Calaveras Unified School District
TK/K Enrollment Checklist

Welcome to Calaveras Unified School District! The following documents are needed for registration:

Required Forms and Documents:

____ Completed Student Enrollment form

____ Emergency Contact form

____ Immunization Records

____ Report of Health Examination for School Entry

____ Proof of age in the form of one of the following: certified copy of a birth record, or a statement by the local registrar or a county recorder certifying the date of birth, or a baptism certificate duly attested, or a passport, or an affidavit of the parent, guardian, or custodian of the student

____ Proof of residency in the form of one of the following: property tax receipts; rental contract, lease, or receipts; utility service contract, statement, or payment receipts; pay stubs; voter registration; correspondence from a government agency; declaration of residency executed by the parent or legal guardian of a pupil

Forms Required After Enrollment (helpful if available at the same time as enrollment):

____ Health & Developmental History

____ Oral Health Assessment or Waiver

Additional Forms and Documents, as applicable:

____ Caregivers Affidavit

____ Emergency Care Forms: Asthma/Anaphylaxis

____ Medications at School Form

____ Custody/Court Documentation

____ Bus Pass Application

____ Interim Placement/IEP Information

____ Household Economic Survey and Meals Benefits Application (available after July 1 for new year)

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GRADE
_____

CALAVERAS UNIFIED SCHOOL DISTRICT
Student Enrollment Form

District Use Only

Proof of Age: Type _____ By _____
Proof of Immunization: ❑ Yes ❑ No
Proof of Residence: Type _____ By _____
❑ Walks ❑ Rides bus Bus Stop _____

▶ **Has your child ever attended a California public school before?** ❑ **Yes** ❑ **No**
▶ **Has your child ever attended a Calaveras Unified school before?** ❑ **Yes** ❑ **No**

PLEASE PRINT – STUDENT'S LEGAL NAME

Legal Last Name	Legal First Name	Legal Middle Name

❑ **Male** ❑ **Female** ❑ **Non Binary Gender**

Birth date: Month / Day / Year

Student Nickname:

Parent/Guardian Last Name	First Name	Relationship	Home Phone / Work Phone	Cell Phone / Email Address
			( )	( )
			( )	

Parent/Guardian Last Name	First Name	Relationship	Home Phone / Work Phone	Cell Phone / Email Address
			( )	( )
			( )	

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

Residence Address (house # & street name) (IF DIFFERENT)	Apt#	City	State	Zip	Nearest Cross Street

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 culture 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 child's race to be.

❑ American Indian or Alaskan Native(100) (Persons having origins in any of the original people of North, Central or South America)
❑ Chinese (201)
❑ Japanese (202)
❑ Korean (203)
❑ Vietnamese (204)
❑ Asian Indian (205)
❑ Laotian (206)
❑ Cambodian (207)
❑ Hmong (208)
❑ Other Asian (299)
❑ Hawaiian (301)
❑ Guamanian (302)
❑ Samoan (303)
❑ Tahitian (304)
❑ Other Pacific Islander (399)
❑ Filipino/Filipino American (400)
❑ African American or Black (600)
❑ White (700) (Persons having origins in any of the original peoples of Europe, North Africa, Northwestern Asia or the Middle East)

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

❑ Graduate Degree or Higher (10)
❑ College Graduate (11)
❑ Some College or Associate's Degree (12)
❑ High School Graduate (13)
❑ Not a High School Graduate (14)

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

❑ Graduate Degree or Higher (10)
❑ College Graduate (11)
❑ Some College or Associate's Degree (12)
❑ High School Graduate (13)
❑ Not a High School Graduate (14)

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THE FORM (CUSD Rev. 3/2021)

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

❑ In a permanent residence (house, apartment, condo, mobile home)
❑ Temporarily doubled-up (sharing housing with other families/individuals due to economic hardship or loss)
❑ In a shelter or transitional housing program
❑ In a motel/hotel
❑ Temporarily unsheltered (car/campsite)
❑ Other (please specify) _____

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

Is Parent or Guardian a member of the Armed Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard) on active duty or full-time National Guard duty? **YES** ☐ **NO** ☐

❑ 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

Who holds legal educational rights for this student? ❑ Father ❑ Mother ❑ Both ❑ Other _____

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

1. ❑ Father ❑ Step Father/Guardian (check one) Full Name: _____

Employer: _____ City: _____ Daytime Phone # (____) _____

2. ❑ Mother ❑ Step Mother/Guardian (check one) Full Name:_____

Employer: _____ City: _____ Daytime Phone # (____) _____

PLEASE COMPLETE INFORMATION BELOW IF THE STUDENT HAS A SECOND RESIDENCE – ALSO RESIDES WITH:

Full Name: _____ Relationship: _____ Phone #: (___)_____

Mailing Address: _____ City: _____ State: _____ Zip code:_____

If divorced/separated, does custody agreement allow for duplicate mailing address? ❑ Yes ❑ No

MOST RECENT SCHOOL ATTENDED:

Name	Address	State	Zip	Phone

Are there psychological or confidential reports available from your child's former school? ❑ Yes ❑ No

Has your child <u>ever</u> been suspended? ❑ Yes ❑ No Has your child <u>ever</u> been expelled? ❑ 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 ❑ Active IEP ❑ None

Other: ❑ Gifted (GATE) ❑ Counseling ❑ English Language Development ❑ Been retained - If yes, at what grade level_____

❑ Participated in athletic program ❑ Other (Specify) _____

Does your child have a health concern? ❑ Yes ❑ No ❑ Wear glasses ❑ Have a hearing problem ❑ Take medication regularly

Explain any yes answer: _____

Name of other children in family	DOB	Relationship	Name of other children in family	DOB	Relationship

Local friend or relative to call in case of emergency	Address	Phone	Relationship

Signature of Parent/Guardian: _____ Date: _____

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THE FORM (CUSD Rev. 3/2021)

EMERGENCY INFORMATION CARD

❑ Medical Alert
❑ Legal Alert

NAME (Last) (First) (Middle) | Sex | Date of Birth | Birth Place | Enroll Date

ADDRESS (Mailing) | City | ADDRESS (Residence) | City | Home Phone

Child resides with: ❑ Father ❑ Mother ❑ Both ❑ Step-Father ❑ Step-Mother ❑ Guardian ❑ Foster/Group Home ❑ Other _____

Name | cell phone

Place of employment | work phone

Email _____

Other custodial parent: ❑ Father ❑ Mother ❑ Both ❑ Step-Father ❑ Step-Mother ❑ Guardian ❑ Foster/Group Home ❑ Other _____

Name | cell phone

Place of employment | work phone

Email _____

In an emergency, child may be released to:

1. _____ _____
Name Phone
Relationship to child _____

2. _____ _____
Name Phone
Relationship to child _____

3. _____ _____
Name Phone
Relationship to child _____

Year / teacher

K _____ 4 _____
1 _____ 5 _____
2 _____ 6 _____
3 _____

After school arrangements _____

Bus Route _____

Nearest cross street

Bus Stop _____ _____

MEDICAL EMERGENCY AUTHORIZATION

Child's name _____ Birth Date _____

In case of accident, serious illness or severe emotional crisis, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his/her instruction or seek emergency medical treatment when it is thought necessary.

Signature of parent / guardian: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Local physician's name: _____ Phone: _____

Physician address: _____

Insurance carrier: _____ ID number: _____

Insurance address: _____ Phone: _____

Current medications: _____

- ☐ Life threatening ALLERGY _____
- ☐ Asthma
- ☐ ADHD
- ☐ Bipolar Disorder
- ☐ Severe Depression
- ☐ Diabetes
- ☐ Migraines / Severe headaches
- ☐ Seizures/Convulsions/Epilepsy
- ☐ Hearing Loss / Hearing aide(s)
- ☐ Vision problems / Wears glasses
- ☐ Other: _____

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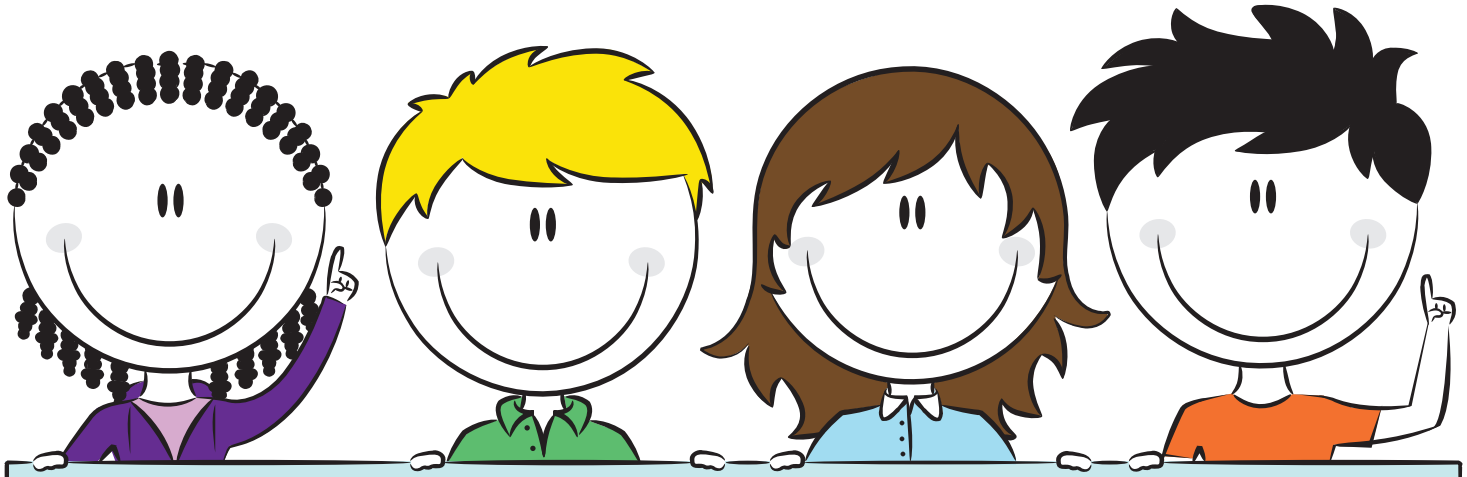
No Shots? No Records? No School.



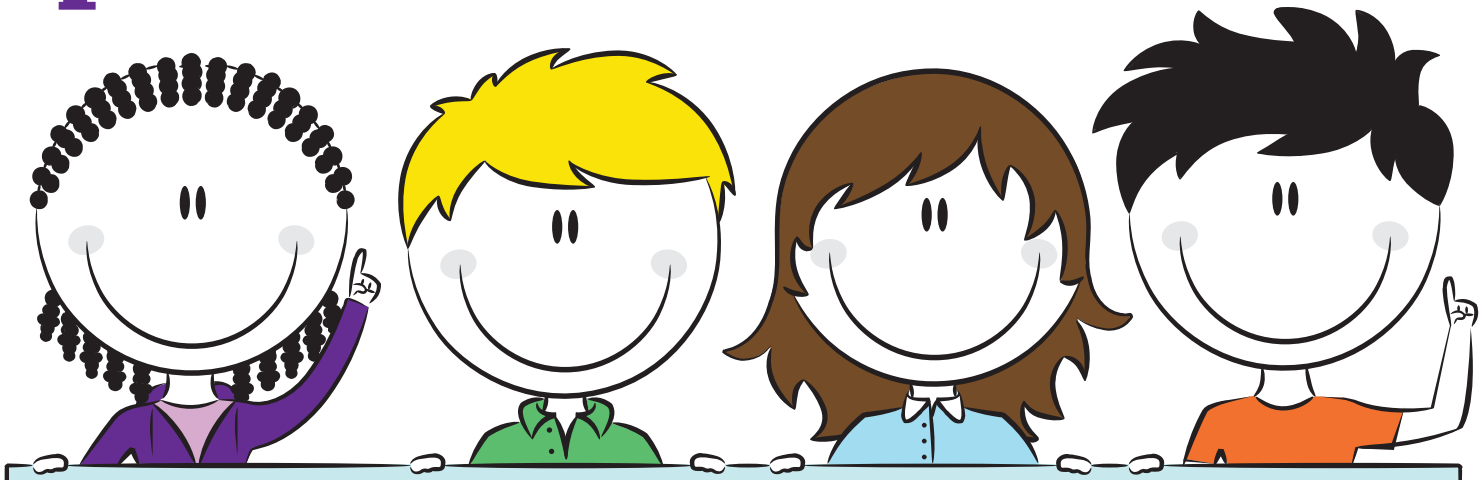
Children will not be enrolled unless an immunization record is presented and immunizations are up-to-date.*

**If your child is unimmunized due to medical reasons, please notify us.*

Go to **ShotsForSchool.org** to access information about immunization requirements, an interactive school look-up tool, implementation materials for schools, and educational materials for parents. ShotsforSchool.org

IMM-1167 (5-16)

¿No está vacunado?
¿No tiene comprobantes?
No puede asistir a la escuela.



No se admitirá a los niños a menos que se presente el comprobante de vacunación y las vacunas estén al día*.

**Avísenos si su hijo(a) no está vacunado(a) por motivos médicos.*

Visite **ShotsForSchool.org** para acceder información sobre los requisitos de vacunación, una herramienta de búsqueda interactiva de escuelas, materiales de implementación para las escuelas y materiales educativos para padres.

ShotsforSchool.org

IMM-1167S (5-16)

REQUIRED FOR SCHOOL ENTRY

Starting July 1, 2019

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.

GUÍA PARA PADRES SOBRE LOS REQUISITOS

DE VACUNACIÓN PARA ENTRAR A LA ESCUELA

A partir del 1 de julio de 2019

Los alumnos ingresando a TK/K-12 necesitan:

- **Vacuna contra la difteria, el tétanos y la tos ferina (DTaP, DTP, Tdap o Td) —5 dosis**
  (4 dosis cumplen con el requisito si una se aplicó al cumplir los 4 años de edad o después;
  3 dosis cumplen con el requisito si una se aplicó al cumplir los 7 años de edad o después)
  Se requiere al menos una dosis de una vacuna con protección contra pertussis (tos ferina) al cumplir los 7 años de edad o después para los alumnos de 7° a 12° grado.

- **Polio (OPV o IPV)—4 dosis**
  (3 dosis cumplen con el requisito si una se aplicó al cumplir los 4 años de edad o después)

- **Hepatitis B—3 dosis**
  (No se requiere para el paso a 7° grado)

- **Vacuna contra el sarampión, las paperas y la rubéola (MMR)—2 dosis**
  (Ambas dosis deben haberse administrado al cumplir el 1er año de edad o después)

- **Varicela—2 dosis**

Estos requisitos de vacunación también aplican a nuevos estudiantes y alumnos de transferencia en cualquier grado, incluyendo el Kínder de Transición.

Los alumnos ingresando a 7º grado necesitan:

- **Vacuna contra el tétanos, la difteria y la tos ferina (Tdap) —1 dosis**
  (El refuerzo de la vacuna contra la tos ferina generalmente se aplica a los 11 años de edad o más.)

- **Vacuna contra la varicela—2 dosis**
  (Generalmente se aplica a los 12 meses de edad y entre los 4 y 6 años de edad)

Los requisitos para K-12 también aplican a alumnos de 7° grado que:

- Antes tenían una exención de las vacunas requeridas por creencias personales que fue presentada antes del 2016 al entrar cualquier grado entre Kínder de Transición/Kínder y 6° grado

- Son nuevos estudiantes

Comprobantes:

Se requiere que las escuelas en California revisen los Comprobantes de Inmunización de todos los nuevos estudiantes ingresando a Kínder de Transición/Kínder hasta el 12° grado y de todos los estudiantes pasando a 7° grado de antes ingresar. Los padres deben presentar el Comprobante de Inmunización de su hijo(a) como prueba de que se vacunó.

CALIFORNIA IMMUNIZATION REGISTRY – REGION IV

DISCLOSURE STATEMENT: ATTENTION PATIENTS OR PARENTS

We are authorized members of California Immunization Registry – Region IV. The Immunization Registry permits the sharing of a computer record of you or your child's immunizations and Tuberculosis (TB) screening tests no matter where they are given. At any time you and your doctor can see what immunizations/TB tests you or your child has received and which immunizations are needed now. It will help you and your doctor protect you or your child from serious illness like polio, whooping cough, measles and meningitis.

The information in the Immunization Registry is confidential. Your information will **ONLY** be shared with (a) Health care providers (i.e. doctors, clinics or hospitals), to help in deciding what vaccines you or your child needs; to phone or send you a reminder when a vaccine is due; and tally numbers of patients who are or are not up-to-date on their vaccines, (b) Schools or child care centers, to help you prove you or your child has had the vaccines required for entry, (c) WIC clinics, to let you know if your child has a vaccine dose due, (d) Health Care Plans, to help process insurance payments, (e) the San Joaquin County Health Information Exchange (SJC HIE), and (f) the California State Department of Public Health Immunization Branch.

This is the information the Immunization Registry will keep about your or your child:

- Name and date of birth
- Names of parents or guardians
- Sex (male or female)
- Current address and phone (only healthcare providers can view this information)
- Types of vaccines/TB tests and dates given
- Any serious reactions to immunizations/TB tests
- Limited additional information that may help identify you or your child accurately

Patient and Parent Rights

It's your legal right to ask:

- not to share your (or your child's) registry immunizations/TB test records with others besides your doctor*
- not to get appointment reminders from the Registry
- to look at a copy of your or your child's immunization/TB test registry records
- who has seen the registry records or to have the doctor change any mistakes

If you DO want your or your child's records in the registry, do nothing. You're all done.

If you DO NOT want your doctor's office to share your immunization/TB test information with other registry users, request a "Refusal Form" from your doctor's office.

For more information about your rights, please contact your healthcare provider.
For more information about the Immunization Registry, please call (209) 468-2292.

**By law, public health officials can also look at the registry, in the case of a public health emergency.*

REGISTRO DE VACUNACIÓN DE CALIFORNIA – REGIÓN IV

DECLARACIÓN DE REVELACIÓN: PARA PACIENTES O PADRES DE FAMILIA

Somos miembros autorizados del Registro de Vacunación de California – Región IV. El Registro de Vacunación permite que se compartan datos electrónicos de vacunación y de pruebas de detección de tuberculosis de usted y de su hijo independientemente de donde se hayan administrado. Usted y su doctor pueden ver en cualquier momento qué vacunas les dieron y qué pruebas de tuberculosis les hicieron a usted o a su hijo y qué vacunas se tienen que dar ahora. Ayudará a usted y a su doctor a protegerlos a usted y a su hijo contra enfermedades serias como la poliomielitis, tos ferina, sarampión y meningitis.

La información del Registro de Vacunación es confidencial. Su información **SOLO** se compartirá con (a.) profesionales de la salud (o sea doctores, clínicas u hospitales), para ayudar a decidir qué vacunas necesitan usted o su hijo; para llamarlo por teléfono o enviarle un recordatorio de que le toca recibir una vacuna; y, contar cuántos pacientes están o no al día con sus vacunas, (b.) escuelas o guarderías de niños, para ayudar a demostrar que usted o su hijo han recibido las vacunas requeridas para ingresar, (c.) las clínicas WIC, para informarles si a su hijo le hace falta una dosis de una vacuna, (d.) planes de atención de la salud, para ayudar a procesar pagos de seguros (e.) el Intercambio de Información de Salud del Condado de San Joaquin (SJC HIE, en inglés) y (f.) la División de Vacunación del Departamento de Salud Pública del Estado de California.

La siguiente es la información que el Registro de Vacunación mantendrá sobre usted o su hijo:

- Nombre y fecha de nacimiento
- Nombres de los padres de familia o tutores
- Sexo (masculino o femenino)
- Dirección y teléfono actuales (solo los profesionales de la salud pueden ver esta información)
- Tipos de vacunas y pruebas de tuberculosis administradas y las fechas
- Reacciones serias a vacunas o pruebas de tuberculosis, si corresponde
- Otra información limitada que pueda ayudar a identificar correctamente a usted o a su hijo

Derechos de pacientes y padres

Tiene derecho legal a pedir lo siguiente:

- Que los datos en el registro de vacunaciones y pruebas de tuberculosis de usted y de su hijo se compartan solo con su doctor*
- Que el Registro no le envíe recordatorios de citas
- Ver una copia de los datos de vacunación y de pruebas de tuberculosis de usted y de su hijo que figuren en el Registro
- Que le digan quiénes han visto los datos en el Registro o que su doctor corrija cualquier error

Si DESEA que sus datos o los de su hijo estén en el Registro, no haga nada. Eso es todo.

Si NO DESEA que el consultorio de su doctor comparta sus datos de vacunación e información sobre sus pruebas de tuberculosis con otros usuarios del Registro, pida en el consultorio de su doctor que le den un "Formulario de rechazo".

Para más información sobre sus derechos, póngase en contacto con su profesional de la salud.
Para más información sobre el Registro de vacunación, llame al (209) 468-2292.

**Por ley, si hay una emergencia de salud pública los funcionarios de salud pública pueden ver el Registro.*

CALAVERAS UNIFIED SCHOOL DISTRICT
Health Services Department

School:_____
Grade:_____
Teacher:_____

HEALTH & DEVELOPMENTAL HISTORY
(To be completed for all students upon registration)

STUDENT'S NAME:_____SEX:____DOB:_____

ADDRESS:_____PHONE:_____

_____CELL:_____

PARENTS' NAME: Father:_____Mother:_____

1. Immunization Record: See California School Immunization Record.

2. Birth History:
a. Pregnancy Complications: (Bleeding, accidents, injuries, edema)_____
b. Pregnancy: Full Term____ Premature:_____ , how many months?_____
c. Delivery: Normal___ Abnormal___ Birth Weight:_____
Any complications: None___ Infections_____ Hemorrhage _____ Forceps____
d. Baby's condition at birth: Normal___ Cyanotic (blue)_____ Jaundiced (yellow)___
Breathing: Normal___ Abnormal___ Was oxygen used? Yes__ No___
e. Any difficulties during the first 30 days?_____
_____

3. Developmental Growth: Was your child slow in any of the following areas?
Sitting alone, walking, talking, toilet training? If so, please explain:_____
_____
_____

4. As a baby was your child: Active___ Easygoing___ Happy___ Cross___ High Strung___ Colicky___
Were there any feeding difficulties? Yes___ No___
As a toddler was your child: Very demanding___ Awkward___ Easygoing___ Extremely Active___
Accident prone____
As a preschooler, did your child: Play most often alone? Yes___ No___
Play well with other children? Yes___ No___
Did your child attend nursery school? Yes___ No___

5. Health History: (Please check)

	No	Yes	Explain "yes" Items
a. Any physical or congenital handicaps?			
b. Any convulsions or high fevers?			
c. Any childhood diseases? Which ones?			
d. Is child taking any medications?			

	Good	Fair	Poor	Explain
e. Vision				
f. Hearing				
g. Large muscle coordination				
h. Small muscle coordination				
i. Speech				

6. List any serious accidents, operation or hospitalizations:

Date	Explanation

7. Last complete physical exam:

Date:_____
Physician's Name:_____
Address:_____
Findings:_____
_____

8. Last dental exam:

Date:_____
Dentist's Name:_____
Address:_____
Work needed? Yes__ No__
Completed? Yes___ No___

9. Is there a history of learning difficulties in the family? Yes__ No__

10. Are there any special conditions to be watched for in school at the present time?

a. Hay fever___ b. Asthma___ c. Bee sting sensitivity___ d. Allergies? Yes___ No__

If allergies, what is child allergic to?_____
_____

11. Does child present any of the following:

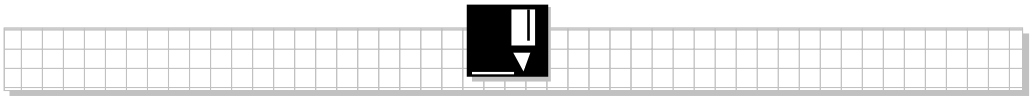
	Yes	No
Poor eating habits		
Enuresis (bed wetting)		
Short attention span		
Shy, tends to withdraw		
Frequent sore throats		
Frequent urination		
Emotional problems		

	Yes	No
Sleep problems		
Temper Tantrums		
Thumb sucking		
Frequent colds		
Headaches		
Tires easily		
Weight problem		

If yes is checked on any of the above, please explain the severity of the problem:

Date:_____ _____
Parent/Guardian Signature

From the Nurse's Desk



CALAVERAS UNIFIED SCHOOL DISTRICT
♦ PO. Box 788♦San Andreas, CA. 95249
Phone 754-2322 ♦ Fax 754-2379

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 do not already have a regular dentist for your child, we recommend that you use this oral health assessment as a way to establish a regular check up schedule. We also realize that access to a regular dentist is not always possible. The dental hygienists with the Calaveras Children's Dental Project are licensed dental professionals and are qualified to perform this assessment. If you have already signed your child up to receive a dental screening or dental cleaning from the Children's Dental Project as part of the classroom Smile Keepers program, your child will automatically receive this assessment. If you are not sure whether your child's class is part of Smile Keepers, or if you signed him or her up, please check with your child's teacher. If you cannot take your child for this required assessment, or chose not to participate in the Smile Keepers program, please indicate the reason for this in Section 3 of the form. 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.

Remember, your child is not healthy and ready for school if he or she has poor dental health! 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.

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.

If you have questions about the new oral health assessment requirement, please contact the school office or district nurse at 754-2322.

Sincerely,

Belinda Brager, MSN, RN, PHN, Credentialed School Nurse
CUSD Health Services Coordinator

Attachment: Oral Health Assessment/Waiver Request Form

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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)

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Sex: □ Male □ Female
Parent/Guardian Name:	Child's race/ethnicity: □ White □ Black/African American □ Hispanic/Latino □ Asian □ Native American □ Multi-racial □ Other_____ □ Native Hawaiian/Pacific Islander □ 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:	Caries Experience (Visible decay and/or fillings present) □ Yes □ No	Visible Decay Present: □ Yes □ No	Treatment Urgency: □ No obvious problem found □ Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) □ 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.

Formulario de evaluación de la salud bucal

La ley de California (Sección 49452.8 del *Código de Educación*) exige que su hijo se haga un chequeo dental antes del 31 de mayo de su primer año en una escuela pública. Un profesional de la salud dental matriculado de California que trabaje dentro de su área de especialización debe realizar el chequeo y completar la Sección 2 de este formulario. Si su hijo tuvo un chequeo dental en los 12 meses anteriores al comienzo del año escolar, pídale a su dentista que complete la Sección 2. Si no puede conseguir un chequeo dental para su hijo, complete la Sección 3.

Sección 1. Información del menor **(debe ser completada por el padre, la madre o el tutor)**

Primer nombre del menor:	Apellido:	Inicial del segundo nombre:	Fecha de nacimiento del menor:
Domicilio:			Dpto.:
Ciudad:			Código postal:
Nombre de la escuela:	Maestro:	Grado:	Sexo del menor: □ Masculino □ Femenino
Nombre del padre/madre/tutor:	Raza/origen étnico del menor: □ Blanco □ Negro/Afroamericano □ Hispano/Latino □ Asiático □ Indio nativo americano □ Multirracial □ Otro_____ □ Nativo de Hawai/islas del Pacífico □ Desconocido		

Sección 2. Información de salud dental: **debe ser completada por un profesional de la salud dental matriculado de California *[Oral Health Data (To be completed by a California licensed dental professional)]***

NOTA IMPORTANTE: Considere cada casilla por separado. Marque cada casilla.
***[IMPORTANT NOTE:** Consider each box separately. Mark each box.]*

Fecha de la evaluación: *[Assessment Date:]*	Incidencia de caries *[Caries Experience]* (Caries visibles y/o empastes presentes) *([Visible decay and/or fillings present])* □ Sí *[Yes]* □ No *[No]*	Caries visibles presentes: *[Visible Decay Present:]* □ Sí *[Yes]* □ No *[No]*	Urgencia de tratamiento: *[Treatment Urgency:]* □ Ningún problema obvio *[No obvious problem found]* □ Se recomienda atención dental temprana (caries sin dolor o infección o el niño se beneficiará del sellador dental o de una evaluación adicional) *[Early dental care recommended (Caries without pain or infection or child would benefit from sealants or further evaluation)]* □ Se necesita atención urgente (dolor, infección, inflamación o lesiones del tejido blando) *[Urgent care needed (pain, infection, swelling or soft tissue lesions)]*

_____ _____ _____

Firma del profesional de salud dental matriculado [Licensed Dental Professional Signature ***Número de matrícula de CA CA License Number*** ***Fecha Date]***

Sección 3. Exención del requisito de evaluación de salud dental

Debe ser completado por el padre, la madre o el tutor que solicita que su hijo/a sea eximido de este requisito.

Solicito que mi hijo sea eximido de este chequeo dental porque: (marque la casilla que describa el motivo)

□ No puedo encontrar un consultorio dental que acepte el plan de seguro dental de mi hijo.
El plan de seguro dental de mi hijo es:

□ Medi-Cal/Denti-Cal □ Healthy Families □ Healthy Kids □ Otro _____ □ Ninguno

□ No puedo pagar el chequeo dental de mi hijo.

□ No quiero que a mi hijo se le haga un chequeo dental.

Opcional: otras razones por las cuales mi hijo no pudo obtener un chequeo dental: _____

Si pide ser eximido de este requisito: ▶_____

Firma del padre, madre o tutor ***Fecha***

La ley establece que las escuelas mantengan la privacidad de la información médica de los estudiantes. El nombre de su hijo no formará parte de ningún informe que se realice como resultado de esta ley. Esta información sólo puede ser utilizada para fines relacionados con la salud de su hijo. Si tiene alguna pregunta, comuníquese con la escuela.

Regrese este formulario a la escuela *antes* del 31 de mayo del primer año escolar de su hijo.
El original de este formulario será guardado en el registro escolar del menor.

Calaveras Unified School District
P.O. Box 788
San Andreas, CA 95249

Authorization for Administration of Medication During School Hours

THIS FORM MUST BE COMPLETED BEFORE ANY MEDICATION CAN BE ADMINISTERED AT SCHOOL

The California Education Code section 49423 permits the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to be functional at school and participate in the educational program.

- Medication must be in the container in which it was purchased with the pharmacy label attached, and must be prescribed to the student to whom it will be administered. No medication (including over-the-counter medication) will be given at school without a current authorized health care provider prescription.
- Parent/guardian is responsible to ensure that the medication supply is delivered to school by an individual legally authorized to be in possession of the medication. Parent/guardian must pick up any outdated or unused medication.
- Parent/guardian is responsible to provide all necessary supplies and equipment.
- Parent/guardian may terminate this consent for administration of medication at any time.
- The renewal of this medication order is needed whenever the prescription changes and at the beginning of each school year.
- Please refer to Board Policy 5141.21 for additional information.

STUDENT:_____ DOB:_____ GRADE:_____ SCHOOL _____

PHYSICIAN AUTHORIZATION (all blanks must be completed by a California licensed physician, surgeon, dentist, optometrist, podiatrist, nurse practitioner, nurse midwife, or physician assistant – CA Code of Reg, Title 5, Sec 601[a]):

Name of Medication:	**Method of administration:**
Dosage (mg.):	**Time(s) to be taken:**
Start Date:	**End Date:**

Diagnosis / Justification: (Nature of condition requiring medication during the regular school day)

California Code of Regulations §605 states that a student with an existing medical condition that requires frequent monitoring, testing or treatment may be allowed to self administer this service.

Student is authorized to carry, and is able to self-administered prescription for asthma or diabetes (authorized licensed healthcare provider initials: _____).
Student is authorized to carry, and is able to self-administer auto-injectable epinephrine independently (authorized licensed healthcare provider initials: _____).

My signature below provides authorization for the above written order. I understand that the medication will be given in accordance with state laws and regulations by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

Authorized Healthcare Provider Name (please print):	**License Number**	**NPI Number:**
Authorized Healthcare Provider's Signature:	**Date:**	**Phone & Fax Number:**

I the undersigned, the parent/guardian of the above named pupil, authorize the school nurse or other designated school personnel to administer the medication as directed by the delegating healthcare provider. I understand that the school nurse/designated employee has my permission to communicate with the prescribing licensed health care provider on matters related to this medication. I will: 1) Provide the necessary medication, supplies, and equipment; 2) notify the school nurse/designee if there are any changes to this order.

Parent/Guardian Signature _____ Date _____ Phone Number _____

Reviewed by Credentialed School Nurse Signature _____ Date _____

1/2019

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Student:	DOB:	Date:
District/Site:	Teacher/Rm:	Grade:

1. Asthma Action Plan attached: ☐ Yes ☐ No

2. Monitoring at school:

☐ Observation and/or pupil report of symptoms

☐ Peak flow meter and symptoms

Measure peak flow when: _____

Personal best peak flow: _____

☐ Monitor peak flow on regular schedule:

Times: _____

3. Asthma symptoms are triggered by:

☐ Exercise
☐ Respiratory infection
☐ Cold weather
☐ Sudden temperature change
☐ Air pollution
☐ Perfumes
☐ Pollens:
☐ grasses
☐ trees
☐ shrubs/flowers
☐ Animal dander/feather
☐ Dust mites
☐ Cockroaches
☐ Molds
☐ Smoke
☐ Strong odors/fumes:
☐ Food: _____

4. Medications to be taken <u>at school</u>:

☐ Quick-relief medication _____

Route: ☐ Inhaler ☐ Inhaler+spacer

☐ Inhaler+spacer+ mask

☐ Nebulizer (requires unit-dose vials);

Monitor pulse & respirations: ☐ No ☐ Yes

☐ Quick-relief medication specified above to prevent exercise-induced asthma (EIA) _____ min. before exertion

☐ Emergency medication: _____

Route: _____ Administer when: _____

☐ Other medication: _____

5. Actions when symptoms occur at school:

☐ Check peak flow reading unless pupil in severe distress

☐ Administer quick-relief medication:

Medication: _____

Dose: _____

☐ Observe pupil for _____ min. after medication taken

☐ Repeat peak flow measurement in _____ min.

☐ If peak flow <u>between</u> _____ OR symptoms <u>do not Improve</u>:

☐ Repeat quick-relief medication; dose: _____

☐ Administer emergency medication: _____

Dose: _____ Route: _____

☐ Call 9-1-1 Emergency Services

☐ Emergency Action Plan attached

☐ Take the following actions: _____

6. **Physical activity or environmental modifications required: _____**

7. Other pertinent information or recommendations:

Authorized Health-Care Provider Authorization for Management in the Educational Setting

My signature below provides authorization for the above written orders. I understand all procedures will be implemented in accordance with state laws and regulations.

_____ (Initial here) I authorize unlicensed designated school personnel, under the training and supervision provided by the credentialed school nurse, may provide this procedure. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

Authorized Health-Care Provider Name** _____NPI Number** _____

Signature _____ **Date**_____

Phone _____ **Address** _____**City** _____**Zip** _____

Supervising Physician Name _____ **NPI Number** _____

Phone _____ **Address** _____**City** _____**Zip** _____

☐ I request that the credentialed school nurse provide me with a copy of the completed Individualized Health-Care Plan (IHP).

Student:	DOB:	Date:

Authorization to Carry and Self-administer Quick- Relief (albuterol) Inhaler

It is my opinion that the student may carry on their person and self-administer prescribed quick-relief inhaler to treat acute asthma symptoms, as needed, in accordance with health-care provider's orders.

☐ **Yes**

☐ **No**

Health-Care Provider Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

Parent Consent for Authorization and Management in the Educational Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above-named student, request that the specialized physical health-care service be administered to my (our) child in accordance with state laws and regulations.

I (we) will:

1. provide the necessary supplies and equipment;
2. notify the credentialed school nurse if there is a change in child's health status or attending authorized health-care provider; and
3. notify the credentialed school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

I (we) give consent for the school nurse to communicate with the authorized health-care provider when necessary.

I (we) understand that I (we) will be provided a copy of my child's completed Individualized Health-Care Plan (IHP).

Parent(s)/Guardian(s) Signature: _____ **Date** _____

_____ **Date** _____

Reviewed by credentialed school nurse (signature) _____ **Date** _____

☐ **Credentialed school nurse has informed principal about health-care services provided for this student.**

Student:	DOB:	Date:
District/Site:	Teacher/Rm:	Grade:

1. **Allergens or factors causing anaphylactic reaction**:

   _____

   _____

2. **Student's most common signs and symptoms**:

   _____

3. **Student's typical reaction time after allergen exposure**:

   ☐ <10 min. ☐ <30 min. ☐ <hour ☐ > an hour

4. **History of anaphylactic reaction:** ☐ Yes ☐ No

5. **Student has asthma:** ☐ Yes ☐ No

6. **Administer EAI when**:

   ☐ **Student has <u>any</u> of the following severe symptoms after eating their allergen or being stung:**

   - Short of breath/wheezing/coughing
   - Pale/bluish color skin
   - Tight/hoarse throat
   - Trouble breathing/swallowing
   - Hives (many) / redness over body
   - Vomiting/diarrhea (combined with other symptoms)
   - Confusion/altered consciousness/agitation/ feeling of impending doom
   - Weak pulse
   - Fainting/dizziness

   ☐ **Student has more than one <u>mild</u> symptom.**

   ☐ **Student has definite exposure to allergen; no immediate symptoms noted**.

   ☐ **Student has one mild symptom**

   - Itchy nose, sneezing, itchy mouth.
   - A few hives.
   - Mild stomach nausea or discomfort.

7. **Medication: Epinephrine Auto-injector (EAI) IM:**

   ☐ 0.3 mg (adult: >66 pounds)

   ☐ 0.15 mg (Jr: 33 to <66 pounds)

8. **Administer 2nd dose 15 minutes after 1st dose if symptoms persist or recur:** ☐ Yes ☐ No

9. **Administer the following medication after EAI**:

   ☐ None

   ☐ Antihistamine:

   Name: _____

   Dose: _____

   Route: _____

   ☐ Other:

   Name: _____

   Dose: _____

   Route: _____

10. **Administer antihistamine if student has <u>one mild</u> symptom:**

    - Itchy nose, sneezing, itchy mouth.
    - A few hives.
    - Mild stomach nausea or discomfort.

    Name: _____

    Dose: _____

    Route: _____

Authorized Health-Care Provider Authorization for Management in the Educational Setting

My signature below provides authorization for the above written orders. I understand all procedures will be implemented in accordance with state laws and regulations.

_____ (Initial here) I authorize unlicensed designated school personnel, under the training and supervision provided by the credentialed school nurse, may provide this procedure. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

Authorized Health-Care Provider Name** _____NPI Number** _____

Signature _____ **Date**_____

Phone _____ **Address** _____**City** _____**Zip** _____

Supervising Physician Name _____ **NPI Number** _____

Phone _____ **Address** _____**City** _____**Zip** _____

☐ I request that the credentialed school nurse provide me with a copy of the completed Individualized Health-Care Plan (IHP).

Authorization to Carry and Self-administer Epinephrine Auto-injector (EAI)

It is my opinion that the student may carry on their person and self-administer prescribed EAI to treat anaphylactic reaction, as needed, in accordance with health-care provider's orders.

☐ **Yes**

☐ **No**

Health-Care Provider Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

Parent Consent for Authorization and Management in the Educational Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above-named student, request that the specialized physical health-care service be administered to my (our) child in accordance with state laws and regulations.

I (we) will:

1. provide the necessary supplies and equipment;
2. notify the credentialed school nurse if there is a change in child's health status or attending authorized health-care provider; and
3. notify the credentialed school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

I (we) give consent for the credentialed school nurse to communicate with the authorized health-care provider when necessary.

I (we) understand that I (we) will be provided a copy of my child's completed Individualized Health-Care Plan (IHP).

Parent(s)/Guardian(s) Signature: _____ **Date** _____

_____ **Date** _____

Reviewed by credentialed school nurse (signature) _____ **Date** _____

☐ **Credentialed school nurse has informed principal about health-care services provided for this student.**

What Does CHDP Offer?

The CHDP program helps to prevent or find health problems through regular, no cost, health check-ups. A check-up includes:

- Health and developmental history
- Physical exam
- Needed shots
- Oral health screening and routine referral to a dentist starting by age 1
- Nutrition screening
- Behavioral screening
- Vision screening
- Hearing screening
- Health information
- Lab tests, which may include: anemia, lead, tuberculosis, and other problems, as needed
- Referral to Women, Infants, and Children (WIC) program for children up to age 5

Other Services

If further health services are needed, we will help you find them, including:

- Dentists that accept Denti-Cal for the care of your child's teeth
- Medical specialists, as needed
- Mental and behavioral health services, as needed

Diagnosis and treatment can be paid for as long as your child has Medi-Cal.

Information

For more information about CHDP, transportation options, or for help setting up an appointment, contact your local CHDP office.

You can find your local CHDP office by visiting the California Department of Health Care Services website at: **www.dhcs.ca.gov/services/chdp**

Regular health check-ups keep your child healthy.

Health check-ups can also find and treat problems before they become serious.

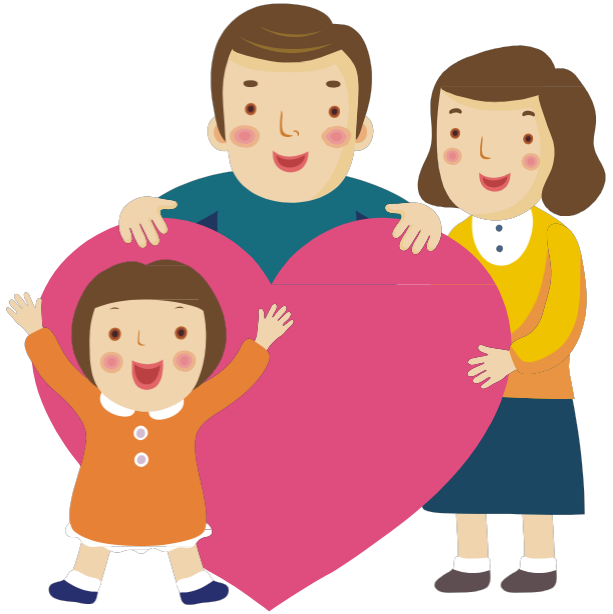
Edmund G. Brown, Jr.
Governor, State of California

PUB 183 (English, 9/15)

English

Child Health and Disability Prevention (CHDP) Program

Medical and Dental Health Check-Ups



FREE

For Babies, Children, and Youth Under age 21 with Full Scope Medi-Cal or Under Age 19 with Low Family Income. No Documentation Required

Why Get Health Check-Ups?

Health check-ups are important for all children and youth. Health check-ups are a time to:

- Find and address medical, dental, mental, and behavioral health problems
- Get needed shots
- Ask your doctor questions

Health check-ups can also be used for foster care, sports, camp, or school entry, as needed.

Who is Eligible?

Children and youth up to age 21 who are eligible for Medi-Cal. Children and youth under age 19 with family incomes less than or equal to 200% Federal Income Guidelines are also eligible. Proof of residence and income is not required.

Babies and Toddlers
Birth Through 3 Years

Regular check-ups can keep your baby happy and healthy. You can find out about your baby's growth, weight, and health, and needed shots are given. At 1 year and 2 years, your baby should be tested for lead. A test for anemia is also given. Your child should see a dentist at least once a year starting by age 1.

School Children
4 Through 12 Years

It is important to make sure your child is healthy and ready for school. State laws require children to be up to date on their shots and get a health check-up.

School children will also get vision and hearing screenings. If your child has not had a lead test before, he/she should have one by age 6 or before. Your child should see a dentist at least once a year.

Teens and Young Adults
13 Through 20 Years

Teens need health check-ups too! This is a chance to make sure your teen is growing and developing well. It is also a time for you or your teen to ask the doctor any questions. Extra health check-ups can be given for sports and camp physicals. Your child should see a dentist at least once a year.

Dental

Please contact your local CHDP office for assistance to find a Dentist who accepts Denti-Cal. CHDP may also assist with appointment scheduling and transportation if necessary.

Vision & Hearing

The local CHDP office can provide assistance to obtain vision and hearing services if medically necessary.

Mental Health, Autism and Behavioral Services

Contact the local CHDP office for assistance to access these services.

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.

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	_____/_____/_____
Physical Examination	_____/_____/_____
Dental Assessment	_____/_____/_____
Nutritional Assessment	_____/_____/_____
Developmental Assessment	_____/_____/_____
Vision Screening	_____/_____/_____
Audiometric (hearing) Screening	_____/_____/_____
TB Risk Assessment and Test, if indicated	_____/_____/_____
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/DT/Td (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 (e.g., TB Test, if indicated)					
OTHER					

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.

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 sera archivado por la escuela en forma confidencial.

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

NOMBRE DEL NIÑO/NIÑA—Apellido	Primer Nombre	Segundo Nombre	FECHA DE NACIMIENTO—Mes/Día/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 (auditivas)	_____/_____/_____
Evaluacion 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				
	Primero	Segundo	Tercero	Quarto	Quinto
POLIO (OPV o IPV)					
DTaP/DTP/DT/Td (difteria, tétano y [acellular] pertusis [tos ferina]) O (tétano y difteria solamente)					
MMR (sarampión, paperas, rubéola)					
HIB MENINGITIS (Hemófilo, Tipo B) (Requerida para centros de cuidado para niños y centros preescolares solamente)					
HEPATITIS B					
VARICELLA (Viruelas locas)					
OTRA (e.g. prueba TB, de ser indicado)					
OTRA					

PARTE III INFORMACIÓN ADICIONAL DEL EXAMINADOR DE SALUD *(optional)* y PERMISO PARA DIVULGAR (DISTRIBUIR) EL INFORME DE SALUD

RESULTADOS Y RECOMENDACIONES

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

☐ 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)

***de ser indicado**

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

www.calaverasusd.com

Calaveras Unified Nutritional Services
P.O Box 788
San Andreas, CA 95249
(209) 754-2120
https://www.calaverasusd.com/departments/nutritional_services

Universal Free School Meals
for ALL children in public school

California became the first state in the nation to permanently adopt free school meals for all K-12 students in public school.

IMPORTANT: We need YOUR help to QUALIFY for SUPPLEMENTAL EDUCATION FUNDING!

After July 1st for the upcoming school year:

Submit your *Household Economic Survey* * - It's simple!

*ONLINE via Campus Parent Portal

***It's Safe and Secure - All Information is strictly confidential*.**
https://www.calaverasusd.com/parents/infinite_campus_parent_portal
Select More/Meal Benefits to begin the application process.

*Or, complete a Hard Copy:

The Economic Survey form is available for printing:
https://www.calaverasusd.com/departments/nutritional_services/economic_survey

If your child is Direct Certified through the County, you will be notified by US mail and therefore it is not necessary to complete the Economic Survey. You may use your letter to qualify for the free or reduced-price bus pass, College prep test fees or for other programs in the community that honor school meal student eligibility.

You will need a Parent Portal account to submit your economic survey online. Do not use a student portal account or the data submission will be rejected. Contact your school office or Technology Services to assist you with setting up your account. Parent Portal information is available at https://www.calaverasusd.com/parents/infinite_campus_parent_portal

Only **one survey per household** is needed. Return hard copies to any school office or kitchen, or mail to Nutritional Services at the above address. You can also scan and email a .pdf or take a picture with your phone and email to mhernandez@calaveras.k12.ca.us An adult household member must sign the form.

This institution is an Equal Opportunity Provider and Employer.

www.calaverasusd.com

Calaveras Unified Nutritional Services
P.O Box 788
San Andreas, CA 95249
(209) 754-2120
https://www.calaverasusd.com/departments/nutritional_services

Comidas escolares gratuitas universales para todos los estudiantes en la escuela pública

California ha adoptado permanentemente comidas escolares gratuitas

IMPORTANTE: ¡Necesitamos SU ayuda para CALIFICAR para el FINANCIAMIENTO DE EDUCACIÓN SUPLEMENTARIA!

Después del 1 de julio para el próximo año escolar:

Envía tu Encuesta Económica de Hogares* - ¡Es sencillo!

****EN LÍNEA en el Portal de Padres del Campus**

Es seguro y protegido: toda la información es estrictamente confidencial.https://www.calaverasusd.com/parents/infinite_campus_parent_portal

Seleccione More/Meal Benefits para comenzar el proceso de solicitud

*** O complete un formulario en papel:**

El formulario de la encuesta está disponible para imprimir:
https://www.calaverasusd.com/departments/nutritional_services/economic_survey

Si su hijo tiene certificación directa a través del condado, se le notificará por correo de los Estados Unidos y por lo tanto no es necesario completar la Encuesta Económica. Puede usar su carta para calificar para el pase de autobús gratuito o de precio reducido, las tarifas de los exámenes de preparación para la universidad o para otros programas en la comunidad que respetan la elegibilidad de los estudiantes para recibir comidas escolares.

Necesitará una cuenta del Portal de Padres para enviar su encuesta económica en línea. No utilice una cuenta del portal de estudiantes o se rechazará el envío de datos. Comuníquese con la oficina de su escuela o los Servicios de tecnología para ayudarlo a configurar su cuenta. La información del Portal de Padres está disponible en
https://www.calaverasusd.com/parents/infinite_campus_parent_portal

Solo se necesita una encuesta por hogar. Devuelva las copias impresas a cualquier oficina o cocina de la escuela, o envíe por correo a Servicios de Nutrición a la dirección anterior. También puede escanear y enviar un archivo .pdf por correo electrónico o tomar una foto con su teléfono y enviar un correo electrónico a mhernandez@calaveras.k12.ca.us
Un miembro adulto del hogar debe firmar el formulario.

Calaveras Unified School District
P.O Box 788
San Andreas, CA 95249
(209) 754-2300
www.calaverasusd.com

We need **YOUR** help!

After July 1st: Complete a Household Economic Survey!

Information is Confidential

School Funding

Increased funding to ensure students receive the educational support they need.

Help CUSD qualify for supplemental and concentration grant funding under LCFF.

SAT, ACT, AP Test Fees

Get discounts on fees for college prep tests.

Option 1.

Submit Online

-Log in to your Campus Parent Portal.
-Scroll to More/Meal Benefits and start the 'application' process.
-For help with portal access visit www.calaverasusd.com and click on the Parent Portal Link.

Option 2.

Complete a Hard Copy

-Available from any school office or,
-Print from www.calaverasusd.com
Go to Departments/Nutritional Services and click on Economic Survey
Send via email or US Mail:
-Scan and email a .pdf or
-Take a picture with your phone and email to:
mhernandez@calaveras.k12.ca.us
-or Mail USPS: Melanie Hernandez
PO Box 788
San Andreas, CA 95249

Option 3.

Over the Phone

-Parents can call and answer a few quick questions over the phone.

-Call (209) 754-2120
Melanie Hernandez
Student Eligibility
Nutritional Services
mhernandez@calaveras.k12.ca.us

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CA Dept. of Education

2022/2023 CALAVERAS USD Household Economic Survey (Complete one per Household after July 1, 2022)

In lieu of this form submit your information SECURELY ONLINE through your Campus Parent Portal under More/Meal Benefits.
https://calaverasusd.infinitecampus.org/campus/portal/calaverasUnified.jsp

UNIVERSAL FREE SCHOOL MEALS FOR ALL STUDENTS IN CALIFORNIA'S PUBLIC SCHOOLS

COMPLETION OF THIS SURVEY DOES NOT AFFECT STUDENT'S ABILITY TO RECEIVE NO COST MEALS - DATA IS USED TO DETERMINE ADDITIONAL EDUCATION FUNDING.

THIS INFORMATION IS KEPT *STRICTLY CONFIDENTIAL* .

SECTION A. CHILDREN INFORMATION

All Households Complete This Section. Enter all children's personal (earned) gross income, if any, and how often received.

Circle the correct Income Codes: W=Weekly, **E**=Every 2 Weeks, **T**=Twice a Month, **M**=Monthly, **Y**=Yearly.

Racial and Ethnic Identities (optional) 1. Circle one Ethnic Identity: N=Not Hispanic/Latino or **H**=Hispanic/Latino **2. Circle one or more racial identities:** (Regardless of ethnicity)

A=Asian, **W**=White, **B**=Black or African American, **I**=American Native or Alsaka Native, **P**=Native Hawaiian or other Pacific Islander. A Foster Child is under the legal responsibility of a foster care agency or court.

				Racial and Ethnic Identities: (Optional)								
CHILDREN: LAST NAME, FIRST NAME	SCHOOL (Write "NONE" if not in school)	GRADE	Date of Birth (Optional)	Circle One Ethnic Identity	Circle one or more	MARK "X" If Foster Child	Mark "X" if No Income	Child's Personal Earned Income	Source of Income (Work)?	Paid How Often? (Circle)	Enter Benefit TYPE: CalFresh, CalWORKs or FDPIR	Enter Benefit CASE NUMBER
①				N OR H	A W B I P	☐	☐	$		W E T M Y		
②				N OR H	A W B I P	☐	☐	$		W E T M Y		
③				N OR H	A W B I P	☐	☐	$		W E T M Y		
④				N OR H	A W B I P	☐	☐	$		W E T M Y		
⑤				N OR H	A W B I P	☐	☐	$		W E T M Y		
⑥				N OR H	A W B I P	☐	☐	$		W E T M Y		

If the child you are applying for is Homeless, Migrant, or Runaway, contact the school and CIRCLE appropriate letter: H M R

Households with a Benefit Case Number for CalFresh/CalWORKs for a child listed above: skip Section B and complete Section C.

SECTION B. ALL OTHER HOUSEHOLD MEMBERS:

Enter Gross Income Under each Income Type that the Household Member Receives and how often the Income is Received.

Use the following Income Codes for each amount: W=Weekly, **E**=Every 2 Weeks, **T**=Twice a Month, **M**=Monthly, **Y**=Yearly. **If No Income, You MUST Mark the "No Income box." DO NOT Leave Blank.**

Adult's Full Name (Do not repeat names from Section A)	MARK "X" If No Income	Gross Earnings from Work Before Deductions, Include All jobs	Paid How Often?	Indicate Pay from Pensions, Retirement, Social Security, VA benefits	Income Source?	Paid How Often ?	Welfare Benefits, Child Support, Alimony Payments	Income Source?	Paid How Often?	Any Other Income, Including Temporary Income	Income Source?	Paid How Often?	Enter Benefit Type: CalFresh, CalWORKS or FDPIR	Enter Benefit Case Number
EXAMPLE: Richard Larath	☐	$ *199.98*	*W*	$ *141.65*	*Pension*	*Y*	$ *99.99*	*Child Support*	*M*	$ *550.00*	*Rental Income*	*M*		
①	☐	$		$			$			$				
②	☐	$		$			$			$				
③	☐	$		$			$			$				
④	☐	$		$			$			$				
⑤	☐	$		$			$			$				

SECTION C. CONTACT INFORMATION, CERTIFICATIONS, AND SIGNATURE:

I certify (promise) that all of the above information is true and correct and that all income is reported. I understand that this information is given in connection with the receipt of state funds and school officials may verify the information on the application at any time, and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and federal laws.

Printed name of adult household member completing this form | **Signature of adult household member completing this form** | **Date (complete after July 1, 2022)**

Street Address, Apt #, etc. | **City** | **State** | **Zip** | **Home Phone Number** | **Cell Phone Number** | **E-mail Address**

DO NOT Write Below This Line - For District Use Only:

Application Status:

☐ **Approved based on:**
☐ **Income** ☐ **Other**

☐ **Denied based on:**
☐ **Income Too High**
☐ **Incomplete**

HSLD Size: _____ **HSLD Income: $** _____

Annual Income Conversion Factors:
Weekly X 52
Every 2 Weeks X 26
Twice A Month X 24, Monthly X 12

Determining Official's Signature _____ **Date** _____

Confirming Official's Signature _____ **Date** _____

Verification Official's Signature _____ **Date** _____

2022-2023 Calaveras USD **O ingrese su información en línea en el Portal para padres:** https://calaverasusd.infinitecampus.org/campus/portal/calaverasUnified.jsp

Formulario Alternativo de Ingreso **(Complete UNA Solicitud por Familia) USE TINTA NEGRA O AZUL Y ESCRIBA EN LETRA DE MOLDE PULCRAMENTE DENTRO DE LAS CAJAS**

TODOS LOS NIÑOS RECIBIRÁN COMIDAS ESCOLARES GRATUITAS EN LAS ESCUELAS PUBLICAS DE CALIFORNIA LOS DATOS DE ESTA ENCUESTA SE UTILIZAN PARA FINANCIAR LA EDUCACIÓN

SECCIÓN A. INFORMACIÓN DE NIÑOS **Todas las Familias Completen Esta Sección. Anote el ingreso bruto (ganado) personal de todos los niños, por cantidad, y qué tan seguido es recibido al colocar un círculo alrededor de los Códigos de Ingresos correctos: S**=Semanal, **C**=Cada 2 semanas, **D**=Dos veces al mes, **M**=Mensualmente, **A**=Anualmente.
Identidades Raciales y Étnicas (opcional) 1. Encierre en un círculo una Identidad Étnica: N=No Hispano/Latino o **H**=Hispano/Latino **2. Encierre en un círculo una o más identidades raciales: (Independientemente de la etnia) A**=Asiático, **B**=Blanco, **N**=Negro o Afroamericano, **I**=Indígena Americano o Nativo Alaska, **P**=Nativo Hawaiano u otro Isleño Pacífico

APELLIDO, NOMBRE	ESCUELA (Escriba "NINGUNA" si no está en la escuela)	AÑO EN LA ESCUELA	Fecha de Nacimiento (Opcional)	Identidades Raciales y Étnicas: (Opcional) Encierre en un círculo Una Identidad Étnica	Encierre en un círculo una o más Identidades Raciales	MARQUE "X" si Niño Acogido	Marque "X" si No Hay Ingreso	Ingreso Ganado Personal del Niño	Fuente del Ingreso ¿(Trabajo)?	¿Qué Tan Seguido Se Le Paga? (Encierre)	ANOTE el Tipo de Beneficio: CalFresh, CalWORKs, Kin-GAP, FDPIR	ANOTE el Número de Caso del Beneficio
①				N o H	A B N I P	☐	☐	$		S C D M A		
②				N o H	A B N I P	☐	☐	$		S C D M A		
③				N o H	A B N I P	☐	☐	$		S C D M A		
④				N o H	A B N I P	☐	☐	$		S C D M A		
⑤				N o H	A B N I P	☐	☐	$		S C D M A		

Si el niño por quien solicita Carece de Hogar, Migrante, o Fugitivo, contacte la escuela y ENCIERRE en un círculo letra apropiada: **C M F**

Familias presentando una solicitud con un Número de Caso del Beneficio para CalFresh/CalWORKs para CADA niño o un miembro Adulto de la familia, por favor brinquense a la Sección C y complete.

Un Niño Acogido está bajo *la responsabilidad legal de una agencia de cuidado de crianza temporal o del tribunal.*

SECCIÓN B. TODOS LOS OTROS MIEMBROS DE FAMILIA: **Anote el Ingreso Bruto Bajo Cada Tipo de Ingreso Cada Miembro de la Familia Recibe y "Qué Tan Seguido" se Recibe el Ingreso al usar los siguientes Códigos de Ingreso: S**=Semanal, **C**=Cada 2 semanas, **D**=Dos veces al mes, **M**=Mensualmente, **A**=Anualmente. **Si No Hay Ingreso, Usted TIENE QUE Marcar la "caja Sin Ingreso". NO la Deje en Blanco.**

Nombre y Apellido Completo del Adulto (No repita nombres de la Sección A)	MARQUE "X" Si No Hay Ingreso	Ganancias Brutas del Trabajo Antes de Deducciones, Incluya Todos los Trabajos	¿Qué Tan Seguido Se Le Paga?	Indique Pago de Pensiones, Jubilación, Seguro Social, Beneficios VA	¿Fuente del Ingreso?	¿Qué Tan Seguido Se Le Paga?	Beneficios de Asistencia Social, Manutención de Niños, Pagos de Pensión Alimenticia	¿Fuente del Ingreso?	¿Qué Tan Seguido Se Le Paga?	Cualquier Otro Ingreso Incluyendo Ingreso Temporal	¿Fuente del Ingreso?	¿Qué Tan Seguido Se Le Paga?	Anote el Tipo de Beneficio: CalFresh, CalWORKs, Kin-GAP, FDPIR	Anote el Número de Caso del Beneficio
Richard, Larath	☐ $	*199.98*	*S*	$ *141.65*	*Pensión*	*A*	$ *99.99*	Manutención de Niños	*M*	$ *550.00*	*Ingreso por Rentas*	*M*		
①	☐ $			$			$			$				
②	☐ $			$			$			$				
③	☐ $			$			$			$				
④	☐ $			$			$			$				
⑤	☐ $			$			$			$				

SECCIÓN C. INFORMACIÓN DE CONTACTO, CERTIFICACIONES, Y FIRMA: **Este formulario puede ser entregado a cualquier hora del día escolar.**

Yo certifico (prometo) que toda información antedicha es verídica y correcta y que todo ingreso es reportado. Tengo entiendo que esta información se da en conexión con el recibir fondos estatales y los funcionarios escolares pueden verificar la información en la solicitud a cualquier hora, y que falsedad intencionada de la informacion me puede sujetar a enjuiciamiento bajo las leyes aplicables Estatales y federales.

Nombre y apellido escrito en letra de molde del miembro adulto de la familia completando este formulario _____

Firma del miembro adulto de la familia completando este formulario X _____

Fecha _____

Domicilio de Calle, # Apt., etc. **Ciudad** **Estado** **Zona Postal** **Núm. Tel. de Casa** **Núm. Tel. Celular** **Domicilio Electrónico**

NO Escriba Abajo de Esta Línea - Sólo Para Uso Escolar:

Estado de Solicitud:

☐ **Aprobada basado en:**
- ☐ **Ingreso**

☐ **Negada basado en:**
- ☐ **Ingreso muy elevado**
- ☐ **Incompleta**

No. de personas en fam.: _____ **Ingreso anual de la fam.: $** _____

Factores de Conversión del Ingreso Anual: Semanal X 52, Cada 2 semanas X 26, Dos veces al mes X 24, Mensualmente X 12

Firma del Funcionario Determinando y Fecha
_____ _____

Firma del Funcionario Confirmando y Fecha
_____ _____

Firma del Funcionario Verificando y Fecha
_____ _____

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School or Agency	2. Site Name	3. Site Phone Number
4. Name of Child or Participant		5. Age or Date of Birth
6. Name of Parent or Guardian		7. Phone Number

8. Description of Child or Participant's Physical or Mental Impairment Affected:

9. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:

10. Indicate Food Texture for Above Child or Participant:

☐ **Regular** ☐ **Chopped** ☐ **Ground** ☐ **Pureed**

11. Foods to be Omitted and Appropriate Substitutions:

Foods To Be Omitted	Suggested Substitutions

12. Adaptive Equipment to be Used:

13. Signature of State Licensed Healthcare Professional*	14. Printed Name	15. Phone Number	16. Date

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or a nurse practitioner.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

INSTRUCTIONS

1. **School or Agency:** Print the name of the school or agency that is providing the form to the parent.

2. **Site:** Print the name of the site where meals will be served.

3. **Site Phone Number:** Print the phone number of site where meal will be served.

4. **Name of Child or Participant:** Print the name of the child or participant to whom the information pertains.

5. **Age of Child or Participant:** Print the age of the child or participant. For infants, please use date of birth.

6. **Name of Parent or Guardian:** Print the name of the person requesting the child or participant's medical statement.

7. **Phone Number:** Print the phone number of parent or guardian.

8. **Description of Child or Participant's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child or participant's diet.

9. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribed by the state healthcare professional.

10. **Indicate Texture:** If the child or participant does not need any modification, check "Regular".

11. **Foods to be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).
    Suggested Substitutions: List specific foods to include in the diet (e.g., calcium-fortified juice).

12. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child or participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).

13. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.

14. **Printed Name:** Print name of state licensed healthcare professional.

15. **Phone Number:** Phone number of state licensed healthcare professional.

16. **Date:** Date state licensed healthcare professional signed form.

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

A person with a disability is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

"Has a record of such an impairment" means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.

INFINITE CAMPUS PARENT PORTAL

Calaveras Unified School District, Nutritional Services

www.calaverasusd.com

Set up your *Infinite Campus Parent Portal Account!*

- **YOU GET: Access to your student's school information;**
  Meal Accounts, Assignments, Attendance, Grades, Transportation, Fees,
  Submit your Household Economic Survey and MORE….
- **Online Payments to Meal Accounts** (Visa, MasterCard or echeck)
  You can view all account transactions, purchases and payment history.

PLUS: There's an app for that!

The Portal is also available as an app for Android, iPhones, iPads and iPad Touch devices.
(Select the appropriate application button from the Portal Family Messages page to download the app.)

FREE **MEALS ARE FREE** FREE

$ Ala Carte items and second meals available for purchase $

NO CASH ACCEPTED – MUST HAVE FUNDS ON ACCOUNT **Prices: TBD**

Activating your Parent Portal:

- **Visit https://www.calaverasusd.com and click on the Parent Portal quick link.**
  - Or to go directly to the Portal log-in page:
    https://calaverasusd.infinitecampus.org/campus/portal/calaverasUnified.jsp
- Once set-up is complete and you are logged in; you have several options within the Portal.
- **TO MAKE ON-LINE MEAL ACCOUNT PAYMENTS**:
  Select **Food Service** (from the list on the left) then, **My Accounts** (upper right)
  Then select **Payment Methods**> to enter your credit/debit card or echeck information. Follow instructions to enter the payment amount you desire and add to Cart. From the Cart verify and click on Submit Payment.
  You can also set up **Recurring Payments>**
  or **Optional Payments>** to access Bus Pass, After School Program and Pre-School payment options.
- **TO VIEW MEAL ACCOUNT TRANSACTIONS**: Select **Food Service** (from the list on the left) and select the account you want to view (if you have multiple students**).**
- **TO COMPLETE YOUR HOUSEHOLD ECONOMIC SURVEY**:
  On the left side of the screen scroll down and select **More,** then select **Meal Benefits**.
  Then select: "click here to start the application process". *This data submission is 100% confidential.*

For questions, or to transfer funds between accounts, contact: CUSD Nutritional Services (209) 754-2120 or mhernandez@calaveras.k12.ca.us ***This Institution is an Equal Opportunity Provider and Employer***

INFINITE CAMPUS PARENT PORTAL

Calaveras Unified School District

www.calaverasusd.com

¡Configure su cuenta del Portal para Padres de Infinite Campus!

- USTED OBTIENE: Acceso a la información de la escuela de sus estudiantes; Cuentas de comidas, asignaciones, asistencia, calificaciones, transporte, tarifas, envíe su encuesta económica del hogar y MÁS ...
- Pagos en línea a cuentas de comidas (Visa, MasterCard or echeck)

  Puede ver todas las transacciones de la cuenta, las compras y el historial de pagos.

ADEMÁS: ¡Hay una aplicación para eso!

El Portal también está disponible como aplicación para dispositivos Android, iPhone, iPad y iPad Touch.
(Seleccione el botón de la aplicación correspondiente en la página Mensajes familiares del Portal para descargar la aplicación).

GRATIS GRATIS

LAS COMIDAS SON GRATIS

$ Artículos a la carta y segundas comidas disponibles para comprar $

NO SE ACEPTA EFECTIVO – DEBE TENER DINERO EN CUENTA **Precios; estar determinado**

Activando su Portal de Padres:

• Visite https://www.calaverasusd.com y haga clic en el enlace rápido del Portal para padres.
O para ir directamente a la página de inicio de sesión del Portal:
https://calaverasusd.infinitecampus.org/campus/portal/calaverasUnified.jsp
• Una vez que se complete la configuración y haya iniciado sesión; tienes varias opciones dentro del Portal.
• PARA REALIZAR PAGOS EN LÍNEA DE COMIDAS EN CUENTA:
Seleccione Servicio de alimentos (de la lista de la izquierda) y luego, Mis cuentas (arriba a la derecha) Luego seleccione Métodos de pago> para ingresar la información de su tarjeta de crédito/débito o cheque electrónico. Siga las instrucciones para ingresar el monto del pago que desea y agregar al carrito. Desde el carrito verifique y haga clic en Enviar pago. También puede configurar pagos recurrentes> o Pagos opcionales> para acceder a las opciones de pago de Pase de autobús, Programa extracurricular y Preescolar.
• PARA VER LAS TRANSACCIONES DE LA CUENTA DE COMIDAS:
seleccione Servicio de alimentos (de la lista de la izquierda) y seleccione la cuenta que desea ver (si tiene varios estudiantes).
• PARA COMPLETAR SU ENCUESTA ECONÓMICA DEL HOGAR:
En el lado izquierdo de la pantalla, desplácese hacia abajo y seleccione Más, luego seleccione Beneficios de comidas. Luego seleccione: "haga clic aquí para iniciar el proceso de solicitud". Esta presentación de datos es 100% confidencial.

CUSD Nutritional Services (209) 754-2120 or email mhernandez@calaveras.k12.ca.us
Esta Institución es un Proveedor y Empleador de Igualdad de Oportunidades

Non-Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: : http://www.ascr.usda.gov/complaint_filing_cust.html and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

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CALAVERAS UNIFIED SCHOOL DISTRICT-TRANSPORTATION DEPARTMENT

SCHOOL BUS PASS APPLICATION

2022-2023 SCHOOL YEAR

Must Be Filled Out Every Year

ALL Payment types need to fill this form out completely and return to CUSD Transportation Department, P.O. Box 788 – San Andreas, CA 95249

Questions? Call us at 754-2315 or go to our website: www.custudents.net

PAYMENT MAY BE MADE ON THE PARENT PORTAL

E-mail notification to transportation@calaveras.k12.ca.us

Parent/GuardianName: (print)			Processed Date Receipt #	Fee
Home Phone	Cell Phone	Work Phone	Chk Amt	Chk # / Cash
Address		Apt. #	Accepted By: Mail / Walk In / Online	
City/Zip			**REPLACEMENT PASSES** Request Date:_____ Name(s) of Student_____ _____ Amt. Paid:_____ Pmt. Made By:_____ Check # _____Cash:_____	

By signing below I confirm I have read and will adhere to the CUSD transportation regulations concerning the transportation of students and the rules that are enforced on District buses for the safety of students. I also verify the information contained in this document is true and correct. I understand falsification of information is cause for the revocation of bus service without refund. I further understand the bus pass must be displayed when boarding the bus and a $10.00 PROCESSING CHARGE will be assessed for replacement passes for any reason. I further understand that my signature commits me to paying the entire amount due.

Signature of Parent/Guardian:_____ _____
Date

Notes:

Student(s) Information

All student(s) information must be completed. Students will be assigned a stop, relative to your home address, if one is not listed below.

NAME	GRADE	SCHOOL	BUS STOP/ROUTE #

On Reverse: Free & Reduced Guidelines – Refund Policy – Discipline/Denial Policy

Type of Service/Fees

Students:	One	Two	Three	Four	Five	Add'l
Annual Service	$200	$380	$560	$650	$740	$90
Round Trip	☐	☐	☐	☐	☐	☐

Punch Cards (20 one-way trips) $30 X _____ = $_____
(Subject to space available) ***Lost punch cards: $30 to replace***

PAYMENT TYPE: ☐ Check ☐Cash ☐Online

Semester Payment Plan: ☐1st Semester
☐2nd Semester (Due January 3)

$25 Charge for Returned Checks

You must show proof of income to be eligible for free or reduced bus passes.

Please fill out the Household Economic Survey

Check here if you receive county services☐

Free ☐

Reduced ☐ (price of half off regular price)

OFFICE USE ONLY

Verified: ☐ Free ☐ Reduced (1/2 Off)
☐Documents Attached
Type of Documents:_____

FREE or REDUCED RATES: MUST BE ELIGIBLE UNDER FEDERAL INCOME REGULATIONS, APPLICATIONS

MUST BE COMPLETE AND INCLUDE REQUIRED DOCUMENTATION AS FOLLOWS:

- Earnings/Wages/Salary - Current paycheck stub or letter from Employer (on business stationery) stating gross wages paid and how often paid.
- Social Security/Pension/Retirement - Social Security Benefit letter or Pension Award letter.
- Unemployment Compensation/Disability or Workers Compensation - Copy of Award letter or check stub.
- Welfare Payments - Benefit letter from Welfare Department stating current eligibility and amount of award. (Passport of Services)
- Child Support/Alimony - Court decree or agreement.
- All Other Income- If you have any other type of income, provide documents showing amounts of income and how often it is received.
- Self-Employment - Copies of last 12 months of bank statements and the last year's annual Federal Tax Return.
- No Income - If you have no income, provide a brief note explaining how you provide food, clothing, and housing and when you expect an income. Include last year's Federal Tax Return.

REFUND POLICY

Requests for refunds must be submitted on the appropriate form, available at the District Office.

1. After a student leaves the District, refunds will be prorated, based on the number of quarters the student was enrolled in the District and able to utilize services.
2. After paying transportation fees a student has been determined to be eligible for Free or Reduced fees.
3. No refund will be issued for students who are ill or who are suspended from the bus or school for disciplinary reasons or due to Board action.
4. A written request for refund along with the bus pass must be sent directly to the Transportation Department and should contain the following information: Name of student, date that the pass would no longer be used, reason for the refund, school of attendance and address where the refund is to be sent. **No refunds will be made for punch cards.**

Students will be required to show their transportation pass when boarding the bus (both a.m. and p.m.)
The student must have the pass ready to show the driver before boarding the bus. The passes may be attached to the student's backpack for safety, but the student must show the pass when boarding the bus. Parents must select a bus stop from the District's approved list of bus stops. Possession of a current pass entitles a student to ride to and from the designated school and bus stop on the assigned bus. Reassignment to a different bus or a different stop can be accomplished through written request to the Transportation Department. If the parent does not indicate a bus stop location on the application, transportation staff will assign a bus stop. Per transportation rules and regulations, **students planning to get off the bus anywhere other than their assigned bus stop, must present a note from their parent/guardian to their driver.**

DENIED SERVICE – Students will not be able to board the bus without the previous years pass or a receipt showing payment made for the current year pass.

RFID cards will be provided to students at the time that the pass is issued. These need not be replaced every year. There is a $10.00 replacement fee for these cards.

Kids Place After School Programs

After School Program
2:00-6:00 PM
Monday through Thursday
12:00-6:00 PM on Friday

Spring and Fall Breaks:
7:15 AM-6:00 PM
Monday through Friday
At Jenny Lind Elementary only

- A safe environment for your children while you work
- Swimming offered during summer break program
- Homework Help
- Nutritious Snacks
- Arts & Crafts
- Service Projects
- Highly qualified staff
- Indoor/Outdoor Games

CALAVERAS UNIFIED SCHOOL DISTRICT

- For JLE, call Debra at 754-2274
- For VSE, call Michelle at 754-2287
- For SAE, call Valerie at 754-2366
- For WPE, call Emilie at 754-2255

Child care subsidies may be available through Resource Connection. Please call 754-3048 for more information

Growing together in one direction...
CUSD
Calaveras Unified School District

CHILD PASSENGER Safety

CALAVERAS COUNTY
PUBLIC HEALTH

Do you need a car seat or booster for your infant or child?

Do you want to be sure your car seat is fitted correctly?

Let a certified safety technician fit your child's car seat.

Safety education and fittings are given at no-cost.

Donations are accepted.

Call For More Information:

CALAVERAS COUNTY
PUBLIC HEALTH
754.6792

Partners In Child Safety
CALAVERAS COUNTY

"The more you know,
the safer they are."

CHP
754.3541

THE RESOURCE
CONNECTION
772.3980

CALAVERAS UNIFIED SCHOOL DISTRICT
P.O. Box 788♦San Andreas, CA 95249♦(209) 754-2300

TO GO OR NOT TO GO TO SCHOOL THAT IS THE QUESTION

Sometimes it is difficult to know when to keep your student home from school due to illness. Here are some guidelines to help you decide.

STAY HOME IF:

Fever 101•F or higher (should be fever free for 24 hours before returning to school without the use of medicine).
Nausea and/or vomiting.
Rashes – any body rash not related to allergic contact especially if accompanied by fever.
Thick, yellowish discharge from eye(s).
Infectious Conjunctivitis (pink eye) – may return 24 hours after starting antibiotic.
Cold sores or fever blisters – lesions must be dry to attend school unless student has age and maturity to use good hygiene.
Severe diarrhea
Head lice – may return after being treated.
Ringworm – may return when treatment is started.
Impetigo – may return 24 hours after treatment is started and lesions are dry.
Scabies – may return 24 hours after being treated.
Chickenpox – may return when ALL blisters are dry and crusted, usually 7-10 days.
Strep Throat – May return 24 hours after treatment is started and no fever for 24 hours.
Asthma – if needing a nebulizer (breathing) treatment more frequently than every 2 hours.
Upper respiratory infections such as cold or bronchitis – keep home if have excessive cough, large amounts of yellow/green nasal discharge, or too ill to function adequately in the classroom. Much depends on individual circumstances depending on the student's age, hygiene habits, and developmental level.

REASONS NOT TO STAY HOME:

Allergies
Constipation with or without abdominal pain
Cold without a fever (see explanation above)
Asthma (unless needing a breathing treatment more frequently than every 2 hours)
Cold/Cough unless accompanied by fever
Temperature less than 100•F (see above)
Stomachache
Poison Oak (if there is drainage, it should be covered by clothing or a dressing)
Minor Anxiety
Homework is not done

There are only four reasons an absence is excused: (Education Code 48205):

1. Pupil's personal illness (not parent or sibling)
2. Quarantine directed by county or city health officer
3. Having medical, dental, optometrical, or chiropractic services rendered
4. Attending funeral services of a member of the pupil's immediate family

When a student has had **14 absences** in the school year for illness, a physician must verify any further absences for illness. (Board Policy Administrative Regulations 5113)

******Please remember that if your student needs to take medication at school both the parent and the physician must complete a "Medication Required During School Hours" form. This form is necessary for all medication both prescriptions and over-the-counter.

If you have any questions regarding these guidelines contact the school or the district nurse at 754-2322.

Resources:
Amador County Unified School District: "To Go Or Not To Go To School That Is The Question"
American Academy of Pediatrics: Red Book
CUSD Board Policy 5113
Calaveras County Public Health Department
California Department of Health Services
California Education Code: 46010-46014, 46100-46119, 46140-46147, 48205
Code of Regulations, Title 5: 306, 420-421
National Association of School Nurses: "Pediculosis in the School Community" www.nasn.org

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