Yosemite Unified School District

Coarsegold School · 45426 Road 415 Coarsegold, CA 93614 · Phone (559) 683-6263 · FAX (559) 683-2625

Rivergold School · 31800 Road 400 Coarsegold CA 93614 · Phone (559) 658-7655 · FAX (559) 658-7244

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School Entry into Transitional Kindergarten & Kindergarten

Medical Requirements Checklist

This is the checklist for health information that you will need to provide to Yosemite Unified School District for enrollment of your child. All completed forms and records need to be brought to your school of enrollment.

1. **Immunizations: Copy of original records provided to school (if you bring the original records we will copy them for you):**
   5 DTaP, DTP or DT (4 doses meet requirement if at least one was given on or after the 4th birthday)
   4 Polio (3 doses meet requirement if at least one was given on or after the 4th birthday)
   3 Hepatitis B
   2 MMR or MMR-V (both on or after 1st birthday)
   2 Varicella, chickenpox, VAR, MMR-V or VZV

2. **TB Skin Test or TB clearance** (if previous skin test was positive) dated within one year of entry into kindergarten. TB skin test must include date given, date read, results and office or physician providing the test.

3. **Report of Health Examination for School Entry Form**
   This health examination is required to be completed for first grade entry and may be acquired up to 18 months prior to first grade.
   Form completed by parent/guardian and doctor and signed by both
   or
   Waiver signed by parent/guardian
   Form not yet completed

4. **Oral Health Assessment Form recommended for kindergarten entry,** required during first year of school (dated on or after 08/01/21)

   Form completed by parent/guardian and dentist/hygienist and signed by both
   or
   Waiver signed by parent/guardian and Section 1 completed by parent
   Form not yet completed

Yosemite Unified School District

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Medical Requirements Checklist

5. **Kindergarten Prenatal and Developmental History**
   Completed and signed by parent/guardian

If you have any other questions, please contact the school's Health Aide

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

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	/ /
Tuberculin Test (Mantoux/PPD)	/ /
Blood Test (for anemia)	/ /
Urine Test	/ /
Blood Lead Test	/ /
Other	/ /

IMMUNIZATION RECORD

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

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DtaP/DTP/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					
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.

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

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*

Yosemite Unified School District

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Kindergarten Prenatal and Developmental Health History 2022-2023

Student's Name _____ DOB _____ M ___ F ___

Prenatal History (to be completed by knowledgeable person):

Prenatal history is unknown □
Length of pregnancy: Term (38-42 weeks□) Preterm (# of week's _____) □ Post term □

Birth Weight _____ Birth Height _____ Prenatal care began what month? _____

While pregnant did the mother do any of the following; if so how much, what kind, how long (e.g. Smoked? Yes □ No □ _____

Smoked? Yes □ No □ _____

Drank alcohol? Yes □ No □ _____

Used medication? Yes □ No □ _____

Used drugs? Yes □ No □ _____

Check any medical problems that the mother had while pregnant: High blood pressure □
Preeclampsia □ Eclampsia □ Preterm labor □ Preterm delivery □
Kidney infections □ Diabetes □ Depression □ Accidents or injuries □
Other □ _____

Labor and delivery was: Normal □ Cesarean □ Difficult □ Explain _____
_____

Baby was born: At hospital (name of hospital) □ _____ At home □

Baby cried right away □ Baby did not cry right away □ _____

Baby was blue and/or needed: Resuscitation □ Oxygen □ Special care □

Special care was provided for _____ days at _____

Baby had jaundice (was yellow) Yes □ No □
If yes was it treated with lights Yes □ No □ Transfusion Yes □ No □

Newborn was: Strong □ Floppy □ Quiet/mellow □ Fussy □ Difficult to feed □
Very hard to calm or soothe □ Other □ _____
Comments _____

Developmental History (to be completed by knowledgeable person):

At what age did your child:

Walk alone _____

Say his first words _____

Say phrases _____

Toilet train _____

Do you have any concerns with your child's development/developmental milestones? If so what?

_____

Is your child's speech and language understandable to most people? Yes □ No □

Is your child able to: Dress self Yes □ No □ Do buttons Yes □ No □
Ride bike or tricycle Yes □ No □

Has your child's development seemed faster (check if Yes □), or slower (check if Yes □) than your other children (or children of your child's same age).

Your child is: Right handed □ Left handed □ Uses both hands equally well □ Unsure □

If you have any questions or need assistance please feel free to contact your school's Health Aide or District School Nurse (cell phone 559-580-5050).

Sincerely,
Lisa Kennedy , District Nurse
Tina Cozzi, Health Aide, Coarsegold Elementary

HD:K-3PDHrev2-2-16

OMB Number: 1810-0021 Expiration Date: 02/29/2020

U.S. Department of Education
Office of Indian Education
Washington, DC 20202
TITLE VI ED 506 INDIAN STUDENT ELIGIBILITY CERTIFICATION FORM

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count. You are not required to complete or submit this form. However, if you choose not to submit a form, your child cannot be counted for funding under the program. **This form should be kept on file and will not need to be completed every year.** Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

STUDENT INFORMATION

Name of the Child _____ Date of Birth _____ Grade _____
(As shown on school enrollment records)

Name of School _____

TRIBAL ENROLLMENT

Name of the individual with tribal enrollment: _____
(Individual named must be a descendent in the first or second generation)

The individual with tribal membership is the: _____ Child _____ Child's Parent _____ Child's Grandparent

Name of tribe or band for which individual above claims membership: _____

The Tribe or Band is (select only one):

_____ Federally Recognized
_____ State Recognized
_____ Terminated Tribe (Documentation required. Must attach to form)
_____ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994. (Documentation required. Must attach to form)

Proof of enrollment in tribe or band listed above, as defined by tribe or band is:

A. Membership or enrollment number (if readily available) _____ OR

B. Other Evidence of Membership in the tribe listed above (describe and attach) _____

Name and address of tribe or band maintaining enrollment data for the individual listed above:

Name _____ Address _____

City _____ State _____ Zip Code _____

ATTESTATION STATEMENT

I verify that the information provided above is accurate.

Name Parent/Guardian _____ Signature _____

Address _____ City _____ State _____ Zip Code _____

Email Address _____ Date _____

Yosemite Unified School District
HOME LANGUAGE SURVEY

Name of Student: _____
(Surname / Family Name) (First Given Name) (Second Given Name)

Age of Student: _____ Grade Level: _____ Teacher Name: _____

Directions to Parents and Guardians:

The California *Education Code* contains legal requirements which direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with these requirements. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered. If an error is made completing this home language survey, you may request correction before your student's English proficiency is assessed.

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

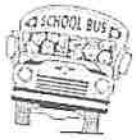
Please sign and date this form in the spaces provided below, then return this form to your child's teacher. Thank you for your cooperation.

_____ _____
Signature of Parent or Guardian Date

Form HLS, Revised December 2016
California Department of Education

COARSEGOLD ELEMENTARY SCHOOL

KINDERGARTEN BUS STOP SIGN-UP



Student Name _____

Parent/Guardian _____

Home Phone Number _____

Cell Phone Number _____

MORNING BUS STOP _____

AFTERNOON BUS STOP _____

(Kindergartners must have a parent or designated adult at the stop)

____Check here if student will not be using bus services.

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Annual Student Health History 2022-2023

Name: _____ **Grade:** ___ **Teacher** _____ **Date:** _____

Yes No Allergies (hives/rash – breathing problems) to (circle): Food Insects Environment Medication Other
Please list the items your student is known to be allergic to _____
Yes No Will your student need medication at school for allergies? List medications needed at school on back.*

Yes No Anaphylaxis (documented life threatening allergic reaction) to: Food Insects Environment Medication
Please list the items that cause your student to have anaphylaxis _____
Yes No Will your student need an Epinephrine Auto Injector (e.g. Epi-pen) at school?
Yes No Will your student need other medication at school for anaphylaxis? List medications needed on back.*

Yes No **Asthma** **Mild** **Moderate** **Severe** Triggered by:
Yes No Will your student require any medications/inhaler at school? List medications needed at school on back.*

Yes No Bone or joint problems. Describe _____
Note: Any physical restrictions will require a note from your student's physician/health care provider.

Yes No Diabetes ☐ Type 1 ☐ Type 2 If 'yes' Parent/Guardian please call for an appointment with the School Nurse.
Yes No Will your student require medication at school? List medications needed at school on back.*

Yes No Epilepsy/Seizures Date of last seizure _____ Number of seizures occurring in the past year ____
Yes No Will your student require any seizure control medications at school? List medications needed on back.*

Yes No Headaches or Migraines How frequently are headaches occurring? _____
Yes No Will your student require any headache control medication at school? List medications needed on back.*

Yes No Hearing Loss Right Left Both Does your student need preferential seating? _____
Yes No Wears a hearing aid? Your student had his/her last hearing evaluation when? _____

Yes No Heart Problems Diagnosis _____
Yes No Will your student require medication at school? List medications needed at school on back.*
Note: Any physical restrictions will require a note from your student's physician/health care provider.

Yes No Speech Problems Presently seeing a therapist? Yes No How Long? _____

Yes No Vision problems Please describe _____ Date of last eye exam _____
Yes No Wears glasses/contacts? ☐ Far vision only ☐ Reading only ☐ Wears glasses at all times

Other (Check all that apply and provide details on back of this form)

___ Breathing problems ___ Eating problems ___ Dental problems ___ ADD/ADHD
___ Neurological problems ___ Bladder problems ___ Bowel problems ___ Requires catheterization
___ Skin problems ___ Blood disorder ___ Fears ___ Blood pressure problems
___ Frequent nose bleeds ___ Behavioral problems ___ Other _____

Yes No **My student has an existing medical condition that prevents him/her from receiving Epinephrine medication for severe life-threatening allergies (known as "anaphylaxis").** I will provide medical documentation from my child's physician which identifies the medical condition preventing the use of Epinephrine. (This references law SB 1266 requiring schools to provide stock Epinephrine to treat anaphylaxis.)

Please Complete Backside of Form Also

OTHER HEALTH CONCERNS

6. **Long Term PE Excuse (greater than 3 days)** must be provided in writing by your student's physician/health care provider. Written note must include a) the reason for the excuse, and b) what the student can, or cannot do (e.g. may self-pace, may not run, no PE, etc.). This note is delivered to the Health Office.

7. **Unlimited Restroom Use or Special Procedures Regarding Restroom Use** request must be provided in writing by your student's physician/health care provider. The request must include the reason for the request or the diagnosis. This note is delivered to the Health Office.

8. **Special Meals and/or Dietary Accommodations** requires the completion of Child Nutrition Programs Form CNP-925 (available on the YUSD website or from your school's Health Aide). This form requires parent/guardian ***AND*** the student's physician/health care provider's signatures.

IF YOUR STUDENT WILL BE TAKING MEDICATION AT SCHOOL, THEN A "*MEDICATION At SCHOOL FORM*" IS NEEDED. YOU MAY GET THIS FROM YOUR SCHOOL HEALTH AIDE.

Any other health concerns: _____

_____

_____

_____

Field Trip/Sports Emergency Information 2022-23 School Year

Home Room	Grade

Student's Last Name	First Name	Middle Initial	Date of Birth
Street Address (Home) (not P.O. Box)			
City	State	Zip Code	Home Phone #
Parent/Guardian	Work phone #s	Other phone #s accessible during field trip	
Emergency Contact (other than parent for time during field trip)	Phone #	Relationship	
Emergency Contact (other than parent for time during field trip)	Phone #	Relationship	
Name of Health Insurance Company	Policy #		
Family/Child's Physician	Phone #		

Signature of Parent/Guardian _____ **Date** _____

Printed Name of Parent/Guardian _____

Yes No I would like to talk to the School Nurse. **Parent's telephone number** _____