SUNRISE ELEMENTARY SCHOOL

Elk Grove Unified School District
Susan Landon, Principal | Carrie Garbett, Vice Principal
11821 Cobble Brook Drive Rancho Cordova, CA 95742
Phone: (916) 985-4350
Sunrise Elementary Office Staff (*SunriseElemInfo@egusd.net*)

LaQreatin Linton, SOAII Enrollment Specialist

Elk Grove Unified School District

2026-2027 School Year Welcome Enrollment Packet

Student Name: _____ **Date of Birth:** ___ / ___ / ___

Grade: _____ **School Year:** 2026-2027

A completed registration includes photocopies of:

- ☐ Student's Proof of Legal Name and Age
- ☐ Student's Immunization Records (see list below)
- ☐ Parent/Guardian's Photo ID
- ☐ Proof of Residence

Immunizations needed for registration:

- ☐ DTP/DTaP/Tdap or Td (x5)
- ☐ Hepatitis B (x3)
- ☐ Polio (x4)
- ☐ MMR (x2)
- ☐ Varicella (x2)

Please Return Registration Packet by:

- ☐ ***Transitional Kinder (TK) & Kindergarten:** Return no later than 2/20/26 at 3pm for lottery*
  (This alleviates the need for our families to stand in line as it will give each family an equal opportunity to receive their preference.)
- ☐ **1st thru 6th Grades:** No later than 2/20/26 at 3pm

Placement information (Teacher, Track, Back to School Packet, & Student Handbook) for the 2026-2027 school year will be emailed on Saturday, June 6th, 2026.

If you have any questions, please email the Sunrise Front Office at **(916) 985-4350**. SunriseElemInfo@egusd.net

'26-'27 Age Eligibility	
GRADE	QUALIFYING BIRTHDAYS
TK	9/2/2021 thru 9/1/2022*
K	9/2/2020 thru 9/1/2021*
1st	9/2/2019 thru 9/1/2020
2nd	9/2/2018 thru 9/1/2019
3rd	9/2/2017 thru 9/1/2018
4th	9/2/2016 thru 9/1/2017
5th	9/2/2015 thru 9/1/2016
6th	9/2/2014 thru 9/1/2015

For office use only:

Date Received: ____/____/____ Verified by: _____ ☐ CGES ☐ SES

Elk Grove Unified School District

Housing Questionnaire

The answers to the following questions will help determine the services you and/or your child(ren) may be eligible to receive under the federal McKinney-Vento Assistance Act 42 U.S.C. 11435 and Title I, Part A. The information provided on this form will be kept confidential and only shared with appropriate school district and site staff.

Student Name (First and Last):_____ Date of Birth:_____

School:_____ Grade:_____

SECTION 1

☐ Check here if you own your home or have a rental agreement.

☐ Check here if you are in a shared living situation that is **NOT** due to economic hardship. (You may be asked to provide an Affidavit of Non-Permanent Residence Form with your enrollment.)

If you checked one of the boxes above, you may stop here, you do not need to complete section 2 of this form.

SECTION 2

At this time, are you and/or your family living in any of the following situations due to **economic hardship, loss of housing, inadequate accommodations, natural disasters, or similar reasons**? Please note that the information provided below will help EGUSD determine what services you and/or your child may be eligible to receive. **Check all that apply.**

- ☐ Sharing a house or apartment **due to economic hardship (for example job loss, loss of housing/eviction)**
- ☐ Moving from place to place / couch surfing
- ☐ Living in a car, park, campground, abandoned building, or other inadequate accommodations.
- ☐ Hotel or Motel
- ☐ Shelter (family shelter, domestic violence shelter, youth shelter) or FEMA trailer
- ☐ In a residence with inadequate facilities (no water, heat, electricity, etc.)
- ☐ I am a student that is age 18 or younger and living apart from parent(s) or guardian(s)

Where did you stay last night? Current Address (or nearest cross streets): _____

Phone/Cell:_____ Email:_____

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

Parent/Guardian Name*: _____ Signature:_____ Date:_____

** Unaccompanied youth (youth who are not in the care or custody of a legal parent/guardian) may also provide their name, sign and date.*

Please list all children (0-18 yrs) living with you even if they do not attend school at this time.

Name	Birthdate	Grade	School

Your child(ren)'s rights are listed on the back of this document. If you have questions about these rights, please contact the EGUSD Homeless Liaison, Tami Silvera, by phone 916-686-7568 or by email at tsilvera@egusd.net.

OFFICE USE ONLY
If Section 2 is marked, please scan a copy of the completed Housing Questionnaire to the SAFE Office at Housingquestionnaire@egusd.net and update the "Special Services-Request for Verification" section in Synergy.

Elk Grove Unified School District

McKinney-Vento Assistance Act Information

McKinney-Vento Assistance Act 42 U.S.C. 11435 SEC. 725.

The McKinney-Vento Assistance Act provides services and supports for children and youth experiencing homelessness.

Your child or children may 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.

McKinney-Vento Assistance Act 42 U.S.C. 11435 SEC. 725.

The McKinney-Vento Assistance Act provides services and supports for children and youth experiencing homelessness.

DEFINITIONS. For purposes of this subtitle:

(1) The terms "enroll" and "enrollment" include attending classes and participating fully in school activities.

(2) The term homeless children and youths

(A) means individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1)); and

(B) includes —

(i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C));

(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

(6) The term "unaccompanied youth" includes a youth not in the physical custody of a parent or guardian.

Additional Resources Parent information and resources can be found at the following:
http://center.serve.org/nche/ibt/parent_res.php

https://naehcy.org/educational-resources/

Elk Grove Unified School District

ELK GROVE UNIFIED SCHOOL DISTRICT (EGUSD)
Part I: Student Enrollment Form
Information on these pages is required for enrollment. Please complete both pages.

STUDENT INFORMATION **DATE**_____

Has student ever attended an EGUSD School (including Preschool): ☐ Yes: EGUSD Student ID # _____ ☐ No

Is this student currently expelled or pending an expulsion hearing in EGUSD or any other district? ☐ Yes ☐No

Student's Full Legal Name: _____
Last First Middle Suffix (Jr. III, IV)

Grade Level: _____ Gender: ☐ Male ☐ Female ☐ Non-Binary

Nickname/Other Name: _____
Last First Middle Suffix (Jr. III, IV)

Birth Date: ___/___/___ (Mo./Day/Yr.) Student's Email: _____ Student's Cell: _____

Residence Address: _____
Number & Street, Apt # City State Zip Code

RACE/ETHNICITY

Ethnicity:

☐ Not Hispanic
☐ Hispanic/Latino (Cuban, Mexican/ Puerto Rican, South/Central American or other Spanish culture or origin)

Race: (Please select all that apply)

☐ African American/Black
☐ American Indian
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Guamanian
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Other Asian
☐ Samoan
☐ Tahitian
☐ Vietnamese
☐ White
☐ _____ Please Specify

HOME LANGUAGE SURVEY

The CA ED Code directs schools to determine the English language proficiency of students. The process begins with identifying the languages(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential for the school to provide adequate instructional programs and services.

1. Which language did your child learn when he/she/they 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 any adults living in the home? _____

Signature of Parent or Guardian: _____

Elk Grove Unified School District

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name (1): _____
Last First Middle Suffix (Jr. III, IV)

☐Legal Guardian ☐ Other (specify): _____

Relationship _____ Does this person live with student? ☐ Yes ☐ No Release to/Contact allowed ☐ Yes ☐ No

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

Cell: _____ Work: _____ Home: _____

Email Address: _____ Preferred Language: _____

Education level – please check one box that most closely applies

- ☐ Not a high school graduate
- ☐ Graduated from high school
- ☐ Some college /AA degree
- ☐ College graduate
- ☐ Grad school/postgrad

Military Service: ☐ Active Armed Forces ☐ Full-Time National Guard ☐ Armed Forces Reserve

Parent/Guardian Name (2): _____
Last First Middle Suffix (Jr. III, IV)

☐Legal Guardian ☐ Other (specify): _____

Relationship _____ Does this person live with student? ☐ Yes ☐ No Release to/Contact allowed ☐ Yes ☐ No

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

Cell: _____ Work: _____ Home: _____

Email Address: _____ Preferred Language: _____

Education level – please check one box that most closely applies:

- ☐ Not a high school graduate
- ☐ Graduated from high school
- ☐ Some college /AA degree
- ☐ College graduate
- ☐ Grad school/postgrad

Military Service: ☐ Active Armed Forces ☐ Full-Time National Guard ☐ Armed Forces Reserve

Name of Person Completing Form (please print): _____
Last First Middle

Relationship _____

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

Thank you for completing your student's enrollment.

To identify and provide the services to best meet the needs of your student, please take a few moments to complete the **Supplemental Student Information Form** (next pages).

FOR OFFICE USE ONLY

School Name _____ Enrollment Date _____

Birth Date Verified ☐ Birth Date Verification Method _____ Address Verification Method(s) _____

Immunizations Complete? ☐ YES ☐ NO Student Notifications? ☐ YES ☐ NO

Permit Type: _____ Permit Date: _____ Track _____ Enrolled by: _____ Date entered in Synergy: _____

Part II: Supplemental Student Information Form

The Supplemental Student Information Form assists Elk Grove Unified School District in providing academic support and services.
This form is not required for purposes of enrolling your child. Submission of this form assists EGUSD in providing your student academic supports, access to specific programs, and critical health and safety information.

Thank you for completing this form.

EDUCATIONAL PROGRAM PARTICIPATION ELIGIBILITY

What special services has your child received?

- ☐ None
- ☐ 504 Accommodation
- ☐ GATE
- ☐ Special Education
- ☐ English Language Development (ELD)
- ☐ Bilingual

Request for Migrant Education Migrant Student ID: _____

Native American Tribal Band Membership: ☐ Yes, Tribal Membership Number: _____ ☐ No

Do you have refugee status? ☐ Yes ☐ No Are you a holder of a Special Immigrant Visa? ☐ Yes ☐ No

Does your child have a current foster care status? ☐ Yes ☐ No

Which of the following best describes where this child is currently living, if applicable? (Federally Required)
Homeless and/or sharing a house or apartment due to economic hardship:
☐ Yes (If yes, please complete the Housing Questionnaire in the Student Enrollment Packet) ☐ No

PRESCHOOL ATTENDANCE

Did your child attend preschool? ☐ Yes ☐ No
If yes, what type of preschool? ☐ EGUSD Preschool ☐ Other Public Preschool ☐ Private Preschool

ADDITIONAL DEMOGRAPHIC INFORMATION

Birthplace: City_____ State_____ Country _____

U.S. School Entry Date:____/____/____ City_____ State _____

NAMES OF ALL OTHER CHILDREN IN FAMILY (18 YEARS AND UNDER)

NAME	RELATIONSHIP	DATE OF BIRTH	SCHOOL OF ATTENDANCE	LIVING AT HOME
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

PREVIOUS ENROLLMENT

Previous School Attended_____ Last Date Attended_____

Address _____ City _____ State _____ Zip _____ Phone _____ Fax _____

Name of Previous School District_____

Please complete both pages

EMERGENCY CONTACTS: Individuals who may be contacted in an emergency when no parent or guardian can be reached.

1. Relationship_____ Name_____ Release to ☐ Yes ☐ No
   Phone_____ Work_____ Email_____
2. Relationship_____ Name_____ Release to ☐ Yes ☐ No
   Phone_____ Work_____ Email_____
3. Relationship_____ Name_____ Release to ☐ Yes ☐ No
   Phone_____ Work_____ Email_____

Day Care Provider _____
Name Address City Zip

Phone_____ Cell_____ Release to ☐ Yes ☐ No

ADDITIONAL CONTACTS

Physician Name_____ Phone_____ Ext_____ Hospital_____

Insurance Provider_____ MED Policy # _____

Social Worker (Agency)_____ Email_____ Phone_____

Social Worker (County)_____ Email_____ Phone_____

Probation Officer_____ Email_____ Phone_____

HEALTH RECORD ☐ PLEASE CHECK HERE IF STUDENT HAS NO KNOWN HEALTH CONDITIONS

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

Medical Alert (unlisted condition – describe below)

- ☐ ADHD
- ☐ Allergy – Non-food
- ☐ Allergy – Food
- ☐ Allergy – Nut
- ☐ Allergy – Peanut
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Autoimmune Disorder
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Cerebral Palsy
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Eczema
- ☐ Headache-Migraine
- ☐ Hearing Impairment
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Intestinal Disorder
- ☐ Orthopedic/Scoliosis
- ☐ Pacemaker
- ☐ Seizure Disorder
- ☐ Sickle cell Anemia
- ☐ Tuberculosis
- ☐ Urinary Disorder
- ☐ Vision Impairment

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:_____ Date: _____
(Certifying information provided is accurate)

ELK GROVE Unified School District

Members of the Board
Beth Albiani
Jennifer Ballerini
Delia Baulwin
Susan Davis
Heidi Moore
Michael Vargas
Sean J. Yang

Jenifer Avey
Assistant Superintendent of Schools
Elementary 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 (Year-Round Calendar School Only).

The circumstances for these conditions include:

- ☐ Overcrowding at the home school
- ☐ Overcrowding at a grade level
- ☐ Overcrowding on a specific track (*Year-Round Calendar School Only*)
- ☐ Boundary changes created by the building of new schools. Boundary changes affect students at all levels; elementary, middle and high school.

PLACEMENT PROCESS

For Transitional Kindergarten and Kindergarten students, we will utilize an automated computer generated Randomized Placement Process. In order to participate in this process, the TK/K Welcome Packet and supporting documentation must be received by 3:30pm on February 20th, 2026. 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 preferred placement.

In regard to 1st through 6th grade students and TK/K Welcome Packets returned after February 20th, those packets 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.

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: _____

SUNRISE ELEMENTARY SCHOOL

Elk Grove Unified School District
Susan Landon, Principal : Carrie Garbett, Vice Principal
11821 Cobble Brook Drive Rancho Cordova, CA 95742
Phone: (916) 985-4350
LaQreatin Linton, SOAII Enrollment Specialist
Sunrise Elementary Office Staff (*SunriseElemInfo@egusd.net*)

Elk Grove Unified School District

Student Name: _____ Grade: _____ School Year: **2026-2027**

SPECIAL SERVICES SURVEY

1. Has your child ever been retained?
   If so, what grade? _____ ____Yes ____No
2. Has your child ever had an Individual Education Plan(IEP) or a 504 Accommodation? ____Yes (IEP/504) ____No
3. Has your child ever received Speech Services? ____Yes ____No
4. Has your child ever received Bilingual Services? Which Language?_____ ____Yes ____No
5. Has your child ever been in a Self-Contained Special Education Class or Learning Center? ____Yes ____No
6. Has your child been "GATE identified"? ____Yes ____No

TRACK PREFERENCE

This is a request only. Track selections are not a guarantee*

Please make your choices in the space provided below.

All spaces MUST have a different choice. (Sunrise Track Choices: A, B, C, or D.)

Proposed SUNRISE SCHEDULE (*Schedule is subject to change.*)

1ST-6TH GRADES: Monday/Tuesday/Wednesday/Friday 8:05am-2:35pm*
*1st-6th Grades: **Early Out Thursday** 8:05am-1:45pm;
***Minimum Day Dismissal** at 12:25pm

AM TK & KINDER CLASSES: Monday-Friday 8:05am-11:31pm
(**NO Early Out Thursdays / NO Minimum Days**)

PM TK & KINDER CLASSES: Monday-Friday 11:04am-2:35pm*
(NO Early Out Thursdays/*Min. Day follow AM TK/K Schedule)

1st Choice ____ 2nd Choice _____ 3rd Choice _____

(TK and KINDER ONLY) SESSION TIME PREFERENCE: ☐ AM ☐ PM

Parent/Guardian Signature:_____ Date:_____

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

1. SCHOOL/AGENCY	2. SCHOOL SITE	3. SITE TELEPHONE NUMBER
EGUSD		
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.

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)

ELK GROVE UNIFIED SCHOOL DISTRICT
Student Support and Health Services
Sunrise Elementary School

HEALTH INFORMATION

Name of Student: _____ Birth Date:_____

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

Medication(s): Name/Dosage/Frequency:

_____

_____

Hospitalizations/Serious Illnesses:_____

Have any special recommendations been made by the pediatrician concerning your child's health during the school day? ____Yes ____No If yes, please explain:_____

_____

_____

PARENT MUST CHECK ONE

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

  _____

  _____.

X_____ x_____

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

PLEASE DETACH THIS PAGE AND ALL REMAINING PAGES/FORMS BEHIND THIS STAPLE.

THE FOLLOWING FORMS DO NOT NEED TO BE COMPLETED AT ENROLLMENT TIME AND MAY BE TURNED IN AFTER ENROLLMENT:

- ❑ **Oral Health Assessment (Dental) Form**
- ❑ **Report of Health Examination for School Entry (Physical) Form**

BEFORE RETURNING THE FORMS MENTIONED ABOVE,
PLEASE HAVE A HEALTH CARE PROVIDER COMPLETE THE FORM NO LATER THAN MAY 31ST
OF THE FIRST YEAR YOUR STUDENT ATTENDS SUNRISE ELEMENTARY.

If you have any questions, please reach out to the Sunrise Front Office at (916) 985-4350 or SunriseElemInfo@egusd.net

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTH DATE—Month/Day/Year

ADDRESS—Number, Street	City	ZIP code	SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	/ /
Physical Examination	/ /
Dental Assessment	/ /
Nutritional Assessment	/ /
Developmental Assessment	/ /
Vision Screening	/ /
Audiometric (hearing) Screening	/ /
TB Risk Assessment and Test, if indicated	/ /
Blood Test (for anemia)	/ /
Urine Test	/ /
Blood Lead Test	/ /
Other	/ /

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER (e.g., TB Test, if indicated)					
OTHER					

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

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)*

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.

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) says every child must have a dental check-up (assessment) by May 31st 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: ☐ Male ☐ Female

Child's Race/Ethnicity:	☐ White	☐ Native American
	☐ Black/African American	☐ Multi-racial
	☐ Hispanic/Latino	☐ Native Hawaiian/Pacific Islander
	☐ Asian	☐ Unknown
	☐ 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.

	Untreated Decay (Visible Decay Present)	*Caries Experience (Visible decay and/or fillings present)
MM – DD – YYYY	☐Yes ☐No	☐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***	MM – DD – YYYY ***Date***

*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?	◯ **Yes** ◯ **No** (If no, entity responsible for follow-up will be encouraged to check back in with parent) ◯ **I don't know**

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.

MEDICATION ASSISTANCE AUTHORIZATION
2026 - 2027

Student Name: _____ SIS#: _____ D.O.B. _____

Address: _____

School: _____ Grade: ____ Teacher: _____

Parent/Guardian Phone: Home: _____ Work: _____ Cell: _____ Emergency: _____

IMPORTANT INFORMATION

In accordance with California Education Code Section 49423, and Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990, students who have a Medical Disability for which a physician has prescribed Medication to be taken during the school day, whether of limited or permanent duration, are entitled to seek Assistance from the District in meeting their Medication needs for when the student is under the District's care, custody, or control, including while on field trips, sporting events, and other off-campus District-sponsored activities.

Before Medication Assistance can be provided, even if the student has an Individualized Education Plan ("IEP") or a "504 Plan," this Medication Assistance Authorization form ("Authorization") must be executed by at least one parent/legal guardian and the student's duly authorized health care provider. **A new Authorization is required at the beginning of each school year and any time there is a change in Medication directives, such as change in Medication, dosage, timing, or frequency.** The parent/legal guardian must immediately notify the District of any change in Medication directives. Until the District receives an updated Authorization, signed by the parent/legal guardian and health care provider, the District will continue the directives in the existing Authorization unless (a) there is evidence the student's health may be endangered by the continued use of the former Medication directive, or (b) the parent/legal guardian provides a written statement that Medication Assistance is to cease or be suspended until the new Authorization can be provided. In such situations, the parent/legal guardian will need to provide the Medication Assistance to the student at agreed times during the school day in a safe and appropriate manner that does not unduly disrupt the educational environment. At the end of the school year, all medication must be picked up within 5 days, or it will be destroyed per safety regulations.

All Medication must be provided to the District by a parent/legal guardian, with the District storing the Medication and dispensing it in compliance with the Medication directive. All medication supplied to the District must be in its original labeled form (i.e., in the original prescription bottle, sealed package, etc.) as received from the physician, pharmacist, or store. Except for personal asthma inhalers and personal epi-pens, **a student may not independently possess Medication during the school day or while on District property.** Due to health and safety concerns, including the potential theft of the Medication or the potential for sharing/use of the Medication by other students who may then suffer unexpected allergic or other negative reactions, there are no exceptions to this requirement. A student personally possessing Medication, or providing Medication to another student, may face discipline.

Medical Disability, means any mental or physical condition limiting a student's ability to engage in major life activities, such as eating, breathing, hearing, speaking, learning, or performing self-care, or who otherwise is subject to a medical disability or condition for which Medication has been prescribed by a physician.

Medication, means any current (unexpired) prescribed Medication, as well as over-the-counter remedies (such as aspirin, decongestant, eye drops) and nutritional/herbal supplements.

Assistance, means the providing of the child with Medication in accordance with a physician's written instructions or directives, when the child presents himself/herself at the agreed time, or in response to urgent or emergency circumstances. Except as otherwise legally required, Assistance may be provided by a District employee other than a nurse or licensed or trained medical care provider. Any emergency Assistance provided to a Student will be promptly brought to the attention of the parent/guardian. All additional reports/reporting of emergency Assistance will be undertaken in keeping with governing laws and District policies and procedures

PARENT/GUARDIAN AUTHORIZATION

I have read, understand, and agree to be bound by the rights and obligations contained in the Important Information section of this Authorization. I request that Medication Assistance be provided to my Student.

The Student understands his/her obligations described in the Important Information section, including the need to ensure he/she complies with the directions for receiving Assistance (i.e. coming to the school or nurse's office each day, at the same time, without need for a District employee to attempt to locate them) and the policy against his/her personal possession or sharing of Medication (except for possession of asthma inhalers and epi-pens). I understand that if the Student fails to meet these obligations that he/she may face discipline and/or this Authorization may be revoked.

Unless required by law, I understand there is no guarantee that Medication Assistance will be performed by a nurse or licensed health care provider, although the District will take reasonable steps to ensure that the District employee providing Assistance has received training that complies with all legal requirements. As a partner with the District in protecting the Student's health and safety, I will work with school staff regarding Medication Assistance issues, including Medication Assistance issues when the Student is expected to be involved in off-campus District-sponsored activities. I will also timely advise the District of any change in Medication directives. It is my responsibility to obtain a new Authorization form, signed by a licensed health care provider, when there is a change in Medication directives. I will comply with my responsibilities described above should those Medication directives change.

With respect to the Medication Assistance issues covered by this Authorization, I authorize the District and the health care provider below to discuss the student's medical and/or Medication information, and I authorize the health care provider to provide any additional information to the District as may be necessary to carry out this Authorization.

_____ Date

_____ Signature Parent/Guardian

_____ Printed Name Parent/Guardian

PHYSICIAN AUTHORIZATION

_____ (student name) is under my care and I have personally direct the following: **(If more than two medications are prescribed, or more explanation is needed, physically attach to this Authorization a separate signed sheet noting the additional information)**

1st Med. Name	Dosage	Method of Admin.	Duration (date/week/month/until discontinued)
	☐ Regular (if yes, add Interval/Time of Day)	☐ Emergency basis (Must Describe Symptoms/Triggers)	☐ As Needed (Must Describe Symptoms/Triggers)
Student capable of self-administering? ☐Yes ☐No		Student may/should carry medication? ☐Yes ☐No (applies only to inhalers/epi-pens)	
Must a District employee have special training/experience before providing assistance? ☐Yes ☐No (If yes, describe the training/experience).			
Post Assistance Care/Potential Adverse Reactions/Follow-up/Emergency Care:			
2st Med. Name	Dosage	Method of Admin.	Duration (date/week/month/until discontinued)
	☐ Regular (if yes, add Interval/Time of Day)	☐ Emergency basis (Must Describe Symptoms/Triggers)	☐ As Needed (Must Describe Symptoms/Triggers)
Student capable of self-administering? ☐Yes ☐No		Student may/should carry medication? ☐Yes ☐No (applies only to inhalers/epi-pens)	
Must a District employee have special training/experience before providing assistance? ☐Yes ☐No (If yes, describe the training/experience).			
Post Assistance Care/Potential Adverse Reactions Requiring Follow-up/Emergency Care:			

Additional Remarks/Directions_____

Physician's Name _____ Medical License No. _____
Address _____ Telephone Number _____
Physician s Signature_____ Date _____