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)

CHAWANAKEE
UNIFIED SCHOOL DISTRICT

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
Darren Q. Sylvia
Superintendent

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

CHAWANAKEE

26065 Outback Industrial Way, O'Neals, CA 93645
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Darren Q. Sylvia
Superintendent

□ 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 4th birthday)
   - 5 DTaP, DPT or DT (4 doses meets requirement if at least one was given on or after the 4th birthday)
   - 2 MMR or MMR-V (both on or after 1st 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

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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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

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

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: ▫ 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

State of California—Health and Human Services Agency

Department of Health Care Services
Child Health and Disability Prevention (CHDP) Program

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.

PM 171 A (09/07) (Bilingual)

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

State of California—Health and Human Services Agency

Department of Health Care Services
Child Health and Disability Prevention (CHDP) Program

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