

TIPTON ELEMENTARY SCHOOL DISTRICT STUDENT REGISTRATION

► Has your student ever attended Tipton Elementary School before? ☐ Yes ☐ No If Yes, Grade _____

PLEASE PRINT – STUDENT'S LEGAL NAME

Legal First Name	Legal Middle Name	Legal Last Name	Other Legal Name (if applicable)
------------------	-------------------	-----------------	----------------------------------

<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date:				Grade (This Year):
<input type="checkbox"/> Other					

Month	Day	Year	
-------	-----	------	--

BIRTHPLACE: City: _____ State: _____ Country: _____
 U.S. Citizen ☐ Yes ☐ No

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

Residence Address (house # & street name) (IF DIFFERENT)	Apt #	City	State	Zip
--	-------	------	-------	-----

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

☐ Father ☐ Mother ☐ Both ☐ Step-Father ☐ Step-Mother ☐ Guardian ☐ Foster/Group Home ☐ Other _____

Is the above (checked) person (s) the student's LEGAL guardian? ☐ Yes ☐ No If No, please complete a "Caregiver Affidavit"

If there is a legal custody agreement regarding this student, please check one: ☐ Joint Custody ☐ Sole Custody ☐ Guardian

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

1. ☐ Father ☐ Step Father/Guardian (check one) Full Name _____
 Cell Phone _____ Email _____
 Employer _____ City _____ Daytime Phone # (____) _____

2. ☐ Mother ☐ Step Mother/Guardian (check one) Full Name _____
 Cell Phone _____ Email _____
 Employer _____ City _____ Daytime Phone # (____) _____

In which language do you wish to receive written communications from the school? ☐ English ☐ Spanish

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

<input type="checkbox"/> In a single family permanent residence (house, apartment, condo, mobile home)	<input type="checkbox"/> In a motel/hotel (110)
<input type="checkbox"/> Doubled-up (sharing housing with other families/individuals due to economic hardship or loss) (120)	<input type="checkbox"/> Unsheltered (car/campsite) (130)
<input type="checkbox"/> In a shelter or transitional housing program (100)	<input type="checkbox"/> Other (please specify) _____

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

☐ Not a High School Graduate (1)
☐ High School Graduate (2)
☐ Some College or Associate's Degree (3)
☐ College Graduate (4)
☐ Graduate Degree or Higher (5)

EMERGENCY CONTACT

Name	
Relationship	Phone #
Address	
Name	
Relationship	Phone #
Address	

BELOW FOR SCHOOL USE ONLY

Proof of Birth: Type: _____ Verified by: _____	Proof of Residence: Type: _____ Verified by: _____	Proof of Immunization: Type: _____ Verified by: _____	Enroll Date: _____	Assigned Grade: Teacher: _____	Permanent ID: Family ID: SSID: _____	Verified By: _____
--	--	---	--------------------	-----------------------------------	--	--------------------

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THE FORM (REV 11/19)

DUPLICATE MAILING – If divorced/separated & joint custody allows duplicate mailing/information to be given to other parent,

Please include their name, address, and phone number:

Full Name: _____ **Email** _____ **Phone #:** () _____
Mailing Address: _____ **City:** _____ **State:** _____ **Zip code:** _____

MOST RECENT SCHOOL ATTENDED:

School	Address/City/State/Zip	Grade(s)	Date(s)

Children in the Family

List all siblings living in the home, by birth order:

First and Last Name	Birthdate and Year	Boy	Girl	Living in Home

Any others besides brothers, sisters, or parents living in pupil's home.

List of Adults who may pick-up my Child.

First and Last Name	Relationship	Phone Number
1		
2		
3		

COURT ORDER

Court Order On File: Yes _____ No _____, Order No. _____

List anyone who CANNOT pick-up my child: _____

Treatment for Life Threatening Anaphylaxis

Anaphylaxis is a rapid, severe allergic response triggered by insect stings, foods, medications, latex materials, exercise or in rare cases by unknown causes. This is a life threatening allergic condition requiring immediate treatment. Administering epinephrine to students during a medical emergency may help to insure the student's health and safety at school. Tulare County Office of Education has adopted a protocol for giving life saving epinephrine to students in need of such treatment.

The School staff may administer the EpiPen emergency treatment to my child, in the event that my child experiences a severe, life threatening anaphylactic (allergic) reaction during school hours or during school related activities.

Yes, I give my Consent (Signature Required) _____ Date _____

No, I DO NOT give my Consent (Please Initial) _____ Date _____

Has your child been suspended? ☐ Yes ☐ No Has your child ever been expelled? ☐ Yes ☐ No
Do you have any health Insurance? ☐ Yes ☐ No **(please check box that apply)** ☐ Healthy Families ☐ Medi-Cal ☐ Insurance
(No. _____)
Does your child have any chronic health problems? ☐ Yes ☐ No If yes, what _____
Is your child allergic to insect, food or drugs? ☐ Yes ☐ No If yes, what _____
Are there psychological or confidential reports available from your child's former school? ☐ Yes ☐ No

What special services has your child received? **(please check all boxes that apply)**

Special Education: ☐ Resource (RSP) ☐ Special Day Class (SDC) ☐ Speech/Language ☐ 504

In case of serious injury or illness, and I cannot be reached, you have my permission to take my child to the nearest hospital for medical emergency treatment or care. ☐ Yes ☐ No

Your signature certifies that all information given on this form is to be fact and true. Your signature also certifies that you understand all the information on this form:

Signature of Parent/Guardian: _____ Date: _____

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THE FORM (REV 11/19)

Tipton Elementary School

Home Language Survey

STUDENT NAME _____ Teacher _____

WHAT IS YOUR CHILD'S ETHNICITY? (Please check one):

- ☐ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Cultures or origin, regardless of race)
- ☐ Not Hispanic or Latino

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

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

- | | | |
|--|--|---|
| <input type="checkbox"/> American Indian or Alaskan Native (100) | <input type="checkbox"/> Laotian (206) | <input type="checkbox"/> Tahitian (304) |
| <input type="checkbox"/> Chinese (201) | <input type="checkbox"/> Cambodian (207) | <input type="checkbox"/> Other Pacific Islander (399) |
| <input type="checkbox"/> Japanese (202) | <input type="checkbox"/> Hmong (208) | <input type="checkbox"/> Filipino/Filipino American (400) |
| <input type="checkbox"/> Korean (203) | <input type="checkbox"/> Other Asian (299) | <input type="checkbox"/> African American or Black (600) |
| <input type="checkbox"/> Vietnamese (204) | <input type="checkbox"/> Hawaiian (301) | <input type="checkbox"/> White (700) (Persons having |
| <input type="checkbox"/> Asian Indian (205) | <input type="checkbox"/> Guamanian (302) | origins of the original people of |
| | <input type="checkbox"/> Samoan (303) | Europe, North Africa, or Middle East) |

HOME LANGUAGE INFORMATION:

1. Which language did your son or daughter learn when he/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. What language is most often spoken by adults at home? _____
5. Has your child ever been given the CELDT Test (Calif English Language Development test)?
☐ Yes ☐ NO ☐ I don't know

Date first attended school in the U.S.

Month

Day

Year

Date first attended school in California

Month

Day

Year



**TULARE COUNTY
HEALTH & HUMAN SERVICES AGENCY**

Cheryl L. Duerksen, Ph.D.
Agency Director

Karen Haught, MD, M.P.H. • Health Officer • Department of Public Health

January 6, 2016

Dear Parent or Guardian:

Re: New immunization requirements for 2016

Under a new law known as SB 277, beginning January 1, 2016 exemptions based on personal beliefs, including religious beliefs, will no longer be an option for the vaccines that are currently required for entry into child care or school in California. Most families will not be affected by the new law because their children have received all required vaccinations. Personal beliefs exemptions on file for a child already attending child care or school will remain valid until the child reaches the next immunization checkpoint at kindergarten (including transitional kindergarten) or 7th grade.

For more information about SB 277, please see the Frequently Asked Questions available at:
<http://www.shotsforschool.org/laws/sb277faq/>.

For more information about school immunization requirements and resources, you may do one of the following:

1. Visit the California Department of Public Health's website at www.shotsforschool.org
2. Contact the Tulare County Public Health Department at (559) 687-5725
3. Contact the Tulare County Office of Education at (559) 651-0130.

Thank you for helping us to keep our children and community healthy.

Sincerely,

Karen Haught, MD, M.P.H.
Health Officer

[School Principal]
[School Nurse]

PARENTS' GUIDE TO IMMUNIZATIONS REQUIRED FOR SCHOOL ENTRY



Entry Requirements by Age and Grade:

Vaccine	4-6 Years Old Elementary School at Transitional-Kindergarten/ Kindergarten and Above	7-17 Years Old Elementary or Secondary School	7th Grade*
Polio (OPV or IPV)	4 doses (3 doses OK if one was given on or after 4th birthday)	4 doses (3 doses OK if one was given on or after 2nd birthday)	
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT, or Tdap)	5 doses of DTaP, DTP, or DT (4 doses OK if one was given on or after 4th birthday)	4 doses of DTaP, DTP, DT, Tdap, or Td (3 doses OK if last dose was given on or after 2nd birthday. At least one dose must be Tdap or DTaP/ DTP given on or after 7th birthday for all 7th-12th graders.)	1 dose of Tdap (Or DTP/DTaP given on or after the 7th birthday.)
Measles, Mumps, and Rubella (MMR or MMR-V)	2 doses (Both doses given on or after 1st birthday. Only one dose of mumps and rubella vaccines are required if given separately.)	1 dose (Dose given on or after 1st birthday. Mumps vaccine is not required if given separately.)	2 doses of MMR or any measles-containing vaccine (Both doses given on or after 1st birthday.)
Hepatitis B (Hep B or HBV)	3 doses		
Varicella (chickenpox, VAR, MMR-V or VZV)	1 dose	1 dose for ages 7-12 years. 2 doses for ages 13-17 years.	

*New admissions to 7th grade should also meet the requirements for ages 7-17 years.

WHY YOUR CHILD NEEDS SHOTS:

The California School Immunization Law requires that children be up to date on their immunizations (shots) to attend school. Diseases like measles spread quickly, so children need to be protected before they enter. California schools are required to check immunization records for all new student admissions at Kindergarten or Transitional Kindergarten **through** 12th grade and all students advancing to 7th grade before entry.

THE LAW:

Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380; California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, Sections 6000-6075

WHAT YOU WILL NEED FOR ADMISSION:

To attend school, your child's Immunization Record must show the date for each required shot above. If you do not have an Immunization Record, or your child has not received all required shots, call your doctor now for an appointment.

If a licensed physician determines a vaccine should not be given to your child because of medical reasons, submit a written statement from the physician for a **medical exemption** for the missing shot(s), including the duration of the medical exemption.

A personal beliefs exemption is no longer an option for entry into school; however, a valid personal beliefs exemption filed with a school before January 1, 2016 is valid until entry into the next grade span (7th through 12th grade). Valid personal beliefs exemptions may be transferred between schools in California. For complete details, visit ShotsforSchool.org.

You must also submit an immunization record for all required shots not exempted.

Questions? Visit ShotsForSchool.org or contact your local health department (bit.do/immunization).

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	SCHOOL
ZIP code			

PART II TO BE FILLED OUT BY HEALTH EXAMINER**HEALTH EXAMINATION**

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

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

IMMUNIZATION RECORD

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

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

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

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.

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 their 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 starts school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:	Child's race/ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other _____ <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown		

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

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

Assessment Date:	<u>Caries Experience</u> (Visible decay and/or fillings present) <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Visible Decay Present:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Treatment Urgency:</u> <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended (Caries without pain or infection or child would benefit from sealants or further evaluation) <input type="checkbox"/> Urgent care needed (pain, infection, swelling or soft tissue lesions)
_____ Licensed Dental Professional Signature		_____ CA License Number	_____ Date

Section 3: Waiver of Oral Health Assessment Requirement

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

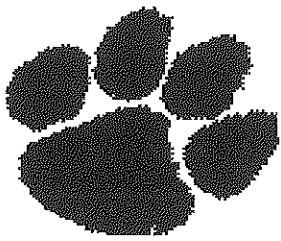
Please excuse my child from the dental check-up because: (Check the box that best describes the reason)

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

If asking to be excused from this requirement: ► _____
Signature of parent or guardian
Date

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

Return this form to the school *no later than* May 31 of your child's first school year.
Original to be kept in child's school record.



TIPTON ELEMENTARY SCHOOL

370 N. Evans Road • P.O. Box 787 • Tipton, CA 93272
559-752-4213 • FAX: 559-752-1231

Stacey Bettencourt
Superintendent

Cherie Solian Ed.D.
Principal

Maryann Henry
Business Manager

Fausto Marlin
MOT Director

Connie Sanchez
Cafeteria Manager

Tiger Pride!

Tulare County Office of Education
School Health Programs

Medication in School Procedure

Dear Parents/Guardians,

_____ extends you the courtesy of giving your child the necessary medications during school hours. However, for your child's health and safety, we can assist with administration of medication **only** if the following procedure is followed.

Medication Procedure: (All must be completed)

1. Pick up medication form from the school office to be completed by the parent and doctor. (At beginning of each school year, a new form must be completed).
2. The form should be completed by the student's physician detailing the method and time schedules for taking the medication.
3. Medication must be brought to school in the original prescription bottle by parent or guardian.

Facts You Should Know:

1. **A note from home is not enough.** A medication form **must** be completed by physician and parent.
2. Medication brought to school by the child, even with a note, **cannot be given at school.**
3. Tylenol®, cough drops, ointments, cold pills, eye drops, asthma inhalers, etc. are all medications. This medication procedure must be followed with these as well.

By law, no exceptions can be made to these rules. If they are not followed, we cannot assist with administering your child's medication at school. You must then come to the school and administer the medication to your child.

Thank you for your understanding and cooperation in this matter. If you have any questions, please do not hesitate to call: _____.

Board Members

Greg Rice
President

Iva Sousa
Clerk

John Cardoza
Trustee

Shelley Heeger
Trustee

Fernando Cunha
Trustee

TULARE COUNTY OFFICE OF EDUCATION
SCHOOL HEALTH PROGRAMS
(559) 651-0130, #3730

MEDICATION IN SCHOOL

SCHOOL: Tipton Elementary	Address: PO Box 787, Tipton CA 93272	Phone: (559) 752-4213	FAX: (559) 687-2221
Student's Name:	Date of Birth:	Grade:	Teacher:

California Education Code 49423 states that medication may be given at school, when absolutely necessary for adequate treatment of the child, with the following provisions:

1. A request in writing signed by the parent.
2. An order in writing from the physician giving instructions for medication - the type, dosage, and method of administration. Time limit must be stated, such as: order effective 3 mos., 6 mos., etc.
3. **Medication must be clearly labeled and in the original and current prescription container.**
4. Form is valid only for the current school year.

Please COMPLETE for ALL Medications:

Medication is absolutely necessary at school for the following reason: _____

Precautions or Side Effects: _____

Medication:	Dosage and Frequency:
Route:	Time(s) to be given at School:

For Asthma Inhalers or Auto-Injector Epinephrine

Student has been instructed by physician and **may** carry and administer his/her asthma medication. ☐ Yes ☐ No

Student has been instructed by physician and **may** carry auto-injector epinephrine (EpiPen). ☐ Yes ☐ No

Health Care Provider Signature

Date

Health Care Provider Name/Address (Please Print)

Telephone

I give consent for school personnel to provide medication as ordered for my child. I also give consent for the school nurse and my child's medical provider to exchange medication information regarding my child. I will notify the school if there are changes in my child's health status.

Parent/Guardian Signature

Date

For the safety of your child, this form MUST BE COMPLETED and RETURNED to the school nurse or administrator by parent or physician. All medications must be in the original container.