CALAVERAS UNIFIED SCHOOL DISTRICT

Proof of Birth: Type _______________ By _________
Proof of Immunization: ☐ Yes ☐ No
☐ Walks ☐ Rides bus Bus stop ________

GRADE

▶ **Has your child ever attended Calaveras Unified schools before?** ☐ **Yes** ☐ **No** **If yes, year** __________

PLEASE PRINT – STUDENT'S LEGAL NAME

Legal Last Name	**Legal First Name**	**Legal Middle Name**	**Student's Social Security #**
			- -

☐ **Male** ☐ **Female** | **Birth date:** | **Month** | **Day** | **Year** | **Student Nickname:**

Parent/Guardian Last Name	**First Name**	**Relationship**	**Home Phone** ( )	**Cell Phone** ( )
			Work Phone ( )	**Driver's License #**

Parent/Guardian Last Name	**First Name**	**Relationship**	**Home Phone** ( )	**Cell Phone** ( )
			Work Phone ( )	**Driver's License #**

Mailing Address (P.O Box or house # & street name)	**Apt#**	**City**	**State**	**Zip**	**Email address**

Residence Address (house # & street name) **(IF DIFFERENT)**	**Apt#**	**City**	**State**	**Zip**	**Nearest Cross Street**

WHAT IS YOUR CHILD'S ETHNICITY? (Please check one): ☐ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)
☐ Not Hispanic or Latino

WHAT IS YOUR CHILD'S RACE? (Please check up to five racial categories)

The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your child's race to be.

- ☐ American Indian or Alaskan Native(100) (Persons having origins in any of the original people of North, Central or South America)
- ☐ Chinese (201)
- ☐ Japanese (202)
- ☐ Korean (203)
- ☐ Vietnamese (204)
- ☐ Asian Indian (205)
- ☐ Laotian (206)
- ☐ Cambodian (207)
- ☐ Hmong (208)
- ☐ Other Asian (299)
- ☐ Hawaiian (301)
- ☐ Guamanian (302)
- ☐ Samoan (303)
- ☐ Tahitian (304)
- ☐ Other Pacific Islander (399)
- ☐ Filipino/Filipino American (400)
- ☐ African American or Black (600)
- ☐ White (700) (Persons having origins in any of the original peoples of Europe, North Africa, Northwestern Asia or the Middle East)

PARENT EDUCATION – Check the response that describes the education level of the **most educated parent**.

- ☐ Graduate Degree or Higher (10)
- ☐ College Graduate (11)
- ☐ Some College or Associate's Degree (12)
- ☐ High School Graduate (13)
- ☐ Not a High School Graduate (14)

Date your child first attended school in the U.S.

Month	Day	Year

Date your child first attended school in California

Month	Day	Year

STUDENT BIRTHPLACE: City: ______________________________ State:______ Country: ____

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THE FORM (CUSD / AR Rev 8/2012)

HOME LANGUAGE SURVEY: Indicate only one language (most frequently used) per line:

1. What language/dialect does your son/daughter most frequently use at home? ______________________________________
2. Which language/dialect did your son/daughter learn when he/she first began to talk? _______________________________
3. What language/dialect do you most frequently speak to your child? ____
4. Has your child ever been given the CELDT Test (Calif English Language Development Test)? ❑ **Yes** ❑ **No** ❑ **I don't know**

Residence – where is your child/family currently living? (federally mandated by NCLB) – **Please check appropriate box:**

❑ In a permanent residence (house, apartment, condo, mobile home)
❑ Temporarily doubled-up (sharing housing with other families/individuals due to economic hardship or loss)
❑ In a shelter or transitional housing program
❑ In a motel/hotel
❑ Temporarily unsheltered (car/campsite)
❑ Other (please specify) ____________________
____

Parent/Guardianship Information (with whom the student lives) – check all that apply :

❑ Father ❑ Mother ❑ Both ❑ Step-Father ❑ Step-Mother ❑ Guardian ❑ Foster/Group Home ❑ Other ___________________
Is the above (checked) person (s) the student's LEGAL guardian? ❑ Yes ❑ No If No, please complete a "Caregiver Affidavit"
If there is a legal custody agreement regarding this student, please check one: ❑ Joint Custody ❑ Sole Custody ❑ Guardian
Who holds legal educational rights to this student? ❑ Father ❑ Mother ❑ Both ❑ Other ___________________________________

PLEASE COMPLETE INFORMATION BELOW FOR PARENT(S)/GUARDIAN WITH WHOM THE STUDENT LIVES :

1. ❑ Father ❑ Step Father/Guardian (check one) **Full Name:** ____

Employer: ______________________________ **City:** ______________________ **Daytime Phone # (____)** ____________

2. ❑ Mother ❑ Step Mother/Guardian (check one) **Full Name:**____

Employer: ______________________________ **City:** ______________________ **Daytime Phone # (____)** ____________

PLEASE COMPLETE INFORMATION BELOW IF THE STUDENT HAS A SECOND RESIDENCE – ALSO RESIDES WITH:

Full Name: ________________________________ **Relationship:** ________________ **Phone #: (____)** __________________

Mailing Address: ____ **City:** _________________ **State:** ______ **Zip code:**__________

If divorced/separated, does custody agreement allow for duplicate mailing address? ❑ **Yes** ❑ **No**

MOST RECENT SCHOOL ATTENDED:

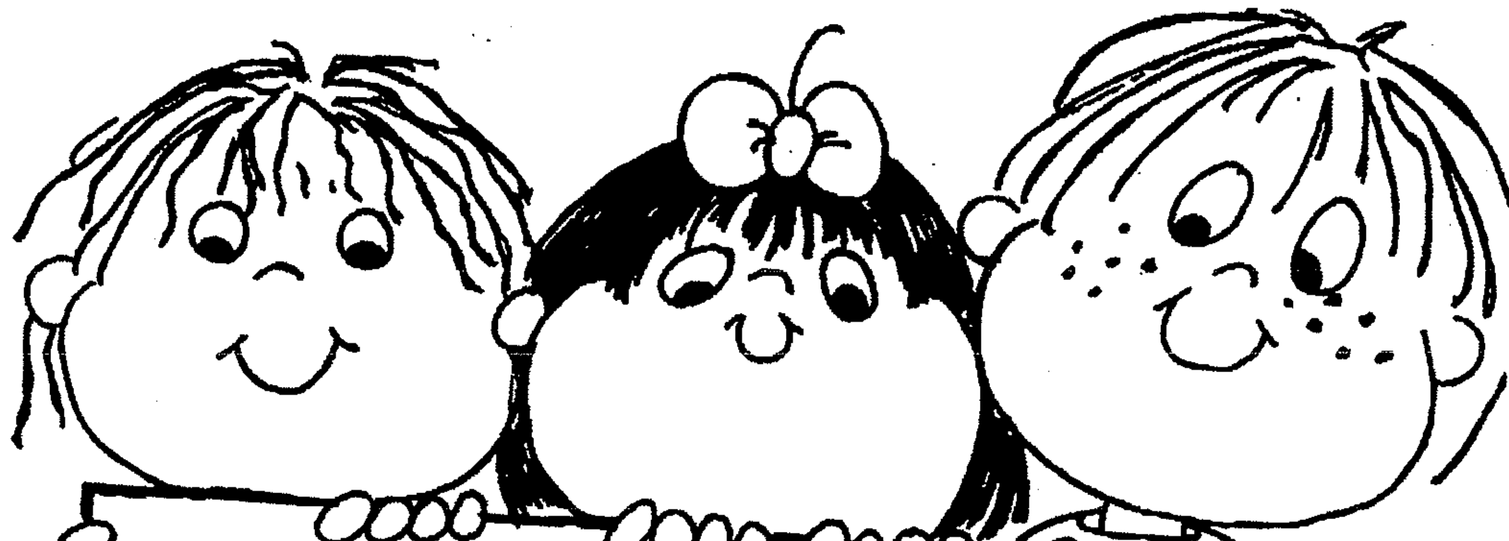
Name	**Address**	**State**	**Zip**	**Phone**

Are there psychological or confidential reports available from your child's former school? ❑ Yes ❑ No
Has your child ever been suspended? ❑ Yes ❑ No Has your child ever been expelled? ❑ Yes ❑ No
What special services has your child received? (**please check all boxes that apply**)
Special Education: ❑ Resource (RSP) ❑ Special Day Class (SDC) ❑ Speech/Language ❑ 504 ❑ Active IEP
Other: ❑ Gifted (GATE) ❑ Counseling ❑ English Language Development ❑ Been retained - If yes, at what grade level__________
❑ Participated in athletic program ❑ Other (Specify) ____
Does your child have a health concern? ❑ Yes ❑ No ❑ Wear glasses ❑ Have a hearing problem ❑ Take medication regularly
Explain any yes answer: ____

Name of other children in family	**DOB**	**Relationship**	**Name of other children in family**	**DOB**	**Relationship**

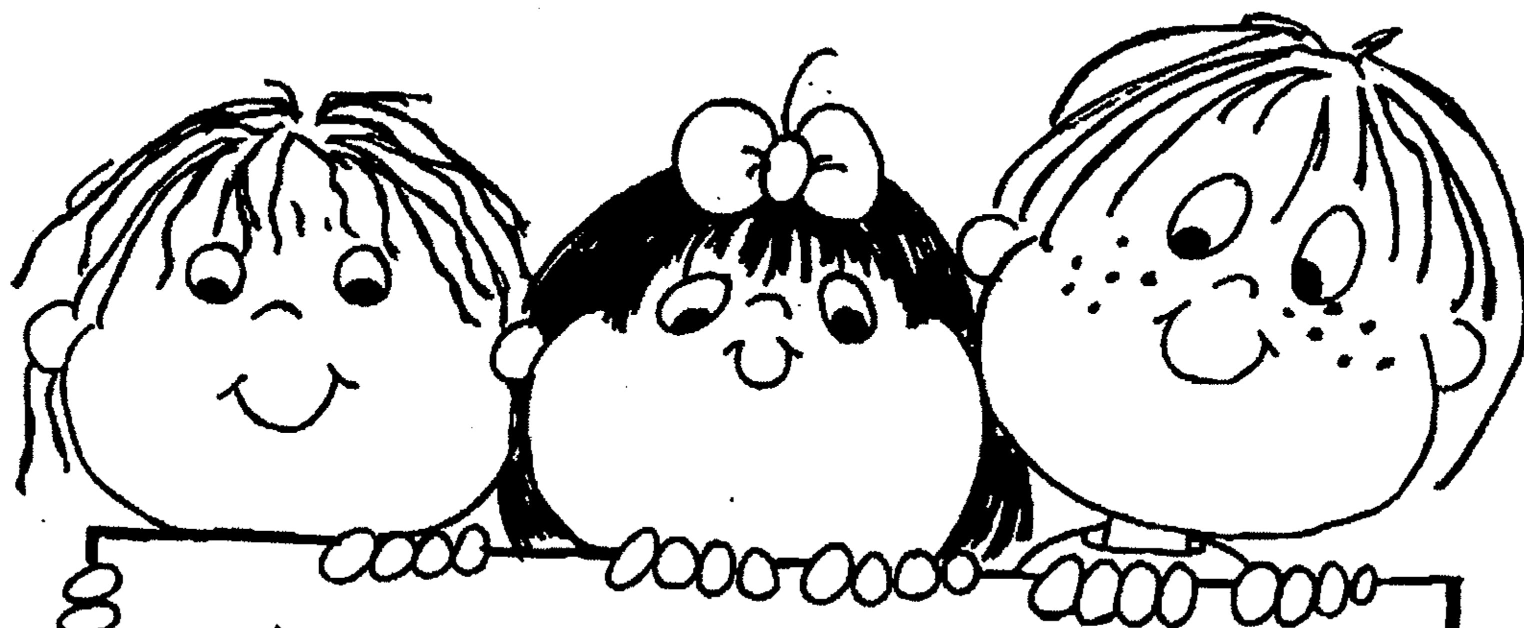
Local friend or relative to call in case of emergency	**Address**	**Phone**

Signature of Parent/Guardian: ____ **Date:** _________________________



Children will not be enrolled unless an immunization record is presented and immunizations are up-to-date.*

**If your child is unimmunized due to religious, personal, or medical reasons, please notify us.*



No se inscribirá a los niños a menos que se presente el comprobante de vacunación y las vacunas estén al día.*

**Avísenos si su hijo no está vacunado por motivos religiosos, personales o médicos.*

GUIDE TO IMMUNIZATIONS REQUIRED FOR SCHOOL ENTRY

Grades K-12

INSTRUCTIONS

Use this guide as a quick reference to help you determine whether children seeking admission to your school meet California's school immunization requirements. For the actual laws, see 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. If you have any questions, call the Immunization Coordinator at your local health department.

IMMUNIZATION REQUIREMENTS

To enter into public and private elementary and secondary schools (grades kindergarten through 12, including transitional kindergarten), children under age 18 years must have immunizations.

VACCINE	REQUIRED DOSES
Polio	**4 doses at any age, but...** 3 doses meet requirement for ages 4–6 years if at least one was given on or after the 4th birthday[1]; 3 doses meet requirement for ages 7–17 years if at least one was given on or after the 2nd birthday.[1]
Diphtheria, Tetanus, and Pertussis	***Age 6 years and under**:* DTP, DTaP or any combination of DTP or DTaP with DT (diphtheria and tetanus) **5 doses at any age, but...** 4 doses meet requirements for ages 4–6 years if at least one was on or after the 4th birthday.[1]
	Age 7 years and older: Tdap, Td, or DTP, DTaP or any combination of these **4 doses at any age, but...**3 doses meet requirement for ages 7–17 years if at least one was on or after the 2nd birthday.[1] If last dose was given before the 2nd birthday, one more (Tdap) dose is required.
Measles, Mumps, Rubella (MMR)	***Age 4-6 years*** **(kindergarten and above): 2 doses[2]** both on or after 1st birthday.[1]
	7th grade: **2 doses[2]** both on or after 1st birthday.[1]
	Age 7-17 years and not entering or advancing into 7th grade: **1 dose** on or after 1st birthday.[1]
Hepatitis B[3]	***Age 4-6 years*** **(kindergarten and above): 3 doses.**
Varicella	**1 dose**[4, 6]
Tdap Booster (Tetanus, reduced diphtheria, and pertussis)	***7th grade**:* **1 dose** on or after 7th birthday. [5, 7]

1 Receipt of a dose up to (and including) 4 days before the birthday will satisfy the school entry immunization requirement.
2 Two doses of measles-containing vaccine required. One dose of mumps and rubella-containing vaccine required; mumps vaccine is not required for children 7 years of age and older.
3 Not required for 7th grade.
4 Physician-documented varicella (chickenpox) disease history or immunity meets the varicella requirement.
5 Tdap, DTaP, or DTP given on or after 7th birthday will meet the requirement. Td does not meet the requirement.
6 2 dose varicella requirement for ages 13-17 years applies to transfer students who were not admitted to a California school before July 1, 2001.
7 8th-12th grade students transferring from outside of California must meet the requirement.

EXEMPTIONS

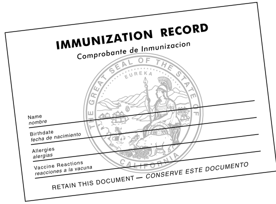
The law allows parents/guardians to submit an exemption from immunization requirements based on their personal beliefs or medical conditions. For children with medical exemptions, the physician's written statement should be submitted. Schools should maintain an up-to-date list of pupils with exemptions, so they can be excluded quickly if an outbreak occurs. For more information, visit shotsforschool.org

NOT MEETING REQUIREMENTS

Refer pupils who do not meet these State requirements to their physician or local health department. Give families a written notice indicating which doses are lacking.

CONDITIONAL ADMISSIONS

Children who lack one or more required vaccine doses that are not currently due may be admitted on condition that they receive the remaining doses when due (Title 17, CCR Section 6035).



Is Your Child Ready For Kindergarten?

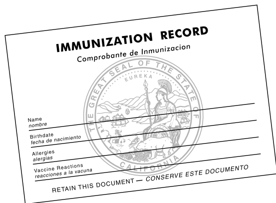
Chickenpox (varicella) vaccine now is required by California law for kindergarten entry. If your child has not had a chickenpox shot, see your doctor or clinic.

DTaP (diphtheria, pertussis, tetanus), Polio, Hepatitis B and MMR (measles, mumps, rubella) immunizations are also required for school entry. Your child needs school boosters after his or her 4th birthday.

You must show proof of immunization, such as the yellow California Immunization Record, to register your child. Check with your doctor or clinic about the shots needed for school.

*As of 1/1/14 a health care provider must sign all personal beliefs exemption forms.

IMM-711 (8/02)



¿Está Su Hijo Listo Para El Jardín De Niños?

La ley de California requiere que los niños estén vacunados contra la varicela entrar al jardín de niños. Si su hijos o está vacunado contra la varicela, vaya a su doctor o a su clínica.

Para entrar a la escuela también se requiere que los niños estén vacunados contra DTaP (difteria, tos ferina, tétano), poliomielitis, hepatitis B y MMR (sarampión, paperas, rubéola). Su hijo también necesita vacunas de refuerzo al cumplir 4 anos de edad.

Para inscribir a su hijo, usted debe presentar algún comprobante de vacunación, como el Comprobante de Vacunación de California, de color amarillo. Pregunte a su médico o a su clínica qué vacunas son necesarias para entrar a la escuela.

*1/1/14: profesionales medicos deben firmar formulario exención por creencias personales.

IMM-711S (8/02)

CALAVERAS PUBLIC HEALTH SERVICES
COMMUNITY IMMUNIZATION CLINICS

ELIGIBILITY FOR IMMUNIZATION SERVICES
EFFECTIVE AUGUST 1, 2014

LOCATION	SCHEDULE		TIME
San Andreas Public Health Services 700 Mountain Ranch Road Suite C-2	**Weekly** **Weekly**	Every Monday Every Thursday	3:00 PM – 5:30 PM 8:00 AM – 12:00 PM

IMMUNIZATIONS PROVIDED TO:

- **Individuals Under 19 Years of Age Who Are [any of the following]**
  Uninsured
  Medi-Cal/CHDP
  American Indian or Alaska Natives

- **Individuals 19 Years & Older for Tdap & MMR Vaccinations Only Who Are [one of the following]**
  Uninsured
  Have Insurance that does not cover Tdap or MMR

- **All Individuals without Restrictions for Seasonal Flu**

FEE - $26 FOR EACH IMMUNIZATION
NO ONE WHO IS ELIGIBLE TO RECEIVE VACCINE IS DENIED BECAUSE OF INABILITY TO PAY.

Parent or legal guardian must come with children under 18 years.
For more information call 209.754.6460 www.calaveraspublichealth.com

CALAVERAS UNIFIED SCHOOL DISTRICT
Health Services Department

School:________________
Grade:________________
Teacher:______________

HEALTH & DEVELOPMENTAL HISTORY
(To be completed for all students upon registration)

STUDENT'S NAME:____**SEX:**____**DOB:**___________________

ADDRESS:____**PHONE:**______________________

____**CELL:**________________________

PARENTS' NAME: Father:____________________________**Mother:**___________________________________

1. **Immunization Record: See California School Immunization Record.**

2. **Birth History:**
   a. **Pregnancy Complications: (Bleeding, accidents, injuries, edema)**_____________________________________
   b. **Pregnancy: Full Term____ Premature:_____ , how many months?______**
   c. **Delivery: Normal___ Abnormal___ Birth Weight:_____________**
   Any complications: None___ Infections_______________ Hemorrhage ______ Forceps____
   d. **Baby's condition at birth: Normal___ Cyanotic (blue)_____ Jaundiced (yellow)___**
   Breathing: Normal___ Abnormal___ Was oxygen used? Yes__ No___
   e. **Any difficulties during the first 30 days?**____
   ____

3. **Developmental Growth: Was your child slow in any of the following areas?**
   Sitting alone, walking, talking, toilet training? If so, please explain:__________________________________
   ____
   ____

4. **As a baby was your child: Active___ Easygoing___ Happy___ Cross___ High Strung___ Colicky___**
   Were there any feeding difficulties? Yes___ No___
   As a toddler was your child: Very demanding___ Awkward___ Easygoing___ Extremely Active___
   Accident prone____
   As a preschooler, did your child: Play most often alone? Yes___ No___
   Play well with other children? Yes___ No___
   Did your child attend nursery school? Yes___ No___

5. **Health History: (Please check)**

	No	Yes	Explain "yes" Items
a. Any physical or congenital handicaps?			
b. Any convulsions or high fevers?			
c. Any childhood diseases? Which ones?			
d. Is child taking any medications?			

	Good	Fair	Poor	Explain
e. Vision				
f. Hearing				
g. Large muscle coordination				
h. Small muscle coordination				
i. Speech				

6. List any serious accidents, operation or hospitalizations:

Date	Explanation

7. Last complete physical exam:

Date:_____________________________
Physician's Name:____________________________
Address:_____________________________________
Findings:____________________________________
____

8. Last dental exam:

Date:________________________________
Dentist's Name:________________________
Address:______________________________
Work needed? Yes__ No__
Completed? Yes___ No___

9. Is there a history of learning difficulties in the family? Yes__ No__

10. Are there any special conditions to be watched for in school at the present time?

a. Hay fever___ b. Asthma___ c. Bee sting sensitivity___ d. Allergies? Yes___ No__

If allergies, what is child allergic to?____
____

11. Does child present any of the following:

	Yes	No
Poor eating habits		
Enuresis (bed wetting)		
Short attention span		
Shy, tends to withdraw		
Frequent sore throats		
Frequent urination		
Emotional problems		

	Yes	No
Sleep problems		
Temper Tantrums		
Thumb sucking		
Frequent colds		
Headaches		
Tires easily		
Weight problem		

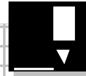
If yes is checked on any of the above, please explain the severity of the problem:

____
____
____

Date:________________________ ____

Parent/Guardian Signature

From the Nurse's Desk



CALAVERAS UNIFIED SCHOOL DISTRICT
♦ PO. Box 788♦San Andreas, CA. 95249
Phone 754-2322 ♦ Fax 754-2379

Dear Parent or Guardian:

To make sure your child is ready for school, California law, *Education Code* Section 49452.8, now requires that your child have an oral health assessment (dental check-up) **by May 31 in** either **kindergarten** or first grade, whichever is his or her first year in public school. Assessments that have happened within the 12 months before your child enters school also meet this requirement. The law specifies that the assessment must be done by a licensed dentist or other licensed or registered dental health professional.

Take the attached Oral Health Assessment/Waiver Request form to the dental office, as it will be needed for your child's check-up.

If you do not already have a regular dentist for your child, we recommend that you use this oral health assessment as a way to establish a regular check up schedule. We also realize that access to a regular dentist is not always possible. The dental hygienists with the Calaveras Children's Dental Project are licensed dental professionals and are qualified to perform this assessment. If you have already signed your child up to receive a dental screening or dental cleaning from the Children's Dental Project as part of the classroom Smile Keepers program, your child will automatically receive this assessment. If you are not sure whether your child's class is part of Smile Keepers, or if you signed him or her up, please check with your child's teacher. If you cannot take your child for this required assessment, or chose not to participate in the Smile Keepers program, please indicate the reason for this in Section 3 of the form. 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.

Remember, your child is not healthy and ready for school if he or she has poor dental health! Many things influence a child's progress and success in school, including health. Children must be healthy to learn, and children with cavities are not healthy. Cavities are preventable, but they affect more children than any other chronic disease.

Baby teeth are very important. They are not just teeth that will fall out. Children need their teeth to eat properly, talk, smile, and feel good about themselves. Children with cavities may have difficulty eating, stop smiling, and have problems paying attention and learning at school. Tooth decay is an infection that does not heal and can be painful if left without treatment. If cavities are not treated, children can become sick enough to require emergency room treatment, and their adult teeth may be permanently damaged.

If you have questions about the new oral health assessment requirement, please contact the school office or district nurse at 754-2322.

Sincerely,

Belinda Brager, RN, PHN, MSN
CUSD District Nurse

Attachment: Oral Health Assessment/Waiver Request Form

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)

□ 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.

CALAVERAS UNIFIED SCHOOL DISTRICT

P. O. Box 788
San Andreas, CA 95249

Authorization for Administration of Medication During School Hours

THIS FORM MUST BE COMPLETED WITH M.D./DENTIST AND PARENT/GUARDIAN SIGNATURES BEFORE ANY MEDICATION CAN BE ADMINISTERED AT THE SCHOOL.

The California Education Code Section 49423 permits the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to be functional at school and participate in the educational program.

- Medication must be in the container in which it was purchased with the pharmacy label attached, and must be prescribed to the student to whom it will be administered. No medication (including over-the-counter medication) will be given at school without a current authorized health care provider prescription.
- Parent/guardian is responsible to ensure that the medication supply is delivered to school by an individual legally authorized to be in possession of the medication.
- Parent/guardian is responsible to provide all necessary supplies and equipment.
- Parent/guardian may terminate this consent for administration of medication at any time.
- The renewal of this medication order is needed whenever the prescription changes and at the beginning of each school year.
- Please refer to Board Policy 5141.21 for additional information.

STUDENT:______________________________DATE OF BIRTH:_____________________ GRADE:_________

Physician authorization (all blanks must be completed by a physician):

Name of Medication:	Method of Administration:	
Dosage (mg):	Time(s) to be taken:	
Start Date:	End Date:	
Diagnosis/Justification		
Precaution – Possible Reactions		
California Code of Regulations §605 states that a student with an existing medical condition that requires frequent monitoring, testing or treatment may be allowed to self-administer this service (example may be for diabetes, asthma, anaphylactic reaction). Please check box below if applicable: ☐ **Please check this box if in the authorized health care provider's opinion, the student is competent to safely carry and self-administer the medication according to the conditions in the provider's written statement.** My signature below provides authorization for the above written order. I understand that the medication will be given in accordance with state laws and regulations by unlicensed designed school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.		
Authorized Healthcare Provider Name (please print):	Address:	
Authorized Healthcare Provider's Signature:	Date:	Telephone Number:

I, the undersigned, the parent/guardian of the above named pupil, request that the school nurse or other designated school personnel assist my student with the above named medication in accordance with state laws and regulations. I will: 1) Provide the necessary medication, supplies and equipment, and; 2) notify the school nurse if there any changes to this order. I give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

Parent/Guardian Signature:___________________________________**Date:**____________**Phone Number:**_______________________

Address:____

Parent Consent and Authorized Healthcare Provider Authorization for Management of
Moderate to Severe Persistent or Poorly Controlled Asthma at School and School-sponsored Events

Pupil:	**DOB:**	**Date:**
School:	**Teacher/Rm:**	**Grade:**
Medical office:	**Patient Identification #:**	

1. Asthma Action Plan attached: ☐ Yes ☐ No

2. Monitoring at school:

☐ Observation and/or pupil report of symptoms
☐ Peak flow meter and symptoms
Measure peak flow when: _____
Personal best peak flow: _____
☐ Monitor peak flow on regular schedule:
Times: _____

3. Asthma symptoms are triggered by:

☐ Exercise
☐ Respiratory infection
☐ Cold weather
☐ Sudden temperature change
☐ Air pollution
☐ Perfumes
☐ Pollens: ☐ grasses ☐trees ☐shrubs/flowers
☐ Animal dander/feathers
☐ Dust mites
☐ Cockroaches
☐ Molds
☐ Smoke
☐ Strong odors/fumes: _____
☐ Food: _____

4. Medications to be taken at school:
(Please complete attached medication authorization forms.)

☐ Quick-relief medication:_____
Route: ☐ Inhaler ☐ Inhaler+spacer ☐ Inhaler+spacer+ mask
☐ Nebulizer (requires unit-dose vials);
Monitor pulse & respirations: ☐ No ☐ Yes
☐ Quick-relief medication specified above to prevent EIA
_____ min. before exertion
☐ Emergency medication: _____
Route: _____ Administer when: _____
☐ Other medication: _____

5. Actions when symptoms occur at school:

☐ Check peak flow reading unless pupil in severe distress
☐ Administer quick-relief medication:
Medication: _____
Dose: _____
☐ Observe pupil for _____ min. after medication taken
☐ Repeat peak flow measurement in _____ min.
☐ If peak flow between _____ OR symptoms do not improve:
☐ Repeat quick-relief medication; dose: _____
☐ Administer emergency medication: _____
Dose: _____ Route:_____
☐ Call 911 Emergency Services
☐ Emergency Action Plan attached
☐ Take the following actions: _____

6. Physical activity or environmental modifications required: _____

7. Other pertinent information or recommendations;

Authorized Healthcare Provider Authorization for Management of Asthma In School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical healthcare services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

***Authorized Healthcare Provider Name** ________________________**Signature** ______________________________
Date________ **Phone** ______________ **Address** _______________________**City** ___________________**Zip** _______
***Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number** ______________________________
Supervising Physician Name ______________________ **Address** _________________________ **Phone** ___________

☐ I request that the school nurse provide me with a copy of the completed Individualized Healthcare Plan (IHP).

Parent Consent for Authorization and Management of Asthma in School Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the specialized physical healthcare service, asthma management, be administered to my (our) child in accordance with state laws and regulations. I (we) will:

1. provide the necessary supplies and equipment;
2. notify the school nurse if there is a change in child's health status or attending authorized healthcare provider; and
3. notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

I (we) give consent for the school nurse to communicate with the authorized healthcare provider when necessary.
I (we) understand that I (we) will be provided a copy of my child's completed Individualized Healthcare Plan (IHP).

Parent(s)/Guardian(s) Signature (1)___________________________ **(2)** ___________________________ **Date** __________

Reviewed by school nurse (signature) ____ **Date** ___________

☐ **School nurse has informed principal about healthcare services provided for this pupil.**

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/EVALUAITONS	DATE (mm/dd/yy)
Heath 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 here if you do not want the health examiner to fill out Part III

______________________________ Signature of Parent or Guardian

______________ Date

______________________________ Signature of Health Care 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 171B) found at your child's school.
CHDP website: www.dhcs.ca.gov/services/chdp

CALAVERAS UNIFIED SCHOOL DISTRICT
FOOD SERVICES

MEAL APPLICATIONS FOR THE 2015/2016 SCHOOL YEAR

WILL BE AVAILABLE JULY 1, 2015

- Application processing takes up to 10 school days
- The processing of applications will begin the week of July 20, 2015
- Students must be completely enrolled at the school site(s) in order to receive meal benefits.

IF YOUR STUDENT(S) CURRENTLY RECEIVES FREE/REDUCED MEALS:

- Unless you receive notification from the Food Service Office that your child has been directly certified for meal benefits, you must reapply for the new school year.
- Applications may be downloaded from the Calaveras Unified School Districts website (go to www.calaveras.k12.ca.us, choose Departments, Food Services, Applications) OR you may wish to apply online using the same web address, Departments, Food Services, Apply Online. Applications received online are processed within a 24 hour period with eligibility benefits awarded in the same time frame.
- Meal benefits carry forward into the new school year for **30 school days** or until a new application for the new school year is received and approved.
- If a new application is not received by September 8, 2015, your student(s) will be charged full price for their meal(s).

IF YOUR STUDENT(S) ARE NOT CURRENTLY RECEIVING FREE/REDUCED MEALS:

- And your family's financial circumstances change, you may apply any time during the school year for the free/reduced meal program.
- While you are waiting for your application to be processed, students must pay full-price for their meal(s) or bring their own meals to school.

CALAVERAS UNIFIED SCHOOL DISTRICT
FOOD SERVICES

IT'S EASY TO SIGN UP FOR FREE OR REDUCED-PRICED SCHOOL MEALS

During these tough economic times Calaveras Unified Food Service Department would like to remind parents that it's easy to sign up for free or reduced price meals – breakfast and lunch – for your child(ren). Please fill out a Meal Application. Who is eligible?

- Children of all ages – from tots to teens – whose household income is at or below the criteria levels (as stated on the California Department of Education Income Eligibility Guidelines for Free and Reduced-price meals)
- Families who receive Food Stamps (SNAP/CalFresh), California Work Opportunity (CalWORKs), Kinship Guardian Assistance Payment (KinGAP), or Food Distribution Program on Indian Reservations (FDPIR) benefits. On your application please include your benefit case number.
- Foster children who are the legal responsibility of a welfare agency or court regardless of the income of the household with whom they reside; please check the box verifying the student is a Foster child.
- Migrant and homeless children.

Applications for the National School Lunch and Breakfast Program are available at every Calaveras Unified school site. They are also easily accessed through our District's webpage: www.calaveras.k12.ca.us. (Select Departments; then Food Services; then Applications) **Or for quicker benefit determination you may choose to apply online** (Select Departments; then Food Services; then log into the "Infinite Campus Parent Portal"). You will need to activate your Parent Portal to apply online. Your school office can assist you with setting up your account.

To apply, households must fill out the application – only **one application per household** is needed – and return it to any school kitchen. An adult household member **must sign** the application**. NOTE: Applications may be submitted at any time during the school year.** Assistance is also available for completing the application. Feel free to phone (209) 754-2120 to speak with a Food Service staff member.

We strongly encourage all parents to apply. Every child goes through the cafeteria lines in the same manner, whether they are paying full price, the reduced price, or receiving meals free. Confidentiality is assured. ALL CUSD sites serve breakfast AND lunch – including Toyon Middle School and Calaveras High School.

If you require more information about free or reduced price meals, please do not hesitate to call CUSD Food Services at (209) 754-2120.

Under the provisions of the free and reduced-price meal policy, CUSD Nutrition and Food Services staff will review applications and determine eligibility. Parents or guardians dissatisfied with the ruling of the official may wish to discuss the decision with the reviewing official on an informal basis. Parents who wish to make a formal appeal for a hearing on the decision may make the request either orally or in writing to:

Mark Campbell, Superintendent
Calaveras Unified School District
P.O. Box 788
San Andreas, CA 95249-0788
Telephone: (209) 754-2300

Calaveras Unified Food Services
501 Gold Strike Road, Bd. E
P.O Box 788
San Andreas, CA 95249
(209) 754-2120
www.calaveras.k12.ca.us

INFINITE CAMPUS PARENT PORTAL

Activating your Parent Portal:

- You will first need to activate your Parent Portal Account. Please contact your child's school for an activation key and instructions for activating your account.
- Go to the district website at www.calaveras.k12.ca.us
- Scroll down to find the Portal Information tab. Click on the tab to begin. Click the Help button to create your account.

Parent Portal Features:

- Online meal applications
- Online meal pre-payments using debit or credit cards: Visa, Mastercard or echeck.
- View meal account transactions and payment history.

Meal Prices:	**K – 6**	**BREAKFAST Full Price = $1.25***	**Reduced Price = No Charge**
	7th – 12th	**BREAKFAST Full Price = $1.75***	**Reduced Price = No Charge**
	K – 6	**LUNCH Full Price = $2.75***	**Reduced Price = $.40**
	7th – 12th	**LUNCH Full Price = $3.00***	**Reduced Price = $.40**
	K – 12th	**Individual Milk = $.50*** (if sold separately / milk is included in meal prices)	

*** Prices are Board Approved for the 2015-2016 school year.**

CALAVERAS UNIFIED SCHOOL DISTRICT-TRANSPORTATION DEPARTMENT

SCHOOL BUS PASS APPLICATION

2015-2016 SCHOOL YEAR

ALL Payment types need to fill this form out completely and return to CUSD Transportation Department,
P.O. Box 788 – San Andreas, CA 95249
Questions? Call us at 754-2315 or go to our website: www.calaveras.k12.ca.us
transportation@calaveras.k12.ca.us

Family Information:

Parent/GuardianName: (print)

Home Phone	Cell Phone	Work Phone

Address Apt. #

City/Zip

By signing below I confirm I have read and will adhere to the CUSD transportation regulations concerning the transportation of students and the rules that are enforced on District buses for the safety of students. I also verify the information contained in this document is true and correct. I understand falsification of information is cause for the revocation of bus service without refund. I further understand the bus pass must be displayed when boarding the bus and a $10.00 PROCESSING CHARGE will be assessed for replacement passes for any reason. I further understand that my signature commits me to paying the entire amount due.

Signature of Parent/Guardian:______________________________ ______________

Date

FOR OFFICE USE ONLY

Processed Date Fee

Chk Amt Chk # Cash

Accepted By:

Mail Walk In Online

REPLACEMENT PASSES

Request Date:____________________________
Name(s) of Student________________________
____
Amt. Paid:________________________________
Pmt. Made By:_____________________________
Check # ____________Cash:________________

Request Date:____________________________
Name(s) of Student________________________
____
Amt. Paid:________________________________
Pmt. Made By:_____________________________
Check #:______________ Cash:_____________

Student(s) Information

All student(s) information must be completed. Students will be assigned a stop, relative to your home address, if one is not listed below.

NAME	GRADE	SCHOOL	BUS STOP/ROUTE #

On Reverse: Free & Reduced Guidelines – Refund Policy – Discipline/Denial Policy

Type of Service/Fees

Students:	One	Two	Three	Four	Five	Add'l
Annual Service	$180	$360	$540	$630	$720	$90 Ea.
Round Trip	☐	☐	☐	☐	☐	☐

Punch Cards (20 one-way trips) $20 X _______ = $__________
(Subject to space available) ***Lost punch cards: $20 to replace***

PAYMENT TYPE: ☐ Check ☐Cash

Semester Payment Plan: ☐1st Semester
☐2nd Semester (Due January 11)

$25 Charge for Returned Checks
(And a $25 Late Fee Will Be Assessed after 30 Days)

If you qualify for reduced rate meals your price is half off the bus pass rate.

You must attach a copy of the approval letter from Food Service to verify you qualify for free or reduced meal rates in order to qualify for free or reduced bus rates. Or you may attach copies of documents listed on the reverse side. Bus passes will not be printed if documentation is not provided.

Free ☐
Reduced ☐ (price of half off regular price)

OFFICE USE ONLY

Verified: ☐ Free ☐ Reduced (1/2 Off)
☐Documents Attached
Type of Documents:____________________________

FREE or REDUCED RATES: MUST BE ELIGIBLE UNDER FEDERAL INCOME REGULATIONS, APPLICATIONS MUST BE COMPLETE AND INCLUDE REQUIRED DOCUMENTATION AS FOLLOWS:

- Earnings/Wages/Salary - Current paycheck stub or letter from Employer (on business stationery) stating gross wages paid and how often paid.
- Social Security/Pension/Retirement - Social Security Benefit letter or Pension Award letter.
- Unemployment Compensation/Disability or Workers Compensation - Copy of Award letter or check stub.
- Welfare Payments - Benefit letter from Welfare Department stating current eligibility and amount of award. (Passport of Services)
- Child Support/Alimony - Court decree or agreement.
- All Other Income- If you have any other type of income, provide documents showing amounts of income and how often it is received.
- Self-Employment - Copies of last 12 months of bank statements and the last year's annual Federal Tax Return.
- No Income - If you have no income, provide a brief note explaining how you provide food, clothing, and housing and when you expect an income. Include last year's Federal Tax Return.

REFUND POLICY

Requests for refunds must be submitted on the appropriate form, available at the District Office.

1. After a student leaves the District, refunds will be prorated, based on the number of quarters the student was enrolled in the District and able to utilize services.
2. After paying transportation fees a student has been determined to be eligible for Free or Reduced fees.
3. No refund will be issued for students who are ill or who are suspended from the bus or school for disciplinary reasons or due to Board action.
4. A written request for refund along with the bus pass must be sent directly to the Transportation Department and should contain the following information: Name of student, date that the pass would no longer be used, reason for the refund, school of attendance and address where the refund is to be sent. **No refunds will be made for punch cards.**

Students will be required to show their transportation pass when boarding the bus (both a.m. and p.m.)
The student must have the pass ready to show the driver before boarding the bus. The passes may be attached to the student's backpack for safety, but the student must show the pass when boarding the bus. Parents must select a bus stop from the District's approved list of bus stops. Possession of a current pass entitles a student to ride to and from the designated school and bus stop on the assigned bus. Reassignment to a different bus or a different stop can be accomplished through written request to the Transportation Department. If the parent does not indicate a bus stop location on the application, transportation staff will assign a bus stop. Per transportation rules and regulations, **students planning to get off the bus anywhere other than their assigned bus stop, must present a note from their parent/guardian to their driver.**

DENIED SERVICE - Initially, no child will be left in the morning for non-payment. However, if fees remain unpaid for a period of 10 school/attendance days, or documentation is not provided to verify qualification for the reduced or free rate bus service, the following steps will be taken:

1. The student will receive a written warning and parents will be contacted. This will notify you there will be 3 days to provide payment for your student or to provide the documentation to verify qualification for free or reduced rates.
2. After 3 days the student will receive a citation stating they will be denied transportation until payment is received or documentation is provided to verify free or reduced rate qualification. Parents will be notified.
3. Parents failing to send students to school because of denied bus service will be referred to the Calaveras County Student Attendance Review Board (SARB).

REAR-FACING CAR SEAT

FORWARD-FACING CAR SEAT

BOOSTER SEAT

SEAT BELT

CALAVERAS COUNTY PUBLIC HEALTH

CHILD PASSENGER *Safety*

Do you need a car seat or booster for your infant or child?

Do you want to be sure your car seat is fitted correctly?

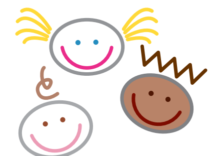
Let a certified safety technician fit your child's car seat.

Safety education and fittings are given at no-cost.

Donation - $20 for safety seats.

Call For More Information:

CALAVERAS COUNTY PUBLIC HEALTH: 209.754.6792
CENTRAL CALAVERAS FIRE & RESCUE: 209.754.4330
SAN ANDREAS CHP: 209.754.3541
THE RESOURCE CONNECTION: 209.772.3980 OR 209.754.2000



Partners In Child Safety
CALAVERAS COUNTY

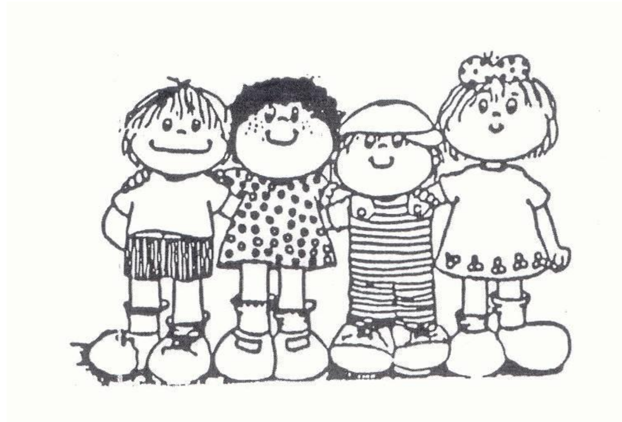
"The more you know, the safer they are."

www.calaveraspublichealth.com

Kids Place After School Programs

After School Program
2:00-6:00 PM
Monday through Thursday
12:00-6:00 PM on Friday

Program for Summer & School Breaks:
7:15 AM-6:00 PM
Monday through Friday
At Jenny Lind Elementary only



- **A safe environment for your children while you work**
- **Swimming offered during summer break program**
- **Homework Help**
- **Nutritious Snacks**
- **Arts & Crafts**
- **Service Projects**
- **Highly qualified staff**
- **Indoor/Outdoor Games**

CALAVERAS UNIFIED SCHOOL DISTRICT

- For JLE, call Debra at 754-2274
- For VSE, call Patty at 754-2287
- For RRF, call Melissa at 754-2275
- For WPE, call Mike at 754-3601

Child care subsidies may be available through Resource Connection. Please call 754-3048 for more information