Dear Parent of Prospective Richland School District Kindergarten Student:

Welcome to the Richland School District! On behalf of the Richland School District, I would like to request that you complete the enclosed enrollment packet and return on May 16th from 4:30pm – 6:30pm during TK/KG early registration or August 1st from 4:30pm – 6:30pm during late registration to ensure proper placement of your student with the District.

If you have any questions regarding enrollment, please feel free to contact the school site or the District Office at the numbers listed above.

Thank you. We look forward to your student’s participation within our District.

*********************************************************************************************************************************************************************************************************

Estimado padre de alumno prospectivo de Kindergarten del Distrito Escolar de Richland:

¡Bienvenido al Distrito Escolar de Richland! De parte del Distrito Escolar de Richland, deseo solicitarle que llene las hojas de inscripción y regrese el 16 de mayo durante las horas de 4:30pm – 6:30pm durante la inscripción temprana de kinder y kinder de transición, o el día 1 de agosto durante las horas de 4:30pm – 6:30pm durante la inscripción tarde para asegurar la colocación apropiada de su niño(a) dentro del Distrito.

Si usted tiene alguna pregunta sobre la inscripción, por favor siéntase libre de comunicarse con el sitio escolar o la oficina del Distrito en los números mencionados arriba.

Gracias. Estamos deseosos de tener la participación de su niño dentro de nuestro Distrito.

Sincerely/Atentamente,

District Superintendent/Superintendente de Distrito
REGISTER YOUR TK-KINDERGARTEN STUDENT FOR THE 2019-2020 SCHOOL YEAR!

ALL ELEMENTARY SCHOOLS
REGISTER YOUR TK-KINDERGARTEN STUDENTS

EARLY REGISTRATION:

DATE: MAY 16, 2019
TIME: 4:30 p.m. – 6:30 p.m.
Location: Activity Center (Blue Building)
300 N. Valley Shafter, CA 93263

LATE REGISTRATION:

DATE: AUGUST 1, 2019
TIME: 4:30 p.m. – 6:30 p.m.
Location: Activity Center (Blue Building)
300 N. Valley Shafter, CA 93263

TK= Students must be turning five from Sept 2, 2019 - Dec 2, 2019
KG= Students must be 5 by September 1, 2019

PLEASE BRING:
- Birth Certificate
- Proof of Address
- Immunizations (Up to Date)
- Medical Physical (Dated after Feb. 15)
- Dental Exam
- TB Test or TB Risk Assessment Questionnaire

You may pick up a registration packet from these offices starting March 4, 2019.

Golden Oak Elementary School 195 S. Wall St. (661) 746-8670
Redwood Elementary School 331 Shafter Ave. (661) 746-8650
Richland Junior High School 331 Shafter Ave. (661) 746-8630
Richland District Office 300 N. Valley St. (661) 746-8600
Sequoia Elementary School 500 E. Fresno Ave. (661) 746-8740
Migrant Office 300 N. Valley St. (661) 746-8647
Healthy Start Office 300 N. Valley St. (661) 746-8690
Registration Check-list

☐ Call your doctor to make an appt. for a physical exam

*(Physical needs to be dated February 15 or later)*

☐ Call your dentist to make an appt. for a dental exam

☐ Call the school office to make an appt. to register your child

☐ Proof of Age (Birth Certificate, Passport or Baptismal Record)

☐ Proof of Address

*Acceptable proof: Gas, Electric, Water bill, or Rental agreement listing your name and current address. If unavailable, please contact the school site office for alternative options.*

☐ Immunizations (All UP TO DATE)

☐ Dental Exam

☐ Medical Physical

☐ TB Test or TB Risk Assessment Questionnaire

☐ Asthma Survey
STUDENT RESIDENCY QUESTIONNAIRE/AFFIDAVIT

This document is intended to address the McKinney-Vento Assistance Act. Your answers will help determine documents necessary to enroll your child quickly.

Student:_________________________________________ Male___________ Female___________
Birthdate:_________________________________________ Grade:______________

1. Do you and your student live in a fixed, regular, adequate nighttime residence? Yes____ No_______
   (If you marked “Yes,” stop here. You must provide a gas or electric bill in your name as proof of residence.
   If you marked “NO,” please continue with this form.)

2. Do you and the student live in:
   o shelter
   o motel/hotel
   o temporarily with another family in a house, mobile home, or apartment
   o in a car or RV
   o at a campsite
   o transitional housing
   o other location:______________________________________________

3. The student lives with:
   o one parent
   o two parents
   o a qualified relative
   o friend(s)
   o an adult that is not the legal guardian
   o alone with no adult(s)

4. I am:
   o the parent/legal guardian of the above-named student
   o a qualified adult relative of the above-named student
   Relationship:______________________________________________

I declare under penalty of perjury under the laws of this state that the information provided here is true and correct and of my own personal knowledge.

Signature:_________________________________________ Date:______________

Print Your Name:______________________________________________

Residence:___________________________________________________
   Street    City    Zip

Mailing Address:______________________________________________
   Street    City    Zip

Telephone (___)_________________________________ Cell Phone:(___)_________________________________
<table>
<thead>
<tr>
<th>Student ID #</th>
<th>Family ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Entry Date</th>
<th>English Learner</th>
<th>All Immunizations Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### Student Information

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
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</thead>
<tbody>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Birth Date:</th>
<th>Grade:</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student SS#</th>
<th>Gender:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birthplace:</th>
<th>City</th>
<th>State</th>
<th>Country</th>
</tr>
</thead>
<tbody>
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</table>

### ETHNICITY:

**Is the child Hispanic or Latino?** ☐ Yes ☐ No
*(If “No” Secondary Ethnicity – Must Select From The Choices Below)*

- ☐ American Indian/Alaskan Native (1)
- ☐ Asian (2)
  - ☐ Chinese (01)
  - ☐ Japanese (02)
  - ☐ Korean (03)
  - ☐ Vietnamese (04)
- ☐ Native Hawaiian or Pacific Islander (3)
  - ☐ Hawaiian (01)
  - ☐ Guamanian (02)
  - ☐ Samoan (03)
  - ☐ Tahitian (04)
  - ☐ Other Pacific Islander (99)
- ☐ Filipino/Filipino American (4)
- ☐ Black/Not of Hispanic Origin (6)
- ☐ White/Not Hispanic Origin (7)
- ☐ Multiple (Please Check All Ethnicities That Apply)

### Student is a foster child:

☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Name of Social Worker:</th>
<th>Phone #</th>
<th>(Add to student’s contacts)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Guardian:</th>
<th>[Foster Parent]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Legal Documents must be presented**

<table>
<thead>
<tr>
<th>Client ID:</th>
<th>Case #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Where is your family currently living?

- ☐ In a single-family residence
- ☐ In a shelter or transitional housing program
- ☐ In a motel, car or campsite
**Student Physical Residence: [Student Information]**

Physical Street Address

Mailing Address (If different from physical address)

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Student Primary Phone Number *(only one phone number)*

- Yes
- No

- Student resides at one residence only (primary)
- Student resides part-time at another residence
- Student has a second mailing address

**Head(s) of Household (1):**

<table>
<thead>
<tr>
<th>Relationship:</th>
<th>Lives In Primary Residence:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Please circle one)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father (FA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stepfather (SF)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster Father (FP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guardian (GA)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Military (Please circle one)**

- Yes
- No

- Currently on active duty
- Not on active duty

**Last Name**

**First Name**

**Middle**

(Jr, Sr, etc.)

**Primary Language Spoken by Parent:**

**Language Preferred for Communication from School:**

**Home:**

(____) ____- _____

**Cell:**

(____) ____- _____

**Work:**

(____) ____- _____ ext.____

**Message:**

(____) ____- _____

**Email:**

_____________________________________________________

**Education Level:**

- Not a High School Graduate (14)
- High School Graduate (13)
- College Graduate (11)
- Graduate School/Post Graduate (10)
- Some College (includes AA degree) (12)

**Migrant Education Information: Have you been employed in any of the following trades within the past three (3) years in the United States?**

- Agriculture (1)
- Canneries
- Food packing
- Cotton Research Station (2)
- Farm work
- Forestry
- Irrigation
- Fish
- Poultry
- Hauling
- Dairy
- Beekeeping
**Head(s) of Household (2)**

<table>
<thead>
<tr>
<th>Residence:</th>
<th>Lives In Primary Residence:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Relationship:**
- □ Mother (MO)
- □ Stepmother (SM)
- □ Foster Mother (FP)
- □ Caregiver (CR)

**Military** (Please circle one)
- □ Yes
- □ No

- □ Currently on active duty
- □ Not on active duty

---

**Last Name**

**First Name**

**Middle**

**Street Address** (If Different from Head of Household 1)

**Unit/Apt #**

**City**

**Zip Code**

**Home:** (___) ___ - ______

**Cell:** (___) ___ - ______

**Primary Language Spoken by Parent:**

**Language Preferred for Communication from School:**

**Work:** (___) ___ - ______ ext. __

**Message:** (___) ___ - ______

**Email:**

---

**Education Level:**

- □ Not a High School Graduate (14)
- □ College Graduate (11)
- □ High School Graduate (13)
- □ Graduate School/Post Graduate (10)
- □ Some College (includes AA degree) (12)

---

**Migrant Education Information:** Have you been employed in any of the following trades within the past three (3) years in the United States?

- □ Agriculture (1)
- □ Canneries
- □ Food packing
- □ Cotton Research Station (2)
- □ Farm work
- □ Forestry
- □ Irrigation
- □ Fish
- □ Poultry
- □ Hauling
- □ Dairy
- □ Beekeeping
### SIBLINGS:

<table>
<thead>
<tr>
<th>Last name</th>
<th>First</th>
<th>Middle</th>
<th>Currently Enrolled in Richland</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes  No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last name</th>
<th>First</th>
<th>Middle</th>
<th>Yes  No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Last name</th>
<th>First</th>
<th>Middle</th>
<th>Yes  No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Last name</th>
<th>First</th>
<th>Middle</th>
<th>Yes  No</th>
</tr>
</thead>
</table>

### SCHOOL ATTENDANCE:

Date First Enrolled in US School __ / ___ / ______

Date First Enrolled In CA School __ / ___ / ______

Last School Student Attended: ____________________________________________

Phone: ( _____ ) _____ - _______  Fax: ( _____ ) _____ - _______

Address: ___________________________  City: ___________________ State: _______

Has your child previously attended school in the Richland School District?  Yes  No
Has your child qualified for the G.A.T.E. Program?  Yes  No
Has your child qualified for a Special Education Program?  Yes  No
Has your child qualified for the Migrant Program?  Yes  No
Has your child qualified for 504 services?  Yes  No

Records Requested:  ____ / ____ / ____  By: ____________________________
Custody Ruling □ Yes □ No (If yes must provide official legal documentation).

Do Not Release to: ________________________________ [ENTER IN COMMENTS]

Notes/Custody/Restraining Order Information:

Signature of Parent/Guardian __________________________ Date ________________

1. Legal documentation authorizing foster care must be presented during the registration process.
2. Caregiver Certification must be completed and submitted during the registration process if not Legal Guardian

RICHLAND SCHOOL DISTRICT does not provide medical or accident insurance for students. Healthy Families is a low-cost, comprehensive health, dental, and vision insurance for children ages one through eighteen and for children on Medi-Cal with a share of cost. Application assistance for Healthy Families is available at Shafter Healthy Start by the Family Advocates. Request further information when you submit this form.
### Student Medical Information: (MEDICAL FOLDER)

**Student Name:**

**Student Id:**

Please check or fill in all appropriate areas below: *(if your child has no on-going health problems, please check the box at the bottom of this page)*

<table>
<thead>
<tr>
<th>Health Problem(s)</th>
<th>(091)</th>
<th>(092)</th>
<th>(093)</th>
<th>Medication(s) for this Problem</th>
<th>Taken at Home</th>
<th><strong>Taken at School</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>693.10 Allergy (food)</td>
<td></td>
<td></td>
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<tr>
<td>477.00 Allergy (pollen)</td>
<td></td>
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<tr>
<td>995.30 Allergy (other)</td>
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<tr>
<td>477.90 Allergy (rhinitis, cause unspecified)</td>
<td></td>
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<tr>
<td>368.01 Amblyopia/Strabismus</td>
<td></td>
<td></td>
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<tr>
<td>493.90 Asthma</td>
<td></td>
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<tr>
<td>314.00 Attention Deficit Disorder ADD/ADHD</td>
<td></td>
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<tr>
<td>299.00 Autism</td>
<td></td>
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<tr>
<td>989.50 Bee Sting Allergy Reaction</td>
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<tr>
<td>239.60 Brain Tumor</td>
<td></td>
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<tr>
<td>343.90 Cerebral Palsy</td>
<td></td>
<td></td>
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<tr>
<td>558.00 Colitis</td>
<td></td>
<td></td>
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<tr>
<td>555.90 Crohn’s Disease</td>
<td></td>
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<tr>
<td>250.01 Diabetes</td>
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<tr>
<td>V011.80 Emotional Concerns and/or Other Mental Disorders</td>
<td></td>
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<tr>
<td>V44.10 Gastrostomy (Tube Feed)</td>
<td></td>
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<td></td>
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<tr>
<td>389.30 Hearing Problems</td>
<td></td>
<td></td>
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<tr>
<td>hearing aide: yes □ no □</td>
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<tr>
<td>429.90 Heart Disease</td>
<td></td>
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<tr>
<td>331.40 Hydrocephalus with Shunt</td>
<td></td>
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<tr>
<td>208.00 Leukemia</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>346.90 Migraine Headaches</td>
<td></td>
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<tr>
<td>359.10 Muscular Dystrophy</td>
<td></td>
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<tr>
<td>367.00 Must Wear Glasses/Contacts</td>
<td></td>
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<tr>
<td>756.00 Other Congenital Anomalies, Musculoskeletal</td>
<td></td>
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<tr>
<td>369.00 Profound Uncorrectable Vision Loss</td>
<td></td>
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<tr>
<td>729.00 Rheumatoid Arthritis</td>
<td></td>
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<tr>
<td>737.30 Scoliosis</td>
<td></td>
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<tr>
<td>345.10 Seizure Disorder</td>
<td></td>
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<tr>
<td>315.30 Speech Difficulty</td>
<td></td>
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<tr>
<td>741.00 Spina Bifida</td>
<td></td>
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</tr>
<tr>
<td>307.23 Tourette Syndrome</td>
<td></td>
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<tr>
<td>44.00 Tracheostomy</td>
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</tbody>
</table>

List Physical Health Care Needs at School (excluding medications) i.e., epi-pens, G-tube feedings, etc.:

No on-going health problems or concerns: □

**For a student to take medication at school during the school day the “Request for Medication to be Taken During School Hours” form must be completed by Physician and parent.
Please check and specify all required medical devices that will be necessary for your child:

- Wheelchair – Specify Width: Electric: ☐ Manual: ☐
- Walker
- Braces (non-dental) – Leg: ☐ Body: ☐
- Protective Helmets
- Special restraining harness
- Oxygen unit – Description:
- Drip Feeding unit
- Suctioning Unit – Description:
- Other – Explain:

### Developmental History & Milestones

#### Ages 2 to 5

<table>
<thead>
<tr>
<th>Task</th>
<th>Advanced</th>
<th>Average</th>
<th>Delayed</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting, crawling, and reaching up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Running, jumping, throwing, catching</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talking in sentences, vocabulary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social development, making friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counting, knowledge of alphabet, doing puzzles, understanding concepts</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age/Months or years</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sat up alone</td>
<td></td>
</tr>
<tr>
<td>Crawled</td>
<td></td>
</tr>
<tr>
<td>Walked</td>
<td></td>
</tr>
<tr>
<td>Talked</td>
<td></td>
</tr>
<tr>
<td>Toilet trained</td>
<td></td>
</tr>
</tbody>
</table>

Other health care comments, or special health related requirements (optional):

---

Signature of Parent/Guardian ___________________________ Date _______________
The Richland School District participates in a state program that allows school districts to bill Medi-Cal for services by the school nurse, speech therapists, school psychologists and school counselors. This program allows the District to provide additional services to students and families. Parents are not billed for any of these services and school services currently required by California Education Code remain unchanged. The State of California and the Federal government require school districts to attempt to bill health insurance carriers of all students. In order to do this the District is required to ask for the following information, which is your option to provide.

Medical Insurance Information (EMERGENCY INFORMATION)

Is your child covered by medical insurance?
☐ Private  ☐ Healthy Families  ☐ Medi-Cal  ☐ Other ______________________________________

Insurance Information:
Insurance Company Name:__________________________________________________________________
Address:_________________________________________________________________________________
Group #:___________________________________________      Policy #:   __________________________

Response to insurance claims by the school district (check one only)
☐ I consent to submission of claims to my insurance carrier.
☐ I do not consent to submission of claims to my insurance carrier.

I authorize release of information by the Richland School District to my insurance carrier as necessary to process the claim or to request payment of Medi-Cal assistance benefits.

________________________________________       _______________________________        ____/___/_____
Signature of parent/guardian                                   Print name of parent/guardian                       Date

AUTHORIZATION TO TREAT A MINOR:
I authorize the Richland School District to act as my agent to consent to an X-ray examination, anesthetics, medical or surgical diagnosis, or treatment and hospital care which are deemed advisable by, and are licensed under the provisions of the Medical Practice Act for the above name child if my designee or I cannot be reached. The physician named will be contacted or the child will be taken to an emergency room licensed under the Medicine Practice Act, at my expense. (Section 25.8 of the Civil Code of California) I hereby grant permission for authorized school personnel to transport my child as deemed necessary in an emergency, and/or on supervised study trips.

☐ I agree to allow Richland School District to act as my agent
☐ I do not agree to allow Richland School District to act as my agent

Physician:_________________________________________________________________________________
Physician’s Phone:________________________________________________________________________

I confirm that the above information is correct to the best of my knowledge.

________________________________________       ____/____/_____
Signature of parent/guardian                                                  Date
# Richland School District Emergency Card

<table>
<thead>
<tr>
<th>Teacher</th>
<th>Room</th>
<th>Student ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Grade</th>
<th>Birthday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Address</th>
<th>Mailing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Email Address</th>
<th>Primary Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternate Phone Number</th>
<th>Primary Phone Type (Please mark one):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Cell  ☐ Home  ☐ Work  ☐ Message</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YES / NO</th>
<th>YES / NO</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>(1) Head of Household</th>
<th>Relation</th>
<th>Telephone</th>
<th>Resides in Home</th>
<th>Military</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>YES / NO</td>
<td>YES / NO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(2) Head of Household</th>
<th>Relation</th>
<th>Telephone</th>
<th>Resides in Home</th>
<th>Military</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>YES / NO</td>
<td>YES / NO</td>
<td></td>
</tr>
</tbody>
</table>

Please call the persons listed below who will be able to contact me, the parent, in case of an emergency. The school cannot release my child to anyone without my written permission. This form must be kept current! **Please come to the school immediately to report changes.**

<table>
<thead>
<tr>
<th>#1 Alternate Contact Name</th>
<th>Telephone</th>
<th>Relation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>#2 Alternate Contact Name</th>
<th>Telephone</th>
<th>Relation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>#3 Alternate Contact Name</th>
<th>Telephone</th>
<th>Relation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Please sign and return to your school site office.**

In the event of an emergency, the principal or his/her designee will call: Fire Department, Police Department, RSD Health Services, Ambulance, and/or your physician. I authorize the Richland School District to act as my agent to consent to an X-ray examination, anaesthetic, medical or surgical diagnosis, or treatment and hospital care which are deemed advisable by, and are licensed under the provisions of the Medical Practice Act for the above name child if my designee or I cannot be reached. The physician named will be contacted or the child will be taken to an emergency room licensed under the Medicine Practice Act, at my expense. (Section 25.8 of the Civil Code of California) I hereby grant permission for authorized school personnel to transport my child as deemed necessary in an emergency, and/or on supervised study trips.

Parent Signature:__________________________ Date:__________________________
Dear Parents/Guardians,

The California Education Code requires schools to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students. Your cooperation in helping us meet this important requirement is requested at the time of registration.

In accordance with Ed Code 11518.5 Initial Assessment; if the response of the parent or guardian on the **Home Language Survey** indicates a primary or native language other than English, the District determines the pupil is eligible for the initial assessment, and shall promptly notify the parent or guardian in writing, prior to administering the Initial English Language Proficiency Assessment to the pupil.

Be advised that if your son/daughter is identified as an English Learner (EL) your son/daughter will be administered the Initial English Language Proficiency Assessment for California (ELPAC) within 30 calendar days of the initial enrollment in our District.

You are an important part of your child’s education. To help your child get ready for the test, you can:

- Read to your child, or have them read to you on a regular basis.
- Use pictures and ask your child to tell you what they see, or what is happening in each picture.
- Provide your child with opportunities to use language outside of school.
- Talk with your child’s teacher about your child’s listening, speaking, reading, and writing skills to help support their progress.

To learn more about the ELPAC, go to the California Department of Education Parent Guide to understanding the ELPAC Web page [https://www.cde.ca.gov/ta/tg/ep/elpacparentguide.asp](https://www.cde.ca.gov/ta/tg/ep/elpacparentguide.asp). You also can look at sample test questions on the ELPAC practice tests, which can be found on the ELPAC Web site at [https://www.elpac.org/resources/practicetests/](https://www.elpac.org/resources/practicetests/).

If you have any questions please contact Elia Sagasta, Director of Data & Instruction at 661-746-8625.
# Home Language Survey

**English**

**TO BE FILLED OUT BY PARENT OR GUARDIAN:**
The California Education Code requires schools to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students. Your cooperation in helping us meet this important requirement is requested. Please answer the following questions and have your son/daughter return this form to his/her teacher. Thank you for your help.

<table>
<thead>
<tr>
<th>Name of Student:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>M / F</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State / Country</td>
<td>Month / Day / Year</td>
<td>Place of Birth</td>
<td>Date of Birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State / Country</td>
<td>Month / Day / Year</td>
<td>Place of Birth</td>
<td>Date of Birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

2. Which language does your son or daughter most frequently use at home? ______

3. Which language do you use most frequently to speak to your son or daughter? ______

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

5. When did your child first enter a public school in the U.S.? ___/___/___  In California? ___/___/___

**PARENT SIGNATURE** ____________________________  **DATE** ____________

If you can speak a language other than English and are willing to help tutor or translate for students who do not speak English, please indicate.

I would be willing to volunteer: ☐ Yes ☐ No

Language(s) spoken: _______________________________ Telephone: _______________________________
PHOTO/VIDEO RELEASE
Parent Consent and Waiver of Rights

Program or Series Title: _______________________________________________________

Production Date(s): ________________  Working Title: _______________________________________

Production Location(s): _________________________________________________________

I hereby grant consent for the child named below (“Child”) to participate and appear in a still photograph or audio-visual programming (collectively “the programming”), whether via television, film, video, audio tape or electronic media for the Richland School District and waive any right to control approval use or reuse of the Programming.

All rights of any nature which may also arise from the Programming are hereby granted, worldwide and in perpetuity, to the Richland School District.

On behalf of myself and Child, I hereby waive any rights to fees, royalties, or other compensation which may arise from Child’s participation in the Programming under the laws of the United States or any state thereof, or under the laws of any other nation or jurisdiction.

On behalf of Child, I grant full permission for the use of Child’s name, likeness, performance, voice and biography for the purpose of publicizing, advertising or promoting the Programming in any medium, including the print media, radio, television, film, and audio or video tape.

I expressly represent that I have authority, either as a parent or legally appointed guardian, to execute this Consent and Release on behalf of Child.

PLEASE PRINT THE FOLLOWING:

Name of Child (please print): __________________________________________ Age: ______

Name of Parent or Legal Guardian (please print): _____________________________

Address: __________________________________________ City: ______________________

State: __________________________________________ Zip Code: ____________________

Phone Number (including area code): __________________________________________

_________________________ __________________________
Signature of Parent or Legal Guardian Date
Why Whooping Cough is Serious:

Whooping cough (also known as pertussis) is a contagious disease that can be passed easily from person to person. It is very serious for babies and can cause them to cough so much that they cannot breathe. Hundreds of babies are hospitalized each year for whooping cough, and some die from it. Whooping cough can cause adults or teens to have severe coughing that leads to vomiting or broken ribs. They can be hospitalized for pneumonia and miss weeks of work or school. Even worse, they can spread whooping cough to the babies at home.

Low-cost Tdap vaccine available in our Bakersfield clinic Monday-Friday 8:00 a.m. - 4:00 p.m. No appointment necessary.

For more information please call (661) 868-0306 or visit our website www.kernpublichealth.com

Parents:

Whooping Cough is growing in Kern County. Protect yourself and your children!

Bakersfield 1800 Mt. Vernon Ave. (661) 868-0306
Arvin 204 South Hill St. (661) 854-6411
Delano 455 Lexington St. (661) 721-3820
Lake Isabella 7050 Lake Isabella Blvd. (760) 375-5157
Lamont 12014 Main St. (661) 868-5824
Mojave 1775 Highway 58 (661) 824-7066
North of the River (Oildale) 125 E. Tejon St. (661) 866-5250
Ridgecrest 250 W. Ridgecrest Blvd. (760) 375-5157
Shafter 329 Central Valley Hwy. (661) 746-7562
Taft 315 Lincoln St. Room 150 (661) 763-8591
Tehachapi 125 East “F” St. (661) 822-3005
Wasco 810 Eighth St. (661) 756-3006

Revised 06/22/2010
Ways to Protect Yourself and Your Family:

Get Your Tetanus Booster (Tdap)
Everybody in the family should be immunized against whooping cough to protect themselves and the baby at home. Parents should ask their doctor for the new Tdap vaccine that includes a tetanus and diphtheria booster and also protects against whooping cough.

Make Sure Your Children are Up-to-Date on Their Immunizations
Children 10 years of age and older can also get the new Tdap booster. Infants and toddlers need four shots against whooping cough, and a booster before starting kindergarten.

Cover Your Cough and Wash Your Hands
Whooping cough is spread by coughing. Remind everyone to cover their mouths when coughing and to wash their hands often.

Protect yourself. Protect your family.
Get Immunized!
HEALTH REQUIREMENTS FOR KINDERGARTEN/FIRST GRADE SCHOOL ENTRY

Children beginning school for the first time must show proof that they have received a health examination and immunizations, before they can attend school.

Each school will ask that the attached, “REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY” be brought to school, completed and signed by a doctor.

THE HEALTH EXAMINATION:

Must be obtained no earlier than six months before entering kindergarten or eighteen months before entering first grade.

Must include the following services:
- a health and development history
- a complete physical history
- an examination of teeth and gums
- a vision test
- a hearing test
- urine and blood screening test
- a tuberculosis skin test
- other tests if needed

THE IMMUNIZATIONS:

Must include immunizations against measles, mumps and rubella,(MMR or MMR-V). Both doses given on or after the first birthday and only one of mumps and rubella vaccines are required if given separately; against diphtheria, tetanus and whooping cough (DPT/DTaP/DT/Td); against polio (IPV); against Hepatitis B (Hep B), and against chickenpox (varicella) or health care provider documented varicella disease. (See the attached sheet for more information).

HOW AND WHERE TO GET SERVICES:

If your child is on Medi-Cal or your family income is lower than 200% of the Federal Poverty Level, your child may be eligible for a FREE EXAMINATION AND IMMUNIZATIONS.

The child must go to one of the CHDP PROGRAM CERTIFIED PHYSICIANS OR CLINICS listed in this packet to get a free exam. If you have Medi-Cal, call your Primary Care Physician for an appointment.

If your child is not eligible for a free examination, call your family doctor, pediatrician, or USUAL SOURCE OF MEDICAL CARE. (The usual fee will be charged.)

If your child is not eligible for a free examination but still needs more immunizations and you cannot afford them, call the KERN COUNTY DEPARTMENT OF PUBLIC HEALTH at (661) 321-3000 to ask about immunization clinics.

IF YOU HAVE ANY QUESTIONS ABOUT SCHOOL ENTRY REQUIREMENTS:

Call your school district office for more information about your district’s requirements. Call the Health Department’s CHDP Program if you need more information about health examinations or are unable to obtain an examination for your child : (661)321-3000 or toll free (877) 818-4787.
Students Admitted at TK/K-12 Need:

- Diphtheria, Tetanus, and Pertussis (DTaP, DTP, Tdap, or Td) — 5 doses
  (4 doses OK if one was given on or after 4th birthday.
  3 doses OK if one was given on or after 7th birthday.)
  For 7th-12th graders, at least 1 dose of pertussis-containing vaccine is required on or after 7th birthday.

- Polio (OPV or IPV) — 4 doses
  (3 doses OK if one was given on or after 4th birthday)

- Hepatitis B — 3 doses
  (Not required for 7th grade entry)

- Measles, Mumps, and Rubella (MMR) — 2 doses
  (Both given on or after 1st birthday)

- Varicella (Chickenpox) — 2 doses
  These immunization requirements apply to new admissions and transfers for all grades, including transitional kindergarten.

Students Starting 7th Grade Need:

- Tetanus, Diphtheria, Pertussis (Tdap) — 1 dose
  (Whooping cough booster usually given at 11 years and up)

- Varicella (Chickenpox) — 2 doses
  (Usually given at ages 12 months and 4-6 years)
  In addition, the TK/K-12 immunization requirements apply to 7th graders who:
  • previously had a valid personal beliefs exemption filed before 2016 upon entry between TK/Kindergarten and 6th grade
  • are new admissions

Records:

California schools are required to check immunization records for all new student admissions at TK/Kindergarten through 12th grade and all students advancing to 7th grade before entry. Parents must show their child’s Immunization Record as proof of immunization.
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 (fill in appropriate local contact information, available at http://www.dhs.ca.gov/mcs/medi-Calhome/CountyListing1.htm.)

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.healthyfamilies.ca.gov/hfhome.asp.

3. For additional resources that may be helpful, contact the local public health department at (fill in appropriate local contact information, available at http://www.dhs.ca.gov/mcs/medi-Calhome/CountyListing1.htm)

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 the health office at your school. Redwood (746-8650), Sequoia (746-8740), Golden Oak (746-8760).

Sincerely,

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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Apt.:</th>
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<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>ZIP code:</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>School Name:</th>
<th>Teacher:</th>
<th>Grade:</th>
<th>Child’s Sex:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Male □ Female</td>
</tr>
</tbody>
</table>

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

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

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

**Licensed Dental Professional Signature**

<table>
<thead>
<tr>
<th>CA License Number</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>Signature of parent or guardian</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.*
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

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.

<table>
<thead>
<tr>
<th>REQUIRED TESTS/EVALUATIONS</th>
<th>DATE (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health History</td>
<td></td>
</tr>
<tr>
<td>Physical Examination</td>
<td></td>
</tr>
<tr>
<td>Dental Assessment</td>
<td></td>
</tr>
<tr>
<td>Nutritional Assessment</td>
<td></td>
</tr>
<tr>
<td>Developmental Assessment</td>
<td></td>
</tr>
<tr>
<td>Vision Screening</td>
<td></td>
</tr>
<tr>
<td>Audiometric (hearing) Screening</td>
<td></td>
</tr>
<tr>
<td>TB Risk Assessment and Test, if indicated</td>
<td></td>
</tr>
<tr>
<td>Blood Test (for anemia)</td>
<td></td>
</tr>
<tr>
<td>Urine Test</td>
<td></td>
</tr>
<tr>
<td>Blood Lead Test</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

IMMUNIZATION RECORD

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

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)

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. CHDP: website: www.dhcs.ca.gov/services/chdp

Signature of parent/guardian: ____________________________ Date: __________

Name, address, and telephone number of health examiner

Signature of health examiner: ____________________________ Date: __________
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 negative 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 3 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*

  *Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for foreign-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.

See the Pediatric TB Risk Assessment User Guide for more information about using this tool.

To ensure you have the most current version, go to the RISK ASSESSMENT page at: [https://cdph.ca.gov/tcb](https://cdph.ca.gov/tcb)
ASTHMA SURVEY

Student’s Name: _________________________________________ Birthdate: ____________________________

School: _________________________ Grade: _________________ Teacher: ___________________________

Physician Student Sees for Asthma: _________________________ Phone#: _____________________________

Please check all that apply to the student:

- Identify the things that will trigger an asthma episode
  - ☐ Exercise
  - ☐ Respiratory infections
  - ☐ Change in temperature
  - ☐ Animals
  - ☐ Food
  - ☐ Strong odors or fumes
  - ☐ Chalk dust
  - ☐ Pollens
  - ☐ Molds
  - ☐ Other ______________________________

- Symptoms which alert of an asthma episode
  - ☐ Coughing
  - ☐ Wheezing
  - ☐ Prolonged Expiration
  - ☐ Tightness in Chest
  - ☐ Gasping for air
  - ☐ Color change (pale or blue)
  - ☐ Other ______________________________

- Control of School Environment
  List any environmental control measures and/or dietary restrictions that the student needs to prevent an asthma episode:
  - __________________________________________
  - __________________________________________

- Medication Prescribed for Asthma: __________________________
  - ☐ Home
  - ☐ School
  *If medication is needed at school, a Permission Form for Prescribed Medication must be completed by your child’s health provider

- PE Restrictions: ______________________________(Attach a copy of doctor’s order)

Parent’s Consent for Release of Child’s Health Information

I ________________________________ authorize __________________________ to release health information regarding ________________________________ to Richland School District.

________________________________        __________________        _______________________________
Signature                           Date               Relationship to Student