

Galt Joint Union Elementary School District

Registration Information

1018 C Street, Suite 210, Galt, CA 95632-1733 (209)744-4545 (209)744-4553 Fax www.galt.k12.ca.us

This Form is Available Online at www.galt.k12.ca.us

Grade _____

Student Information

Student's Complete Legal Name (Last) _____ (First) _____ (Middle) _____
Residence Address _____ City _____ Zip Code _____
Home Phone (_____) _____ Other Name(s) Used: _____
Mailing Address (if different) _____ City _____ Zip Code _____
Gender M F Birth Date _____ Birth Place: City _____ State _____ Country _____
Date or grade student first enrolled in a U.S. school _____ (See Secretary if you have any questions)

Previous Enrollment Information

Last School Attended _____ Teacher's Name _____
Telephone _____ FAX _____ Address _____
City _____ State _____ Date Entered _____ Date Left _____ Grade _____
Has student ever been accelerated (advanced a grade earlier than expected)? Yes No Grade Level(s) _____
Has student ever been retained? Yes No Grade Level(s) _____
Has student been suspended from school in the last three years for any reason (EC 49079)? Yes No Reason _____
Has student been expelled from any previous school district? Yes No Is expulsion pending? Yes No
If yes, reason _____
If yes, from which school? _____ Is student currently on Juvenile Probation? Yes No
Has this student ever been enrolled in Galt Elementary schools before? No Yes If yes, last year and/or grade enrolled: _____
I authorize the release of all records including special education. Parent/Guardian Signature: _____

Parent Information (those living with student)

Check One Mother Stepmother Guardian Foster Other _____

Mrs. Ms. Miss Dr. Other _____

Last Name _____ First Name _____

Employment By _____ City _____ Work Phone & Ext. (_____) _____ DNC

Cell/Message Phone (_____) _____ * Emergency Contact # (_____) _____ *Email _____

Check One Father Stepfather Guardian Foster Other _____

Mr. Dr. Other _____

Last Name _____ First Name _____

Employment By _____ City _____ Work Phone & Ext. (_____) _____ DNC

Cell/Message Phone (_____) _____ * Emergency Contact # (_____) _____ *Email _____

*** This information shall be used in the District's "ALERT NOW" System**

Please indicate the highest level of education in the household - Check One

- Not a high school graduate (includes GED) High School Graduate Some college (includes AA and vocational school)
 College graduate (four year degree) Graduate school (MA, PhD, etc.) Declines to state

Other Children Living in the Home

Name _____ Birthdate _____ Name _____ Birthdate _____
 Name _____ Birthdate _____ Name _____ Birthdate _____
 Name _____ Birthdate _____ Name _____ Birthdate _____

Other Family Information

Is there a birth parent not residing in the home? If yes, please complete below. Deceased Parent? Yes No
 Last Name _____ First Name _____ Telephone _____
 Address _____ City _____ State _____ ZIP _____

- Is there a court order regarding custody of this child? Yes No
- Is there a restraining order regarding a birth parent or other party? Yes No
- If yes, you must provide the school with a copy of the most current court order within 10 days of registering your child (Please initial) _____
- If no court order is provided, information will be released to this parent upon request. Court orders must be resubmitted to the school at the beginning of each school year.

Race and Ethnicity

The federal government now requires school districts to collect data on students' race and ethnicity. In addition, California law requires that data on Asian and Pacific Islander subgroups be collected. Please answer both questions.

1. Is this child Hispanic/Latino?
 Yes No
2. Please mark all of the following groups that best describe this child's race.

Race	Primary (Mark only 1)	Other (Mark all that apply)
American Indian or Alaska Native		
Asian		
Chinese		
Japanese		
Korean		
Filipino		
Cambodian		
Laotian		
Vietnamese		
Asian Indian		
Other Asian		
Native Hawaiian or Other Pacific Islander		
Hawaiian		
Samoa		
Tahitian		
Guamanian		
Other Pacific Islander		
Black/African American		
White		

Home Language Survey

The California Education Code requires schools to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students.

Your cooperation in helping us meet this important requirement is requested. Please answer the following questions:

Language first spoken by child _____
 Language most spoken **by** child at home _____
 Language most spoken **to** child at home _____
 Language most spoken by adults at home _____
 Do parents need to receive notices in a language other than English? Yes No
 If yes, what language? _____

Special Education

Please submit a copy of your child's current IEP/psych report

- | | |
|--|---|
| <input type="checkbox"/> Mental Retardation (MR) | <input type="checkbox"/> Other Health Impairment (OHI) |
| <input type="checkbox"/> Hard of Hearing (HH) | <input type="checkbox"/> Established Medical Disability (EMD) |
| <input type="checkbox"/> Deafness (DEAF) | <input type="checkbox"/> Specific Learning Disability (SLD) |
| <input type="checkbox"/> Speech or Language Impairment (SLI) | <input type="checkbox"/> Deaf-Blindness (DB) |
| <input type="checkbox"/> Visual Impairment (VI) | <input type="checkbox"/> Multiple Disability (MD) |
| <input type="checkbox"/> Emotional Disturbance (ED) | <input type="checkbox"/> Autism (AUT) |
| <input type="checkbox"/> Orthopedic Impairment (OI) | <input type="checkbox"/> Traumatic Brain Injury (TBI) |
- 504 (submit a copy of the Accommodation Plan) GATE

Residence: Where is your child/family currently living? Please check the appropriate box (This question is federally mandated by NCLB)

- Single Family permanent residence (house, apartment, condo, mobile home) (200)
- Doubled-up (sharing housing with other families/individuals due to economic hardship or loss) (120)
- In a shelter or transitional housing program (100)
- In a motel/hotel (110)
- Foster Family Home or Kinship Placement 210
- Unsheltered (car/campsite) (130)
- Other (please specify) (300) _____

Emergency Contact Information (other than parent)

List names of all people authorized to pick up child other than parent (stepparent, grandparent, friends, etc.). Must be 18 years of age or older.

Relationship	Name	Home Phone	Contact Phone
_____	_____	(____) _____	(____) _____
_____	_____	(____) _____	(____) _____
_____	_____	(____) _____	(____) _____
_____	_____	(____) _____	(____) _____

Medical Information

Medical Conditions (check all that apply)

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Emotional Disorder | <input type="checkbox"/> Kidney/Bladder | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Allergies (specify below) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Aide/Tubes | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Skin Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stomach Problem |
| <input type="checkbox"/> Asthma Inhaler | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Bee Sting | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hernia | <input type="checkbox"/> Musculo-Skeletal | <input type="checkbox"/> Tourette Syndrome |
| <input type="checkbox"/> Epi-pen | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Prosthetic Device | <input type="checkbox"/> Vision/Glasses |
| <input type="checkbox"/> Other _____ | | | | |

Medication(s)

If your child receives daily medication, please list the name of the medication, dose, and time it is given. Medication cannot be dispensed at the school without a formal request signed by a doctor and parent. Medication forms are available in the school office.

Name	Dosage (How Much?)	Times Given
_____	_____	_____
_____	_____	_____
_____	_____	_____

As legal custodian of _____, a minor, I hereby authorize the principal or his/her designee, into whose care the aforementioned minor pupil has been entrusted, to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

This authorization shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand that the Galt Joint Union Elementary School District, its employees, and its Board assume no liability of any nature in relation to the transportation or treatment of said minor.

I further understand that all costs of paramedic transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my responsibility.

Preferred Doctor _____ Phone No. (____) _____ Preferred Hospital _____

Health Insurance Carrier _____ Group No. _____ Policy No. _____

- In the event of an accident or emergency, I give permission for school staff or emergency contact to obtain necessary emergency medical care for my child.
- I do not consent to medical care for my child I release the school/district from liability. Please initial. _____

Medical/Health Information: Parent/Guardian Signature _____

Registration Signature

Parent/Guardian Signature _____ Print Name _____ Date _____

Office Use Only

Residence School _____ Enrollment Date _____ Start Date _____ Grade _____

Student Enrolled By: Parent/Guardian Foster Care Giver (Copy of Affidavit must be attached)

School Assigned _____ Reason: Residence Overflow Choice SPED Registered By _____

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 their 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 starts 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 Signature:	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 <u>Present:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Urgency: <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended (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.



Galt Joint Union Elementary School District



School Readiness Questionnaire

(2012 KINDERGARTEN)

School of Enrollment: _____ Today's Date: _____

Child's Name _____ Birthdate: _____

Parent/Guardian: _____

Address _____

Home Telephone _____ Work/Cell # _____

Does your Child currently attend Preschool? YES NO

Which Preschool? : ___ Fairsite ___ Head Start ___ NH ___ City Tots
___ Migrant Education ___ New Hope Other Private: _____

If your child is not currently attending preschool:

Are you interested in enrolling your child in the school district's 5-week Jumpstart Kinder Summer Camp program? YES NO

Fairsite School Readiness Program provides free School Readiness services to families with children ages 0-5 years.

Please check all areas of interest:

___ **Parent Education Classes:** Positive Discipline, Nutrition, Wellness, Child Development

___ **Family Literacy Classes:** Activities that promote school readiness and reading success

___ **Free Health Screenings:** Dental, Hearing, Vision, Height/Weight & Developmental

___ **Parent & Toddler Playgroup Classes:** For parents and their children ages 0-4 years old

___ **Speech/Language & Psychological Screenings:** Early identification of special needs

___ **Free/Low Cost Health Insurance Referrals**

Parent/Guardian Signature: _____



Notification of Placement in English Classroom

To: The parents of English Learners
Subject: English Learner Programs

As a parent of an English Learner, it is important to know about your child's placement in the English Learner program at his/her school site. *As required by law, all students are placed in English language classrooms. Your child will be placed in such a classroom.*

However, if you feel your child would be better served in an alternative program, you have the opportunity to apply for a **Parental Exception Waiver** for your child to participate in the **Alternative Bilingual Program**. **In this program, reading, and writing are taught in Spanish. All other subjects are taught in English with Spanish support.**

Educational Programs for English Learners

- By law, the primary purpose of these programs is to help students learn the English language as rapidly and effectively as possible.
- All students, including English Learners, are placed in English-language classrooms unless a parental exception waiver has been granted for an alternative program.
- Parents must personally visit the school to apply for a parental exception waiver. Waivers are available in the school offices.

English Learner Programs:

The Mainstream English Language Program:

This program is designed for English Learners who score at the Intermediate or Advanced levels on the annual CELDT test given by the State of California. All lessons are taught in English with specially designed instruction for English Learners and students receive a daily English Language Development class.

Structured English Immersion Program:

This program is designed for English Learners who score at the Beginning levels on the annual CELDT test given by the state of California. While the majority of instruction in this program is in English, Spanish may be used to help clarify concepts and support student understanding. All lessons taught with specially designed instruction for English Learners and students receive a daily English Language Development class. Students generally stay in this program for one year.

Alternative Bilingual Program:

This program is for English Learners whose native language is Spanish and who have an approved Bilingual Waiver. Instruction in reading, writing and spelling is conducted in Spanish. All other subjects are taught in English with Spanish used to help students understand concepts and subject matter. Students also receive a daily English Language Development class.

If you have any questions please stop by the school office and a Program Specialist will meet with you to discuss your options

Karen Schauer, District Superintendent ~ Debbie Schmidt, Business Director
Judy Bullard, Curriculum Director ~ Robert Nacario, Educational Services Director

Board of Trustees: John Gordon, Susan Richardson, Jennifer Collier, Kevin Papineau, Wesley B. Cagle