revised November 7, 2019

Start Date:
Grade:
Teacher:

JANESVILLE UNION ELEMENTARY SCHOOL
P.O. Box 280, 464-555 Main Street
Janesville, California 96114
(530) 253-3551

Registration Form

Last Name _____ First _____ Middle _____ Male Female (circle one) _____ Date of Birth _____ Social Security # (Optional)

Home Address _____ City _____ Zip Code _____ Place of Birth: City _____ State _____ Country

Mailing Address (If different from above) _____ Home Phone _____ Cell Phone _____

Last School Attended: Name of School _____ City _____ State _____ Date Last Attended

Was this child born outside the United States? _____ If so, was he/she born on a military base? _____
What was the first date of attendance in a U.S. school? _____

Student Resides with: (Please circle) Both Parents Shared Custody Father Step-Father Mother Step-Mother Grandparent Guardian

Name _____ Relationship _____

Employer _____ Phone _____ Ext. _____

Name _____ Relationship _____

Employer _____ Phone _____ Ext. _____

In case of an emergency, a person who can ***ALWAYS*** be reached:

Name _____ Phone _____ Cell Phone _____

Name of Sibling(s)	Relationship	Date of Birth	Grade	School Attending	At home

Please check if your child has an ACTIVE:	
IEP	
504	
Speech	
Other:	

Parent Education Level:	
Graduate School / post-graduate training	
College Graduate	
Some college (includes AA degree)	
High school graduate	
Not a high school graduate	
Decline to state or unknown	

Primary Ethnicity:			
White (not of Hispanic origin)		American Indian or Alaskan Native	
Hispanic		Filipino	
African American or Black (not of Hispanic origin)		Native Hawaiian	
		Guamanian	
Chinese		Samoan	
Japanese		Tahitian	
Korean		Other Pacific Islander	

_____ Parent / Guardian Signature

_____ Date

_____ E-mail address

Student Name: _____
Last First Middle Date of Birth

EMERGENCY MEDICAL TREATMENT

AUTHORIZATION OF CONSENT FOR TREATMENT OF MINOR

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

This authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California. This authorization shall remain effective until revoked in writing and delivered to said agent.

It is understood that parents / guardians are responsible for all medical costs. Our school insurance is a secondary insurance and only covers a portion of the actual costs.

Parent/Guardian Name: _____
(Please print) Last First

SIGNATURE: _____

_____ _____ _____
Home address (please print) Home phone # Cell Phone #

_____ _____
City, State, Zip Work phone

_____ _____ _____
Alternate person (In case you can't be contacted) Home Phone # Cell Phone #

****

MEDICAL HISTORY

_____
Family Physician Address Phone

_____
Insurance Company (Medical Coverage) Policy #

PHYSICAL CONDITION OF STUDENT: (PLEASE CHECK ALL THAT APPLY)

❑Allergies ❑Asthma ❑Heart Condition ❑Rheumatic Fever ❑Stomach upsets ❑Diabetes ❑Epilepsy

Date of last Tetanus shot:_____

Any activity restriction:_____ Specify:_____

Is your child allergic to any medication? _____Specify:_____

Janesville Elementary School
HOME LANGUAGE SURVERY

Name of Student: _____
(Surname / Family Name) (First Given Name) (Second Given Name)

Age of Student: _____ Grade Level: _____ Teacher Name: _____

Directions to Parents and Guardians:

The California Education Code contains legal requirements which direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with these requirements. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered. If an error is made completing this home language survey, you may request correction before your student's English proficiency is assessed.

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

Which language does your child most frequently speak at home? _____

Which language do you (the parents or guardians) most frequently use when speaking with your child? _____

Which language is most often spoken by adults in the home? (parents, guardians, grandparents, or any other adults) _____

Please sign and date this form in the spaces provided below, then return this form to your child's teacher. Thank you for your cooperation.

_____ _____
Signature of Parent or Guardian Date

Form HLS, Revised December 2016
California Department of Education

Janesville Elementary School
ENCUESTA DEL IDIOMA EN EL HOGAR

Name of Student: _____
(Surname/Family Name) (First Given Name) (Second Given Name)

Age of Student: _____ Grade Level: _____ Name of Teacher: _____

Note: School district personnel should complete all of the information items above this line.

Instrucciones para padres y tutores:

El Código de Educación de California contiene requisitos legales que guían a las escuelas a dar un examen de proficiencia en ingles a los estudiantes. El proceso comienza con determinar el idioma o idiomas que se hablan en el hogar de cada estudiante. Las respuestas a esta encuesta del idioma ayudarán al personal de la escuela saber si el estudiante debe tomar el examen. Esta información es esencial para que la escuela pueda proveer programas y servicios adecuados a los estudiantes.

Como padre o tutor, su cooperación es necesaria para cumplir con estos requisitos. Por favor responda a cada una de las cuatro preguntas siguientes de la forma más precisa posible. Para cada pregunta, escriba el nombre(s) del idioma(s) que corresponde en el espacio suministrado. Por favor, responda a todas las preguntas. Si contestó con error a las preguntas de esta encuesta de idioma, Ud. puede solicitar corrección de su respuesta antes de que la proficiencia de su estudiante sea evaluada.

¿Qué idioma aprendió su hijo cuando empezó a hablar? _____

¿Qué idioma habla su hijo en casa con más frecuencia? _____

¿Qué idioma utilizan ustedes (los padres o tutores) con más frecuencia cuando hablan con su hijo? _____

¿Qué idioma se habla con más frecuencia entre los adultos en el hogar (padres, tutores, abuelos o cualquier otro adulto)? _____

Por favor firme y feche este formulario en el espacio suministrado a continuación y devuelva el formulario al maestro de su hijo. Muchas gracias por su cooperación.

_____ _____
(Firma del padre/madre o tutor) (Fecha)

Form HLS, Source Document Revised December 2016
California Department of Education

JANESVILLE UNION SCHOOL DISTRICT

STUDENT HEALTH INVENTORY

Student's Name: _____
Last First Middle

Date of Birth: _____

Parent(s) / Guardian(s) _____

ALL STUDENTS (INCLUDING TRANSFERS) MUST PRESENT AN IMMUNIZATION RECORD AT THE TIME OF REGISTRATION.

1. Has your child been exposed to Tuberculosis?_____
   If so, when_____
2. **MEDICAL HISTORY:** Please check if your child has a history of disease or condition:

❑Heart condition	❑Bone and/or joint problems
❑Fainting spells	❑Diabetes
❑Convulsions	❑Epilepsy
❑Kidney problems	❑Asthma
❑Speech problem	❑Other_____
❑Measles (Year____)	❑Rubella (Year____)
❑Mumps (Year____)	❑Chicken Pox (Year)

3. Does your child have any allergies?_____
   If so, please specify: (insects, stings, foods, medication, etc...)
   _____
4. Does your child have a "current" health problem?_____
   If so, please specify:_____
5. Is your child under a doctor's care?_____
   If so, please explain:_____
6. Is your child taking any medications regularly?_____
   If so, name of medication:_____

Chapter 5, Division 9, Article 2.5 of the Education Code reads as follows:
12020. The parent or legal guardian of any public school pupil on a continuing medication regimen shall inform the school nurse or other person(s) designated by the Superintendent of the medication being taken, the current dosage, and the name of the supervising physician. With the consent of the parent or legal guardian, the school nurse may communicate with the physician and may counsel with the school personnel regarding the possible effects of the drug on the child's physical, intellectual, and social behavior, as well as possible behavioral signs and symptoms of adverse side effects, omission, or overdose. The superintendent of each school district shall be responsible of informing parents of all pupils of the requirements of this section.

7. Has your child ever received medical treatment through California Children's Services? Yes_____ No_____
8. Does your child have an ear or hearing problem? _____
   If so, please explain:_____
   Does your child wear a hearing aid? Yes _____ No _____

-OVER-

9. Does your child have an eye or vision problem? Yes_____ No_____
Does your child wear glasses? Yes_____ No_____

10. Has your child had a complete physical examination within the last three years? Yes_____ No_____If yes, give date:_____
Name of doctor/clinic:_____

11. **PHYSICAL EDUCATION:** THE EDUCATION CODE OF THE STATE OF CALIFORNIA MAKES IT MANDATORY THAT A DAILY PERIOD OF PHYSICAL EDUCATION BE PROVIDED IN THE SCHOOL. IF AT ANY TIME YOUR CHILD IS ILL OR HAS A CONDITION WHICH YOU FEEL NECESSITATES HIS/HER BEING EXCUSED FROM PHYSICAL ACTIVITY FOR MORE THAN THREE DAYS, **WE REQUIRE A NOTE FROM YOUR DOCTOR.**

12. **ABSENCES FROM SCHOOL: YOUR CHILD MUST HAVE A NOTE UPON HIS/HER RETURN TO SCHOOL FOR ANY ABSENCE.**

13. **I UNDERSTAND THAT IF MY CHILD DOES NOT COMPLY WITH THE CALIFORNIA STATE IMMUNIZATION LAW, HE/SHE CAN BE EXCLUDED FROM SCHOOL.**

_____ _____

Date Signature of Parent/Guardian

Janesville Union Elementary School
Emergency Information

PLEASE PRINT LEGIBLY.

1. _____ _____ _____
Student's Name (Last, First) Date of Birth Teacher

2. _____ _____ _____
Student's Name (Last, First) Date of Birth Teacher

3. _____ _____ _____
Student's Name (Last, First) Date of Birth Teacher

_____ _____ _____ _____
Father/Guardian/Step-Father/Other_____ Home phone # Cell phone # E-mail Address

_____ _____ _____
Street Address City Zip

_____ _____ _____
Mailing Address (if different) City Zip

_____ _____ _____
Place of Employment Work phone # Ext.

_____ _____ _____ _____
Mother/Guardian/Step-Mother/Other _____ Home phone # Cell phone # E-mail Address

_____ _____ _____
Street Address City Zip

_____ _____ _____
Mailing Address (if different) City Zip

_____ _____ _____
Place of Employment Work phone # Ext.

If my child needs to be sent home because of an illness/emergency and I/we cannot be reached, please call...

Name	Home phone	Work phone	Cell phone
Name	Home phone	Work phone	Cell phone
Name	Home phone	Work phone	Cell phone

SPECIAL MEDICAL CONDITIONS (allergies, reactions, other medical info):

1. _____

2. _____

3. _____

Oral Health Assessment/Waiver Request Form

(Return this form to the school by May 31)

California law, *Education Code* Section 49452.8, now requires that your child have an oral health assessment by May 31 in kindergarten or first grade, whichever is his/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 completing Section 3 of this form.

SECTION 1 (To be completed by the parent or guardian)

Child's Last Name:	First Name:	Middle Initial:	Child's birthdate:
Address:			Apt. or Space No.:
City:			Zip Code:
School Name:	Teacher:	Grade:	Child's Gender: ☐ Male ☐ Female
Parent/Guardian Name (Print):	Child's race/ethnicity: ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ Hispanic/Latino ☐ American Indian ☐ Alaskan Native ☐ Multi-racial ☐ Asian ☐ Unknown		

By signing this form, I am consenting for the child named above to receive a basic oral health assessment/dental screening. I understand this screening is only a very basic evaluation. Dental screenings only find obvious dental problems and are meant to identify children who need dental care. No x-rays were taken, and this screening does not replace a thorough dental examination by a dentist. Also, I will not hold the dentist or those performing this assessment responsible for the oral health consequences or results should I choose NOT to follow the Treatment recommendation(s) listed below.

_____

Parent/Guardian/Representative Signature *Date*

SECTION 2 - Oral Health Data Collection

To be completed by the dental professional conducting the assessment

Assessment Date:	Visible fillings present? ☐ Yes ☐ No	Visible caries present? ☐ Yes ☐ No	Treatment urgency: ☐ No obvious dental problem found. ☐ Further evaluation needed. Contact a dentist for an exam as soon as possible. ☐ Some dental problems. Contact a dentist immediately.

_____

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.

Other reasons my child could not get an oral health assessment (optional): _____

_____

_____

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.

Distribution: White – School; Yellow – Dental Health Professional; Pink – Parent/Guardian

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.

If your child is enrolling into Kindergarten, please take these forms to your private medical/dental provider at the time of your appointment. Please return to the school when completed.

This is a requirement for enrollment.

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