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

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

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.
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

<table>
<thead>
<tr>
<th>Name of Sibling(s)</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Grade</th>
<th>School Attending</th>
<th>At home</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>White (not of Hispanic origin)</th>
<th>American Indian or Alaskan Native</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>Filipino</td>
</tr>
<tr>
<td>African American or Black (not of Hispanic origin)</td>
<td>Native Hawaiian  Guamanian</td>
</tr>
<tr>
<td>Chinese</td>
<td>Samoan</td>
</tr>
<tr>
<td>Japanese</td>
<td>Tahitian</td>
</tr>
<tr>
<td>Korean</td>
<td>Other Pacific Islander</td>
</tr>
</tbody>
</table>

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: ________________________________
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

(Parrents, Guardians, Grandparents, or any other adults)

Which language is most often spoken by adults in the home?

______________________________

When speaking with your child?

______________________________

Which language do you (the parents or guardians) most frequently use?

______________________________

Which language does your child most frequently speak at home?

______________________________

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

Student's English proficiency is assessed.

As parents of guardians, your cooperation is requested in completing this home language survey. This information is essential in order for the school to provide adequate instructional programs and services. The California Education Code contains legal requirements which direct schools to assess the English language proficiency of students. The process begins with determining if a student's proficiency in English should be tested. This information is essential. It is your responsibility to respond to the home language survey.

Directions to Parents and Guardians:

______________________________

Teacher Name: ________________

______________________________

Grade Level: ________________

______________________________

Age of Student: ________________

______________________________

(First Given Name) (Second Given Name)

______________________________

Surname / Family Name: ________________

______________________________

Name of Student: ________________

Janesville Elementary School

HOME LANGUAGE SURVEY
(Peche)  

(Prima del padre/madre o tutor)

Gracias por su cooperación.

Por favor, conteste a estas preguntas sobre el idioma que se habla en el hogar de su hijo.

¿Cuál idioma habla su hijo en casa?

¿Cuándo habla su hijo en casa?

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

¿Qué idioma aprendió su hijo en casa con más frecuencia?

¿Qué idioma habla su hijo con sus padres?

¿Qué idioma habla su hijo con sus hermanos?

¿Qué idioma habla su hijo con su hermano/a?

¿Qué idioma habla su hijo con su profesor/a?

¿Cuál idioma habla su hijo con su amigo/a?

¿Qué idioma habla su hijo con su uñer/la?

¿Qué idioma habla su hijo con su vecino/o?

¿Qué idioma habla su hijo con sus padrinos/los padrinos o tutores?

¿Qué idioma habla su hijo con sus abuelos/los abuelos o tutores?

¿Qué idioma habla su hijo con sus primos/los primos o tutores?

¿Qué idioma habla su hijo con sus tíos/los tíos o tutores?

¿Qué idioma habla su hijo con sus hermanos/cuñados?

¿Qué idioma habla su hijo con sus hermanos/cuñados?

¿Qué idioma habla su hijo con sus hermanos/cuñados?

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¿Qué idioma habla su hijo con sus hermanos/cuñados?
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...

<table>
<thead>
<tr>
<th>Name</th>
<th>Home phone</th>
<th>Work phone</th>
<th>Cell phone</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Child’s Last Name:</th>
<th>First Name:</th>
<th>Middle Initial:</th>
<th>Child’s birthdate:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Apt. or Space No.:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Zip Code:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>City:</th>
<th>School Name:</th>
<th>Teacher:</th>
<th>Grade:</th>
<th>Child’s Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Male</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Name (Print):</th>
<th>Child’s race/ethnicity:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Black/African American</td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>Hispanic/Latino</td>
<td>Native Hawaiian/Pacific Islander</td>
</tr>
<tr>
<td></td>
<td>Alaskan Native</td>
<td>American Indian</td>
</tr>
<tr>
<td></td>
<td>Multi-racial</td>
<td>Asian</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unknown</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Assessment Date:</th>
<th>Visible fillings present?</th>
<th>Visible caries present?</th>
<th>Treatment urgency:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
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</tbody>
</table>

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.
**Report of Health Examination for School Entry**

If your child is unable to get the school health check-up, call the Child Health and Disease 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 176B) found at your child's school.

**Date:**

**Signature of parent or guardian:**

**Name, address, and telephone number of health examiner:**

---

If your child has a physical disability, please explain:

☐ Examination shows no condition of concern to school program activities.

☐ Examination shows a condition which requires the release of health information.

Please check this box if you do not want the health examiner to fill out Part III.

Please check this box if the school is expected to fill out Part III.

I give permission for the health examiner to enter the additional information about the health check-up.

---

### Release of Health Information by Parent or Guardian

<table>
<thead>
<tr>
<th>Health Information</th>
<th>Release of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>VacCellA (Cibeplex)</td>
<td>Other</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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### Part II - To Be Filled Out by Health Examiner

**School:**

**Address:**

**Zip code:**

**Birthdate—Month/Year:**

**Child’s name:**

---

**Immunization Record:**

- *Note: All tests and evaluations except the blood test must be done after the child is 4 years and 2 months of age.*

**Health Examination:**

- *Note: All tests and evaluations except the blood test last year.*

---

To protect the health of children, California law requires a health examination on school entry. Please have this report filed by a health examiner and return it to the 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.