

## **KINDERGARTEN ROUNDUP CHECKLIST**

Please bring/complete the following for Kindergarten Roundup:

- Online New Student Pre-Enrollment Application - Step 1
- Receive Acceptance Email
- Online Registration (link will be emailed in July)
- Provide Birth Certificate
- Provide Immunization Record
- Provide Proof of Residency (utility bill, CA driver's license, or CA ID card)
- Complete Kindergarten Offline Health Forms Packet (attached)





33030 Road 228, North Fork, California 93643  
Mailing: PO Box 400, North Fork, California 93643  
559 877-6209 559 877-2065 FAX  
[www.chawanakee.k12.ca.us](http://www.chawanakee.k12.ca.us)

**Darren Q. Sylvia**  
Superintendent

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## AGE REQUIREMENT FOR TK AND KINDERGARTEN

Eligibility for Transitional Kindergarten:

**Fifth birthday is between September 2 and December 2**

Eligibility for Kindergarten:

**Fifth birthday is on or before September 1**



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- Hillside Elementary • 800 Treasure Hills Dr. Madera, CA 93636 • Phone (559) 877-6209 • Fax (559) 868-4488  
□ North Fork Elementary • 33087 Road 228 North Fork, CA 93643 • Phone (559) 877-2215 • Fax (559) 877-2377  
□ Spring Valley Elementary • 46655 Road 200 O'Neals, CA 93645 • Phone (559) 868-3343 • Fax (559) 868-3407

## **Health Requirements for Entry into Transitional Kindergarten, Kindergarten or First Grade**

This is the *health* information that you will need to provide to Chawanakee Unified School District for enrollment of your child into Transitional Kindergarten (TK) or Kindergarten (K) at Hillside, North Fork, and Spring Valley Schools.

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

Children entering kindergarten are required to have:

- 4 Polio (3 doses meets requirement if at least one was given on or after the 4<sup>th</sup> birthday)
- 5 DTaP, DPT or DT (4 doses meets requirement if at least one was given on or after the 4<sup>th</sup> birthday)
- 2 MMR or MMR-V (both on or after 1<sup>st</sup> birthday)
- 3 Hepatitis B
- 1 Varicella, chickenpox, VAR, MMR-V or VZV

2. **Tuberculosis TST Screening / TB Skin Test (ppd) within one year of entry into school.** The TST screening / TB Skin test must include date given, results of screening/testing and office or physician providing the test. Additionally the TB skin test (ppd) must include the date that the test was read. **OR** If your child previously had a positive TB skin test (ppd) then a TB clearance dates within one year of entry into TK or K will be needed from your child's physician / primary health care provider.

3. **Oral Health Requirements:** Your child is required to have an oral health assessment (dental check-up) in his or her first year in public school (TK, K or first grade). This dental check-up needs to have happened **within 12 months** of your child's entry into school. The dental check-up must be done by a licensed dentist or other licensed or registered dental health professional. The Oral Health Assessment Form is included in this TK/K packet and is also available at your child's school or online. <https://www.cde.ca.gov/ls/he/hn/documents/oralhlthassess.doc>

4. **Physical Examination Requirements:** California law requires that all children must have received a comprehensive health screening within 18 months *prior to entry into first grade* or within 90 days after entering first grade. The "Report of Health Examination for School Entry" form is included in this packet and is also available at your child's school or online. [http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/pm171a\(bi\).pdf](http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/pm171a(bi).pdf)

5. **Kindergarten Confidential Developmental History**

6. **Annual Health Information**

Free and low cost health examinations may possibly be obtained from CHDP Providers in Madera County you may obtain names of CHDP providers by calling the CHPD office 675-7608. If you have any questions or need assistance please feel free to contact your District School Nurse.



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Superintendent

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 cannot take your child for this required assessment, please indicate the reason for this in Section 3 of the form. You can get more copies of the necessary form at your child's school or online from the California Department of Education's Web site at <http://www.cde.ca.gov/ls/he/hn/>. 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.

The following resources will help you find a dentist and complete this requirement for your child:

1. Medi-Cal/Denti-Cal's toll-free number or Web site can help you to find a dentist who takes Denti-Cal: 1-800-322-6384; <http://www.denti-cal.cd.gov>. For help enrolling your child in Medi-Cal /Denti-Cal, contact your local social service agency at <http://www.insurekidsnow.gov/state/ca/find-a-dentist>.
2. Healthy Families' toll-free number or Web site can help you to find a dentist who takes Healthy Families insurance or to find out if your child can enroll in the program: 1-800-880-5305 or <http://www.benefitscal.com/>.
3. For additional resources that may be helpful, contact your local public health department at [www.maderacounty.com](http://www.maderacounty.com)

Remember, your child is not healthy and ready for school if he or she has poor dental health! Here is important advice to help your child stay healthy:

- Take your child to the dentist twice a year.
- Choose healthy foods for the entire family. Fresh foods are usually the healthiest foods.
- Brush teeth at least twice a day with toothpaste that contains fluoride.



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The school nurse is at this school to do specific state mandated health screenings. These screenings include but are not limited to **vision, color vision, hearing and tympanograms**. (California Educational Code 49452, 49452.5)

Screenings for vision and hearing are routinely done on kindergarten/new first, second, fifth and eighth graders. Color vision is done on kindergarten/new first grade boys. However, these health screenings may be done on other students at the parent's or teacher's request.

If you **do not** want to have these state mandated health screenings it is **your responsibility** to notify the school in writing each year.

If you have any questions please feel free to contact the school. They should be able to answer your questions. If not, they know how to contact me for information.

Amy Sheller  
School Nurse

# CHAWANAKEE UNIFIED SCHOOL DISTRICT

## Confidential Developmental History (Kindergarten)

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last) (First) (Middle)

### For Kindergarten/Pre-School Students:

Please print

Length of pregnancy \_\_\_\_\_ Birth weight \_\_\_\_\_ Baby cried right away: Yes No

Labor/Delivery: Normal Difficult Caesarian If Caesarian, was it: Planned Emergency

Prenatal care from month number \_\_\_\_\_ with Dr. \_\_\_\_\_ Phone \_\_\_\_\_

While pregnant, did student's mother smoke? Yes No If yes, how much, how often? \_\_\_\_\_

Did mother drink alcohol? Yes No If yes, how much, how often? \_\_\_\_\_

Did mother take medications or drugs? Yes No If yes, how much, how often? \_\_\_\_\_

Baby was born at: home hospital (name of hospital): \_\_\_\_\_

Baby had jaundice (yellow) and was treated with: lights transfusion

Baby was blue and needed: resuscitation oxygen incubator How long? \_\_\_\_\_

Baby was: strong floppy mellow fussy other \_\_\_\_\_

Baby: was very hard to calm or soothe was difficult to feed had problem with weight gain

At what age did your baby: walk alone \_\_\_\_\_ say first words \_\_\_\_\_  
say phrases \_\_\_\_\_ toilet train \_\_\_\_\_

Is child able to: Dress self? Yes No Do buttons? Yes No Ride tricycle? Yes No  
Ride Bicycle? Yes No

Compared to your other children, this child developed: faster slower the same only child

Which hand does your child use most often? right left both haven't decided

Has your child attended preschool? Yes No If yes, when and where? \_\_\_\_\_

Please check any of the following that usually apply to your son/daughter:

gets along well	is always moving	misunderstands
shares	acts without thinking	doesn't listen
takes turns	quick to anger	doesn't remember instructions
acts shy	cries easily	clumsy
prefers quiet activities	daydreams, tunes out	accident prone
is able to sit and listen to a story for 10 minutes		
listens without interrupting while someone else is talking		
strangers can easily understand his/her speech		
other concerns/comments _____		

Date \_\_\_\_\_ Parent Signature \_\_\_\_\_

**Chawanakee Unified School District  
Student Health Information**

Student Name: \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last                                  First                                  Initial

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_


**PARENT/GUARDIAN:** Please check the appropriate box(es), if any, that best describes your student's current health condition(s) and return the completed form to school. Please provide specific information regarding conditions that may affect student learning and participation in school activities.


**MEDICATION:** All medication (prescription, over-the-counter, homeopathic remedies, vitamins, etc.), *which is to be administered during the school day, or during school-sponsored activities*, requires an Authorization for Medication Administration to be completed and signed by physician and parent. Students are not allowed to carry medication and/or inhalers without a signature by physician and parent on Authorization for Medication Administration form.

✓	Health Condition	Medication	Specific Information
<input type="checkbox"/>	ADD/ADHD		
<input type="checkbox"/>	Allergy-Bee/Insect     Life Threatening Yes/No		
<input type="checkbox"/>	Allergy-Food           Life Threatening Yes/No		
<input type="checkbox"/>	Allergy-Medication   Life Threatening Yes/No		
<input type="checkbox"/>	Allergy-Other(animal,latex,etc.) Life Threatening Yes/No		
<input type="checkbox"/>	Asthma-Mild to Moderate or <b>Serious</b> (circle one)		
<input type="checkbox"/>	Autism		
<input type="checkbox"/>	Birth Defect/Genetic Disorder		
<input type="checkbox"/>	Bladder/Kidney Problem		
<input type="checkbox"/>	Blood disorders (Chronic)		
<input type="checkbox"/>	Cerebral Palsy		
<input type="checkbox"/>	Chicken Pox (Varicella Disease) <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	Colitis/Crohn's Disease		
<input type="checkbox"/>	Diabetes <b>(Requires meeting w/District Nurse)</b>		
<input type="checkbox"/>	Down Syndrome/Intellectual Disability		
<input type="checkbox"/>	Emotional/Psychological/Eating Disorder		
<input type="checkbox"/>	Hearing Problems (infections, tubes, nerve damage, etc.)		
<input type="checkbox"/>	Deaf/Hard of Hearing <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear		
<input type="checkbox"/>	Hearing Aids <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear		
<input type="checkbox"/>	Heart Problems—No restrictions or Restrictions (circle one)		
<input type="checkbox"/>	Hemophilia — Call District Nurse		
<input type="checkbox"/>	Hypoglycemia/physician diagnosed		
<input type="checkbox"/>	Medication Taken at Home, explain		
<input type="checkbox"/>	Medication Taken at School (Requires physician note)		
<input type="checkbox"/>	Menstrual Problems (Severe)		
<input type="checkbox"/>	Migraine Headaches (physician diagnosed, list med)		
<input type="checkbox"/>	Nosebleeds — Severe		
<input type="checkbox"/>	Orthopedic Condition-Description:		
<input type="checkbox"/>	Physical Activity Limitation (Requires physician note)		
<input type="checkbox"/>	Prosthesis		
<input type="checkbox"/>	Scoliosis (physician diagnosed)		
<input type="checkbox"/>	Seizure Disorder-Type:		
<input type="checkbox"/>	Sickle Cell Anemia (explain)		
<input type="checkbox"/>	Skin Disorder		
<input type="checkbox"/>	Speech Difficulties		
<input type="checkbox"/>	Traumatic Brain Injury		
<input type="checkbox"/>	Tuberculosis/or history of positive skin tests Chest X-ray required w/positive skin test. List Med		
<input type="checkbox"/>	Visual Impairment <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye		
<input type="checkbox"/>	Glasses/Contact lens <input type="checkbox"/> Distance <input type="checkbox"/> Reading		
<input type="checkbox"/>	<b>Other Health Concern(s) not listed-Describe:</b>		
<input type="checkbox"/>	<b>NO HEALTH CONCERNS AT THIS TIME</b>		

Do you currently have Health Insurance/Medi-cal?    Yes No    Dental Insurance    Yes No    Vision Insurance    Yes No  
 If yes, please state name of insurance company or companies: \_\_\_\_\_

**IF IN NEED OF EMERGENCY MEDICAL CARE AND WE ARE NOT ABLE TO CONTACT YOU, WE WILL CALL 911.**

 \_\_\_\_\_  
Parent/Guardian Signature

 \_\_\_\_\_  
Date

PLEASE READ SCHOOL NURSE RESPONSIBILTIES ON THE OTHER SIDE OF THIS FORM    (Rev 12/10cq)



**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: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:	Child's race/ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other _____ <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown		

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

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

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

**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.



## 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 285).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DTPa/DTP/dTdT (diphtheria, tetanus, and acellular pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
H1B MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER (e.g., TB Test, if indicated)					
OTHER					

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

#### RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

- Examination shows no condition of concern to school program activities.
- Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: (please explain)

#### RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

Please check this box if you do not want the health examiner to fill out Part III.

Signature of parent or guardian  Date

Name, address, and telephone number of health examiner

Signature of health examiner  Date

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.  
CHDP website: [www.dhs.ca.gov/services/chdp](http://www.dhs.ca.gov/services/chdp)

### WAIVER OF HEALTH EXAMINATION FOR SCHOOL ENTRY

CHILD'S NAME—Last		First	Middle	DATE OF BIRTH—Month/Day/Year	
ADDRESS—Number, Street		City	ZIP Code	SCHOOL	Teacher

**PARENT OR GUARDIAN:**

Please fill out this form if you want to excuse your child from the health examination required by California law for school entry. **SIGN AND RETURN THIS FORM TO THE SCHOOL** where it will be maintained as confidential information.

**NOTE: SIGNING THIS WAIVER DOES NOT EXCUSE YOUR CHILD FROM RECEIVING THE IMMUNIZATIONS REQUIRED BY CALIFORNIA LAW FOR CHILDREN IN SCHOOL. ALSO, SIGNING THIS WAIVER WILL NOT DENY YOUR CHILD THE VISION AND HEARING TESTS DONE BY THE SCHOOL.**

I have been informed about the health examination recommended by health professionals and required by state law. I have been informed about where my child can receive a health examination and about the income levels for receiving it at no cost to me.

Please check one of the following:

I choose not to have my child receive a health examination as part of the school entry requirement.

I would like my child to receive a health examination, but I am unable to obtain it.

Reason (see Health and Safety Code, Section 124085): \_\_\_\_\_

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

INQUIRE AT THE SCHOOL OFFICE OR YOUR LOCAL HEALTH DEPARTMENT IF YOU WANT MORE INFORMATION.

CHDP website: [www.dhcs.ca.gov/services/chdp](http://www.dhcs.ca.gov/services/chdp)