



Members of the Board

Beth Albiani
Nancy Chaires Espinoza
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Assistant Superintendent,
PreK-6 Education

(916) 686-7704
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Robert L. Trigg Education Center
9510 Elk Grove-Florin Rd., Elk Grove, CA 95624

January 2019

Dear Parents/Guardians:

We are delighted to welcome you and your child to Elk Grove Unified School District. This first day of kindergarten will be one that you and your child will always remember. It is the first step of a joyous and never-ending adventure into a world filled with exciting and fascinating things to do and learn!

IMPORTANT REGISTRATION INFORMATION
for
YEAR ROUND SITES
2019 - 2020

Please return this registration packet by **February 13, 2019 at 3:30p.m.** in order to receive a priority track selection number. If the packet is returned after this date, you will miss the **Randomized Kindergarten Track Selection Process** and assignment which will result in placement according to space availability.

When returning the completed registration packet, you must bring the following items with you:

- Birth Certificate
- Immunization Records – Please see attached Immunization Requirement Sheet
- Proof of Residence within the District (must be street address, P.O. Box not acceptable) consisting of the following:

Must produce ONE from this column:

- Property tax receipts for the current residence.
- Mortgage statements in parent/guardian's name.
- If the home is under construction, a title/deed or signed sales or purchase agreement in parent/guardian's name will be accepted. **Additionally**, if you use one of these documents above, a current PG&E or SMUD bill that indicates location of service or a mortgage statement must be presented to the school within six months.
- Rental/Lease agreement – Current or recently signed in parent/guardian's name. **Additionally**, if you use one of these documents, two consecutive months of a current PG&E or SMUD bill in the parent/guardian's name must be presented to the school within two months.

AND

Must produce ONE from this column:

- Parent/Guardian's motor vehicle registration with current address.
- Parent/Guardian's driver's license with current residence.
- Court documents indicating current address.
- Payment verification (paid invoice, credit card receipt, cashed check) for two consecutive months of two of the following utilities: gas, electricity, water or garbage for the current residence must be presented within two months of enrollment.
- Rent payment receipts for two consecutive months for the current residence must be presented within two months of enrollment.
- Documentation from the Department of Human Assistance with current residence.

Registrations will be accepted Monday through Friday between the hours of 7:30 a.m. and 3:30 p.m.

Exceptions to Column A and Column B residency requirements:

- Homeless: Families should contact the District Liaison at 916.686.7568.
- Foster Youth: Families should contact the District Liaison at 916.686.7568.

- Court Orders: If you are registering your child and have a current court order in place stipulating child custody, **please provide the court order to the school site.**

Additional Documents (as applicable)

- Affidavit of Non-Permanent Residence Form: Parent/Guardian and legal resident must complete and submit to the school **if**:
 - Your family does not have a permanent home and is living with a legal resident within the school's boundary.
 - Your family rents a room from a legal resident within the school's boundary.

This form can be downloaded from the EGUSD website.

- Caregiver's Authorization Affidavit: Qualified relative must complete and submit to the school **if**:
 - You are over the age of 18, **and** are a qualified relative as listed on the form,
 - You take care of a child who lives in your home, **but**
 - You do not have a court order that gives you custody of the child.

This form can be downloaded from the EGUSD website.

- IntraDistrict Transfer Request: If you are requesting to attend an Elk Grove Unified school that is outside your home school attendance area, you **must enroll at your home school site** and submit the transfer request to the home school according to the intradistrict process guidelines. The home school will begin accepting completed intradistrict transfer requests on April 8, 2019. (Intradistrict transfers are subject to eligibility requirements based on space availability and childcare.)

This form is available at your home school office.

- Verification of Child Care Form: Parent/Guardian of K-8 students must complete and submit **if**:
 - Your child is receiving before and/or after school care in a private home within the school's boundary for a minimum of three days per week. Your private home childcare provider must supply the school site with the documents listed on the form.
 - Your child is enrolled at a before and/or after school care facility within the school's boundary for a minimum of three days per week. Ask your daycare facility to provide you with proof of registration at the daycare facility. Take this to the school.

This form can be downloaded from the EGUSD website.

We look forward to partnering with you and your child's school to help your child grow into a happy, healthy, and well-educated individual. The Elk Grove Unified School District welcomes you and your child to our "Community of Learners".

Sincerely,



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



STUDENT INFORMATION

Has student ever attended an EGUSD School (including Preschool): [] YES [] NO EGUSD Student ID# _____
Is this student currently expelled or pending an expulsion hearing in EGUSD or any other District? [] YES [] NO

*Indicates that a response is required

*Student's full legal name _____
(As it appears on birth certificate) Last First Middle Suffix (Jr. III. IV)

*Grade Level _____ Student's SSID# (if known) _____ *Gender: [] Male [] Female

Nick Name AKA Last Name AKA First Name AKA Middle Name AKA Suffix

*Birth Date (Month/Day/Year): _____ *Birthplace: _____
City State Country

Student's Email Address: _____

RACE / ETHNICITY

*1) Ethnicity [] Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican, South/Central American or other Spanish culture or origin) [] Not Hispanic or Latino

*2) Race - Please select one or more Race Categories

- [] White [] African American-Black [] American Indian
[] Chinese [] Japanese [] Korean
[] Vietnamese [] Asian Indian [] Laotian
[] Cambodian [] Hmong [] Other Asian
[] Native Hawaiian [] Guamanian [] Samoan
[] Tahitian [] Other Pacific Islander [] Filipino

DEMOGRAPHICS

*Residence Address: _____
(Number & Street - Apt.) (City) (State) (Zip Code)

*Mailing Address: _____
(if different from Residence address) (Number & Street - Apt. or P.O.) (City) (State) (Zip Code)

*Primary Phone: _____ *Type: [] Home [] Personal Cell [] Work

*HOME LANGUAGE SURVEY (For "new" student registrations only, i.e. students registering for enrollment in the District for the first time.)

- *1. Which language did your child learn when he/she first began to talk? _____
*2. What language does your child most frequently speak at home? _____
*3. What language do you most frequently use at home when speaking with your child? _____
*4. What is the language most often spoken by the adults in the home? _____
(parents, guardians, grandparents, or any other adults)

FOR OFFICE USE ONLY
School Name _____ Enrollment Date _____ Birth Date Verified [] Birthplace Verified []
Birth Verification Method _____ Address Verification Method (1) _____ (2) _____
Immunizations Complete? [] YES [] NO Student Notifications? [] YES [] NO Permit Type _____ Permit Date _____
Track _____ Enrolled by _____ Date entered in Synergy _____

ADDITIONAL STUDENT INFORMATION

Which of the following best describes where this child is currently living, if applicable? (Federally Required)

Homeless (If yes, please identify residence category) Temporary shelter Hotel/Motel Temporarily doubled-up Temporarily unsheltered
Foster Primary Residence (If yes, please identify dwelling type) Foster Family Home or Kinship Plan Licensed Children's Institution (Group Home)

What special services has your child received? 504 Accommodation GATE Special Ed. Program ESL/Bilingual None
 Request for Migrant Ed. Migrant Student ID: _____

PARENT/GUARDIAN INFORMATION

*Parent/Guardian: _____ * Legal Guardian * Other

*Relationship: _____ Does this person live with student: YES NO Release contact: YES NO

*Mailing Address: _____
(if different from student) (Number & Street) (City) (State) (Zip Code)

*Primary phone: _____ Contact? _____ Not Listed? _____
 Home Telephone: _____
 Personal Cell: _____
 Work Phone: _____ Ext. # _____

*Email Address: _____ Preferred Language: _____

*Education level - please check one box that most closely applies:
 Not a high school graduate Some college or Associate's degree Graduate school/post graduate
 Graduated from high school College graduate
Military Service: Active in Armed Forces Full-time National Guard Armed Forces Reserve

Parent/Guardian: _____ * Legal Guardian * Other Deceased: YES

*Relationship: _____ Does this person live with student: YES NO Release contact: YES NO

Mailing Address: _____
(if different from student) (Number & Street) (City) (State) (Zip Code)

Primary phone: _____ Contact? _____ Not Listed? _____
 Home Telephone: _____
 Personal Cell: _____ Ext. # _____
 Work Phone: _____ Ext. # _____

Email Address: _____ Preferred Language: _____

*Education level - please check one box that most closely applies:
 Not a high school graduate Some college or Associate's degree Graduate school/post graduate
 Graduated from high school College graduate
Military Service: Active in Armed Forces Full-time National Guard Armed Forces Reserve

ENROLLMENT

Previous School Attended: _____
(Name of School) (Address) (City) (State) (Zip) (Phone / Fax #s)

Previous School District: _____ Last Date Attended: _____

*What month, day and year did your child enter (or enroll) in a California Public School? Month/Day/Year: _____

*U.S. School Entry Date: - Month/Day/Year: _____

ADDITIONAL STUDENT INFORMATION

NAMES OF ALL/OTHER CHILDREN IN FAMILY (ALL AGES)	RELATIONSHIP	DATE OF BIRTH	SCHOOL OF ATTENDANCE	LIVING AT HOME
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO

Emergency Contacts: Individuals who may be contacted in an emergency when no Parent or Guardian can be reached.
(Valid identification must be provided in order to release student.)

*Relationship: _____ Name: _____ Release: YES NO

Home Telephone: _____ Personal Cell: _____ Work Phone: _____ Ext.: _____

Email Address: _____ Preferred Language: _____

*Relationship: _____ Name: _____ Release: YES NO

Home Telephone: _____ Personal Cell: _____ Work Phone: _____ Ext.: _____

Email Address: _____ Preferred Language: _____

*Relationship: _____ Name: _____ Release: YES NO

Home Telephone: _____ Personal Cell: _____ Work Phone: _____ Ext.: _____

Email Address: _____ Preferred Language: _____

Day Care Provider Name: _____ Cell Phone: _____ Home Phone: _____

Address: _____ City: _____ Zip Code: _____

Probation Officer: _____ Email Address: _____ Phone/Ext.: _____

Social Worker (Agency): _____ Email Address: _____ Phone/Ext.: _____

Social Worker (County): _____ Email Address: _____ Phone/Ext.: _____

Physician Name: _____ Phone: _____ Ext.: _____ Hospital: _____

Insurance Company: _____ Phone _____ Ext.: _____ Policy #: _____

Additional Information: _____

***HEALTH RECORD PLEASE CHECK HERE IF STUDENT HAS NO KNOWN HEALTH PROBLEMS**

Please check any and all conditions in this student's medical history. Use the area below to add an explanation/recommendation.

- MEDICAL ALERT (unlisted condition – describe below)
- ADHD Allergy – Nonfood Allergy – Food Allergy - Nut Allergy - Peanut Anxiety Disorder Arthritis
- Asthma Autism Autoimmune Disorder Blood Disorder Cancer Celiac Disease Cerebral Palsy
- Concussion Cystic Fibrosis Dental Diabetes Eating Disorder Eczema Fracture
- Headache - Migraine Health Plan Hearing Impairment Heart Condition Hepatitis Hypertension IEP Nursing Services
- Immunization Alert Intestinal Disorder Orthopedic / Scoliosis Pacemaker Seizure Disorder Sickle Cell Anemia Skin Condition – Other
- Specialized Healthcare Procedure Speech Impairment Syndrome – Other Tuberculosis Urinary Disorder Vision Impairment Weight Disorder

Explanation/Recommendations regarding above: _____

Is the student currently taking medications? YES NO | Is the medication required during school hours? YES NO

**MEDICATION CANNOT BE DISPENSED AT SCHOOL WITHOUT A FORMAL REQUEST SIGNED BY A DOCTOR AND PARENT.
MEDICATION FORMS ARE AVAILABLE IN THE SCHOOL OFFICE.**

I UNDERSTAND THAT IN AN EMERGENCY *WHEN NO GUARDIAN OR EMERGENCY CONTACT CAN BE LOCATED*, THE SCHOOL IS AUTHORIZED TO TAKE MY STUDENT TO THE FAMILY DOCTOR, LICENSED PHYSICIAN OR TO THE NEAREST HOSPITAL AT PARENT/GUARDIAN EXPENSE.

* Name of person completing form (please print): _____ * Relationship: _____

* Signature of Parent/Guardian (certifying information provided is accurate): _____ Date: _____

Immunization Requirements for 2019-2020 School Year

Grades TK/K - 12th

Vaccine	4-6 Years Old Elementary School at Transitional-Kindergarten/ Kindergarten and Above	7-17 Years Old Elementary or Secondary School	7th Grade* (or pupils 12 years and older for ungraded grades)
Polio (OPV or IPV)	4 doses (3 doses OK if one was given on or after 4th birthday)	4 doses (3 doses OK if one was given on or after 4th birthday)	
Diphtheria, Tetanus, and Pertussis	5 doses of DTaP, DTP, or DT (4 doses OK if one was given on or after 4th birthday)	5 doses of DTaP, DTP, DT, Tdap, or TD (4 doses OK if one was given on or after 4th birthday. Three doses meet the requirement if at least one dose of Tdap, DTaP, or DTP vaccine was given on or after the 7th birthday. One or two doses of Td vaccine given on or after the seventh birthday count towards the required doses.)	1 dose of Tdap (Given on or after the 7th birthday.)
Measles, Mumps, and Rubella (MMR or MMR-V)	2 doses (Two doses of measles, two doses of mumps, and one dose of rubella vaccine meet the requirement, separately or combined. Only doses administered on or after the first birthday meet the requirement.)	2 doses (Two doses of measles, two doses of mumps, and one dose of rubella vaccine meet the requirement, separately or combined. Only doses administered on or after the first birthday meet the requirement.)	
Hepatitis B (Hep B or HBV)	3 doses	3 doses**	
Varicella (chickenpox, VAR, MMR - V, or VZR)	2 doses	2 doses	2 doses

* All 7th grade students must also meet requirements for 7-17 years.

**For 7th grade admits and advancement, students can start without full immunization for Hep B, but will need follow-up care to receive all 3 doses.

INSTRUCTIONS:

California schools are required to check immunization records for all new student admissions at Kindergarten/TK through 12th grade and all students advancing to 7th grade before entry.

1. Notify parents of required immunizations and collect immunization records
2. Copy the date of each vaccine from the child's immunization record to the California School Immunization
3. Compare number of doses on the Blue Card to the requirements above.
4. Determine whether child can be admitted.

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 | ____ Mental Health (Diagnosis/Counseling) |
| ____ Allergies (Food/Medication/Pollen) | ____ Orthopedic Concerns |
| ____ Asthma | ____ Seizure Disorder |
| ____ Autism | ____ Sickle Cell Anemia (Diagnosis/Trait) |
| ____ Behavioral Concerns | ____ Sleeping Problems |
| ____ Dental | ____ Skin Conditions (Eczema/Rashes) |
| ____ Diabetes | ____ Toileting Concerns |
| ____ Hearing (Aids, Myringotomy Tubes) | ____ Vision (Glasses/Contacts/Glaucoma/Impairment) |
| ____ Gastrointestinal Conditions | ____ 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: _____



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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

This year we will begin Randomized Kindergarten Track Selection done through an automated computer generated process. This 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 make for a more balanced representation of our community on each track.

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: _____



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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?
Which Language? _____ Yes No
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

**EMERGENCY INFORMATION (REQUIRED)*
ELK GROVE UNIFIED SCHOOL DISTRICT**

School _____	Track _____
Grade _____	Room _____
Teacher/Counselor _____	
Bus # _____	Bus Stop _____
Student Number _____	

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 _____ Home Phone: _____
 to Child: _____ Employer: _____ Work Phone: _____

Name: _____ Relationship _____ Home Phone: _____
 to Child: _____ Employer: _____ 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 _____

**U.S. Department of Education
Office of Indian Education
Washington, DC 20202
TITLE VI ED 506 INDIAN STUDENT ELIGIBILITY CERTIFICATION FORM**

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count. You are not required to complete or submit this form. However, if you choose not to submit a form, your child cannot be counted for funding under the program. **This form should be kept on file 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 _____
(As shown on school enrollment records)

Name of School _____

TRIBAL ENROLLMENT

Name of the individual with tribal enrollment: _____
(Individual named must be a descendent in the first or second generation)

The individual with tribal membership is the: _____ Child _____ Child's Parent _____ Child's Grandparent

Name of tribe or band for which individual above claims membership: _____

The Tribe or Band is (select only one):

- _____ Federally Recognized
- _____ State Recognized
- _____ Terminated Tribe (Documentation required. Must attach to form)
- _____ 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. (Documentation required. Must attach to form)

Proof of enrollment in tribe or band listed above, as defined by tribe or band is:

A. Membership or enrollment number (if readily available) _____ OR

B. Other Evidence of Membership in the tribe listed above (describe and attach) _____

Name and address of tribe or band maintaining enrollment data for the individual listed above:

Name _____ Address _____

City _____ State _____ Zip Code _____

ATTESTATION STATEMENT

I verify that the information provided above is accurate.

Name Parent/Guardian _____ Signature _____

Address _____ City _____ State _____ Zip Code _____

Email Address _____ Date _____

INSTRUCTIONS FOR THE ED 506 FORM

FOR APPLICANTS:

PURPOSE: To comply with the requirements in 20 USC 7427(a), which provides that: "The Secretary shall require that, as part of an application for a grant under this subpart, each applicant shall maintain a file, with respect to each Indian child for whom the local educational agency provides a free public education, that contains a form that sets forth information establishing the status of the child as an Indian child eligible for assistance under this subpart, and that otherwise meets the requirements of subsection (b)".

MAINTENANCE: A separate ED 506 form is required for each Indian child that was enrolled during the count period. A new ED 506 form does **NOT** have to be completed each year. All documentation must be maintained in a manner that allows the LEA to be able to discern, for any given year, which students were enrolled in the LEA's school(s) and counted during the count period indicated in the application.

FOR PARENTS/GUARDIANS:

DEFINITION: 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 and school name and grade level.

TRIBAL ENROLLMENT INFORMATION: Write the name of the individual with the tribal membership. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one name: either the child, child's parent or grandparent, for whom you can provide membership information.

Write the name of the tribe or band of Indians to which the child claims membership. 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. If Terminated Tribe or Organized Indian Group is elected, additional documentation is required and must be attached to this form.

- **Federally Recognized-** an American Indian or Alaska Native tribal entity limited to those indigenous to the U.S. The Department of Interior maintains a list of federally-recognized tribes, which OIE can provide you upon request.
- **State Recognized-** an American Indian or Alaska Native tribal entity that has recognized status by a State. The U.S. Department of Education does not maintain a master list. It is recommended that you use official state websites only.
- **Terminated Tribe-**a tribal entity that once had a federally recognized status from the United States Department of Interior and had that designation terminated.
- **Organized Indian Group-** 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.

Write the enrollment number establishing the membership of the child, if readily available, or other evidence of membership. If the child is not a member of the tribe and the child's eligibility is through a parent or grandparent, either write the enrollment number of the parent or grandparent, or provide other proof of membership. Some examples of other proof of membership may include: affidavit from tribe, CDIB card or birth certificate. Write the name and address of the organization that maintains updated and accurate membership data for such tribe or band of Indians.

ATTESTATION STATEMENT: Provide the name, address 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.

The Department of Education will safeguard personal privacy in its collection, maintenance, use and dissemination of information about individuals and make such information available to the individual in accordance with the requirements of the Privacy Act.

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 3W203, Washington, D.C. 20202-6335. OMB Number: 1810-0021 Expiration Date: 07/31/2019.

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.



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: <input type="checkbox"/> Participant has a disability or a medical condition and <i>requires</i> 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. <input type="checkbox"/> 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: <i>(PLEASE DESCRIBE IN DETAIL TO ENSURE PROPER IMPLEMENTATION)</i>					
12. INDICATE TEXTURE: <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed					
13. FOODS TO BE OMITTED AND SUBSTITUTIONS: <i>(PLEASE LIST SPECIFIC FOODS TO BE OMITTED AND SUGGESTED SUBSTITUTIONS. YOU MAY ATTACH A SHEET WITH ADDITIONAL INFORMATION)</i>					
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)



KINDERGARTEN TRACK PRIORITY 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

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