CHECKLIST FOR ROSS SCHOOL REGISTRATION

- ☐ AERIES AIR ONLINE REGISTRATION
- ☐ BIRTH CERTIFICATE (ORIGINAL OR PASSPORT)
- ☐ HOME LANGUAGE SURVEY
- ☐ PRE-SCHOOL INFORMATION FORM (PROVIDE STAMPED ENVELOPE TO PRE-SCHOOL ADDRESSED TO ROSS SCHOOL)
- ☐ CUMULATIVE RECORDS REQUEST
- ☐ STUDENT INFORMATION FORM
- ☐ PROOF OF RESIDENCE (PLEASE BRING ORIGINAL DOCUMENTS-TO.DISTRICT.OFFICE)
- ☐ DENTAL REPORT
- ☐ EMERGENCY CARD
- ☐ IMMUNIZATION RECORD (PLEASE BRING A COPY OF THE RECORD
- ☐ MEDICAL EXAM REPORT (PLEASE BRING A COPY OF THE PHYSICAL FROM YOUR CHILD'S PHYSICIAN)

ENGLISH

_____ _____

Date School

_____

Teacher

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 for schools to provide meaningful instruction for all students.

Your cooperation in helping us meet this important requirement is requested. Please answer the following questions and have your son/daughter return this form to his/her teacher. Thank you for your help.

Name of Student: _____ _____ _____

Last First Middle Grade Age

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

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

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

4. Name the language most spoken by adults at home: _____

_____

Signature of Parent or Guardian

State of California
Department of Education

PRE-SCHOOL INFORMATION

Dear Pre-School Teacher:

To assist with this child's transition to Kindergarten, please complete the information below and mail this completed form along with the Permission Form completed by the parent/guardian to his/her elementary school by June 5th. This information will be passed on to the child's kindergarten teacher. Please keep this information confidential.
Thank you.

Pre-School Teacher Completing Form

_____ _____ _____
Name (please print) Phone Number Name of Program/School

_____
Signature

Child's Name — Child's Date of Birth

_____
First Middle Last Month / Day / Year

Child's Social Emotional Development

1. Are there other children that this child should not be placed with?
   ☐ Yes ☐ No ☐ Don't Know
   Other Child's Name: _____ Other Child's Name: _____

2. At school, does this child play mostly alone, with others, or both?
   ☐ Mostly Alone ☐ Mostly With Others ☐ Both

How often is this child able to…(please check one)

a. Sit attentively for 10-15 minutes for large group or circle time?
   ☐ Most of the time ☐ Some of the time ☐ Never

b. Cooperate with and share with others?
   ☐ Most of the time ☐ Some of the time ☐ Never

c. Follow the classroom routines?
   ☐ Most of the time ☐ Some of the time ☐ Never

d. Make a choice and engage in the selected activity?
   ☐ Most of the time ☐ Some of the time ☐ Never

e. Ask the teacher for help?
   ☐ Most of the time ☐ Some of the time ☐ Never

f. Follow two-step directions?
   ☐ Most of the time ☐ Some of the time ☐ Never

Please describe any areas in which this child needs help (e.g. toileting, classroom behavior).

Please describe strategies or accommodations that work well for this child.

Cognitive and Physical Development

1. Can this child identify letters?
☐ None ☐ Few ☐ Many ☐ All ☐ Don't Know

2. Does this child show developmentally appropriate fine motor skills (for example, use scissors, grip pencil, etc.)?
☐ Yes ☐ No ☐ Don't Know

3. Can this child recognize numbers 1-10?
☐ None ☐ Few ☐ Many ☐ All ☐ Don't Know

4. Can this child write symbols to create meaning?
☐ Yes ☐ No ☐ Don't Know

5. Can this child read?
☐ Yes ☐ No ☐ Don't Know

Language Development

1. How often does this child communicate clearly?
☐ Most of the time ☐ Some of the time ☐ Never

2. How often does this child use sentences to communicate?
☐ Most of the time ☐ Some of the time ☐ Never

Special Needs

1. Does this child have an Individual Education Plan (IEP)? ☐ Yes ☐ No ☐ Don't Know

2. What services has this child received?

3. Please describe this child's learning style.

Special Interests / Strengths

1. Please describe this child's favorite activities.

2. Please describe this child's strengths.

3. What would you like another teacher to know about this child? (For example: family situation, personality, behavior, living arrangements, etc.)

REQUEST FOR CUMULATIVE RECORDS

SCHOOL/FACILITY WHERE EDUCATIONAL RECORDS AND MEDICAL RECORDS ARE PRESENTLY ON FILE

School/facility: _____

Address: _____

City, State, Zip Code: _____

The following student(s) has(ve) enrolled in Ross School.

Name: _____ Birthdate:_____ Grade: _____
Name: _____ Birthdate: _____ Grade: _____
Name: _____ Birthdate: _____ Grade: _____

Please send complete information by forwarding educational records, special education records/psychological/psychometric reports to:

Ross School District
Attention: Student Records
P.O. Box 1058
Ross, CA 94957

Parent/Guardian Signature: _____

Date: _____

Ross School
Student Information Update

Each year it is helpful for us to have information that affects your child's learning and school experience. Please complete this form and return to you Shari Byrnes.

Student Name: _____ Age: _____ Grade: _____ Date: _____

Please list siblings and ages:
_____birthdate _____ _____birthdate _____

_____birthdate _____ _____birthdate _____

1. What goals or issues do you feel are important for us to address with your student this year?

   Are these issues new this year or are continuing from prior years?

2. Since last year, what changes have occurred that are important for us to know about (i.e. family changes, illnesses, challenges, achievements)?

3. Please tell us about your child's interests and activities:

4. Describe any evaluations or interventions which are related to school and learning which your child has had since last school year. Please attach any reports and/or describe programs.

5. Please tell us about any academic assistance your child receives outside of Ross School.

6. What strengths does your child have as a learner?

7. What challenges does your child face as a learner?

8. Is there anything else that will help us better understand and serve your student this year?

Include copies of proof from ALL THREE categories as indicated below. **EXHIBIT 5111.1**

ROSS SCHOOL DISTRICT

AFFIDAVIT OF PROOF OF RESIDENCY

California Government Code (sections 243 and 244) defines residency as the location where a person lives/sleeps/domiciles.

Last Name	First Name	Grade

HOME ADDRESS:_____

PROVIDE **TWO** FROM CATEGORY I BELOW:	PROVIDE **ONE** FROM CATEGORY II BELOW:
CATEGORY I	**CATEGORY II**
☐ **PG&E STATEMENT** Complete Statement Within the last 60 days Utility set-up and 15-day notices are NOT accepted. If you do not have a PG&E statement in your name because you sub-lease and/or live with another individual, you are required to submit a notarized affidavit (Exhibit 5111.2) Additionally, the individuals that you live with must provide a PG&E statement in their name. ☐ **COPY OF CURRENT LEASE AGREEMENT** A current dated lease agreement showing the address with the lessor-lessee-realtor names and signatures. If lease is not current then proof of lease payment within the last 60 days must accompany lease agreement. **Not** accepted: Lease extensions, handwritten or month-to-month leases and grant deeds. If you sub-lease or live with another individual, you are required to submit a notarized affidavit (Exhibit 5111.2) ☐ **COPY OF MOST RECENT PROPERTY TAX BILL** Must include your physical address. If property is in a trust, please submit copies of these additional trust pages: **1)** first page, **2)** page that names applicant as Beneficiary, **3)** signature page, **4)** property description page (Exhibit/Schedule A) referencing the parcel number or property address.	☐ **CABLE BILL** Complete Statement Within the last 60 days Utility set-up and 15-day notices are NOT accepted. ☐ **WATER BILL** Complete Statement Within the last 60 days Utility set-up and 15-day notices are NOT accepted. ☐ **GARBAGE BILL** Complete Statement Within the last 60 days Utility set-up and 15-day notices are NOT accepted. ***If you use a P.O. Box for mail delivery** If you use a P.O.Box for mail delivery you must provide a copy of your entire PG&E, cable, water or garbage bill. These statements reflect the address where the service is provided.

CATEGORY III

PROVIDE **ONE**:

☐ **VALID IDENTIFICATION**

Valid State Driver's License **or** Valid State Photo Identification Card **or** Gov't Issued Photo ID Card

By signing below, I declare under penalty of perjury under the laws of the State of California that all the information set forth above, and that the documents I have submitted, including the address I have listed as my residence, and the fact that I am the parent or legal guardian of the student are true and corrrect.

_____

Name (Signature) Relationship to Student Date

For office use only: Approved by: _____ Date: _____

Board Approved: May 11, 2016; Revised: September 14, 2016

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: ☐ Male ☐ Female
Parent/Guardian Name:	Child's race/ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Multi-racial ☐ Other_____ ☐ Native Hawaiian/Pacific Islander ☐ 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) □ Yes □ No	Visible Decay 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)

_____ _____ _____

Licensed Dental Professional Signature ***CA License Number*** ***Date***

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)

☐ 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.

Marin County Report of Health Examination for School Entry

Child's Name _____ Birthdate _____ Grade _____ Medi-Cal # _____

Address _____ City _____ ZIP _____ Phone _____

Reason for referral if other than pre-school physical: _____ School Nurse _____ Phone _____

HEALTH EXAMINATION MUST INCLUDE AREAS NOTED IN BOLD. (Please check if done and note results as appropriate)

Date of Exam: _____ Is child ___New? ___ Established to your care?

Follow-Up / Referral
Please indicate who will follow-up
HEALTH PROVIDER | SCHOOL NURSE

___ **Health and Developmental History**

___ **Nutritional Assessment** **Height** _____ **Weight** _____ **B/P** _____

___ **Physical Examination** **Dental Assessment** [ ]Normal [ ]Possible caries DENTAL

___ **Blood Test for Anemia** Blood Test for Lead: [ ]No [ ]Yes Result: _____

___ **Urine Test** Exposure to second hand smoke? [ ]No [ ]Yes

___ **Vision Testing:** **Acuity Test Used:** [ ]Snellen [ ]Titmus VISION

Right: 20/ ____ **Left: 20/** ____ Eye muscle testing: [ ]Normal [ ]Abnormal

Referred? [ ]Yes [ ]No Student should wear glasses: [ ]Yes [ ]No

___ **Audiometry Screening** ___ Tympanograms (Optional) AUDIO

	1000	2000	3000	4000
Right				
Left				

Right _____ Left _____

Referred? [ ]Yes [ ]No

Comments: _____

ADDITIONAL INFORMATION FROM HEALTH EXAMINER: OTHER

Does this child have any conditions that might concern the school? [ ]No [ ]Yes

If yes, explain condition(s) and recommendations for follow-up: _____

Are there any restrictions from physical activities? [ ]No [ ]Yes

If yes, explain: _____

Does this child take any medication(s)? [ ]No [ ]Yes If yes, explain _____

(If child must take medication at school, please request and complete a medication form.)

Stamp or print examiner's name, address, phone number

_____
Examiner's Signature

TB skin test (PPD) required for school entry *regardless* of BCG

Date given ___/___/___ Date read ___/___/___

Induration _____ mm [ ]Negative [ ]Positive

Chest X-Ray required If positive

Date ___/___/___ [ ] Normal [ ]Abnormal

Immunization Dates

Polio (OPV or IPV)					
DTP / DTaP					
DT / Td					
HIB Meningitis					
MMR					
Hepatitis B					
Varicella					
Other					

If any required immunizations were not given, list reason: _____

_____ Exemption expiration date ___/___/___

01/28/97

ROSS SCHOOL
HEART-MIND-ACTION

ROSS School District

A California Distinguished School

We are an exceptional learning community that connects children to the world by keeping their hearts, minds and actions at the center of all we do.

P.O. Box 1058
9 Lagunitas Rd.
Ross, CA 94957
(415) 457-2705
fax (415) 457-8923
www.rossbears.org

January 22, 2016

Dear Parent or Guardian:

To protect the health of all in school, California State Law requires that every child have a health exam for entry into school. THIS EXAM MUST BE DONE PRIOR TO THE START OF KINDERGARTEN BUT NO EARLIER THAN MARCH OF THE YEAR THE CHILD ENTERS KINDERGARTEN. If your child is not on Medi-Cal, you may be able to obtain this required examination free of charge. To find out whether your child is eligible, contact your local CHDP office at 415-473-6887.

PLEASE SIGN THIS RELEASE OF HEALTH INFORMATION, HAVE THIS REPORT COMPLETED BY THE HEALTH EXAMINER, AND RETURN IT TO THE SCHOOL. You may deliver the completed form to school or ask your child's doctor to FAX it to 415-457-8923. The school will keep and maintain the form as confidential information. If you cannot get an exam, or you do not want your child to have it, you must sign a form (PM 171-B) which may be obtained at the school.

Sincerely,

Laura

Laura Bauernfeind, RN MSN
Ross School Nurse
lbauernfeind@rossbears.org
Phone: 415-457-2705, EXT. 204
FAX: 415-457-8923

I give my consent to share health information about my child

_____ with the school nurse.
(Student's Name)

_____ _____
(Parent's Signature) (Date)

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Notice to Parents and Guardians about Vaccine Exemptions

Dear Parent or Guardian:

Re: New immunization requirements for 2016

Under a new law known as SB 277, beginning January 1, 2016 exemptions based on personal beliefs, including religious beliefs, will no longer be an option for the vaccines that are currently required for entry into child care or school in California. Most families will not be affected by the new law because their children have received all required vaccinations. Personal beliefs exemptions on file before January 1, 2016 for a child already attending school will remain valid until the child reaches the next immunization checkpoint at kindergarten (including transitional kindergarten) or 7th grade.

A medical exemption for a required immunization will be permitted with a signed statement from a California licensed physician (MD or DO). The written statement must state the following:

- That the physical condition or medical circumstances of the child are such that the required immunization(s) cannot be given.
- Which vaccines are being medically exempted.
- Whether the medical exemption is permanent or temporary.
- The expiration date, if the exemption is temporary.

For more information about SB 277, please see the Frequently Asked Questions available at: http://www.shotsforschool.org/laws/sb277faq/ or contact your local health department or your school nurse.

Thank you for helping us to keep our children and community healthy.

Sincerely,

Melissa Benson
K-4 Principal

Laura Bauernfeind
School Nurse

PARENTS' GUIDE TO IMMUNIZATIONS
REQUIRED FOR SCHOOL ENTRY

Entry Requirements by Age and Grade:

Vaccine	4-6 Years Old Elementary School at Transitional-Kindergarten/ Kindergarten and Above	7-17 Years Old Elementary or Secondary School	7th Grade*
Polio (OPV or IPV)	**4 doses** (3 doses OK if one was given on or after 4th birthday)	**4 doses** (3 doses OK if one was given on or after 2nd birthday)	
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT, or Tdap)	**5 doses of DTaP, DTP, or DT** (4 doses OK if one was given on or after 4th birthday)	**4 doses of DTaP, DTP, DT, Tdap, or Td** (3 doses OK if last dose was given on or after 2nd birthday. At least one dose must be Tdap or DTaP/ DTP given on or after 7th birthday for all 7th-12th graders.)	**1 dose of Tdap** (Or DTP/DTaP given on or after the 7th birthday.)
Measles, Mumps, and Rubella (MMR or MMR-V)	**2 doses** (Both doses given on or after 1st birthday. Only one dose of mumps and rubella vaccines are required if given separately.)	**1 dose** (Dose given on or after 1st birthday. Mumps vaccine is not required if given separately.)	**2 doses of MMR** or any measles-containing vaccine (Both doses given on or after 1st birthday.)
Hepatitis B (Hep B or HBV)	**3 doses**		
Varicella (chickenpox, VAR, MMR-V or VZV)	**1 dose**	**1 dose** for ages 7-12 years. **2 doses** for ages 13-17 years.	

*New admissions to 7th grade should also meet the requirements for ages 7-17 years.

WHY YOUR CHILD NEEDS SHOTS:

The California School Immunization Law requires that children be up to date on their immunizations (shots) to attend school. Diseases like measles spread quickly, so children need to be protected before they enter. California schools are required to check immunization records for all new student admissions at Kindergarten or Transitional Kindergarten **through** 12th grade and all students advancing to 7th grade before entry.

THE LAW:

Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380; California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, Sections 6000-6075

WHAT YOU WILL NEED FOR ADMISSION:

To attend school, your child's Immunization Record must show the date for each required shot above. If you do not have an Immunization Record, or your child has not received all required shots, call your doctor now for an appointment.

If a licensed physician determines a vaccine should not be given to your child because of medical reasons, submit a written statement from the physician for a **medical exemption** for the missing shot(s), including the duration of the medical exemption.

A personal beliefs exemption is no longer an option for entry into school; however, a valid personal beliefs exemption filed with a school before January 1, 2016 is valid until entry into the next grade span (7th through 12th grade). Valid personal beliefs exemptions may be transferred between schools in California. For complete details, visit ShotsforSchool.org.

You must also submit an immunization record for all required shots not exempted.

Questions? Visit ShotsForSchool.org or contact your local health department (bit.do/immunization).

Ross School Emergency Card

Please Complete Both Sides and Print Clearly

_____, _____ Home Phone_____
Last Name First Name

Additional Emergency Phone _____
E-Mail Mother _____
E-Mail Father _____

F ____ M ____ Date of Birth _____ Grade 12 Teacher_____

Mother's Name _____, _____ Home Phone_____
Street Address_____ P.O. Box _____ Town_____
Zip Code_____
Work Number_____ Place of Work_____
Cell Phone Number_____ Pager Number_____

Father's Name _____, _____ Home Phone_____
Street Address_____ P.O. Box _____ Town_____
Zip Code_____
Work Number_____ Place of Work_____
Cell Phone Number_____ Pager Number_____

List phone numbers **ONLY** of those that can be reached during school hours.

Relative or Neighbor's Name:_____
Relationship to Child:_____
Home Number:_____Work Number:_____
Cell Phone Number:_____ Pager Number:_____

Relative or Neighbor's Name:_____
Relationship to Child:_____
Home Number: _____Work
Number:_____
Cell Phone Number:_____ Pager Number:_____

Please continue on back…

Authorization to Treat a Minor

I (we) the undersigned parent, parents, or legal guardian of _____a minor, do hereby authorize and consent to any X-Ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the medicine practice act and on the staff of any acute general hospital holding a current license to operate a hospital or from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but it is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that every effort shall be made to contact the undersigned prior to entering treatment to the patient but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any Restrictions on Medical Treatment:

_____

_____

Signature: _____ Date:_____
Father, Mother or Legal Guardian

Allergies to Food/Bees/Wasps/Drugs? ☐ **NO** ☐ **Yes** **If yes, l**ist_____

Special Health Problems ☐ **NO** ☐ **Yes** **If yes**, describe_____

_____

Daily Medication? ☐ **NO** ☐ **Yes** If yes, name of medication(s) and dosage _____

_____

Insurance Company: _____Policy Number:_____

Physician to be called: _____ Phone Number:_____

Address: _____ City:_____

Dentist to be called: _____ Phone Number:_____

Address: _____ City:_____

If hospitalization is necessary, please designate hospital: _____

1. My signature does not indicate that consent to participate in any particular program has been given or withheld.
2. If parents are divorced, may either parent pick up child?
   (if NO, please provide legal documentation) Yes ☐ No ☐

Parent / Guardian Signature _____