

# TK/KINDERGARTEN CHECKLIST

## Items to Return to office

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	Blue Emergency Medical Card
	Student Registration Form
	Oral Health Assessment Form
	Confidential Health Questionnaire
	Health Exam for School Entry
	Home Language Survey
	Housing Questionnaire
	Birth Certificate
	Immunization Record
	Lunch Application

## McCloud Union School District

Shelley Cain, Superintendent-Principal

P.O. Box 700

McCloud, California 96057

530-964-2133

FAX 964-2153

Dear Parents of Students Entering Transitional Kindergarten and Kindergarten:  
Congratulations on your child reaching one of life's important milestones, TK/Kindergarten!  
In order to ensure that your child is healthy and ready to learn, you will need to turn in the following documents to school in order for your child to be enrolled in school:

- Proof of Age. Birth certificate, record of birth from a hospital, baptism certificate, passport or any other legal means of proving the age of the child (this document is to verify your child's age and not a health requirement).
- Immunization Record. See the back of this form for a list of the required immunizations for school entry. Your child will not be allowed to enroll in school if you do not present an immunization record. Even if your child's immunizations are not yet complete, you can still fill out the packet to get the process started so your child's school will know how many students will be enrolling. After you have turned in your registration packet, be sure to give a copy of your child's immunization record to the school secretary or health clerk each time your child receives an additional immunization.
- Oral Health Exam. The purpose of this state mandated exam is to educate families as to the importance of oral health for children and to determine whether or not children have access to dental care. This form is to be completed by a dental care professional who has agreed to provide oral health care for your child. If you do not have access to dental care for your child, it is very important that you turn in this form and fill in the section that indicates the reason you did not have the exam done. In the past, there has been limited access to dental care for children who are uninsured or have some insurances that are not accepted by most dentists in Siskiyou County. We are interested in determining whether or not the dental needs of children in Siskiyou County are being met. A report of the numbers of children who received the exam and of those who are not able to have an exam done is sent to the California Dental Association for analysis.
- School Entry Physical. This exam is required to be completed within 18 months of a student entering first grade. Many schools require it for school entry since the students are already visiting their health care providers for immunizations before beginning kindergarten. This exam can be done up to six months before a child begins kindergarten or transitional kindergarten.
- Health Questionnaire. Since your child may be spending most of their waking hours at school, on the school bus or at school day care and after school programs, it is very important that the school staff are aware of any health issues your child may have that could result in an emergency of interfere with your child's ability to learn.

Thank you for completing these important tasks. Healthy children learn better and this is a positive way to start out your child's educational career!

Welcome to  
Kindergarten

McCloud Union School District

Shelley Cain, Superintendent-Principal

P.O. Box 700

McCloud, California 96057

530-964-2133

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School Year: \_\_\_\_\_

Student Name: \_\_\_\_\_  
Last Name First Name Middle Name or Initial aka

Male / Female \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthplace: \_\_\_\_\_  
Circle One City State Country

Lives With: \_\_\_ Father \_\_\_ Mother \_\_\_ Stepfather \_\_\_ Stepmother \_\_\_ Other: \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street / PO Box City State Zip Code

Residence Address: \_\_\_\_\_  
(If different from above) Street / PO Box City State Zip Code

What is your child's ethnicity? (Please check one)  Hispanic or Latino  Not Hispanic or Latino (Regardless, complete race section)

Race: (Choose the group with which the student most closely identifies.)  
 American Indian/Alaska Native (100)  Korean (203)  
 Asian Indian (205)  Laotian (206)  
 Black/African American (600)  Other Asian (299)  
 Cambodian (207)  Pacific Islander (399)  
 Chinese (201)  Samoan (303)  
 Filipino/Filipino American (404)  Tahitian (304)  
 Guamanian (302)  Vietnamese (204)  
 Hawaiian (301)  White (Not Hispanic) (700)  
 Japanese (202)

Primary Home Language:  
 Arabic (11)  Armenian (12)  Cantonese (03)  
 English (00)  Farsi (16)  Filipino (05)  
 French (17)  German (18)  Hindi (22)  
 Hmong (23)  Japanese (08)  Khmer (09)  
 Korean (04)  Lao (10)  Mandarin (07)  
 Punjabi (28)  Russian (29)  Samoan (30)  
 Spanish (01)  Taiwanese (46)  Thai (32)  
 Ukrainian (38)  Urdu (35)  Vietnamese (02)  
 Other: \_\_\_\_\_ (99)

Has your child ever been retained? Yes / No If yes, what grade? \_\_\_\_\_

Has your child ever been expelled? Yes / No If yes, what year? \_\_\_\_\_ What school? \_\_\_\_\_

Special Services: \_\_\_ RSP \_\_\_ Speech \_\_\_ GATE \_\_\_ 504 Plan \_\_\_ Behavior Plan

Parent Education: Highest level of education of father  
\_\_\_ Not High School Graduate \_\_\_ High School Graduate/GED \_\_\_ Some College/AA \_\_\_ College Graduate \_\_\_ Graduate School/Post Graduate

Parent Education: Highest level of education of mother  
\_\_\_ Not High School Graduate \_\_\_ High School Graduate/GED \_\_\_ Some College/AA \_\_\_ College Graduate \_\_\_ Graduate School/Post Graduate

Duplicate Mailing: \_\_\_ Father \_\_\_ Mother (If divorced/separated & joint custody allows duplicate mailing/information to be given to other parent, please include their name, address, and telephone number.)

Full Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
Street / PO Box \_\_\_\_\_

**EMERGENCY CONTACTS:** (Other than above. Parent/guardian will be contacted first.)

_____	_____	_____	Release OK: Yes / No Circle One
<i>Full Name</i>	<i>Phone/Cell Number</i>	<i>Relationship to student</i>	
_____	_____	_____	Release OK: Yes / No Circle One
<i>Full Name</i>	<i>Phone/Cell Number</i>	<i>Relationship to student</i>	
_____	_____	_____	Release OK: Yes / No Circle One
<i>Full Name</i>	<i>Phone/Cell Number</i>	<i>Relationship to student</i>	
_____	_____	_____	Release OK: Yes / No Circle One
<i>Full Name</i>	<i>Phone/Cell Number</i>	<i>Relationship to student</i>	

**COURT ORDERS:** (If you have a court order please make sure the office has a copy of it on file.)

List Order(s): \_\_\_\_\_

**Health Conditions:** \_\_\_ Asthma \_\_\_ Epilepsy \_\_\_ Diabetes \_\_\_ Heart Problems \_\_\_ Seizures \_\_\_ Bee Allergies  
\_\_\_ Food Allergies (if this is checked, please fill out the Medical Statement for Participants with Allergies/Chronic Diseases form.)

Does your child take medication regularly?	Yes / No	If yes, what kind? _____
Does your child have a speech problem?	Yes / No	Please explain: _____
Does your child have an ear problem?	Yes / No	If yes, what kind? _____
Does your child have a physical handicap?	Yes / No	Please explain: _____
Does your child have an eye problem?	Yes / No	Please explain: _____

**We will ALWAYS try to contact parents or contacts before a student will be transported for emergency medical treatment**

Doctor's Name: _____	Phone Number: _____
Dentist's Name: _____	Phone Number: _____
Hospital Name: _____	Phone Number: _____

Does your child have health insurance? \_\_\_ Yes \_\_\_ No If no you may be eligible for free or low cost insurance through Medi-Cal or Covered California  
Please check with the School office to get more information or assistance in obtaining health coverage

Medical Insurance Co./Group Number: \_\_\_\_\_

\_\_\_ I DO NOT wish medical care secured for my child because of religious/personal beliefs. Please Explain: \_\_\_\_\_

I hereby authorize the staff of McCloud Union Elementary School District to secure and sign for emergency medical care for my child at my expense, when necessary

\_\_\_\_\_  
*Parent's Signature* *Date*

According to appropriate grade level schedules, all children will receive vision, hearing, dental, scoliosis, speech and language screening. You have the right to refuse these services for your child. Unless you notify the office in writing, your child will be screened at no expense to you.

**Oral Health Assessment Form**

California law (*Education Code* Section 49452.8) says every child must have a dental check-up (assessment) by May 31<sup>st</sup> of his/her first year in public school. A California licensed dental professional must do the check-up and fill out Section 2 of this form. If your child had a dental check-up in the last 12 months, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out the separate Waiver of Oral Health Assessment Requirement Form.

This assessment will let you know if there are any dental problems that need attention by a dentist. This assessment will also be used to evaluate our oral health programs. Children need good oral health to speak with confidence, express themselves, be healthy and, ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of California’s children.

**Section 1: Child’s Information (Filled out by parent or guardian)**

Child’s First Name:	Last Name:	Middle Initial:	Child’s Birth Date: MM – DD – YYYY
Address:			Apt.:
City:		ZIP Code:	
School Name:	Teacher:	Grade:	Year child starts kindergarten:   Y   Y   Y   Y
Parent/Guardian First Name:	Parent/Guardian Last Name:	Child’s Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Child’s Race/Ethnicity:	<input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Black/African American <input type="checkbox"/> Multi-racial <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Other (please specify)		

*Continued on Next Page*

**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:  MM – DD – YYYY	Untreated Decay (Visible Decay Present)  <input type="checkbox"/> Yes <input type="checkbox"/> No	*Caries Experience (Visible decay and/or fillings present)  <input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Urgency: <input type="radio"/> <b>No obvious problem found</b> <input type="radio"/> <b>Early dental care recommended</b> (caries without pain or infection; or child would benefit from sealants or further evaluation) <input type="radio"/> <b>Urgent care needed</b> (pain, infection, swelling or soft tissue lesions)		
_____ <b>Licensed Dental Professional Signature</b>		_____ <b>CA License Number</b>
		_____ <b>Date</b>

\*Check "Yes" for Caries experience if there is presence of untreated decay or fillings  
Check "No" for Caries experience if there is no untreated decay and no fillings

**Section 3: Follow-up to Urgent Care (Filled out by entity responsible for follow up)**

Parent notified that child has urgent dental care need on:	MM – DD – YYYY
A follow-up appointment for this child has been scheduled for:	MM – DD – YYYY
Did child receive needed treatment?	<input type="radio"/> <b>Yes</b> <input type="radio"/> <b>No</b> (If no, entity responsible for follow-up will be encouraged to check back in with parent) <input type="radio"/> <b>I don't know</b>

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 31st of your child's first school year.**

***Original to be kept in child's school record.***

2026/27

## Confidential Health Questionnaire

Child's Name:	M / F	Birthdate:
Physician:	Phone number:	
Dentist:	Phone number:	
<input type="checkbox"/> Check here if your child has NO KNOWN HEALTH CONCERNS		
<input type="checkbox"/> Check here if your child has KNOWN HEALTH CONCERNS and check all that apply below:		
<input type="radio"/> ADD/ADHD		
<input type="radio"/> Asthma		
<input type="radio"/> Severe Allergy to _____		
<input type="checkbox"/> Has an epinephrine auto-injector		
<input type="checkbox"/> Seizures		
<input type="checkbox"/> Diabetes    ___ Type I    ___ Type II		
<input type="checkbox"/> Other:		
<input type="checkbox"/> Check here if your child wears glasses or contact lenses.		
<input type="checkbox"/> Check here if your child has a hearing loss or uses hearing aids.		
<input type="checkbox"/> Check here if your child has had chicken pox.		
<input type="checkbox"/> My child has dietary restrictions (please explain)		
Does your child have a condition that limits participation in :		
<input type="checkbox"/> Classroom		
<input type="checkbox"/> Physical Education		
Explain:		
<b>List all medication your child takes and indicate whether it is needed at home, school or both. Note: If your child requires medication while attending school, there are forms that need to be completed by you and your child's physician so that the school may dispense the medication safely (California Education Code 49423).</b>		
AT HOME:		
AT SCHOOL:		
<b>Special Instructions/Comments/Health Needs/Emergency Care Plans:</b>		
If you would rather not use this form or would like to discuss any matter with the School Nurse, you may call your child's school and request that the School Nurse call you.		
Name of person completing form	Relationship to the student	Date

## 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/DT/DTd (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)

#### RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

- Examination shows no condition of concern to school program activities.
- Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: *(please explain)*

#### RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

- Please check this box if you **do not** want the health examiner to fill out Part III.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

Name, address, and telephone number of health examiner \_\_\_\_\_

Signature of health examiner \_\_\_\_\_ Date \_\_\_\_\_

**If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.**



## McCloud Union School District

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### HOME LANGUAGE SURVEY

Name of student: \_\_\_\_\_  
Last First Middle

Age \_\_\_\_\_ Grade \_\_\_\_\_

School \_\_\_\_\_ Date \_\_\_\_\_

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 and return this form with the registration packet.

Thank you for your help.

- 1) What language did your son/daughter learn when he/she first began to talk? \_\_\_\_\_
- 2) What language does your son/daughter most frequently use at home? \_\_\_\_\_
- 3) What language do you use most frequently to speak to your son/daughter? \_\_\_\_\_
- 4) Name the language most often spoken by the adults at home. \_\_\_\_\_

\_\_\_\_\_  
Signature of parent or guardian

McCloud Elementary School  
Shelley Cain, Administrator  
Housing Questionnaire

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Student Last Name	First	Middle
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Name of School
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The information provided below will help the LEA determine what services you and/or your child may be eligible for. This could include additional educational services through Title I, Part A and/or the federal McKinney-Vento Assistance Act. The information provided on this form will be kept confidential and only shared with appropriate school district and site staff.

Presently, are you and/or your family living in any of the following situations? *Check all that apply.*

- Staying in a shelter (family shelter, domestic violence shelter, youth shelter) or Federal Emergency Management Agency (FEMA) trailer
- Sharing housing with other(s) due to loss of housing, economic hardship, natural disaster, lack of adequate housing, or similar reason
- Living in a car, park, campground, abandoned building, or other inadequate accommodations (i.e. lack of water, electricity, or heat)
- Temporarily living in a motel or hotel due to loss of housing, economic hardship, natural disaster, or similar reason
- Living in a single-home residence that is permanent
- I am a student under the age of 18 and living apart from parent(s) or guardian

***The undersigned parent/guardian certifies that the information provided above is correct and accurate.***

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Print Parent/Guardian Name	Signature	Date
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(Area Code) Phone Number	Street Address	City	State	Zip
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Your child or children have the right to:

- Immediate enrollment in the school they last attended (school of origin) or the local school where you are currently staying, even if you do not have all the documents normally required at the time of enrollment.
- Continue to attend their school of origin, if requested by you and it is in the best interest.
- Receive transportation to and from their school of origin, the same special programs and services, if needed, as provided to all other children, including free meals and Title I.
- Receive the full protections and services provided under all federal and state laws, as it relates to homeless children, youth, and their families.

Please list all children currently living with you.

Name	M/F	Birthdate	Grade	School

If you have any questions about these rights, please contact the local homeless liaison, Shelley Cain, by phone at (530)964-2133 or by email at [scain@sisnet.ssku.k12.ca.us](mailto:scain@sisnet.ssku.k12.ca.us)



The information submitted on this form is a confidential educational record and is therefore protected by all relevant federal and state privacy laws that pertain to educational records including, without limitation, the Family Educational Rights and Privacy Act of 1974 (FERPA), as amended (20 U.S.C. § 1232g; 34 CFR Part 99); Title 2, Division 4, Part 27, Chapter 6.5 of the California Education Code, beginning at Section 49060 et seq.; the California Information Practices Act (California Civil Code Section 1798 et seq.) and Article 1, Section 1 of the California Constitution.

### **Who should I include in "Household Size"?**

You must include yourself and all people living in your household, related or not (for example, children, grandparents, other relatives, or friends) who share income and expenses. If you live with other people who are economically independent (for example, who do not share income with your children, and who pay a pro-rated share of expenses), do *not* include them.

**What is included in "Total Household Income"?** Total Household Income includes all of the following:

- **Gross earnings from work:** Use your gross income, not your take-home pay. Gross income is the amount earned before taxes and other deductions. This information can be found on your pay stub or if you are unsure, your supervisor can provide this information. Net income should only be reported for self-owned business, farm, or rental income.
- **Welfare, Child Support, Alimony:** Include the amount each person living in your household receives from these sources, including any amount received from CalWORKs.
- **Pensions, Retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits:** Include the amount each person living in your household receives from these sources.
- **All Other Income:** Include worker's compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income received. Do not include income from CalFresh, WIC, federal education benefits and foster payments received by your household.
- **Military Housing Allowances and Combat Pay:** Include off-base housing allowances. *Do not* include Military Privatized Housing Initiative or combat pay.
- **Overtime Pay:** Include overtime pay **ONLY** if you receive it on a regular basis.

### **How do I report household income for pay received on a weekly, twice per month, every other week, monthly, and annual basis?**

- For each household member determine the frequency in which income is received (weekly, twice per month, every other week, monthly, or annually) and enter amount in appropriate column. For example, if you are paid twice per month report the gross amount of your paycheck in the appropriate column.
- Repeat these steps for each source of income for each household member. If you have more sources of income than columns provided, report all additional income in the appropriate column.
- Add amounts reported in each column in the subtotal row. Multiply each subtotal by the appropriate number, as indicated on the form.
- Add all columns to determine the Total Household Income.

If your income changes, include the wages/salary that you regularly receive. For example, if you normally make \$1,000 each month, but you missed some work last month and made \$900, put down that you made \$1,000 per month. Only include overtime pay if you receive it on a regular basis. If you have lost your job or had your hours or wages reduced, enter zero or your current reduced income.

**For additional information on Household Size and Gross Household Income, please see the Eligibility Manual for School Meals on the U.S. Department of Agriculture Guidance and Resource Web page at <http://www.fns.usda.gov/cnd/guidance/default.htm>.**

Student Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

AGE \_\_\_\_\_

**CONSENT FOR EMERGENCY MEDICAL TREATMENT OF MINOR**

I hereby give my consent for all medical care prescribed by a duly licensed physician (M.D.) for \_\_\_\_\_ as his/her parent or legal guardian. This care may be given under whatever conditions are necessary to preserve life, limb or well-being of my dependent.

Parent/Guardian (printed) \_\_\_\_\_

Parent/Guardian (signed) \_\_\_\_\_

Home Address \_\_\_\_\_

Student/Athlete Name: \_\_\_\_\_

Student's Allergies 1. \_\_\_\_\_

2. \_\_\_\_\_

Student's past medical problems \_\_\_\_\_

Our Insurance Co. is: \_\_\_\_\_

Policy #: \_\_\_\_\_ Date: \_\_\_\_\_

If in town, we prefer Dr. \_\_\_\_\_