



2012-2013

KINDERGARTEN REGISTRATION FOR  
OLIVET, SCHAEFER & JACK LONDON SCHOOLS

BEGINS:

Thursday, FEBRUARY 2, 2012

- ▶ PLEASE RETURN:  Completed REGISTRATION PACKET to:  
your SCHOOL OF ATTENDANCE BOUNDARY
- ▶ PLEASE BRING:  County Certified BIRTH CERTIFICATE  
 Original IMMUNIZATION RECORD  
 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 SCHOOL  
Azura Leon  
1825 Willowside Rd.  
522-3045  
Monday – Friday  
9:00 a.m. – 3:00 p.m.

Jack London  
Sue Cole  
2707 Francisco Ave  
522-3030  
Monday – Friday  
9:00 a.m. – 3:00 p.m.

SCHAEFER SCHOOL  
Katie Birge  
1370 San Miguel Ave.  
522-3015  
Monday – Friday  
9:00 a.m. – 3:00 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.





**PINER-Olivet UNION SCHOOL DISTRICT  
KINDERGARTEN REGISTRATION CHECK SHEET  
www.pousd.org**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Name of Parent(s) \_\_\_\_\_ Grade **K** 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**

- |   |                                     |
|---|-------------------------------------|
| <input type="checkbox"/> REGISTRATION FORM                                    | <input type="checkbox"/> TECHNOLOGY |
| <input type="checkbox"/> EMERGENCY CARD                                       | <input type="checkbox"/> LIBRARY    |
| <input type="checkbox"/> BIRTH CERTIFICATE ( <b>**MUST BRING ORIGINAL**</b> ) |                                     |

**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

YELLOW - Parent Copy

**OFFICE USE ONLY**

Date Received \_\_\_\_\_  
 Date Enrolled \_\_\_\_\_  
 Inter \_\_\_\_\_ Intra \_\_\_\_\_ O/E \_\_\_\_\_  
 Displaced \_\_\_\_\_



**Piner-Olivet Union School District**  
 3450 Coffey Lane ♦ Santa Rosa, CA ♦ 95403-1919  
 (707) 522-3000 ♦ Fax (707) 522-3007

**OFFICE USE ONLY**

Grade \_\_\_\_\_  
 Teacher \_\_\_\_\_  
 School \_\_\_\_\_

**BIRTHDATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**MALE:**

**FEMALE:**

**STUDENT REGISTRATION INFORMATION (PLEASE PRINT)**

<b>CHILD'S LEGAL LAST NAME</b>	<b>FIRST</b>	<b>M. INITIAL</b>
<b>Address</b>		<b>Apt. #</b>
<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Phone Number</b>		
<b>Child's Birth Place</b>		<b>State Zip</b>
<b>School Last Attended</b>		<b>Dates:</b>
<b>School Address</b>	<b>City</b>	<b>State Zip</b>
• Date first attended a California School: ____ / ____ / ____ • Date first attended United States School: ____ / ____ / ____		
• <b>ETHNIC BACKGROUND</b> <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Hawaiian <input type="checkbox"/> Chinese <input type="checkbox"/> Guamanian <input type="checkbox"/> Japanese <input type="checkbox"/> Samoan <input type="checkbox"/> Korean <input type="checkbox"/> Tahitian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Cambodian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Other Asian <input type="checkbox"/> White (not Hispanic)		
• <b>SPECIAL SERVICES STUDENT HAS RECEIVED</b> <input type="checkbox"/> Resource Specialist Program <input type="checkbox"/> Gifted Program (GATE) <input type="checkbox"/> Special Education Class <input type="checkbox"/> Counseling <input type="checkbox"/> Speech/Language Therapy <input type="checkbox"/> Health Problem _____ <input type="checkbox"/> Special Reading Help <input type="checkbox"/> Title I <input type="checkbox"/> Other _____ <input type="checkbox"/> ESL/ELD Program		
• <b>HOME LANGUAGE SURVEY</b> 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)**

<b>FATHER'S NAME</b>		
<b>Birth Place</b>		<b>Occupation</b>
<b>MOTHER'S NAME</b>		
<b>Birth Mother's Maiden Name</b>		
<b>Birth Place</b>		<b>Occupation</b>
• <b>STUDENT LIVES WITH</b> <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> Foster Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Foster Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Other _____		
<b>Name of Step/Foster Parent - Guardian</b>		
<b>Address (if other than student's)</b>		
• If student lives with other than both natural parents <i>full time</i> , please explain: (Please attach pertinent court orders) _____ _____		
• <b>PARENT WITH HIGHEST LEVEL OF EDUCATION</b> <input type="checkbox"/> Graduate school or, postgraduate training <input type="checkbox"/> High school graduate: grade completed _____ <input type="checkbox"/> College graduate <input type="checkbox"/> Not a high school graduate <input type="checkbox"/> Some college <input type="checkbox"/> Declined to state or unknown		
• <b>OTHER CHILDREN ATTENDING PINER-OLIVET SCHOOLS:</b> (Please list oldest child first)		
<b>Name</b>	<b>School</b>	<b>Grade</b>
_____	_____	_____
<b>Name</b>	<b>School</b>	<b>Grade</b>
_____	_____	_____
<b>Name</b>	<b>School</b>	<b>Grade</b>
_____	_____	_____
• <b>OTHER CHILDREN LIVING IN HOUSEHOLD</b>		
<b>Name</b>	<b>Birthdate</b>	
_____	_____	
<b>Name</b>	<b>Birthdate</b>	
_____	_____	
<b>Name</b>	<b>Birthdate</b>	
_____	_____	

Parent's/Guardian's Signature

Date

WHITE - CUM

YELLOW - SPECIAL SERVICES (Send to District Office)

PINK - TEACHER



Olivet – Schaefer – Jack London Elementary Schools  
**TEMPORARY EMERGENCY PROCEDURE FORM**

**KINDERGARTEN - 6<sup>th</sup> GRADE NEW 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.

Name(Last)		Name(first)	
Male <input type="checkbox"/> Female <input type="checkbox"/>	Birth Date:	Home Phone:	Grade:
Address:		City:	Zip Code:
<b>MOTHER:</b>		<b>FATHER:</b>	
Home Phone Number:	Cell:	Home Phone Number:	Cell:
E-mail:		E-mail:	
Employer:	Work Phone Number:	Employer:	Work Phone Number:
Student lives with:		Relationship:	
If other than both parents (above), please supply name and address of non-resident parent:			
Siblings Attending District		School:	
Name:		School:	
Name:		School:	

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 of preference) below:

1	Name:	Home Phone:	Cell:
	Relationship:		
	Employer:	Work Phone:	
2	Name:	Home Phone:	Cell:
	Relationship:		
	Employer:	Work Phone:	

<p><b>EMERGENCY INFORMATION</b></p> <p><input type="checkbox"/> I DO authorize</p> <p><input type="checkbox"/> I DO NOT authorize my son/daughter to be taken to the nearest medical center for treatment, (if I am unavailable)</p> <p>Hospital: _____</p> <p>Physician: _____</p>	<p><b>SERIOUS HEALTH PROBLEMS</b></p> <p>(Please Note all Health Concerns &amp; any New Concerns)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>OFFICE USE ONLY</b></p> <p><input type="checkbox"/> RSO</p> <p><input type="checkbox"/> EPI-PEN</p> <p><input type="checkbox"/> GRANTED</p> <p><input type="checkbox"/> DENIED</p>
<p>In case of an emergency, <input type="checkbox"/> I DO authorize <input type="checkbox"/> I DO NOT authorize my son/daughter to be given a blood transfusion, (if I am unavailable)</p> <p>IN THE EVENT OF A LIFE-THREATENING ALLERGIC REACTION, <input type="checkbox"/> I DO authorize <input type="checkbox"/> I DO NOT authorize, TRAINED SCHOOL PERSONNEL TO ADMINISTER EMERGENCY TREATMENT (ADRENALINE VIA EPI-PEN) TO MY CHILD</p>		

Signature of Parent/Guardian

Date

# Sonoma County Office of Education STUDENT HEALTH HISTORY

Date: \_\_\_\_\_ School: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Sex: M F

Birthdate: \_\_\_\_\_ Teacher: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Street                      Apt.                      City                      Zip

Telephone: (Home) ( ) \_\_\_\_\_ (Work) ( ) \_\_\_\_\_

**HAS YOUR CHILD HAD ANY OF THE FOLLOWING:**

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies	<input type="checkbox"/> Stinging Inset Allergy
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Convulsion, Seizure
<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Recurring Ear Infections	<input type="checkbox"/> Eye Problems
<input type="checkbox"/> Movement Limitation		
<input type="checkbox"/> 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?     Yes     No

If yes, please complete an "Authorization for Administration of Medication" (obtain form from the school secretary)

**Please indicate:**

Medication _____	Dosage _____	Hour(s) given _____
Medication _____	Dosage _____	Hour(s) given _____

Date of last physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_    Doctor \_\_\_\_\_

Date of last dental exam: \_\_\_\_/\_\_\_\_/\_\_\_\_    Dentist \_\_\_\_\_

Does your child wear glasses?     Yes     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

## Oral Health Assessment/Waiver Request Form

California law, *Education Code Section 49452.8*, now requires that your child have an oral health assessment in Kindergarten through Fifth Grade, whichever is his or her first year of public school. The law specifies that the assessment must be performed by a licensed dentist or other licensed or registered dental health professional. Oral health assessments that have happened within the 12 months before your child enters school also meet this requirement.

If you cannot take your child for this assessment, you may be excused from this requirement by filling out Section 3 of this form.

### Section 1

To be completed by the 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 Gender: <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"/> Indio Americano <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown		

### Section 2

#### Oral Health Data Collection

To be completed by the dental professional conducting the assessment

Assessment Date:	<u>Visible caries and/or fillings present:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Visible caries present:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Urgency <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended <input type="checkbox"/> Urgent care needed
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\_\_\_\_\_ *Dental professional's signature*

\_\_\_\_\_ *Date*

*Updated: 12/22/09*

*Original to be retained in child's school record.*

### Section 3

### Waiver of Oral Health Assessment Requirement

To be completed by a parent or guardian requesting to be excused from this requirement

I request that my child be excused from the oral health assessment requirement for the following reason: (Please check the box that best describes the reason.)

- I am unable to find a dental office that will take my child's insurance plan.
- My child is covered by the following insurance plan:
  - Medi-Cal/Denti-Cal     Healthy Families     Healthy Kids     None
  - Other \_\_\_\_\_
- I cannot afford an oral health assessment for my child.
- I do not wish my child to receive an oral health assessment.

Optional: other reasons my child could not get an oral health assessment: \_\_\_\_\_

California law requires schools to maintain the privacy of student's health information. Your child's identity will not be associated with any report produced as a result of this requirement. If you have any questions about this requirement, please contact your school office.

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

\_\_\_\_\_  
*Date*

*Original to be retained 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.

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)					
DTP/DTp/DTTd (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.

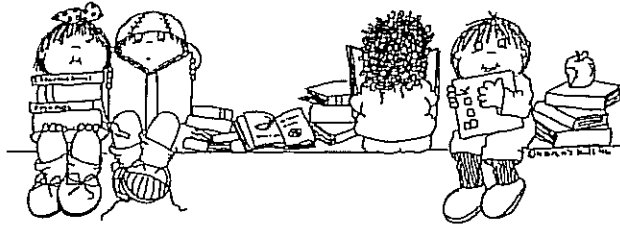
CHDP website: [www.dhcs.ca.gov/services/chdp](http://www.dhcs.ca.gov/services/chdp)

PM 171 A (09/07) (Bilingual)





# Piner-Olivet Union School District



## Library Materials Permission Slip

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\*\***

Updated: 1/10/10