Kindergarten Track Preference Selection Form

*Complete One Form for Each Incoming Kindergarten Student

Child's Name: ________________________________

Address: ____
(Street) (Apt.#) (City) (Zip)

Parent/Guardian: ______________________ Home Phone: ____________

Part I

Please list the names of all other children residing in the household and presently attending (or registered to attend) in the Elk Grove Unified School District (Grades K-12).

Last Name	First Name	Current Track	Grade Level	Current School

Part II

TRACK PREFERENCE:

Please make your choices in the space provided below. All spaces must have a different choice (A, B, C, D)

1st Choice ________ 2nd Choice ________ 3rd Choice ________ 4th Choice ________

SESSION TIME:

☐ AM or ☐ PM

Bell Schedule

AM-

PM-

Do you want your children placed on the same track? Yes ___________No ______________

*Complete one Track Request Form for each kindergarten student.

My signature indicates that I have read and fully understand that the signing of this form does not guarantee track selection/session time as requested. *(Student track assignment may change due to enrollment or conditions listed on Notice of Understanding.)*

______________________________ ______________________
Parent/Guardian Signature Date

ELK GROVE UNIFIED SCHOOL DISTRICT
Student Support and Health Services

HEALTH INFORMATION

Name of Student: ____ Birth date: ____________________

School: ____ Grade:_______________________

Parent/Guardian: _____________________________________ Phone: (______) ________________________

Pediatrician (Name and Phone):____

Dentist (Name and Phone):____

Other Medical Care Provider/s Name and Phone): ____

********************HEALTH HISTORY********************

Please mark with a (✓) if your child has ever been diagnosed with any of the following:

_____ADHD

_____Allergies (Food/Medication/Pollen)

_____Asthma

_____Autism

_____Behavioral Concerns

_____Dental

_____Diabetes

_____Hearing (Aids, Myringotomy Tubes)

_____Gastrointestinal Conditions

_____Mental Health (Diagnosis/Counseling)

_____Orthopedic Concerns

_____ Seizure Disorder

_____Sickle Cell Anemia (Diagnosis/Trait)

_____Sleeping Problems

_____Skin Conditions (Eczema/Rashes)

_____Toileting Concerns

_____Vision (Glasses/Contacts/Glaucoma/Impairment)

_____Other Health Concerns

Please explain any of the health conditions that you have check (✓) marked: ____________________________
____
____
____

Medication(s): Name/Dosage/Frequency: ____
(Inquire about EGUSD Medication Policy and Medication Assistance Authorization form)

Hospitalizations/Serious Illness: ____

Date of last physical: ____

Have any special recommendations been made by the pediatrician concerning your child's health during the school day? _____Yes _____ No If answer is yes, please explain: ______________________________________
____

Signature of Parent/Guardian: ____

Members of the Board
Beth Albiani
Nancy Chaires Espinoza
Carmine S. Forcina
Gina Jamerson
Dr. Crystal Martinez-Alire
Anthony "Tony" Perez
Sean J. Yang

Bindy Grewal, Ed.D.
Assistant Superintendent
PreK-6 Education

(916) 686-7704
FAX: (916) 686-7796

Robert L. Trigg Education Center
9510 Elk Grove-Florin Rd., Elk Grove, CA 95624

NOTICE OF UNDERSTANDING

Please be aware that conditions exist in the Elk Grove Unified School District which may require:
1. Your child to be reassigned to another classroom at their home school;
2. Your child to be reassigned to another Elk Grove school during the school year;
3. Your child to be reassigned to another track

The circumstances for these conditions include:
- ☐ Overcrowding at the home school
- ☐ Overcrowding at a grade level
- ☐ Overcrowding on a specific track
- ☐ Boundary changes created by the building of new schools. Boundary changes affect students at all levels; elementary, middle and high school.

PLACEMENT PROCESS
We will utilize a Randomized Kindergarten Track Assignment through an automated computer generated process. In order to participate in this process, the kindergarten Welcome Packet and supporting documentation must be received by 3:30pm on February 24th, 2022. The randomized placement process alleviates the need for our families to stand in line, and it will give each family an equal opportunity for their track selection. This automated process allows for a greater opportunity for the distribution of demographics and results in a more balanced representation of our community on each track.

Transitional kindergarten and 1st through 6th grade student Welcome Packets will be date and time stamped upon receipt of the completed forms and supporting documentation. In addition, kindergarten Welcome Packets returned after February 24th will receive a date and time stamp. These placements at our schools and in our classrooms are filled based on the student's date and time of registration at the school, special services or program needs as required by law, and class size limits.

In so far as possible, students of the same family shall be placed on the same track unless one or more of such students are enrolled in a special education class or unless the parent/ guardian requests that the students be placed on different tracks.

Thank you for your understanding and for allowing the Elk Grove Unified School District an opportunity to provide a quality educational program for your child.

Your signature below acknowledges that you have been informed of the circumstances which could result in the reassignment of your child and the process used to determine placement.______________________________________ ____________________

Parent/Guardian Signature Date

☐**Original to School**
☐**Copy to Parent/Guardian**

Office Use Only
Date Received: ________________

SPECIAL SERVICES SURVEY

Student Name: ____ **Grade:** _________

Date of Birth: ____/____/____ **Previous School District:** ________________________________

1. Has your child ever been retained? If so what grade? _______________ ☐ Yes ☐ No
2. Has your child ever had an Individualized Education Plan (IEP)? ☐ Yes ☐ No
3. Do you have a copy of your child's IEP? ☐ Yes ☐ No
4. Has your child ever received Speech Services? ☐ Yes ☐ No
5. Has your child ever received Title I Services? ☐ Yes ☐ No
6. Has your child ever received Bilingual Services? ☐ Yes ☐ No
   Which Language? ____________________________
7. Has your child ever been in a Self-Contained Special Education Class or Learning Center? ☐ Yes ☐ No
8. Has your child been "GATE" identified"? ☐ Yes ☐ No
9. Do you have other children who have received special services? If yes, please explain what services. ☐ Yes ☐ No

Child's Name	**Grade**	**School**

10. Is there any special information you would like your child's teacher to know regarding your child's academic background or special needs?

____

____

____

____ ______________________
Parent/Guardian Signature Date

04-special services survey
October 2021

School____________________Track__________
Grade____________________Room__________
Teacher/Counselor____________________
Bus #__________ Bus Stop____________________
Student Number____________________

EMERGENCY INFORMATION (REQUIRED)*
ELK GROVE UNIFIED SCHOOL DISTRICT

Name____ Sex: F______ M______
Last First Middle

Legal last name (if different) ____________________ Birthdate:______________ Home Phone:______________

Address______________________________ Apt.__________ City______________ Zip__________

List below parent(s) or guardian child lives with:

Name:____________________ Relationship to Child:__________ Employer:______________ Home Phone:__________ Work Phone:__________

Name:____________________ Relationship to Child:__________ Employer:______________ Home Phone:__________ Work Phone:__________

If parents are divorced or separated, who has physical custody? Parents should notify the district immediately if there is a change.

Joint Custody ☐ Mother ☐ Father ☐ Guardian ☐

Day Care: Name______________________________ Phone______________ In case of illness, emergency or accident and parent/guardian cannot be located, the following adults are authorized to act on behalf of the parent/guardian.
(Please enter two names of local neighbors, friends, relatives, or sitter.)

1. ______________________________ Phone______________ Relationship______________
2. ______________________________ Phone______________ Relationship______________

Physician's Name____________________ Medical Coverage by______________ ID#______________
Address____________________ Physician Phone #______________ Hospital of Preference______________

PARENT MUST CHECK ONE

☐ 1. In the event of an emergency, when a parent or guardian is unavailable, I authorize school personnel to make arrangements for my child to receive medical//hospital care, including necessary transportation, in accordance with their best judgment. I authorize the physician named above to undertake such care and treatment as is considered necessary. In the event said physician is unavailable, I authorize such care and treatment to be performed by a licensed physician or surgeon. I agree to pay all costs incurred as a result of the foregoing.

☐ 2. I do not choose the above statement and desire the following action in the event of an emergency:
____.

I understand that the Elk Grove Unified School District does not provide medical insurance for student injuries, but does make voluntary student insurance available. I have received the information on this program.

X______________________________ X______________________________
Parent/Guardian's Signature Date Parent/Guardian's Signature Date

PLEASE CHECK THE FOLLOWING ITEMS IF THEY PERTAIN TO YOUR CHILD

CHECK HERE IF THERE ARE NO KNOWN HEALTH PROBLEMS

EYES

Wears glasses ☐ To be worn at all times ☐

Wears contacts ☐ To be worn at all times ☐
Requires preferential seating ☐ Date of last eye exam:__________
Under care of Dr.____________________ Phone__________
Comments:______________________________

EARS

Has a hearing problem ☐ Has tubes in ears ☐ Uses hearing aid ☐
Requires preferential seating ☐
Under care of Dr.____________________ Phone__________
Comments:______________________________

BROTHERS & SISTERS NAME(s)	SCHOOL OF ATTENDANCE	GRADE
1.__________	__________	__________
2.__________	__________	__________
3.__________	__________	__________

*California Education Code 49408 requires that emergency information be kept current.

**The parent or legal guardian of a public school pupil on a continuing medication regimen for a nonepisodic condition (pupils taking medication on a long-term regular schedule) shall inform the school nurse or other designated certificated employee of the medication being taken. (California Ed Code 49480)

***The California Education Code makes it mandatory that every student be provided with physical education. If, at any time you child is ill or has a condition which you feel requires being excused from activity for more than five (5) school days, an explanatory note is required from your child's health advisor.

GENERAL HEALTH

1. Has the following condition(s):
   Epilepsy ☐ Fainting spells ☐ Diabetes ☐
   Hyperactive (ADHD) ☐ Heart condition ☐ Migraines ☐
   Asthma ☐
   Allergies ☐ (describe):______________________________
   ____

   Allergic reaction to bee stings ☐ (describe):______________
   ____

   Other:______________________________

   Are any of the above life threatening? ☐ Yes ☐ No
   Please Explain______________________________

2. List medication(s) prescribed:______________________________

   Current dosage:______________________________
   For (diagnosis):______________________________

   Does the drug need to be taken during school hours? ☐ Yes ☐ No
   Prescribed by Dr.____________________ Ph.__________

3. Has a physical condition which limits participation in:
   classroom activities ☐ physical education ☐
   Please explain:
   ____

   Under care of Dr.____________________ Ph.__________

4. DATE OF LAST TETANUS SHOT____________________

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: □ Male □ Female
Parent/Guardian Name:	Child's race/ethnicity: □ White □ Black/African American □ Hispanic/Latino □ Asian □ Native American □ Multi-racial □ Other___________ □ Native Hawaiian/Pacific Islander □ 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) □ Yes □ No	Visible Decay Present: □ Yes □ No	Treatment Urgency: □ No obvious problem found □ Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) □ Urgent care needed (pain, infection, swelling or soft tissue lesions)

____________________________ ____________________ __________________

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.

EGUSD FOOD & NUTRITION SERVICES
MEDICAL STATEMENT
FOOD SUBSTITUTION AND/OR ACCOMMODATIONS

1. SCHOOL/AGENCY EGUSD	2. SCHOOL SITE	3. SITE TELEPHONE NUMBER
4. NAME OF PARTICIPANT		5. AGE OR DATE OF BIRTH
6. NAME OF PARENT OR GUARDIAN		7. TELEPHONE NUMBER

8. CHECK ONE:

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to definitions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A licensed physician must sign this form.**

☐ Participant does not have a disability, and will be limited in some of the foods they can consume. EGUSD Food and Nutrition Services will strive to accommodate reasonable requests and to notify site cafeteria staff about restrictions and limitations due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. **A licensed physician, physician's assistant, or registered nurse must sign this form.**

9. DISABILITY OR MEDICAL CONDITION REQUIRING A FOOD SUBSTITUTION OR ACCOMMODATION:

10. IF PARTICIPANT HAS A DISABILITY, PROVIDE A BRIEF DESCRIPTION OF PARTICIPANT'S MAJOR LIFE ACTIVITY AFFECTED BY THE DISABILITY:

11. DIET PRESCRIPTION AND/OR ACCOMMODATION: *(PLEASE DESCRIBE IN DETAIL TO ENSURE PROPER IMPLEMENTATION)*

12. INDICATE TEXTURE:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

13. FOODS TO BE OMITTED AND SUBSTITUTIONS: *(PLEASE LIST SPECIFIC FOODS TO BE OMITTED AND SUGGESTED SUBSTITUTIONS. YOU MAY ATTACH A SHEET WITH ADDITIONAL INFORMATION)*

A. **Foods To Be Omitted**	B. **Suggested Substitutions**

14. ADAPTIVE EQUIPMENT:

15. SIGNATURE OF PREPARER*	16. PRINTED NAME	17. TELEPHONE NUMBER	18. DATE
19. SIGNATURE OF MEDICAL AUTHORITY*	20. PRINTED NAME	21. TELEPHONE NUMBER	22. DATE

* **Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or registered nurse must sign the form.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

In accordance with Federal law and U.S. Department of Agriculture policy, this agency is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410, or call 202-720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

MEDICAL STATEMENT TO REQUEST
FOOD SUBSTITUTION AND/OR ACCOMMODATIONS

INSTRUCTIONS

1. **School/Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served (e.g., school site, child care center, community center, etc.)
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
5. **Age of Participant:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Telephone Number:** Print the telephone number of parent or guardian.
8. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
9. **Disability or Medical Condition Requiring a Special Meal or Accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.)
10. **If Participant has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition affects disability. For example: "Allergy to peanuts causes a life-threatening reaction."
11. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician, or describe diet modification requested for a non-disabling condition. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
12. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
13. **A. Foods to Be Omitted:** List specific foods that must be omitted. For example, the "exclude fluid milk."
    B. Suggested Substitutions: List specific foods to include in the diet. For example, "soy milk."
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. (Examples may include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.)
15 **Signature of Preparer:** Signature of person completing form.
16. **Printed Name:** Print name of person completing form.
17. **Telephone Number:** Telephone number of person completing form.
18. **Date:** Date preparer signed form.
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
20. **Printed Name:** Print name of medical authority.
21. **Telephone Number:** Telephone number of medical authority.
22. **Date:** Date medical authority signed form.

DEFINITIONS*:

"A Person with a Disability" is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

"Physical or mental impairment" means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Major life activities" are functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

"Has a record of such an impairment" is defined as having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

(*Citations from Section 504 of the Rehabilitation Act of 1973)

OMB Control No. 1810-0021 (Exp. 04/30/2023)

ED 506 Form
Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

Student Information

Name of the Child ____________________________________Date of Birth ___________Grade level __________

Name of School ____________________________________School District ________________________________

Tribal Membership

The individual with Tribal membership is the (select only one): ____child ____child's parent ____child's grandparent

If the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: __________________________________

Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name ____Address ____

City ________________________________State _______Zip Code ___________

The Tribe or Band is (select only one):

- ☐ Federally Recognized Tribe
- ☐ State Recognized Tribe
- ☐ Terminated Tribe
- ☐ Alaska Native
- ☐ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

- o Membership or enrollment number establishing membership (if readily available) or
- o Other evidence establishing membership in the Tribe listed above (describe and attach)

Membership or enrollment number establishing membership (if readily available) or other evidence establishing membership in the Tribe listed above (describe and attach). ____

Attestation Statement
I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian _______________________________ Signature____________________________

Address ______________________________ City ________________________State _______Zip Code __________

Phone Number ____________________________Email ______________________________Date ________________

For Parent/Guardians:

Definitions:
Indian means an individual who is (1) A member of an Indian Tribe or Band, as membership is defined by the Indian Tribe or Band, including any Tribe or Band terminated since 1940, and any Tribe or Band recognized by the State in which the Tribe or Band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, Aleut, or other Alaska Native; or (5) A member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect on October 19, 1994.

Student Information: Write the name of the child, date of birth, grade level, name of school and school district. Only name one child per form.

Tribal Membership: Write the name of the individual with the tribal membership, if it is not the child listed. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one identifier: the child, child's parent or grandparent, for whom you can provide membership information.

Write the name and address of the organization that maintains updated and accurate membership data for such Tribe or Band of Indians. The name does not need to be the official name as it appears exactly on the Department of Interior's list of federally recognized Tribes, but the name must be recognizable and be of sufficient detail to permit verification of the eligibility of the Tribe. Check only one box indicated whether it is a Federally Recognized, State Recognized, Terminated Tribe or Organized Indian Group. Write the enrollment number establishing the membership for the child, parent or grandparent, if readily available, or other evidence of membership.

Attestation Statement: Provide the printed name of parent/guardian and signature, address, phone number and email of the parent or guardian of the child. The signature of the parent or guardian of the child verifies the accuracy of the information supplied.

Paperwork Burden Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3W238, Washington, D.C. 20202-6335