**Washington TK/K Registration**

**Dates and Times**

**In person or zoom registration by appointment only**

**Dates and Times:**
Tuesday- Friday, Feb. 9th-12th and 16th-19th
7:20-3:30pm

Saturday, Feb. 20th 12:00pm- 4:00pm

**Age Requirements:**

**Kindergarten:**
Students that turn 5 years old on or before September 1st, 2021 are eligible for Kindergarten.

**Transitional Kindergarten:**
Students that turn 5 years old between September 2, 2021 and December 2, 2021 are eligible for Transitional Kindergarten.

**First Step: New Student Online Registration starting Jan. 25th, 2021**

New student registration must be completed online before coming to the office to register.

Online registration is open for enrollment. If you do not have computer/internet access, call Washington at 897-2955 and we will have a computer available to you.

Please access the following website for online registration: register.kesd.org

Once the website is accessed, please select “Aeries AIR” and continue to pick language preference. Next, click on “enroll a new student.” Select 2021-2022 school year and click next for valid address. On the login page click “create a new account.” Continue through the process by following the prompts.

**Second Step:**

**Call for a Registration appointment in the Office or through zoom**

The following documents must be brought with you to Washington on registration day:

1. Certified birth certificate, baptismal certificate, or passport.
2. Immunization Record, including TB Risk Assessment.
3. Completed physical exam within 1 year of the start of school.
4. Proof of Residency- Acceptable proof of residency (current):
   -mortgage statement/ receipts, rental contract/agreement/receipts, PG&E bill, or gas bill.
5. Joint Residency Form, if your family/ child resides with another family.

*Please complete the following forms which are available in our office or online on our website: https://www.kesd.org/washington*

**Student Health Inventory and Oral Health Assessment**

**Southwest Transportation Forms, if your child will ride the bus to/from school**
Superintendent: Wes Sever, Ed. D.  Principal: Laura North

Asst. Superintendent: Melanie Sembrutzki

Dear Washington Parents,

We are excited to have you join us at Washington for the school year. We are proud to be the first step in your child’s public education career. We want to thank you for your work with your child from birth to now. You always will be your child’s biggest influence and their first teacher. Thank you for trusting us with the next steps.

This is our mission statement written by the staff at Washington:

Every student will learn in an environment in which they feel loved, safe, and respected. All children in every classroom will learn a rigorous curriculum differentiated to prepare them for the next grade level. Each student’s success will be acknowledged. We will form the foundation for building productive citizens of our community and the world.

Important information:

**VERY IMPORTANT- The first step of registration is to do the online portion.**

*Once this is completed make sure that you have the required documents and then call and make an appointment for registration.*

For students that are transferring from another school to start school at Washington this school year you can call immediately after registering online.

For students that are registering for the 2021-2022 school year, you may call our office after doing the online portion and we will set your appointment for a date and time between Feb. 9th-20th to come in person and register.

Should you have any questions, please feel free to contact me here in the office at 897-2955. I look forward to working with you and your child. Together, we will make this a great experience for our little Patriots!!! Love our Patriots!!

Thank you for your trust in us,

Laura North (Principal)

Washington Elementary School
# Kingsburg Elementary Charter School District 2021-22 School Calendar

**Opening Day:** August 16, 2021

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<td><strong>August</strong></td>
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<td>Preservice Days - August 11-13</td>
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<td>Labor Day - Sept 6</td>
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<td><strong>October</strong></td>
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<td>Parent Teacher Conference Week October 4 - 8</td>
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<td>Red Ribbon Week - October 25 - October 29</td>
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<td>Veterans' Day - Nov 11</td>
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<td>Thanksgiving Break - Nov 22 - Nov 26</td>
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<td><strong>December</strong></td>
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<td>Minimum Days - December 16-17</td>
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<td>Winter Break - Dec 20 - Jan 4</td>
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<td>Martin L. King, Jr. Birthday - Jan 17</td>
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<td><strong>February</strong></td>
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<td>Lincoln's Day - Feb 14</td>
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<td>President's Day - Feb 21</td>
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<td>Spring Break - April 11 - April 18</td>
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<td>Memorial Day - May 30</td>
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<td>Minimum Days - June 1-3</td>
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<td>Last Day of School - June 3</td>
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</table>

**Service Days:** 4  
**Teaching Days:** 180  
**Total:** 184

[ ] Legal Holidays ( ) Local Holidays ( ) Professional Dev.

**Minimum Day Times:**  
Washington - 11:50/Roosevelt - 12:10/Lincoln - 1:10/Reagan - 12:10 (4th); 12:15 (5th/6th)  
[ ] Refer - 1:30

Board Approved January 13, 2020
Kingsburg Joint Union School District
Kingsburg Elementary Charter School District

Oral Health Notification Letter

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 cannot take your child for this required assessment, please indicate the reason for this in Section 3 of the form. You can get more copies of the necessary form at your child’s school or online from the California Department of Education’s Web site at http://www.cde.ca.gov/ls/he/hn/. 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.

The following resources will help you find a dentist and complete this requirement for your child:

1. Medi-Cal/Denti-Cal’s toll-free number or Web site can help you to find a dentist who takes Denti-Cal: 1-800-322-6384; http://www.denti-cal.ca.gov. For help enrolling your child in Medi-Cal/Denti-Cal, contact your local social service agency at 1-800-421-3484.

2. Healthy Families’ toll-free number or Web site can help you to find a dentist who takes Healthy Families insurance or to find out if your child can enroll in the program: 1-800-880-5305 or http://www.benefitscal.com/.

3. For additional resources that may be helpful, contact your local public health department at 855-832-8082.
Remember, your child is not healthy and ready for school if he or she has poor dental health! Here is important advice to help your child stay healthy:

- Take your child to the dentist twice a year.
- Choose healthy foods for the entire family. Fresh foods are usually the healthiest foods.
- Brush teeth at least twice a day with toothpaste that contains fluoride.
- Limit candy and sweet drinks, such as punch or soda. Sweet drinks and candy contain a lot of sugar, which causes cavities and replaces important nutrients in your child’s diet. Sweet drinks and candy also contribute to weight problems, which may lead to other diseases, such as diabetes. The less candy and sweet drinks, the better!

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.

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.

If you have questions about the new oral health assessment requirement, please contact Robyn Torres, District Nurse at 897-6864.

Sincerely,

[Signature]

Wesley Sever, Ed.D.
Superintendent
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)

<table>
<thead>
<tr>
<th>Child's First Name:</th>
<th>Last Name:</th>
<th>Middle Initial:</th>
<th>Child's birth date:</th>
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</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Apt.:</th>
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<table>
<thead>
<tr>
<th>City:</th>
<th>ZIP code:</th>
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<table>
<thead>
<tr>
<th>School Name:</th>
<th>Teacher:</th>
<th>Grade:</th>
<th>Child's Sex:</th>
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<table>
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<tr>
<th>Parent/Guardian Name:</th>
<th>Child's race/ethnicity:</th>
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<tbody>
<tr>
<td></td>
<td>☐ White ☐ Black/African-American ☐ Hispanic/Latino ☐ Asian</td>
</tr>
<tr>
<td></td>
<td>☐ Native American ☐ Multi-racial ☐ Other</td>
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<tr>
<td></td>
<td>☐ Native Hawaiian/Pacific Islander ☐ Unknown</td>
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</tbody>
</table>

Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box.

<table>
<thead>
<tr>
<th>Assessment Date:</th>
<th>Caries Experience (Visible decay and/or fillings present)</th>
<th>Visible Decay Present:</th>
<th>Treatment Urgency:</th>
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<tbody>
<tr>
<td></td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ No obvious problem found</td>
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<td></td>
<td></td>
<td></td>
<td>☐ Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation)</td>
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<td></td>
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<td></td>
<td>☐ Urgent care needed (pain, infection, swelling or soft tissue lesions)</td>
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</tbody>
</table>

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 ☐ 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.
CONFIDENTIAL

Kingsburg Elementary Charter School District 2020-2021
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

☐ 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 Date/Explain____________________
(Recent 12 months)


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

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
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 __________________
# 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

<table>
<thead>
<tr>
<th>CHILD'S NAME—Last</th>
<th>First</th>
<th>Middle</th>
<th>BIRTH DATE—Month/Day/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS—Number, Street</td>
<td>City</td>
<td>ZIP code</td>
<td>SCHOOL</td>
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</tbody>
</table>

## PART II  TO BE FILLED OUT BY HEALTH EXAMINER

**HEALTH EXAMINATION**

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).

### IMMUNIZATION RECORD

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DATE EACH DOSE WAS GIVEN</th>
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<tbody>
<tr>
<td><strong>POLIO (OPV or IPV)</strong></td>
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<tr>
<td>DTP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)</td>
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<tr>
<td>MMR (measles, mumps, and rubella)</td>
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</tr>
</tbody>
</table>
| HIB MENINGITIS (Haemophilus influenzae B)  
(Required for child care/preschool only) | |
| HEPATITIS B | |
| VARICELLA (Chickenpox) | |
| OTHER (e.g., TB Test, if indicated) | |
| OTHER | |

## PART III  ADDITIONAL INFORMATION FROM HEALTH EXAMINER (optional)

**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: 

**RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN**

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.
California Pediatric Tuberculosis Risk Assessment

- Use this tool to identify asymptomatic children for latent TB infection (LTBI) testing.
- **Do not repeat testing** unless there are **new risk factors** since the last test.
  If initial negative screening test occurred prior to 6 months of age, repeat testing should occur at age 6 months or older.
- Do not treat for LTBI until active TB disease has been excluded:
  For children with TB symptoms or abnormal chest x-ray consistent with active TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

**LTBI testing is recommended if any of the boxes below are checked.**

- **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month
  - Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
  - If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the California Adult Tuberculosis Risk Assessment User Guide for this list).
  - Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥2 years old

- **Immunosuppression**, current or planned
  HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥2 mg/kg/day, or ≥15 mg/day for ≥2 weeks) or other immunosuppressive medication

- **Close contact** to someone with infectious TB disease during lifetime

Treat for LTBI if LTBI test result is positive and active TB disease is ruled out.

- **None**; no TB testing is indicated at this time.

Provider Name: __________________________

Assessment Date: ________________________

Patient Name: __________________________

Date of Birth: _________________________

See the California Pediatric TB Risk Assessment User Guide for more information about using this tool. To ensure you have the most current version, go to the TB RISK ASSESSMENT page (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Risk-Assessment.aspx)
Avoid testing persons at low risk
Routine testing of persons without risk factors is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Local recommendations, mandated testing and other risk factors
Several risk factors for TB that have been used to select children for TB screening historically or in mandated programs are not included among the 3 components of this risk assessment. This is purposeful in order to focus testing on children at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Testing can also be considered in children with frequent exposure to adults at high risk of TB infection, such as those with extensive foreign travel in areas with high TB rates. Local recommendations should also be considered in testing decisions. Local TB control programs and clinics can customize this risk assessment according to local recommendations. Providers should check with local TB control programs for local recommendations. A directory of TB Control Programs is available on the CTCA website (https://www.ctca.org/locations.html)

Most patients with LTBI should be treated
Persons with risk factors who test positive for LTBI should generally be treated once active TB disease has been ruled out with a physical exam, chest radiograph and, if indicated, sputum smears, cultures, and nucleic acid amplification testing (NAAT). However, clinicians should not feel compelled to treat persons who have no risk factors but have a positive test for LTBI.

When to repeat a risk assessment and testing
Risk assessments should be completed for new patients, patients thought to have new potential exposures to TB since last assessment, and during routine pediatric well-child visits. Repeat risk assessments should be based on the activities and risk factors specific to the child. Children who volunteer or work in health care settings might require annual testing and should be considered separately. Retesting should only be done in persons who previously tested negative and have new risk factors since the last assessment (unless they were <6 months of age at the time of testing). In general, new risk factors would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel.

Immunosuppression
The exact level of immunosuppression that predisposes to increased risk for TB progression is unknown. The threshold of steroid dose and duration used in the Pediatric TB Risk Assessment are based on data in adults and in accordance with ACIP recommendations for live vaccines in children receiving immunosuppression.

Foreign travel or residence
Travel or residence in countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with persons with infectious TB, high prevalence of TB in travel location, non-tourist travel). The duration of at least 1 consecutive month to trigger testing is intended to identify travel most likely to involve TB exposure. TB screening tests can be falsely negative within the 8 weeks after exposure, so are best obtained 8 weeks after a child’s return.

IGRA preference in non-U.S.-born children ≥2 years old
Because IGRA has increased specificity for TB infection in children vaccinated with BCG, IGRA is preferred over the tuberculin skin test for non-U.S.-born children ≥2 years of age. IGRA can be used in children <2 years of age, however, there is an overall lack of data in this age group, which complicates interpretation of test results. In BCG vaccinated immunocompetent children with a positive TST, it may be appropriate to confirm a positive TST with an IGRA. If IGRA is not done the TST result should be considered the definitive result.

Negative test for LTBI does not rule out active TB
It is important to remember that a negative TST or IGRA result does not rule out active TB disease. A negative TST or IGRA in a patient with active TB disease can be a sign of extensive disease. Any suspicion for active TB disease or extensive exposure to TB should prompt an evaluation for active TB disease, including physical exam, symptom review, and 2-view chest x-ray.
Emphasis on short course for treatment of LTBI
Shorter regimens for treating latent TB infection have been shown to be as effective as 9 months of isoniazid, and are more likely to be completed. Use of these shorter regimens is preferred in most patients, although the 12 week regimen is not recommended for children <2 years of age or children on antiretroviral medications. It is under study in pregnancy. Drug-drug interactions and contact to drug resistant TB are other contra-indications for shorter regimens.

**Shorter duration LTBI treatment regimens**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Frequency</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rifampin</td>
<td>Daily</td>
<td>4 months</td>
</tr>
<tr>
<td>Isoniazid + rifapentine</td>
<td>Weekly</td>
<td>12 weeks*</td>
</tr>
</tbody>
</table>

* 11-12 doses in 16 weeks required for completion.

**Refusal of recommended LTBI treatment**
Refusal should be documented. Recommendations for treatment should be made at future encounters with medical services. If treatment is later accepted, TB disease should be excluded and chest x-ray repeated if it has been more than 6 months from the initial evaluation for children 5 years or older and 3 months for children less than 5 years of age.

Symptoms that should trigger evaluation for active TB
Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, weight loss, lymphadenopathy, hemoptysis or excessive fatigue.

**Resources**
Fact Sheets for LTBI Regimens, Isoniazid+Rifapentine, Rifampin, and Isoniazid are available on the TBCB LTBI Treatment page. (www.cdph.ca.gov/LTBITreatment)


**Abbreviations**
AFB= acid-fast bacilli  BCG= Bacillus Calmette-Guérin  
CXR=chest x-ray  DOT= directly observed therapy  
IGRA=interferon gamma release assay  LTBI= latent TB infection  
MDR=multiple drug resistant  NAAT= nucleic acid amplification testing  
SAT= self-administered therapy  TST= tuberculin skin test
Washington School Request for Southwest Transportation

Name of Student to be transported: ____________________________  Room: ________
Nombre del Estudiante que va ser transportado: ________________  Salon: ________

Address: _______________________________________
Direccion: _______________________________________

Name of Parent: ____________________________  Phone Number: ______________________
Nombre del padre / madre: _______________________  Telefono: ______________________

Address of pickup or drop off if different than above:
Direccion donde 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