

BELMONT-REDWOOD SHORES SCHOOL DISTRICT
STUDENT REGISTRATION FORM
2010-2011 School Year

STUDENT INFORMATION:

Date _____	Grade: PS	K	1	2	3	4	5	6	7	8	(Circle One)
Resident School: <input type="checkbox"/> Central <input type="checkbox"/> Cipriani <input type="checkbox"/> Fox <input type="checkbox"/> Nesbit <input type="checkbox"/> Redwood Shores <input type="checkbox"/> Sandpiper <input type="checkbox"/> Ralston											

1. Child's Last Name _____ First Name _____ Middle _____ Sex (M/F) _____ Social Security Number _____

2. Address Where Child Lives _____ City/Zip _____ Home Phone Number _____

3. Birthplace: _____ City/State/County _____ Birthdate: Mo. Day Year _____

4. Name/Address of Last School Attended _____ School Phone Number _____

5. Has your child ever been enrolled in a special program? ** Yes No

RSP (Resource Specialist Program) Title 1 Speech & Language
 SDC (Special Day Class) GATE (Gifted & Talented) ELL (English Language Learner)

Date student first enrolled in U.S. school _____

6. Does your child have a current IEP (Individualized Educational Program)? ** Yes No

***Note to school secretary: If any programs are checked on #5 or #6 above, send copy of Registration Form to District Office, Special Education Services Department.*

PARENT INFORMATION

7. Indicate with whom the child lives: Parents (both) Mother Father Shared Custody

Other legal guardian; please state relationship _____

FATHER	MOTHER
<input type="checkbox"/> Natural <input type="checkbox"/> Step-father <input type="checkbox"/> Other	<input type="checkbox"/> Natural <input type="checkbox"/> Step-mother <input type="checkbox"/> Other
Name _____	Name _____
Home Address _____	Home Address _____
Home Phone _____	Home Phone _____
Pager/Cellular _____	Pager/Cellular _____
Work Phone _____	Work Phone _____
E-mail address _____	E-mail address _____
Employed by _____	Employed by _____
Occupation _____	Occupation _____
<u>Education level</u>	
<input type="checkbox"/> Not high school graduate <input type="checkbox"/> College graduate <input type="checkbox"/> High school graduate <input type="checkbox"/> Graduate School <input type="checkbox"/> Some college <input type="checkbox"/> Decline to answer/unknown	<input type="checkbox"/> Not high school graduate <input type="checkbox"/> College graduate <input type="checkbox"/> High school graduate <input type="checkbox"/> Graduate School <input type="checkbox"/> Some college <input type="checkbox"/> Decline to answer/unknown

9. OTHER CHILDREN IN HOUSEHOLD:

Last Name	First Name	Sex M/F	School	Birthdate: Mo / Day / Year
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EMERGENCY HEALTH INFORMATION

10. In case of emergency, I authorize the school to call or take my child to:

_____ Physician Name	_____ Phone Number	_____ Hospital Preferred	_____ Phone Number
_____ Insurance Company	_____ Insurance ID number	_____ Plan number	
_____ Dentist Name	_____ Phone Number		

Other emergency care contact:

If I cannot be reached, I authorize the school to call, release my child to, or take my child to:

_____ Name	_____ Relationship	_____ Phone Number
_____ Name	_____ Relationship	_____ Phone Number

I CONSENT FOR EMERGENCY TREATMENT if it is deemed necessary by the school authorities and after all efforts to reach the parent or designated adult have failed. Your son/daughter will be taken by **ambulance at parent's expense** to the nearest emergency facility.

I WILL NOTIFY THE SCHOOL EACH TIME THERE IS A CHANGE IN ANY OF THIS INFORMATION.

_____ Parent/Guardian Signature	_____ Date
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MEDICAL CONDITIONS: (✓ all that apply)

- On Medication If so, name of medication: _____
 - Allergies If so, allergic to what: _____
 - Limited PE If so, limited to what: _____
 - Heart Problems Seizure Disorders Asthma Diabetes Glasses/Contacts Hearing Problems
- Explanations or comments about medical conditions the school should be aware of: _____

*******NOTE*******

If it is necessary for your child to take medication at school, you must provide the school with the physician's written instruction and your written permission. Medication at school must be kept in the original pharmacy container. No medicine of any kind (prescriptions or non-prescription drugs including aspirin or aspirin substitutes) will be given at school unless the above conditions are met.

11. LANGUAGE SURVEY

This survey is required of all children registered at our school. It helps us receive funds that provide services to students who need extra help with English. Please list one language per question.

- A. What language did your child learn when he/she first began to talk? _____
- B. What language does your child most frequently use at home? _____
- C. What language do you use most frequently to speak to your child? _____
- D. What is the language most often spoken by the adults in your home? _____
- E. Is your child currently in an ELL/Bilingual Program? Yes No

12. WHAT IS YOUR CHILD'S ETHNICITY? (Please check one) Hispanic or Latino Not Hispanic or Latino

13. WHAT IS YOUR CHILD'S RACE? (Select one or more)

- | | | | |
|--|---------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Cambodian | <input type="checkbox"/> Korean | <input type="checkbox"/> Guamanian |
| <input type="checkbox"/> White | <input type="checkbox"/> Chinese | <input type="checkbox"/> Laotian | <input type="checkbox"/> Hawaiian |
| | <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Samoan |
| | <input type="checkbox"/> Hmong | <input type="checkbox"/> Other Asian | <input type="checkbox"/> Tahitian |
| | | | <input type="checkbox"/> Other Pacific Islander |

_____ Signature of Parent/Guardian	_____ Date
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Belmont-Redwood Shores Elementary School District

Informal Primary Language Survey (Form: EL2)

Dear Parent:

Your child recently enrolled in the Belmont-Redwood Shores Elementary School District. When you filled out the Home Language Survey on the registration form, you indicated that you, your child, or someone in your home spoke a language other than English. We would like to know more about your child's skills in your home language. ***Please complete and return this form to your child's school as soon as possible.***

Student's name: _____ Grade: _____ School: _____ Date: _____

Date student first enrolled in an U.S. school: _____

Please circle or write in your answer.

Oral Language

- Is your son/daughter able to understand almost everything that is said in his/her home language? Yes No
- My child uses English most of the time and does not use our home language very often. Yes No
- Is your son/daughter able to speak your home language as well as most children of his/her age who speak this language? Yes No
- Does your son/daughter have difficulty understanding what you say in your home language? Yes No
- Do you have any problems understanding what your child says to you in your home language? Yes No
- What percentage of time do you speak your home language with your child? 25% 50% 75% 100%

Literacy (for grades 2 through 8)

- Does your son/daughter read in your home language as well as most children of his/her age who read in this language? Yes No
- Please describe your child's ability to read in your home language, when compared to children of his/her age:
_____ Does not read _____ Reads very little _____ Is a competent reader
- Does your son/daughter write in your home language as well as most children of his/her age who write in this language? Yes No
- Please describe your child's ability to write in your home language, when compared to children of his/her age:
_____ Does not write _____ Writes very little _____ Is a competent writer

School Experience

- Did your child have an opportunity to attend school in your home country? Yes No
- If yes, what grade level did he/she complete? _____
- How many total years has your child attended school? _____

If you have any questions about this form, please contact the principal at your child's school. Thank you for your cooperation.

PARENTS:

Children need more shots before they can begin kindergarten.

They should have:

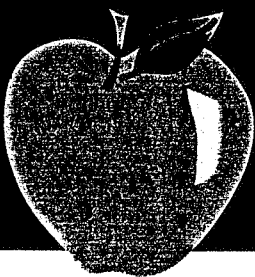
5 DTaP shots

4 Polio

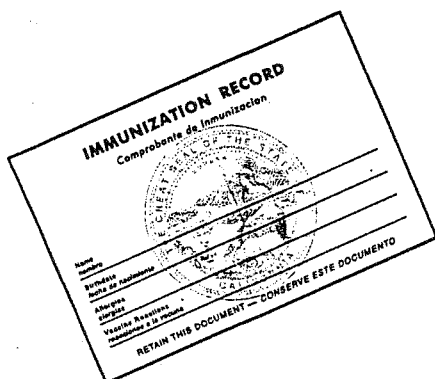
3 Hep B

2 MMR*

1 Chickenpox



*Both must be after 1st birthday.



See your child's doctor now to make sure your child's immunization record has dates for these shots. We will need to see this Immunization record to register your child.

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 _____ SCHOOL _____

ZIP code _____

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/DT/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.



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, pídale al examinador de salud que llene este informe y entregelo a la escuela—este informe será 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)	/ /
Pruebas con Tuberculina (Mantoux/PPD)	/ /
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/DT/dT/d (difteria, tétano y [acelular] pertusis [los 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					
VARICELA (Viruelas locas)					
OTRA					
OTRA					

PARTE III INFORMACIÓN ADICIONAL DEL EXAMINADOR DE SALUD (opcional) Y PERMISO PARA DIVULGAR (DISTRIBUIR) EL INFORME DE SALUD

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)

Por favor marque esta caja si Ud. no desea que el examinador llene la Parte III.

Firma del padre/madre o guardián	Fecha
Nombre, domicilio, y teléfono del examinador	
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 Jóvenes (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.dhs.ca.gov/chdp*