2018-2019
REGISTRATION FOR
OLIVET, SCHAEFER & JACK LONDON SCHOOLS
BEGINS:
TUESDAY, JANUARY 9, 2018

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

► PLEASE BRING: 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.

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.
PINE-OLIVET UNION SCHOOL DISTRICT
www.pousd.org

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
YELLOW - Parent Copy

Updated: 7/14/13
BIRTHDATE: __/__/__

STUDENT REGISTRATION INFORMATION (PLEASE PRINT)

CHILD'S LEGAL LAST NAME  FIRST  M. INITIAL
Address  Apt. #
City  State  Zip
Phone Number
Child's Birth Place  State  Zip
School Last Attended  Dates:
School Address  City  State  Zip
  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

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
☐ Title IV  ☐ 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. ___________________________________________________

* Parent's/Guardian's Signature  Date

FAMILY INFORMATION (PLEASE PRINT)

FATHER'S NAME
Birth Place  Occupation

MOTHER'S NAME
Birth Mother’s Maiden Name
Birth Place  Occupation

STUDENT LIVES WITH
☐ Mother  ☐ Guardian
☐ Father  ☐ Foster Mother
☐ Stepmother  ☐ Foster Father
☐ Stepfather  ☐ Other

Name of Step/Foster Parent - Guardian
Address (if other than student’s)

PARENT WITH HIGHEST LEVEL OF EDUCATION
☐ Graduate school or,  ☐ High school graduate:
postgraduate training  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)
Name  School  Grade
Name  School  Grade
Name  School  Grade

OTHER CHILDREN LIVING IN HOUSEHOLD
Name  Birthdate
Name  Birthdate
Name  Birthdate

WHITE – CUM  *YELLOW- SPECIAL SERVICES (Send to District Office)  PINK - TEACHER

Updated: 11.6.15
**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>
</table>

<table>
<thead>
<tr>
<th>Male ☐ Female ☐</th>
<th>Birth Date:</th>
<th>Home Phone:</th>
<th>Grade:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>City:</th>
<th>Zip Code:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MOTHER:</th>
<th>FATHER:</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>E-mail:</th>
<th>E-mail:</th>
</tr>
</thead>
</table>

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

**Student lives with:**  
**Relationship:**  

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

**Siblings Attending District**  
**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 or preference) below:

<table>
<thead>
<tr>
<th>1</th>
<th>Name:</th>
<th>Home Phone:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Relationship:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employer:</td>
<td>Work Phone:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th>Name:</th>
<th>Home Phone:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Relationship:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employer:</td>
<td>Work Phone:</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)

Hospital: __________________________  
Physician: __________________________

**SERIOUS HEALTH PROBLEMS**  
(Please Note all Health Concerns & any New Concerns)

___________________________________  
___________________________________  
___________________________________  

**OFFICE USE ONLY**

☐ RSO  
☐ EPI-PEN  
☐ GRANTED  
☐ DENIED

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) IN THE EVENT OF A LIFE-THREATENING ALLERGIC REACTION, ☐ I DO authorize ☐ I DO NOT authorize, TRAINED 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:)

<table>
<thead>
<tr>
<th>Name of previous school (Nombre anterior de la escuela)</th>
<th>Area code (código de área)</th>
<th>Telephone (Teléfono)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address (Dirección)</th>
<th>Area code (código de área)</th>
<th>FAX (Número de fax)</th>
</tr>
</thead>
</table>

**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, incluídos los grados y los historiales medicos, así como psicológicos, sociales, educativos o de desarrollo en relación con la información siguiente del alumno (s).)

**Name (Nombre)**

<table>
<thead>
<tr>
<th>Date of Birth (Fecha de nacimiento)</th>
<th>Grade (Grado)</th>
</tr>
</thead>
</table>

**Parent Signature (Firma del padre)**

<table>
<thead>
<tr>
<th>Date (Fecha)</th>
</tr>
</thead>
</table>

**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.)

<table>
<thead>
<tr>
<th>Scale Score</th>
<th>Level</th>
<th>Date Testing Completed:</th>
</tr>
</thead>
</table>

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>
</table>

<table>
<thead>
<tr>
<th>Student’s Name: _______________________</th>
<th>Sex: M  F</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Birthdate: _______________________</th>
<th>Teacher: _______________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian: ___________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>Telephone: (Home) ( ) (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?  
- Yes  
- 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>
<td>Medication</td>
<td>Dosage</td>
<td>Hour(s) given</td>
</tr>
</tbody>
</table>

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

Q:\Forms\SCHOOL FORMS\REGISTRATION PACKET INFO\REGISTRATION FORMS\REGISTRATION FORMS Kindergarten\2010-11 Kindergarten Registration\Student Health History.doc  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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>ZIP code:</th>
</tr>
</thead>
<tbody>
<tr>
<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            □ Female</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.

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).

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

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.

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 el examinador de salud que llene este informe y entregelo a la escuela—este informe sera 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/NIÑA—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.

**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.

<table>
<thead>
<tr>
<th>PRUEBAS Y EVALUACIONES REQUERIDAS</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>Evaluacion de Riesgo y prueba Tuberculosis*</td>
<td>/</td>
</tr>
<tr>
<td>Análisis de Sangre (para anemia)</td>
<td></td>
</tr>
<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>

<table>
<thead>
<tr>
<th>VACUNA</th>
<th>FECHA EN QUE CADA DOSIS FUE DADA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primero</td>
</tr>
<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) (Requerida para centros de cuidado para niños y centros preescolares solamente)</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
</tr>
<tr>
<td>Varicella (Viruelas locas)</td>
<td></td>
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### PARTE III INFORMACIÓN ADICIONAL DEL EXAMINADOR DE SALUD (optional) 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)

*de ser indicado

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 ________________________

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

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 any way 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**