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

www.yosemiteusd.com

School Entry into 1st through 8th Grade
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 at Coarsegold or Rivergold Elementary Schools. All completed forms and records need to be brought to the elementary school where your child will be enrolled.

1. **Immunizations: Copy of original records provided to school (if you bring the original records we will copy them for you):**
   - 5 DTP (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 (first MMR on or after 1st birthday)
   - 1 Varicella (the 2nd varicella is recommended but not required)
   - Tdap (6th through 8th grade only, required for 7th grade entry)

1. **TB Skin Test or Risk assessment screening** dated within one year if prior enrollment was in a school district outside of Madera County. (Must be an original record or copy of the original record.)

3. **"Report of Health Examination (CHDP exam) for School Entry" Form (1st grade requirement only)** ***(Dated on or after 08/01/21)***
   - Form completed by parent/guardian and doctor and signed by both
   - or
   - Waiver signed by parent/guardian

4. **"Oral Health Assessment" Form (requirement for first entry into public school including Transitional Kindergarten, Kindergarten or 1st grade only)**
   - Form completed by parent/guardian and dentist/hygienist and signed by both
   - or
   - Waiver signed by parent/guardian and Section 1 completed by parent

5. **"Annual Student Health History 2022 - 2023 Form" located on our website under "enrollment". If you have health concerns for your student, contact the District School Nurse as soon as possible including the week prior to the first day of school.**
   - 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

Child's usual address: 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.

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*

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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** _____

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