BUCKEYE UNION SCHOOL DISTRICT

HOME LANGUAGE SURVEY

Date: ________________________

School: ________________________

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.

If a language other than English is noted on questions 1-3, your child will be tested for English Proficiency as required by California state law.

Name of Student: ________________________

Last (Legal)   First   Middle

Grade    Age    Date of Birth

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

________________________________________________________________________

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

________________________________________________________________________

3. What 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:

________________________________________________________________________

________________________________________________________________________

Signature of Parent or Guardian
Record of Prior Program Participation

Name of Student

Birthdate ____________________ Grade __________

To provide continuity in your child’s educational program, it is important that we be made aware of any services he/she has received. Please provide the following information to help us expedite your child’s proper placement.

My Child: (please initial)

__________ is not participating in any special programs

__________ has had testing for Special Education at ______________________

School in ___________________________ School District

__________ is currently in a Gifted and Talented Education program (GATE)

__________ is currently in an English Language Development class (ELD)

__________ is currently in Special Day class (SDC)

__________ is currently in a Resource Specialist Program (RSP) or receiving Specialized Academic Instruction (SAI)

__________ is currently receiving Speech/Language Therapy

__________ is currently receiving Adaptive Physical Education

__________ is currently receiving Vision Services

__________ is currently receiving Hearing Services

__________ is currently receiving accommodations from a 504 Plan

If your child is currently in any Special Education programs, you must provide a copy of the current IEP with your completed registration packet. Upon failure to disclose special education services, the District may disenroll or divert your student if special programs are impacted at the school site.

Parent/Guardian Signature __________________________ Date __________

M:FORMS/Registration Forms 22-23/Record of Prior Program
BUCKEYE UNION SCHOOL DISTRICT

William Brooks Elementary School
3610 Park Drive
El Dorado Hills, CA. 95762
Phone: (916) 933-6618/Fax: (916) 933-3910

Authorization to Release Information

To: ____________________________  ____________________________  ____________________________
(Name of School Previously Attended)  (Phone Number)  (Fax Number)

________________________________________  ____________________________  ____________________________
(Mailing Address)  (City)  (State)  (Zip Code)

The following student(s) have enrolled in our school. Please forward the cumulative records, confidential records, and any health information to the school listed above.

<table>
<thead>
<tr>
<th>Student's First and Last Name</th>
<th>Birth Date</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Thank you,

Noel Stedeford
Principal

AUTHORIZATION TO RELEASE INFORMATION

I hereby give __________________ School my consent to obtain any confidential information in my child’s cumulative record, and request you to forward the same to the school at the address listed above.

I understand that I have the right to review a copy of the record if desired and have an opportunity to challenge the content of the record.

__________________________  ____________________________
Parent/Guardian Signature  Date
BUCKEYE UNION SCHOOL DISTRICT
STUDENT RESIDENCY QUESTIONNAIRE

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

<table>
<thead>
<tr>
<th>Student Name – Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Gender (circle one)</th>
<th>M</th>
<th>F</th>
<th>Date of Birth:</th>
<th>Grade:</th>
</tr>
</thead>
</table>

School Teacher

1. Is your current address a temporary living arrangement?  □ Yes  □ No
2. Is this temporary living arrangement due to a loss of housing?  □ Yes  □ No
   Economic Hardship?  □ Yes  □ No
3. Are you enrolling a foster child?  □ Yes  □ No

*If you answered "NO" to all of the above questions, STOP NOW.
If you answered "YES" to any of the above questions, please complete the remainder of the form.*

4. Do you and/or the student live in:
   □ a shelter
   □ motel/hotel
   □ temporarily with another family in a house, mobile home, or apartment
   □ in a car or RV
   □ at a campsite
   □ transitional housing (Hope House, Women's Center, Progress House, Mentor House, Grace Place)
   □ other location ___________________________

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

6. I am:
   □ the parent/legal guardian of the above-named student
   □ a qualified adult relative of the above-named student (relationship: ___________________________

7. Has anyone in the household served in the Military; Active or Reserve/Guard?  □ Yes  □ No

Name of Parent(s)/Legal Guardian/Caregiver

I can be reached for emergencies at the following address:

Phone: ___________________________  Cell Phone: ___________________________

I receive mail at: ___________________________

* See next page regarding possible rights and protections of students in transition.

<table>
<thead>
<tr>
<th>Siblings (include children from 0-21 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>------</td>
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</tbody>
</table>

R 3/19/2018
Fecha

**Distrito Escolar**

**Cuestionario de Domicilio del Estudiante**

Este Documento se enfoca en el Acta de Asistencia del Programa de McKinney-Vento.

Sus respuestas nos ayudarán a determinar cuales documentos son necesarios para registrar al estudiante más pronto.

<table>
<thead>
<tr>
<th>Nombre del Estudiante – Apellido</th>
<th>Primer Nombre</th>
<th>Segundo Nombre</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Género (Marque uno)</th>
<th>Fecha de Nacimiento:</th>
<th>Grado:</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Escuela:</th>
<th>Maestro:</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

1. ¿La dirección donde está viviendo es un arreglo provisional? □ Sí □ No
2. ¿Este arreglo provisional es a causa de la perdida de su vivienda? □ Sí □ No ¿O por razones económicas? Sí No
3. ¿Esta usted registrando un niño de crianza o adoptado? □ Sí □ No

*Si su respuesta es “NO” a todas las preguntas arriba, PARE AHORA.
Si su respuesta es “Sí” a cualquiera de las preguntas arriba, por favor complete el resto de la forma.

4. Está usted y/o el alumno viviendo en:
   □ Un Refugio
   □ Hotel/Motel
   □ En la casa de otra familia en forma provisional, en casa móvil, o apartamento.
   □ En el carro o casa remolque
   □ En un parque para acampar.
   □ Vivienda de Transición (Hope House, Women’s Center, Progress House, Mentor House)
   □ Otro Lugar

5. El alumno vive con:
   □ Solo uno de los padres □ Amistad (es)
   □ Ambos Padres □ Un adulto que no es el guardián legalmente.
   □ Un familiar con derecho □ Solo sin ningún adulto (s)

6. Yo soy:
   □ El padre/madre/guardián legal del antes mencionado alumno.
   □ Un familiar adulto que tiene el derecho sobre el antes mencionado alumno (relación: )

7. ¿Alguien en el hogar ha servido en el Ejército? Activo o Reserva / Guardia? □ Sí □ No

**Nombre de Padre(s)/Guardián Legal/Encargado**

Puedo ser localizado por caso de emergencia en la siguiente dirección:

<table>
<thead>
<tr>
<th>Numero de Teléfono:</th>
<th>Numero de Celular:</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

Recibo mi correo en:

*Vea la siguiente página sobre posibles derechos y protección de alumnos en transición.
Hermanos (Incluya a niños de la edad de 0 – 21 años)*

<table>
<thead>
<tr>
<th>Nombre:</th>
<th>Edad/Grado:</th>
<th>Escuela:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

R. 3/21/2018
Buckeye Union School District
CONFIDENTIAL - STUDENT HEALTH INFORMATION

Student's Name: ____________________________ Birth date: ________________ Teacher: ____________________________ Grade: ____________________________

☐ Blue Oak, 530-676-0164 x1830, Fax: 530-676-0758
☐ Buckeye, 530-677-2277 x1230, Fax: 530-672-1483
☐ Camarao, 530-677-1658 x1530, Fax: 530-677-9537
☐ Oak Meadow, 916-933-9746 x2130, Fax: 916-933-9784
☐ Silva Valley, 916-933-3767 x2730, Fax: 916-933-6399
☐ William Brooks, 916-933-8618 x2430, Fax: 916-933-3910
☐ Rolling Hills, 916-933-9290 x3030, Fax: 916-939-7454
☐ Valley View Charter Montessori 916-939-6640, Fax 916-639-5015

Parent/Guardian: To best plan for your child’s health and wellbeing, please complete front (and back if applicable) of form. Medications required during the school year require a separate medication form that should be updated yearly.

MEDICAL HISTORY – if YES to any *, please complete the REVERSE side of form (** Complete section below).

<table>
<thead>
<tr>
<th>Has your child experienced?</th>
<th>No</th>
<th>Yes-within 12 months</th>
<th>Has your child experienced?</th>
<th>No</th>
<th>Yes-within 12 months</th>
<th>Has your child experienced?</th>
<th>No</th>
<th>Yes-within 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>**Allergies</td>
<td></td>
<td></td>
<td>Diabetes-ask for packet</td>
<td></td>
<td></td>
<td>Headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Asthma</td>
<td></td>
<td></td>
<td>Dizziness</td>
<td></td>
<td></td>
<td>*Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Blood Disorder or Hepatitis</td>
<td></td>
<td></td>
<td>*Epilepsy or Seizures</td>
<td></td>
<td></td>
<td>Nosebleeds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Cardiac/Heart Condition</td>
<td></td>
<td></td>
<td>Ear/Eye or Hearing or Vision Problem</td>
<td></td>
<td></td>
<td>*Treatment required (i.e. catheter, etc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td></td>
<td></td>
<td>Fainting Spells</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OTHER MEDICAL CONDITION:

**Allergy Information**

ALLERGIES (please list and complete SEVERE section if applicable):

MILD/MODERATE ALLERGIES- Action for MINOR reaction, if symptoms is/are:

Provide the following action:

If severe allergies: What specific reaction does your child have? Include concerns for airway (irritation, tightness of throat/chest, cough, hoarse, shortness of breath, coughing, wheezing, difficulty breathing), cardiac (fainting, pale, blueness, thready pulse), oral (itching, tingling, swelling of lips, tongue or mouth), skin (hives, itch, rash, swelling - include location), gastrointestinal (nausea, abdomen pain, cramps, vomiting, diarrhea) or other reaction. **Include DATE of last reaction**

SEVERE ALLERGIES- Action for SEVERE reaction, if symptom(s) is/are:

Provide the following action:

Any previous history of hospitalization, serious illness, accident or surgery:

Does your child require any medication(s) while at school (IF YES please obtain medication form): YES NO

Does your child require any vision or hearing equipment?

Birth History: My child was born __________ Full-Term ______ Premature (if so, at how many weeks? ______) Birth weight: ______

Delivery: Were there any problems? ________________________________________________

Did baby go home with parent(s)? YES NO Was baby hospitalized after birth? ________________________________________________

Developmental: Indicate child was (E)arly, (L)ate or (A)verage for milestones: _____ Sitting _____ Walking _____ Talking _____ Toileting

Parent/Guardian Name: ___________________________________________ Phone #: ____________________________

Alternate Emergency Contact: ______________________________________ Phone #: ____________________________

Physician's Name and Contact information: __________________________

Parent Signature: ____________________________________________ Date: ____________________________
Buckeye Union School District – Individualized Student Health Plan
Asthma, Blood Disorder, Cardiac/Heart Condition, Epilepsy/Seizure Disorder, Treatments Required at School

For students with Diabetic concerns, please obtain and complete the Diabetic Packet at the Health Office prior to school.

Medical condition above or treatment(s) to be addressed in health plan:

For any health concerns not listed that you feel may require a health plan, please complete the Other section.

If additional room is required, please use a separate sheet and attach it to this form for review.

**For severe allergies** Please complete front of form section marked Allergies...

**Asthma:** Student has □ mild, □ moderate, □ SEVERE asthma. □ inhaler at school, □ inhaler at home, □ inhaler both locations. □ Student wears a medical bracelet.

Triggers to asthma include:

Any restrictions or special care required, including medications:

**Blood Disorder:** Type of condition:

Any restrictions, special care required, or medications:

**Cardiac/Heart Condition:** Type of condition:

Any restrictions, special care required, or medications:

**Epilepsy/Seizure Disorder:** Type of condition:

Any restrictions, special care required, or medications:

**Treatments Required at School** (include details of medical condition):

**Other:** Type of condition:

Any restrictions, special care required or medications:

**Emergency Plan:** Please indicate approval of emergency care for any signs of severe distress: Airway (irritation, tightness of throat/chest, cough, hoarse, shortness of breath, coughing, wheezing, difficulty breathing), Cardiac (fainting, pale, blueness, thready pulse), oral (itching, tingling, swelling of lips, tongue or mouth), gastrointestinal (vomiting blood, bloody diarrhea).

Other condition warranting 911 call:

Plan of Action:
1) Contact 911 – do not hesitate to ask for advanced life support
2) Provide basic first aid & CPR as required
3) Call Parent/Guardian and/or emergency contacts listed on previous page & District Nurse
4) Other:

Parent 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

CHILD'S NAME—Last  First  Middle  BIRTH DATE—Month/Day/Year

ADDRESS—Number, Street  City  ZIP code  SCHOOL

PART II  TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

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

<table>
<thead>
<tr>
<th>REQUIRED TESTS/EVALUATIONS</th>
<th>DATE (mm/dd/yy)</th>
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</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>
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<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>Audimetric (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

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).

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DATE EACH DOSE WAS GIVEN</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>First</td>
</tr>
<tr>
<td>POLIO (OPV or IPV)</td>
<td></td>
</tr>
<tr>
<td>DtaP/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)</td>
<td></td>
</tr>
<tr>
<td>(Required for child care/preschool only)</td>
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</tr>
<tr>
<td>HEPATITIS B</td>
<td></td>
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<tr>
<td>VARICELLA (Chickenpox)</td>
<td></td>
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<tr>
<td>OTHER (e.g., TB Test, if indicated)</td>
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<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)

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.

CHDP website: www.dhcs.ca.gov/services/chdp
INFORME DEL EXAMEN DE SALUD PARA EL INGRESO A LA ESCUELA

Para proteger la salud de los niños, la ley de California exige que antes de ingresar a la escuela todos los niños tengan un examen médico de salud. Por favor, pidale al examinador de salud que llene este informe y entregelo a la escuela—este informe será archivado por la escuela en forma confidencial.

PARTE I PARA SER LLENADO POR EL PADRE/LA MADRE O EL GUARDIAN

NOMBRE DEL NIÑO/NINA—Apellido  Primer Nombre  Segundo Nombre  FECHA DE NACIMIENTO—Mes/Dia/Año

DOMICILIO—Número y Calle

Ciudad

Zona Postal

Escuela

PARTE II PARA SER LLENADO POR EL EXAMINADOR DE SALUD

EXAMEN DE SALUD

AVISO: Todas las pruebas y evaluaciones excepto el análisis de sangre para el plomo deben ser hechas después de la edad de 4 años y 3 meses.

PRUEBAS Y EVALUACIONES REQUERIDAS  FECHA (mm/dd/aa)

Historia de Salud

Examen Físico

Evaluación de Dientes

Evaluación de Nutrición

Evaluación del Desarrollo

Pruebas Visuales

Pruebas con Audiómetro (auditiva)

Evaluación de Riesgo y prueba Tuberculosis*

Análisis de Sangre (para anemia)

Análisis de Orina

Análisis de Sangre para el plomo

Otra

REGISTRO DE INMUNIZACIONES

Aviso al Examinador: Por favor dé a la familia, una vez completado, o a la fecha, el Registro de Inmunización de California en papel amarillo.

Aviso a la Escuela: Por favor apunte las fechas de inmunización sobre el Registro de Inmunización de la escuela de California en papel azul.

VACUNA  FECHA EN QUE CADA DOSIS FUE DADA

<table>
<thead>
<tr>
<th>Primero</th>
<th>Segundo</th>
<th>Tercero</th>
<th>Cuarto</th>
<th>Quinto</th>
</tr>
</thead>
</table>

POLIO (OPV o IPV)

DTaP/DTP/DTTd (difteria, tétanos y [acelular] pertussis [tos ferina]) O (tétano y difteria solamente)

MMR (sarampión, papuela, rubéola)

HIB MENINGITIS (Hemolítico, Tipo B) (Requerido para centros de cuidado para niños y centros preescolares solamente)

HEPATITIS B

VARICELLA (Viruela loca)

OTRA (e.g. prueba TB, de ser indicado)

OTRA

PARTE III INFORMACIÓN ADICIONAL DEL EXAMINADOR DE SALUD (optional)

RESULTADOS Y RECOMENDACIONES

Llene esta parte si el padre/madre o el guardián ha firmado el consentimiento para divulgar (distribuir) la información de salud de su niño/a.

☐ El examen reveló que no hay condiciones que conciernen las actividades de los programas escolares.

☐ Las condiciones encontradas en el examen o después de una evaluación posterior que son de importancia para la actividad escolar o física son: (por favor explique)

*y de ser indicado

PERMISO PARA DIVULGAR (DISTRIBUIR) EL INFORME DE SALUD

Yo le doy permiso al examinador de salud para que comparta con la escuela la información adicional de este examen como es explicado en la Parte III.

☐ Por favor marque esta caja si Ud. no desea que el examinador llene la Parte III.

Firma del padre/madre o guardián: ___________________________ Fecha: ____________

Firma del examinador de salud: ___________________________ Fecha: ____________

Si su niño o niña no puede obtener el examen de salud llame al Programa de Salud para la Prevención de Incapacidades de Niños y Jovenes (Child Health and Disability Prevention Program) en su departamento de salud local. Si Ud. no desea que su niño(a) tenga un examen de salud, puede firmar la orden (PM 171 B), formulario que se consigue en la escuela de su niño(a).

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

PM 171 A (3/03) (Bilingual)
**BUCKEYE UNION SCHOOL DISTRICT**

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

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

<table>
<thead>
<tr>
<th>School Name:</th>
<th>Teacher:</th>
<th>Grade:</th>
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<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)

**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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ No obvious problem found</td>
</tr>
<tr>
<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>
</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**

**CA License Number**

**Date**

### Section 3: Waiver of Oral Health Assessment Requirement

**To be filled out by parent or guardian asking to be excused from this requirement**

Please excuse my child from the dental check-up because: (Check the box that best describes the reason)

- ☐ I am unable to find a dental office that will take my child’s dental insurance plan.
  - My child’s dental insurance plan is:
    - ☐ Medi-Cal/Denti-Cal ☐ Healthy Families ☐ Healthy Kids ☐ Other: ☐ None
- ☐ I cannot afford a dental check-up for my child.
- ☐ I do not want my child to receive a dental check-up.

Optional: other reasons my child could not get a dental check-up:

If asking to be excused from this requirement: 

**Signature of parent or guardian**

**Date**

The law states schools must keep student health information private. Your child’s name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school.

Original will be kept in child’s school record.