

MY KINDERGARTEN ROUND UP APPOINTMENT IS _____ @ _____ :

BIGGS ELEMENTARY SCHOOL
KINDERGARTEN REGISTRATION PACKET

WELCOME!

Kindergarten students must be 5 years of age on or before September 1.

*Transitional Kindergarten students must be 5 years of age between September 2 and December 2
(California Ed code 48000 and 48002)*

Attached are forms that will need to be completed for the Kindergarten registration process.

Please complete this packet and return it back to the school office ASAP, preferably **before Kindergarten Round-up.**

- * REGISTRATION FORM
- * BIRTH CERTIFICATE: Accepted documents; Passport **or** Parent Affidavit of Student Age (signed Under penalty of perjury) **or** Baptism Certificate.
- * HOME LANGUAGE SURVEY
- * PROOF OF RESIDENCE IN BIGGS UNIFIED SCHOOL DISTRICT: Accepted documents: a *utility bill or rental agreement or correspondence from a government agency or driver's license with current address.*
- * IMMUNIZATION RECORD: Must be completed and up-to-date (**NO SHOTS, NOT SCHOOL!**)
- * PHYSICAL EXAMINATION FOR SCHOOL ENTRY form completed by physician/medical professional
- * ORAL HEALTH ASSESSMENT form completed by dental professional
- * STUDENT HEALTH HISTORY FORM

MI CITA PARA KINDERGARTEN ROUND UP ES _____ @ _____ : _____

BIGGS ELEMENTARY SCHOOL
KINDERGARTEN REGISTRATION PACKET

Bienvenido

Los estudiantes de kindergarten deben tener 5 años de edad el 1 de septiembre o antes.

Los estudiantes de Transitional Kindergarten deben tener 5 años de edad entre el 2 de septiembre y el 2 de diciembre. (*California Ed code 48000 and 48002*)

Se adjuntan formularios que deberán completarse para el proceso de registro de Kindergarten.

Por favor complete este paquete y devuélvalo a la oficina de la escuela lo antes posible, **preferiblemente antes del Kindergarten Round-up.**

- * FORMULARIO DE INSCRIPCIÓN
- * CERTIFICADO DE NACIMIENTO: Documentos aceptados; Pasaporte o declaración jurada de los padres de edad del estudiante (firmado Bajo pena de perjurio) o Certificado de Bautismo.
- * ENCUESTA DE IDIOMA
- * PRUEBA DE RESIDENCIA EN EL DISTRITO ESCOLAR UNIFICADO DE BIGGS: Documentos que aceptados: unafactura de servicios públicos o contrato de alquiler o correspondencia de una agencia gubernamental o licencia de conducir con dirección actual.
- * REGISTRO DE VACUNAS: Debe estar completo y actualizado. (*Sí no tiene vacunas, no puede comenzar la escuela!*)
- * EXAMEN FÍSICO PARA ENTRAR EN LA ESCUELA completado por el médico / professional médico
- * EVALUACIÓN DE SALUD ORAL completado por un profesional dental
- * FORMULARIO DE HISTORIA DE SALUD DEL ESTUDIANTE



Biggs/Richvale Elementary Schools – REGISTRATION FORM

Grade _____

(Please type or print clearly all information requested on both sides of this form)

Students **LEGAL** Name: _____
FIRST MIDDLE LAST

Street Address: _____ Mailing Address: _____

City: _____ Zip Code: _____ Primary Phone () _____

Birth Date: ____/____/____ Sex: Male _____ Female _____
Mo. Day Year

Is a Parent/Guardian of student ACTIVE in the US Armed Forces: _____ YES _____ NO

Has your student ever received one of these disciplinary actions? Suspension Expulsion

Student previously enrolled in Special Education? Yes No **504?** Yes No

Speech? Yes No

(The Biggs Unified School District accepts all students, regardless of their birthplace and immigration status)

Providing this information is voluntary and will only be used for reporting student statistics to the California Department of Education, as required

WHAT IS YOUR CHILD'S ETHNICITY? (Please check one) _____ Hispanic or Latino _____ Not Hispanic or Latino

Primary Race (Please check one): (Providing this info is voluntary & will be used for reporting student statistics to CDE as required)

___ American Indian or Alaskan Native ___ Cambodian ___ Guamanian ___ Japanese ___ Other Asian ___ Tahitian
___ Other Pacific Islander ___ Chinese ___ Vietnamese ___ Korean ___ Hawaiian ___ Asian Indian
___ Black/African American ___ Filipino ___ Hmong ___ Laotian ___ Samoan ___ White

Secondary Race (Please check one):

___ American Indian or Alaskan Native ___ Cambodian ___ Guamanian ___ Japanese ___ Other Asian ___ Tahitian
___ Other Pacific Islander ___ Chinese ___ Vietnamese ___ Korean ___ Hawaiian ___ Asian Indian
___ Black/African American ___ Filipino ___ Hmong ___ Laotian ___ Samoan ___ White

PARENT OR LEGAL GUARDIAN(S):

NAME: _____

NAME: _____

Relationship: _____

Relationship: _____

Street Address: _____

Street Address: _____

City: _____ Zip: _____

City: _____ Zip: _____

HOME #: _____ CELL #: _____

HOME #: _____ CELL #: _____

Employer: _____

Employer: _____

Work Phone: _____

Work Phone: _____

EMAIL: _____

EMAIL: _____

(Email information is used for communication purposes only)

NAME(S) OF SIBLING(S) AT BIGGS UNIFIED SCHOOL DISTRICT:

<u>NAME</u>	<u>M/F</u>	<u>School</u>	<u>Birthdate</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PARENTS HIGHEST LEVEL OF EDUCATION	<input type="radio"/> Not a high school graduate	<input type="radio"/> High school graduate
<input type="radio"/> Some College (includes AA degree)	<input type="radio"/> College graduate	<input type="radio"/> Graduate School or Post Grad
<input type="radio"/> Decline to state or unknown		

EMERGENCY CONTACTS (Persons below are Authorized to pick up Student)

1.	NAME	RELATIONSHIP	HOME PHONE	CELL PHONE
2.	NAME	RELATIONSHIP	HOME PHONE	CELL PHONE
3.	NAME	RELATIONSHIP	HOME PHONE	CELL PHONE

If emergency contacts are NOT available, ALL emergencies will be transported to the local Hospital Emergency Room. (The district/school does not assume responsibility for medical expenses.)

PUBLICATION AND MEDIA RELEASE:

___YES, my child may be interviewed or photographed for publication, media outlets, websites for school/non-school publications.

___NO, my child may not be interviewed or photographed for publication, media outlets, websites for school/non-school publications.

If available, in what language do you prefer communications from the school be sent? _____

The following information is true and correct to the best of my knowledge. In an emergency, I give the Biggs Unified School District permission to arrange for any necessary emergency medical/surgical treatment or procedure on my behalf.

PARENT/GUARDIAN SIGNATURE _____
DATE

FOR OFFICE USE ONLY		Teacher _____
<input type="checkbox"/> Inter-district	<input type="checkbox"/> Restraining Order	<input type="checkbox"/> Caregiver Affidavit
<input type="checkbox"/> Address Verification	<input type="checkbox"/> Immunization Verification	<input type="checkbox"/> Court Documents
<input type="checkbox"/> Birth Verification		
Transfer School: _____	Home Language Survey _____	
Address: _____	Date Records Received _____	
Enrollment Date: _____	Drop Date: _____	
First Enrolled in District: _____		

It is the policy of Biggs Unified School District not to unlawfully discriminate on the basis of sex, sexual orientation, gender, ethnic group identification, race, ancestry, national origin, color, religion, marital status, age, or mental or physical disability in the educational programs or activities which it operates.

**BIGGS UNIFIED SCHOOL DISTRICT
HOME LANGUAGE SURVEY
ENGLISH VERSION**

Name of Student: _____

Surname / Last Name _____ First Given Name _____ Second Given Name _____

School: _____ Age: _____ Grade Level: _____ Teacher Name: _____

Directions to Parents and Guardians:

The *California Education Code* contains legal requirements which direct schools to determine the language(s) spoken in the home of each student. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with this legal requirement. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered.

1. Which language did your child learn when he/she first began to talk? _____
2. Which language does your child most frequently speak at home? _____
3. Which language do you (the parents or guardians) most frequently use when speaking with your child? _____
4. Which language is most often spoken by adults in the home? (parents, guardians, grandparents, or any other adults) _____

Has your student attended another school in the United States? Yes No If yes, please complete the following information: Name of school: _____ City, State: _____ Dates attended: _____
Has your student attended school in another country? Yes No If yes, please complete the following information: Name of school: _____ City, State: _____ Dates attended: _____
Has your student attended school in California? Yes No If yes, please complete the following information: Name of school: _____ City, State: _____ Dates attended: _____

Please sign and date this form in the spaces provided below, then return this form to the school office. Thank you for your cooperation.

Signature of Parent or Guardian _____ Date _____

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 circled "Yes", stop here. You must provide a gas or electric bill in your name as proof of residence. If you circled "NO", please continue with this form.)

2. Do you and the student live in?

- shelter
- motel/hotel
- temporarily with another family in a house, mobile home, or apartment
- in a car or RV
- at a campsite
- transitional housing
- other location _____

3. The student lives with:

- one parent
- two parents
- a qualified relative
- friend(s)
- an adult that is not the legal guardian
- alone with no adult(s)

4. I am:

- the parent/legal guardian of the above-named student
- 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: (_____) _____

Biggs Unified School District

BIGGS ~ RICHVALE ELEMENTARY SCHOOL

300 B STREET, BIGGS, CALIFORNIA 95917

(530) 868-5870 ext. 221 or 223

Fax (530) 868-5137

REQUEST FOR EDUCATIONAL/CONFIDENTIAL RECORDS

PLEASE FAX AS SOON AS POSSIBLE THE FOLLOWING:

- _____ Birth Verification of any type
- _____ Immunization Record
- _____ Discipline Report and Attendance Report
- _____ Copy of IEP/504 Plan (If applicable to student)

Date Requested: _____ Enrollment/Start Date: _____

Previous School Attended: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

STUDENT(S) NAME

GRADE

DOB

Please forward all educational/confidential records of the above named student(s) to:

**BIGGS/RICHVALE ELEMENTARY SCHOOL
300 B STREET
BIGGS, CA 95917**

Thank you,

School Personnel

I authorize the release of all educational, confidential records to the above named school.

PARENT/LEGAL GUARDIAN SIGNATURE

DATE

~ FOR OFFICE USE ONLY ~

_____ FAXED _____ CALLED COMMENTS: _____



Biggs Unified School District

Student Health History

SCHOOL YEAR: 20_____



Name: _____ Birth Date: _____ Grade: _____

LAST FIRST

BIGGS ELEMENTARY SCHOOL

Family Physician: _____

SCHOOL

NAME AND PHONE NUMBER

HEALTH INFORMATION ABOUT YOUR CHILD

NO KNOWN HEALTH PROBLEMS If none, please sign and return form to school

*****CHECK ONLY THOSE THAT APPLY, SIGN AND RETURN FORM TO SCHOOL*****

Food Allergies What type of foods? _____ Hives/Rash Yes No
What type of reaction? _____

Allergic Reactions To what? _____ Hives/Rash Yes No
Breathing difficulty? Yes No Has Epi-Pen Yes No

Asthma Requires inhaler? Yes No If so, how often? As needed With exercise
Needed at school? Yes No
Name of medication(s) _____

Diabetes Type I Insulin injections? Type II Oral medications?
Name of medication(s) _____
Taken at school? Yes No

Ear Problems Frequent infections? Present Past Hearing Loss
Hearing Aid? Left Right Both

Heart Problems Diagnosis _____ Medications? Yes No
Physical restrictions? Yes No

Seizure Disorder What type of seizures? _____
Date of last seizure _____ Medication at school Yes No

Any other important health or behavior problems? List here _____

MEDICATIONS ADHD Bipolar PTSD Depression Other (explain)
Name of medication(s) _____

California Education Code §49423: Students taking medication at school need a "School Authorization for Medication" form completed EVERY SCHOOL YEAR by doctor and parent/guardian. The form MUST be on file with the school before medication(s) can be taken at school.

Parent Signature _____

Date _____

Oral Health Assessment Form

California law (*Education Code Section 49452.8*) states your child must have a dental check-up by May 15 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)

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:	<input type="checkbox"/> Caries Experience (Visible decay and/or fillings present) <input type="checkbox"/> Yes <input type="checkbox"/> No	Visible Decay Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Urgency: <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 15* 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: _____
 BIRTH DATE—Month/Day/Year: _____

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/DtP/DtTd (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
H1B 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

Ill 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.

ABSENCE VERIFICATION

Please keep this posted at home for reference!

Dear Parent,

When your child is absent from school for ANY reason, it is very important to report the absence to us!

**Don't
Forget!**



To verify an absence, please call one of our secretaries at Biggs Elementary School @ (530)868-5870 ext. 221 or 223.

Also, if an email is easier, please email us at klewis@biggs.org or cclaway@biggs.org and state your child's name and reason.

If your child has been ill and has missed 3 or more consecutive days of school in the current school year, you MUST provide a note from your doctor clearing the absence.

- Bring the note to the front office
- Or... have the doctor's office fax it to us @ (530)868-5137

Should you have any questions or concerns, please feel free to call the Biggs Elementary Office!

THANK YOU,

Kelly Lewis and Clara Callaway
Biggs/Richvale Elementary School Secretaries

Verificació de Ausencia

Estimados padres:

Cuando su niño falte a la escuela por cualquier razón, es muy importante reporter la ausencia a nosotros.

*Just a
quick
reminder!*

Para verificar una falta, por favor llame a uno de nuestras Secretarias de la Escuela Primaria de Biggs al 868-5870 ext 221 o 223 para Español.

Si el correo electrónico es más fácil, por favor envíenos un email a klewis@biggs.org o cclaway@biggs.org y indicar el nombre y la razón de su hijo.

Si su hijo ha estado enfermo y ha **perdido 3 o más días de la escuela**, debe proporcionar una nota de su doctor. Usted debe:

- Llevar la nota a la oficina
....O....
- Pedirle al medico que mande una nota por fax a
(530) 868-5137

¡Gracias!

Kelly Lewis and Clara Callaway

Biggs & Richvale Elementary School Secretaries

PERMISSION FOR FIELD TRIP/EXCURSION
CONSENT TO TRANSPORT AND TREAT

Field Trips and Activities

THIS FORM MAY NOT BE ALTERED IN ANY WAY

Permission for Field Trip/Excursion

_____ has my permission to participate in the activities listed below. I fully understand the following:

- 1. Participation in these activities is voluntary;
- 2. I may revoke this permission at any time by notifying the school district in writing; and
- 3. Revocation is not effective until receipt is acknowledged by the school district.
- 4. "All persons making the field trip or excursion shall be deemed to have waived all claims against the district or the State of California for any injury, accident, illness, or death occurring during or by reason of the field trip or excursion." (California Education Code, Section 35330)
- 5. The field trip / excursion may include but not be limited to:
 - a. museums
 - b. concerts / plays
 - c. libraries
 - d. public / private businesses
 - e. environmental trips
 - f. parks
 - g. _____
 - h. _____
 - i. _____

Consent to Transport

In accordance with California Education Code Section 35350, my signature below gives permission to transport (if applicable).

Consent to Treat

In the event of illness or injury, I hereby consent to whatever X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physicians and/or dentist and performed by or under the supervision of a member of the medical staff of the hospital, facility or office furnishing medical and/or dental services.

Initial all appropriate boxes below and provide additional information where necessary.

_____ There are no special problems that the staff should be aware of and no medications are to be administered on the trip.

_____ The following medication(s) is/are to be administered on the trip: _____

_____ A physician's written instructions on dispensing must be attached to this form. All prescriptions, excepting those which must be kept on the student's person for emergency use, must be kept and distributed by the staff.

_____ My student has a special medical problem of which staff should be made aware. A description of that problem is attached to this form.

_____ No blood transfusions or blood products are to be given.

I fully understand that my student is to abide by all rules and regulations of conduct during the trip. Any violation of these rules and regulations may result in the school contacting me to arrange transportation home for my student at my full expense.

Signature of Parent or Legal guardian

Date

Address where parent will be during field trip

Phone where parent can be reached during field trip

Parent's/Guardian's Health Insurance Company / MEDI-CAL

Policy number