Washington Elementary School
"Finding a way for ALL students to learn!"

1501 Ellis Street, Kingsburg, CA 93631
(559) 897-2955 FAX (559) 6863

Dr. Wes Sever, Superintendent **Mrs. Melanie Sembritzki, Asst. Superintendent**
Mrs. Laura North, Principal

TK/Kindergarten Registration Notice 2018-19

DATES: Monday - Friday, February 5 - 9, 8:30am - 3:30pm
Tuesday, February 6th, 4:00 pm - 6:30 pm
Saturday, February 10th, 12:00 pm - 4:00 pm

WHERE: Washington Elementary School Office

AGE REQUIREMENT:
Students that turn age 5 on or before September 1 are eligible for Kindergarten.
Students that turn age 5 between September 2 and December 2 are eligible for Transitional Kindergarten

NEW STUDENT REGISTRATION:
New student registration must be completed online before coming to the office to register. **Online registration will open for TK/K enrollment on February 1st.** If you need access to a computer, we will have computers available in the office.

Please access the following website: **register.kesd.org**
Once website is accessed, please select **"Aeries AIR" icon** and follow program to complete the online registration.

In order to complete the registration process for a **new student**, the following documents must be brought with you to Washington **on registration day**:

1. **Certified Birth Certificate**
2. **Social Security Card**
3. **Immunization Record, including Proof of TB Skin Test**
4. **Completed Physical Exam**
5. **Proof of Residency** - Acceptable Proof of Residency (current date): mortgage statement, rental contract/agreement, PG&E bill, Southern California Edison bill
6. **Joint Residency Form**, if your family/child resides with another family
7. **Custody Orders**
8. **Guardianship Documents**

Please complete the attached forms and submit to the front office on the day you register:

1. Student Health Inventory
2. Oral Health Assessment
3. Southwest Transportation Forms, if your child will ride the bus to/from school

If you are not a resident of Kingsburg Elementary School District, please complete an inter-district transfer request form available in the front office or at the District Office, located at 1310 Stroud Avenue, Kingsburg.

***Deadline Requirement**-Although we accept new students throughout the year, priority class placement (teacher request consideration) will go to students who have completed the registration process prior to February 12th.

CONFIDENTIAL

Kingsburg Elementary Charter School District 2016-2017
Student Health History/Emergency Information

Last Name_________________ First_________________ MI_____ Birthdate__________ M F Grade___

Doctor_________________ Phone #_______________ Dentist_______________ Phone#__________

Check only those that apply and return to school office

*SIGNATURE AND DATE REQUIRED ON BACK

☐ ADD/ADHD: Requires medication? Yes ☐ No ☐ Name of medication__________________
Given at school? Yes ☐ No ☐ Doctor name/phone__________________

☐ Asthma: Requires medication/inhaler? Yes ☐ No ☐ Daily? ☐ As needed? ☐ With exercise? ☐
Name of medication__________________ Given at school? Yes ☐ No ☐

☐ *Allergic reaction: (Severe) To what? __________ __________ Hive/rash? Yes ☐ No ☐
Breathing difficulty? Yes ☐ No ☐ has epi-pen? Yes ☐ No ☐
Action required__________________
Doctor name/number__________________

☐ Bladder/Kidney Yes ☐ No ☐ Explain: __________________

☐ Clinical Depression Requires medication? Yes ☐ No ☐ Name of medication__________________
Given at school? Yes ☐ No ☐ Doctor name/number__________________

☐ Diabetes: Type I ☐ Type II ☐ Medications? Oral ☐ Injection ☐ given at school? Yes ☐ No ☐ Pump? ☐
Name of medication__________________ Doctor name/number__________________

☐ Ear Problems Frequent infection? Past ☐ Present ☐ Permanent hearing loss? ☐ Date of last exam__________

☐ *Seizure Disorder Date of last seizure__________ Requires medication? Yes ☐ No ☐
Name of medication__________________ Doctor name/number__________________

☐ Heart Problems Diagnosis__________________ Doctor name/number__________________

☐ Hospitalization (Recent 12 months) Date/Explain__________________

☐ Orthopedic Conditions Corrective shoes/braces? ☐ Crutches ☐ Wheelchair? ☐ Physical therapy?
CCS? ☐ Other physical limitations__________________

☐ Vision Problems Wears glasses? ☐ All the time ☐ Reading only ☐ Contacts Date of last exam__________

Calif. Ed Code 49423-Students taking medication at school need an "Authorization for Medication" form completed *annually*.

This form *must* be on file with the school before medication can be given.

*These conditions require a Health Care Plan. Note: Any of the above conditions may require a Health Care Plan.

All forms can be obtained from the School Health Office

Please complete back side and sign

Please list other important health or behavior information

____

____

____

California Education Code 49480 requires parent/legal guardians to inform the school nurse or designated, certified school employee of any child taking medication for a continuing time. With the consent of the parent/legal guardian the school nurse may communicate with the doctor and may counsel school staff regarding possible effects of the drug.

Is the child taking medication regularly? No_______ Yes_______ If yes complete the following:

Kind of Medicine	Dose	Physician	Phone

CEC 49423. If prescribed medication is needed during the required school day, assistance may be given if the school receives: (1) a written statement from the physician detailing the method, amount and time schedule; and (2) a written statement from the parent/guardian, etc. **The medication must be clearly labeled and sent to the school in a container from the pharmacy (form available at school).**

Medical Insurance Carrier____

Policy Number_______________________Address______________________________

Father's/Guardian Driver's License No.______________________________________

Mother's/Guardian's Driver's License No. ____________________________________

Sibling's (Oldest to Youngest)

Last Name	First Name	Date of Birth

☐ NO KNOWN HEALTH PROBLEMS/SPECIAL NEEDS

Parent's/Guardian's
Signature____Date____________________

Oral Health Assessment/Waiver Request Form

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 or 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 filling out Section 3 of this form.

Section 1
To be completed by the 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 Gender: □ Male □ Female
Parent/Guardian Name:	Child's race/ethnicity: □ White □ Black/African American □ Hispanic/Latino □ Asian □ American Indian □ Alaska Native □ Native Hawaiian/Pacific Islander □ Multi-racial □ Unknown		

Section 2
Oral Health Data Collection
To be completed by the dental professional conducting the assessment

Assessment Date:	Visible caries and/or fillings present: □ Yes □ No	Visible caries present: □ Yes □ No	Treatment Urgency: □ No obvious problem found □ Early dental care recommended □ Urgent care needed

____

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.

Optional: other reasons my child could not get an oral health assessment:______________________

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**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.

____

Signature of parent or guardian *Date*

Washington School Request for Southwest Transportation

Escuela Washington Requisitos para el transporte escolar

Office submitted to Southwest on:

Name of Student to be transported: ____________________ Room: ________
Nombre del Estuduante que va ser transportado: Salon:

Address: ____
Direccion:

Name of Parent: ____________________ Phone Number: ____________________
Nombre del padre 'o madre: Telefono:

Address of pickup or drop off if different than above:

____
Direccion dondo sera levantado y dejado solo si es diferente a la arriba:

Circle the appropriate choice and the days that apply:
Circula los dias que nesecites

Pick-Up M T W TH F Effective Date: ____________________
Levantor fecha efectiva

Drop-Off M T W TH F Parent Signature: ____________________
Dejar firmada del padre

SOUTHWEST TRANSPORTATION AGENCY
STUDENT RELEASE TO SIBLING OR
ADULT/GUARDIAN AGREEMENT

School: ____________

Grade: _______

Route: _______

Students Address ________________________________

A. This agreement will allow the student (s) stated below to be released to a sibling and /or an adult/guardian. This agreement also dismisses Southwest Transportation from any responsibility once the student is released.

B. Este acuerdo permitirá al estudiante (s) declarado a continuación para ser lanzado a un hermano y/o un adulto o tutor. Este acuerdo también descarta transporte de Southwest de cualquier responsabilidad, una vez que el estudiante es liberado.

I ______________________ give permission for ____________________ to get off the
Parent Name — Student Name

bus with and / or be released to ___________________________
Name of Sibling/Adult/Guardian

______________________ Parent Signature

________________ Date

Yo______________________ doy permiso para ____________________ a bajarse del
Nombre de Padre — Nombre de Estudiante

autobús con / o liberará a ____________________________
Nombre de Adultos/ Hermano/Tutor

______________________ Firma de Padre

________________ Fecha

SUBMIT

16644 SOUTH ELM AVENUE • CARUTHERS, CALIFORNIA 93609 • PHONE: (559) 644-1000

State of California—Health and Human Services Agency
Primary Care and Family Health Division

Department of Health Services
Children's Medical Services Branch
Child Health and Disability Prevention (CHDP) Program

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last | First | Middle | BIRTHDATE—Month/Day/Year

ADDRESS—Number/Street | City | ZIP Code | SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE
Health History	
Physical Examination	
Dental Assessment	
Nutritional Assessment	
Developmental Assessment	
Vision Screening	
Audiometric (hearing) Screening	
Tuberculin Test (Mantoux/PPD)	
Blood Test (for anemia)	
Urine Test	
Blood Lead Test	
Other	

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DTaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER (optional) *and* RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

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

☐ Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: (please explain)

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

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

➤ Signature of parent or guardian   Date

Name, address, and telephone number of health examiner

➤ Signature of health examiner   Date

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.