2017-2018
REGISTRATION FOR
OLIVET, SCHAEFER & JACK LONDON SCHOOLS
BEGINS:
FRIDAY, JANUARY 13, 2017

► PLEASE RETURN: o Completed REGISTRATION PACKET to:
               your SCHOOL OF ATTENDANCE BOUNDARY

► PLEASE BRING:  o Proof of Residency (at least one)
                    Utility Service Payment Receipt, Rent Payment, Property Tax Payment
                    o County Certified BIRTH CERTIFICATE
                    o Original IMMUNIZATION RECORD
                    o Proof of ORAL HEALTH ASSESSMENT
► If you have any questions, please call the Office Manager of your school of
  attendance boundary during the times listed below. Thank you!

OLIVET ELEMENTARY
CHARTER SCHOOL
1825 Willowside Rd.
522-3045
Monday – Friday
8:00 a.m. – 4:00 p.m.

JACK LONDON
ELEMENTARY SCHOOL
2707 Francisco Ave
522-3030
Monday – Friday
8:00 a.m. – 4:00 p.m.

SCHAEFER CHARTER
SCHOOL
1370 San Miguel Ave.
522-3015
Monday – Friday
8:00 a.m. – 4:00 p.m.

INTERDISTRICT TRANSFERS
Piner-Olivet District Office
Cathy Manno
3450 Coffey Lane
522-3000
Monday – Friday
8:00 a.m.- 4:00 p.m.
**REGISTRATION CHECK SHEET**

Name of Student________________________________________________ Date of Birth_____________

Name of Parent(s)_________________________________ Grade _____ In the School Year of_______

Address __________________________________________________Zip Code_____________________

Home Ph____________________        Cell Ph __________________        Work Ph__________________

*PLEASE NOTE:*
Registration is not complete until all forms and immunizations are completed and verified.

**OFFICE USE ONLY**

- [ ] REGISTRATION FORM
- [ ] TECHNOLOGY
- [ ] EMERGENCY CARD
- [ ] LIBRARY
- [ ] BIRTH CERTIFICATE (**MUST BRING ORIGINAL**)  
- [ ] PROOF OF RESIDENCY
- [ ] RELEASE OF STUDENT RECORDS

**MEDICAL INFORMATION:**

- [ ] HEALTH HISTORY
- [ ] ORAL HEALTH ASSESSMENT
- [ ] IMMUNIZATIONS RECORD (**MUST BRING ORIGINAL**)  
  - [ ] Complete    [ ] Incomplete

**IMMUNIZATIONS NEEDED:**

- Polio:   #1____  #2____  #3____  #4____  #5____
- DTP:     #1____  #2____  #3____  #4____  #5____
- MMR:     #1____  #2____
- Hepatitis B  #1____  #2____  #3____
- Varicella (Chickenpox) #1____

Date of appointment for immunizations: ____________________

- [ ] PHYSICIANS’ REPORT  
  - [ ] Complete    [ ] Incomplete

Date of appointment for physical: ___________________________

Comments:______________________________________________________________

Staff initial: __________   Date Packet Received:__________

**WHITE - Office Copy**  
Q:\Forms\SCHOOL FORMS\REGISTRATION PACKET INFORMATION\REGISTRATION REGISTRATION FORMS Kindergarten\2010-11 Kindergarten Registration Check Sheet - Kindergarten Registration.doc

**YELLOW - Parent Copy**  
Updated: /4/13
### Student Registration Information (Please Print)

<table>
<thead>
<tr>
<th>CHILD'S LEGAL LAST NAME</th>
<th>FIRST</th>
<th>M. INITIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Address**
- Apt. 

**City**
- State
- Zip

**Phone Number**

**Child's Birth Place**
- State
- Zip

**School Last Attended**
- Dates:

<table>
<thead>
<tr>
<th>School Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

- Date first attended a California School: 
- Date first attended United States School: 

**Ethnic Background**

- American Indian or Alaskan
- Hawaiian
- Chinese
- Guamanian
- Japanese
- Samoan
- Korean
- Tahitian
- Vietnamese
- Other Pacific Islander
- Asian Indian
- Filipino
- Laotian
- Latino/Hispanic
- Cambodian
- Black or African-American
- Other Asian
- White (not Hispanic)

**Special Services Student Has Received**

- Resource Specialist Program
- Gifted Program (GATE)
- Special Education Class
- Counseling
- Speech/Language Therapy
- Health Problem
- Special Reading Help
- Title I
- Other
- ESL/ELD Program

**Home Language Survey**

The California Education Code requires schools to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students. Your cooperation in helping us meet the requirement is requested.

Please answer the following:

1. What language did your child learn when first beginning to talk?
2. What language does your child most frequently use at home?
3. What language do you most frequently speak to your child?
4. Name the language most often spoken by the adults in the home.

**Family Information (Please Print)**

<table>
<thead>
<tr>
<th>FATHER’S NAME</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Birth Place**

**Mother’s Name**

**Birth Mother’s Maiden Name**

**Address (if other than student’s)**

- Name of Step/Foster Parent - Guardian

- If student lives with other than both natural parents full time, please explain: (Please attach pertinent court orders)

**Parent with Highest Level of Education**

- Graduate school or, postgraduate training: 
- High school graduate: grade completed
- College graduate: Not a high school graduate
- Some college: Declined to state or unknown

**Other Children Attending Piner-Olivet Schools:**

(Please list oldest child first)

<table>
<thead>
<tr>
<th>Name</th>
<th>School</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other Children Living in Household**

<table>
<thead>
<tr>
<th>Name</th>
<th>Birthdate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Parent’s/Guardian’s Signature**

Date
**STUDENT INFORMATION SHEET**

*PLEASE PRINT ALL INFORMATION*

*RETURN TO SCHOOL OFFICE*

*This is a temporary form—you will receive an emergency card requesting extensive information on the first day of school.*

<table>
<thead>
<tr>
<th>Name(Last)</th>
<th>Name(first)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date</td>
<td>Home Phone:</td>
</tr>
<tr>
<td>Male ☐ Female ☐</td>
<td>Grade:</td>
</tr>
<tr>
<td>Address</td>
<td>City:</td>
</tr>
<tr>
<td>Zip Code:</td>
<td></td>
</tr>
</tbody>
</table>

**MOTHER:**

<table>
<thead>
<tr>
<th>Home Phone Number:</th>
<th>Cell:</th>
</tr>
</thead>
</table>

**FATHER:**

<table>
<thead>
<tr>
<th>Home Phone Number:</th>
<th>Cell:</th>
</tr>
</thead>
</table>

**E-mail:**

<table>
<thead>
<tr>
<th>Employer:</th>
<th>Work Phone Number:</th>
</tr>
</thead>
</table>

**Student lives with:**

<table>
<thead>
<tr>
<th>Relationship:</th>
</tr>
</thead>
</table>

If other than both parents (above), please supply name and address of non-resident parent:

<table>
<thead>
<tr>
<th>Name:</th>
<th>School:</th>
</tr>
</thead>
</table>

**Siblings Attending District**

<table>
<thead>
<tr>
<th>Name:</th>
<th>School:</th>
</tr>
</thead>
</table>

In case of an Emergency, (illness/accident) or Disaster, (flooding/earthquake/etc.), I authorize school personnel to release my child to the individuals, *other than parent* (In order or preference) below:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Home Phone:</th>
<th>Cell:</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Home Phone:</th>
<th>Cell:</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EMERGENCY INFORMATION**

- I DO authorize
- I DO NOT authorize my son/daughter to be taken to the nearest medical center for treatment, *(if I am unavailable)*

<table>
<thead>
<tr>
<th>Hospital:</th>
<th>Physician:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SERIOUS HEALTH PROBLEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Please Note all Health Concerns &amp; any New Concerns)</td>
</tr>
</tbody>
</table>

In case of an emergency, I DO authorize I DO NOT authorize my son/daughter to be given a blood transfusion, *(if I am unavailable)*

<table>
<thead>
<tr>
<th>OFFICE USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSO</td>
</tr>
<tr>
<td>EPI-PEN</td>
</tr>
<tr>
<td>GRANTED</td>
</tr>
<tr>
<td>DENIED</td>
</tr>
</tbody>
</table>

**TRAINING SCHOOL PERSONNEL TO ADMINISTER EMERGENCY TREATMENT (ADRENALINE VIA EPI-PEN) TO MY CHILD**

* Signature of Parent/Guardian  Date
PREVIOUS SCHOOL INFORMATION: (INFORMACIÓN DE LA ESCUELA ANTERIOR:)

Name of previous school (Nombre anterior de la escuela)

Address (Dirección)  Area code (código de area)  Telephone (Teléfono)

City (Ciudad)  State (Estado)  Zip (Código postal)  Area code (código de area)  FAX (Número de fax)

RELEASE OF STUDENT RECORDS: (LANZAMIENTO DE LOS EXPEDIENTES DEL ESTUDIANTE:)

In accordance with the Family Educational Rights and Privacy Act of 1974 and California State Law, I hereby authorize the release of the school name below of all records, including grades and health records, as well as psychological, social, educational, or developmental information regarding the following pupil(s).

(De conformidad con los Derechos Educativos Familiares y Ley de Privacidad de 1974 y la Ley del Estado de California, Yo autorizo la liberación de la escuela nombrada a continuación todos los expedientes, incluidos los grados y los historiales médicos, así como psicológicos, sociales, educativos o de desarrollo en relación con la información siguiente del alumno (s).)

Name (Nombre)  Date of Birth (Fecha de nacimiento)  Grade (Grado)

▼ Parent Signature (Firma del padre)  Date (Fecha)

Office Use Only: (Uso de Oficina Solamente:)

CELDT SCORE: (If Applicable)

Under State and Federal Law, schools and school districts are required to provide student CELDT results to schools receiving English Learner students.

➢ Please complete the CELDT Score section below and return it to the receiving school immediately.

Has student taken the CELDT?  _____ NO  _____ YES  SSID # __________________

If reclassified, provide date: ______________________ (If reclassified, please send documentation.)

Scale Score  Level  Date Testing Completed:

Listening/Speaking

Reading

Writing

Overall

PLEASE SEND RECORDS TO:

☒ OLIVET ELEMENTARY CHARTER SCHOOL
1825 Willowside Rd.
Santa Rosa, CA 95401
(707) 522-3045
(707) 522-3047 Fax

☒ SCHAEFER CHARTER SCHOOL
1370 San Miguel Ave.
Santa Rosa, CA 95403
(707) 522-3015
(707) 522-3017 Fax

☒ JACK LONDON ELEMENTARY SCHOOL
2707 Francisco Avenue
Santa Rosa, CA 95403
(707) 522-3030
(707) 522-3317 Fax

☒ PINER-OLIVET CHARTER
2707 Francisco Avenue
Santa Rosa, CA 95403
(707) 522-3310
(707) 522-3317 Fax

☒ NORTHWEST PREP CHARTER SCHOOL
2590 Piner Rd.
Santa Rosa, CA 95403
(707) 522-3320
(707) 522-3101 Fax
Sonoma County Office of Education  
STUDENT HEALTH HISTORY

<table>
<thead>
<tr>
<th>Date: ___________________________</th>
<th>School: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student’s Name:</td>
<td>Sex: M      F</td>
</tr>
<tr>
<td>Birthdate: _______________________</td>
<td>Teacher: __________________________</td>
</tr>
<tr>
<td>Parent/Guardian:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>Apt.</td>
</tr>
<tr>
<td>Telephone: (Home) ( )</td>
<td>(Work) ( )</td>
</tr>
</tbody>
</table>

HAS YOUR CHILD HAD ANY OF THE FOLLOWING:
- Chicken Pox
- Tuberculosis
- Diabetes
- Asthma
- Allergies
- Stinging Inset Allergy
- Heart Problems
- Behavior Problems
- Convulsion, Seizure
- Frequent Colds
- Recurring Ear Infections
- Eye Problems
- Movement Limitation
- Recent illness, hospitalization, surgery or other physical condition which limits your child’s physical activity at school

Please provide additional information for any of the above conditions checked:
__________________________________________________________________________

➢ ALL MEDICATION SENT TO SCHOOL MUST BE IN THE PRESCRIPTION CONTAINER WITH A CURRENT DATE.

Does your child require medication while at school?  o Yes  o No
If yes, please complete an “Authorization for Administration of Medication” (obtain form from the school secretary)

Please indicate:
<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Hour(s) given</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Date of last physical exam:   /   /   Doctor __________________________
Date of last dental exam:     /   /   Dentist __________________________

Does your child wear glasses?  o Yes  o No

Does your child have any medical condition which might require care while at school or which might restrict his/her physical activity, such as in contact sports? (Please describe)
__________________________________________________________________________

Information obtained from this health history may be included on a confidential health conditions list, if appropriate. For more information/concerns, please contact the school nurse.

PARENT SIGNATURE ___________________________ DATE ___________________________

White: CUM File                                  Yellow: Health Office

Updated: 12-18-03
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)**

<table>
<thead>
<tr>
<th>Child's First Name:</th>
<th>Last Name:</th>
<th>Middle Initial:</th>
<th>Child's birth date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Apt.:</th>
<th>City:</th>
<th>ZIP code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School Name:</th>
<th>Teacher:</th>
<th>Grade:</th>
<th>Child's Sex:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Male</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Name:</th>
<th>Child's race/ethnicity:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ White      □ Black/African American □ Hispanic/Latino □ Asian</td>
</tr>
<tr>
<td></td>
<td>□ Native American □ Multi-racial □ Other___________</td>
</tr>
<tr>
<td></td>
<td>□ Native Hawaiian/Pacific Islander □ Unknown</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Assessment Date:</th>
<th>Caries Experience (Visible decay and/or fillings present)</th>
<th>Visible Decay Present:</th>
<th>Treatment Urgency:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ No obvious problem found</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Urgent care needed (pain, infection, swelling or soft tissue lesions)</td>
</tr>
</tbody>
</table>

**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.*
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.

<table>
<thead>
<tr>
<th>REQUIRED TESTS/EVALUATIONS</th>
<th>DATE (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health History</td>
<td></td>
</tr>
<tr>
<td>Physical Examination</td>
<td></td>
</tr>
<tr>
<td>Dental Assessment</td>
<td></td>
</tr>
<tr>
<td>Nutritional Assessment</td>
<td></td>
</tr>
<tr>
<td>Developmental Assessment</td>
<td></td>
</tr>
<tr>
<td>Vision Screening</td>
<td></td>
</tr>
<tr>
<td>Audiometric (hearing) Screening</td>
<td></td>
</tr>
<tr>
<td>TB Risk Assessment and Test, if indicated</td>
<td></td>
</tr>
<tr>
<td>Blood Test (for anemia)</td>
<td></td>
</tr>
<tr>
<td>Urine Test</td>
<td></td>
</tr>
<tr>
<td>Blood Lead Test</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

IMMUNIZATION RECORD

VACCINE

<table>
<thead>
<tr>
<th>DATE EACH DOSE WAS GIVEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>POLIO (OPV or IPV)</td>
</tr>
<tr>
<td>DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular pertussis] OR (tetanus and diphtheria only)</td>
</tr>
<tr>
<td>MMR (measles, mumps, and rubella)</td>
</tr>
<tr>
<td>HIB MENINGITIS (Haemophilus Influenzae B)</td>
</tr>
<tr>
<td>HEPATITIS B</td>
</tr>
<tr>
<td>VARICELLA (Chickenpox)</td>
</tr>
<tr>
<td>OTHER (e.g., TB Test, if indicated)</td>
</tr>
<tr>
<td>OTHER</td>
</tr>
</tbody>
</table>

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
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, pidale al examinador de salud que llene este informe y entregue 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

<table>
<thead>
<tr>
<th>NOMBRE DEL NIÑO/NINA—Apellido</th>
<th>Primer Nombre</th>
<th>Segundo Nombre</th>
<th>FECHA DE NACIMIENTO—Mes/Día/Año</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOMICILIO—Número y Calle</td>
<td>Ciudad</td>
<td>Zona Postal</td>
<td>Escuela</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>PRUEBA</th>
<th>FECHA(mm/dd/aa)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historia de Salud</td>
<td></td>
</tr>
<tr>
<td>Examen Físico</td>
<td></td>
</tr>
<tr>
<td>Evaluación de Dientes</td>
<td></td>
</tr>
<tr>
<td>Evaluación de Nutrición</td>
<td></td>
</tr>
<tr>
<td>Evaluación del Desarrollo</td>
<td></td>
</tr>
<tr>
<td>Pruebas Visuales</td>
<td></td>
</tr>
<tr>
<td>Pruebas con Audiómetro (auditivas)</td>
<td></td>
</tr>
<tr>
<td>Evaluación de Riesgo y prueba Tuberculosis*</td>
<td></td>
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<tr>
<td>Análisis de Sangre (para anemia)</td>
<td></td>
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<tr>
<td>Análisis de Orina</td>
<td></td>
</tr>
<tr>
<td>Análisis de Sangre para el plomo</td>
<td></td>
</tr>
<tr>
<td>Otra</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>PRUEBA</th>
<th>FECHA(mm/dd/aa)</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLIO (OPV o IPV)</td>
<td></td>
</tr>
<tr>
<td>DTaP/DTP/DT/Td (difteria, tétano y [acellular] pertusis [tos ferina]) O (tétano y difteria solamente)</td>
<td></td>
</tr>
<tr>
<td>MMR (sarampión, papera, rubéola)</td>
<td></td>
</tr>
<tr>
<td>HIB MENINGITIS (Hemófilo, Tipo B)</td>
<td>Requerida para centros de cuidado para niños y centros preescolares solamente</td>
</tr>
<tr>
<td>HEPATITIS B</td>
<td></td>
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<tr>
<td>VARICELLA (Viruelas locas)</td>
<td></td>
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<tr>
<td>OTRA (e.g. prueba TB, de ser indicado)</td>
<td></td>
</tr>
<tr>
<td>OTRA</td>
<td></td>
</tr>
</tbody>
</table>

PARTE III INFORMACIÓN ADICIONAL DEL EXAMINADOR DE SALUD (optional)

RESULTADOS Y RECOMENDACIONES

Llene esta parte si el padre/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)

*de ser indicado

PERMISO PARA DIVULGAR (DISTRIBUIR) EL INFORME DE SALUD

Yo le doy permiso al examinador de salud para que comparta con la escuela la información adicional de este examen como es explicado en la Parte III.

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

Firma del padre/madre o guardián Fecha

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 Jovenes (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.dhcs.ca.gov/services/chdp

PM 171 A (3/03) (Bilingual)
Dear Parents:

We are pleased to provide Internet services for our students. Use of the Internet for educational projects will assist in preparing your child for success in life and work in the 21st Century.

The District Use Policy restricts access to material that is inappropriate in the school environment. Although your student’s use of the Internet will be supervised by staff, we cannot guarantee that your child will not gain access to inappropriate material.

We would like to encourage you to use this as an opportunity to have a discussion with your child about your family values and your expectations about how these values should guide your child’s activities while they are on the Internet. It is also a good time to caution children about talking to or e-mailing strangers.

PINER-OLIVET UNION SCHOOL DISTRICT

TECHNOLOGY PROMISES

ACCEPTABLE USE POLICY
WHILE ATTENDING PINER-OLIVET UNION SCHOOL DISTRICT

I promise never to give out personal information such as my address, telephone number, or the name and location of my school.

I promise to tell my teacher or parents right away if I come across any information that makes me feel uncomfortable.

I promise to never agree to get together with someone I “meet” online without checking with my teacher or parents.

I promise to never send a person my picture or anything else without checking with my teacher or parents.

I promise to never send or respond to any messages that are mean or in anyway make me or someone else feel uncomfortable.

I promise that I will not access areas that are not approved by my teacher, librarian, or technology lab personnel.

I promise not to break these rules.

If I break these rules, I understand that I will not be allowed to access the Internet in my classroom, the library or technology lab during the school year.

Please return to your child’s school office immediately. Thank you!

(PRINT) Student’s Name: ____________________________ Grade: _____

My Signature: _____________________________________________

My Parent’s Signature: _______________________________________

Date: _____________________________

White – CUM File

Yellow – Parent Copy

Updated: 11/1/15
Dear Parents:

The Piner-Olivet Union School District values having a strong library program at each school. In order to have quality library materials readily available, we ask for your support and help seeing that students observe the following:

1. Books need to be returned on time. K-3 students will have their books for one (1) week. Students in grades 4-6 will have their books for two (2) weeks.

2. Students are responsible for the care and condition of library materials in their possession. It will be necessary to charge parents for lost or damaged items. Students will lose their library privileges until their library record is clear.

3. Notices will be sent to students with outstanding books or fines. We would greatly appreciate a response as soon as possible so that we can clear our records and students can regain their library privileges. If students have outstanding books or fines, their report cards will be held until these are cleared.

Thank you for your support of the library program.

Please return to your child’s school office immediately. Thank you!

My child, ___________________________________________ in grade ____________

has my permission to check out library materials from the school library while attending Piner-Olivet Union School District. I understand that we are responsible for paying for lost or damaged items.

________________________________   _______________________
Parent Signature                  Date

**PLACE IN CUM FILE**