

Arena Elementary School 2026-2027

Transitional Kindergarten (TK) and Kindergarten Registration



Arena Elementary School Begins TK and Kindergarten Registration

Tuesday, March 24th

9:00a.m. – 2:00p.m.

Arena Elementary Shelley Aubrey School library

Your child must meet the age requirement to enroll:

Children turning age 5 **on or before** September 1, 2026 will enroll in kindergarten

Children turning age 4 **by** September 1, 2026 are eligible to enroll in transitional kindergarten

To enroll your child, you will need to provide, at minimum, the following required documentation to the school.

1. **Your child's birth record** (birth certificate, or affidavit of birth)
2. **Your child's immunization records**
 - a. 4 doses of polio (3 doses meet requirements for ages 4-6 years if at least one was on or after the 4th birthday)
 - b. 5 doses of DTP or DTaP (4 doses meet requirement for ages 4-6 years if at least one was on or after the 4th birthday)
 - c. 2 doses of MMR (measles, mumps, and rubella)
 - d. 3 doses of hepatitis B vaccine
 - e. 2 doses of Varicella or Physician documented varicella (chickenpox) immunity.
3. **Proof of Residence** in our school district- current electric or gas utility and a Photo I.D

Other requested documents are:

4. **School Entry Health Examination**
5. **Dental Assessment/Exam**
6. ***Proof of Legal Guardianship*** If in guardian care, please provide an affidavit.

Enrollment Forms are available at school and online. If you have questions regarding enrollment, please contact the school office:

20 School Street, Point Arena, CA 95468

Telephone: (707) 882-2131 ext. 202 or ext. 231

Email: arena@aesfamily.org

School Website: <https://pointarenschools.org/aes/>

Kindergarten is a full day from 8:20a.m.-2:15p.m. Students in the Arena Union Elementary School District will take priority over out of district registration. Special circumstances may apply.

Incomplete Date _____

Complete Date _____

Students Name: _____ DOB _____

KINDERGARTEN & TK ENROLLMENT CHECKLIST

To expedite your child's registration, please bring the following documents.

_____ **Registration form**

_____ **Emergency & Health Information Form**

_____ **Birth Record:**

Kindergarten-Must be age 5 on or before September 1, 2026

Transitional Kindergarten (TK)-Must turn age 4 by September 1, 2026

_____ **Health Examination for School Entry Form:** Medical examination clinical history, physical examination Urine, blood and tuberculosis examination, Eye and hearing examinations

_____ **Oral Health Assessment Form:** Return this form to the school no later than May 31 of your child's first school year.

_____ **Immunization Record**

_____ **4 doses of polio** (3 doses meet requirement if at least one dose was given on or after the 4th birthday.)

_____ **5 doses of DTP or DTaP** (4 doses meet requirement if at least 1 dose was given on or after the 4th birthday)

_____ **2 doses of MMR** (measles, mumps, and rubella) 1 dose may be a measles-only vaccine, both doses given on or after the 1st birthday.

_____ **3 doses of Hepatitis B** vaccine

_____ **2 doses of Varicella or Physician-documented Varicella** (chickenpox) disease history or immunity will also meet the requirement.

_____ **Proof of Residence** *current electric or gas utility bill and a photo ID.

_____ **Proof of Legal Guardianship** (If the child is not living with their custodial parents, proof of legal guardianship must be presented.)

ARENA UNION ELEMENTARY SCHOOL DISTRICT

NEW STUDENT ENROLLMENT

STUDENT INFORMATION: PLEASE PRINT LEGAL NAME

Legal Last Name		Legal First name		Date:	
				Legal Middle Name	
Alias Last Name		Alias First Name		Alias Middle Name	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary	Age:	Grade:	Birthdate:	Place of Birth	
			Month (MM)/Day (DD)/Year (YYYY)	City	State Country

Primary Telephone Number: ()

Residence Address (house/apt # & street name) City State Zip

Mailing Address (PO Box or other mail location) City State Zip

STUDENT RESIDES WITH (check all that apply) Mother Father Step-parent Legal Guardian(s) Other :

1. Parent/Guardian Name Primary Phone Work Phone

1. PARENT EDUCATION – Check the response that describes the education level of the most educated parent.

- Not a High School Graduate (14) Some College or Associate's Degree (12) Graduate Degree or Higher (10)
 High School Graduate (13) College Graduate (11)

2. Parent/Guardian Name Primary Phone Work Phone

2. PARENT EDUCATION – Check the response that describes the education level of the most educated parent.

- Not a High School Graduate (14) Some College or Associate's Degree (12) Graduate Degree or Higher (10)
 High School Graduate (13) College Graduate (11)

STUDENT ETHNICITY AND RACE - Both Sections must be completed: Regardless of your answer to question 1, please continue to question 2.

1. ETHNICITY: What is the ethnicity of this student? Choose the ethnicity with which the student most closely identifies. Please check one:

- Hispanic or Latino** (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)
 Not Hispanic or Latino

2. RACE: What is the race of this student? (Please check at least one category and a maximum of 5 categories)

- | | | |
|---|---|---|
| <input type="checkbox"/> American Indian or Alaskan Native(100) (Persons having origins in any of the original peoples of North, Central or South America) | <input type="checkbox"/> Asian Indian (205) | <input type="checkbox"/> Samoan (303) |
| <input type="checkbox"/> Chinese (201) | <input type="checkbox"/> Laotian (206) | <input type="checkbox"/> Tahitian (304) |
| <input type="checkbox"/> Japanese (202) | <input type="checkbox"/> Cambodian (207) | <input type="checkbox"/> Other Pacific Islander (399) |
| <input type="checkbox"/> Korean (203) | <input type="checkbox"/> Hmong (208) | <input type="checkbox"/> Filipino/Filipino American (400) |
| <input type="checkbox"/> Vietnamese (204) | <input type="checkbox"/> Other Asian (299) | <input type="checkbox"/> African American or Black (600) |
| | <input type="checkbox"/> Hawaiian (301) | <input type="checkbox"/> White (700) (Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.) |
| | <input type="checkbox"/> Guamanian (302) | |

SPECIAL PROGRAM PARTICIPATION: What Special Services has your child received? Please check all boxes that apply.

- Counseling English Language Development 504 Plan IEP (Please attach copy)
 Resource (RSP) Speech/Language Special Day Class (SDC) Other:

Are there psychological or confidential reports available from your child's former school? Yes No

MOST RECENT SCHOOL ATTENDED: Address/City/State/Zip Grade(s) Date(s)

I have reviewed this document and to the best of my knowledge, the information contained herein is true and complete. By signing this I declare under penalty of perjury that I am the parent or legal guardian of the above-named student

Parent/Guardian Name (please print): Date:

Signature of Parent/Guardian:

Point Arena School District prohibits discrimination, intimidation, harassment (including sexual harassment) or bullying based on a person's actual or perceived age, ancestry, color, disability, ethnicity, gender, gender expression, gender identity, genetic information, immigration status, marital status, medical information, national origin, parental status, pregnancy status, race, religion, sex, sexual orientation, or association with a person or group with one or more of these actual or perceived characteristics.) For questions or complaints, contact: Title IX Coordinator: Michelle Egger (707) 882-2131, 504 Coordinator: Michelle Egger, (707) 882-2131, Title II Coordinator: Warren Galletti (707) 882-2803 or wgalletti@mcn.org)

Home Language Survey

STUDENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Birthdate: _____

Grade Level: _____

HOME LANGUAGE INFORMATION

Dear Parents and Guardians:

The California *Education Code* contains legal requirements which direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with these requirements. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered. If an error is made completing this home language survey, you may request correction before your student's English proficiency is assessed.

Which language did your child learn when they first began to talk? _____

Which language does your child most frequently speak at home? _____

Which language do you (the parents and guardians) most frequently use when speaking with your child?

Which language is most often spoken by adults in the home? (parents, guardians, grandparents, or any other adults)

Has your child ever taken an English Language Proficiency Assessment (ELPAC)? Yes No I don't know?

Please sign and date this form in the spaces provided below, then return this form to school.

Thank you for your cooperation.

Parent/Guardian Signature: _____ Date: _____

**ARENA ELEMENTARY SCHOOL
STUDENT EMERGENCY INFORMATION**

PLEASE PRINT – STUDENT’S LEGAL NAME: _____ Grade: _____ Birthdate (Month/Day/Year): _____

Likes to be called (nickname): _____ Student email address: _____

GENDER: Female Male. Nonbinary PRIMARY TELEPHONE#: _____ ALTERNATE/CELLPHONE#: _____

How does your child get to/from school? Please mark all that apply. Walks Personal Vehicle Rides the School Bus

BUS ROUTES: Point Arena AM/PM Manchester AM/PM Ridge AM/PM Coast AM/PM 2:15. 3:15

PLEASE LIST YOUR CHILD’S BUS STOP(S): _____

MAILING ADDRESS (PO Box or house/apt # & street name) _____ City _____ State _____ Zip _____

RESIDENCE ADDRESS (house/apt # & street name) _____ City _____ State _____ Zip _____

PARENT/GUARDIAN INFORMATION: ★ STAR Best daytime phone number

Parent/Guardian Name: _____ Home Phone: _____

Relationship to Student: Parent Step Parent Foster Parent *Legal Guardian Cell Phone: _____

Employer: _____ Work Phone: _____

Email Address: _____

Parent/Guardian Name: _____ ★ STAR Best daytime phone number
Home Phone: _____

Relationship to Student: Parent Step Parent Foster Parent *Legal Guardian Cell Phone: _____

Employer: _____ Work Phone: _____

Email Address: _____

Student resides with (check all that apply): Mother Father Legal Guardian Joint Household Alternating household
* If you are the student’s Legally Appointed Guardian, please provide documentation.

Does the student have a parent/guardian on Active Duty with the Armed Forces or Full-Time National Guard? Yes No
If yes, please list the parent’s name, branch, and rank: _____

RESIDENCE– Where is your child/family currently living? (McKinney Vento) – Please check appropriate box:

In a single family permanent residence (house, apartment, condo, mobile home) In a motel/hotel International Exchange Program
 In a shelter or transitional housing program Unsheltered (car, campsite, etc.)
 Doubled-up (sharing housing with other families/individuals due to economic hardship or loss) Other (please specify): _____

If there is a legal custody agreement regarding this student, please check one: Joint Custody Sole Custody Legally Appointed Guardianship

DUPLICATE MAILING (if custody agreement allows duplicate mailing / information to be provided to other parent, please complete the section below)

Full Name: _____ Relationship to Student: _____
Emergency contact for student? Yes No To receive Copy all mail Copy of grades only

Lives with student? Yes. No Phone Number: _____

Mailing Address (P.O Box or house/apt # & street name, City, State & Zip) _____

EMERGENCY CONTACTS (Please include relationship to student-relative, friend, neighbor, etc):

Name:	_____	Phone #:	_____
Name:	_____	Phone #:	_____
Name:	_____	Phone #:	_____
Name:	_____	Phone #:	_____

Please complete both sides of this form

STUDENT NAME: _____

BIRTHDATE: _____

In which language do you wish to receive written communications from the school? English Spanish

HEALTH AND MEDICATION INFORMATION

Check here if student has NO KNOWN HEALTH PROBLEMS

Check here if student has KNOWN HEALTH PROBLEMS and check all that apply below.

ADD/ADHD

Heart Problems

Seizures

Asthma

Diabetes

TYPE 1

TYPE II

SEVERE Allergy to: _____

Epi-Pen

Other: _____

Check here if student wears glasses/contact lenses.

Check here if student has hearing loss or uses hearing aids

Check here if student has physical challenges

Does the student have a condition that limits participation in Classroom activities Physical Education. Explain: _____

MEDICATION: List any medication (including dosage) taken by your child for the above condition and indicate whether medication is needed at home, school, or both. Note: California Education Code 49423 requires that if medications are taken at school, there must be a medication form on file at school, signed by both parents and physician. Parent or guardian shall inform the school nurse or designated certificated employee of the medication being taken.

AT HOME _____

AT SCHOOL _____

PHYSICIAN / DENTIST INFORMATION & HEALTH INSURANCE COVERAGE

Family Physician Name: _____

Telephone: _____

Address: _____

Emergency Facility: _____

Telephone: _____

Dentist Name: _____

Telephone: _____

Address: _____

Does this student have health insurance? Yes No

Does this student have dental insurance? Yes No

Name of Health Insurance and Health Plan Provider ID#: _____

ANAPHYLACTIC (ALLERGIC) CONSENT

*California Education Code 49414: In the event that my child experiences a severe, life threatening anaphylactic (allergic) reaction during school hours or during school related activities,

I/WE GIVE MY/OUR CONSENT or DO NOT GIVE MY/OUR CONSENT

for trained designated school staff to administer the epinephrine auto-injector (Epi-pen) emergency treatment, under the indirect supervision of the school nurse

EMERGENCY AUTHORIZATION & TREATMENT

In the event of an emergency, when a parent/guardian is unavailable, I authorize school personnel to make such arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgment. In addition, I further authorize the physician named above to undertake such care of my child, as he/she considers necessary. In the event said physician is not available, I authorize such care and treatment to be performed by a licensed physician or surgeon. I understand that the parent or guardian is responsible for the cost of such emergency care. Likewise, our signature below is not sufficient for the release of confidential information protected by Federal law.

The information provided is accurate to the best of my/our knowledge, and I/we understand my/our responsibility.

Print parent/legal guardian name: _____

Relationship to student: _____

Signature of Parent/Guardian: _____

Date: _____

Print parent/legal guardian name: _____

Relationship to student: _____

Signature of Parent/Guardian: _____

Date: _____

(FOR SCHOOL USE ONLY)

STU PERM #

SSID#

Please complete both sides of this form

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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/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 (e.g., TB Test, if indicated)					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER (optional) and RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

<p>RESULTS AND RECOMMENDATIONS</p> <p>Fill out if patient or guardian has signed the release of health information.</p> <p><input type="checkbox"/> Examination shows no condition of concern to school program activities.</p> <p><input type="checkbox"/> Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: <i>(please explain)</i></p>	<p>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.</p> <p><input type="checkbox"/> Please check this box if you do not want the health examiner to fill out Part III.</p> <p>Signature of parent or guardian _____ Date _____</p> <p>Name, address, and telephone number of health examiner _____</p> <p>Signature of health examiner _____ Date _____</p>
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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 Audiometro (auditivas)	/ /
Evaluación de Riesgo y prueba Tuberculosis*	/ /
Análisis de Sangre (para anemia)	/ /
Análisis de Orina	/ /
Análisis de Sangre para el plomo	/ /
Otra	/ /

REGISTRO DE INMUNIZACIONES

Aviso al Examinador: Por favor de 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	Cuarto	Quinto
POLIO (OPV o IPV)					
DTaP/DT/DTTd (difteria, tétano y [acetular] pertusis [los ferri]) 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					
VARICELLA (Viruelas locas)					
OTRA (e.g. prueba TB, de ser indicado)					
OTRA					

PARTE III INFORMACIÓN ADICIONAL DEL EXAMINADOR DE SALUD (opcional)

RESULTADOS Y RECOMENDACIONES

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)

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 _____

*de ser indicado

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).

ARENA UNION ELEMENTARY SCHOOL DISTRICT
Oral Health Notification Letter
(to accompany Oral Health Assessment/Waiver Request Form)

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.ca.gov>. For help enrolling your child in Medi-Cal/Denti-Cal, contact your local social service agency at (fill in appropriate local contact information, available at <http://www.denti-cal.ca.gov/WSI/Bene.jsp?fname=ProvReferral>.)
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 (fill in appropriate local contact information, available at <http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx>).

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.
- Limit candy and sweet drinks, such as punch or soda. Sweet drinks and candy contain a lot of sugar, which causes cavities and replaces important nutrients in your child's diet. Sweet drinks and candy also contribute to weight problems, which may lead to other diseases, such as diabetes. The less candy and sweet drinks, the better!

Baby teeth are very important. They are not just teeth that will fall out. Children need their teeth to eat properly, talk, smile, and feel good about themselves. Children with cavities may have difficulty eating, stop smiling, and have problems paying attention and learning at school. Tooth decay is an infection that does not heal and can be painful if left without treatment. If cavities are not treated, children can become sick enough to require emergency room treatment, and their adult teeth may be permanently damaged.

Many things influence a child's progress and success in school, including health. Children must be healthy to learn, and children with cavities are not healthy. Cavities are preventable, but they affect more children than any other chronic disease.

If you have questions about the new oral health assessment requirement, please contact Lynn Finley, (707) 882-4090 and/or e-mail lfinley@mcoe.us or arena@aesfamily.org.

Sincerely,

Lynn Finley
School Nurse
Point Arena Schools District

Attachment

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: <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"/> Native American <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other _____ <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No	Visible Decay Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Urgency: <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) <input type="checkbox"/> Urgent care needed (pain, infection, swelling or soft tissue lesions)
_____		_____	
<i>Licensed Dental Professional Signature</i>		<i>CA License Number</i>	

		<i>Date</i>	

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.

