

**SOUTHERN HUMBOLDT UNIFIED SCHOOL DISTRICT  
PUPIL REGISTRATION INFORMATION 2021-2022**

TODAY'S DATE: \_\_\_\_\_

Has your child ever been *expelled* from any school district? :  Yes  No

First day attending this school: \_\_\_\_\_

Last School Attended \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**Full Legal Name of Pupil:**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Sex:  M  F  X(non-binary)

Other names used by pupil \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_

**BIRTH DATE** \_\_\_\_\_ Place \_\_\_\_\_

**Pupil's Mailing Address:** \_\_\_\_\_ CA \_\_\_\_\_  
Address/PO Box \_\_\_\_\_ City/Town \_\_\_\_\_ Zip \_\_\_\_\_

**Physical Address** and/or directions: \_\_\_\_\_

Family Email Address: \_\_\_\_\_ Student e-mail address (SFHS only) \_\_\_\_\_

**HOME PHONE** \_\_\_\_\_  Listed  Unlisted **STUDENT CELL (HIGH SCHOOL ONLY)** \_\_\_\_\_

Please check pupil's ethnic/racial background (demographic use) Hispanic/Latino:  Yes  No

Asian  Black  American Indian/Alaskan Native  Pacific Islander/ Native Hawaiian  Caucasian

Primary language \_\_\_\_\_ Language when student first began to talk \_\_\_\_\_

Language student uses most at home \_\_\_\_\_ Language used most often by ADULTS at home \_\_\_\_\_

Language parents use most with student \_\_\_\_\_

When did your child first enter a private or public school (NOT PRE-SCHOOL): \_\_\_\_\_  
Month/Date/ Year

When did your child first enter a private or public school in **California** (NOT PRE-SCHOOL): \_\_\_\_\_

Does your child have a current Individual Educational Plan?  Yes  No Has your child ever had an IEP?  Yes  No  
Does your child have a current 504 Plan?  Yes  No Has your child ever had a 504 Plan?  Yes  No

**CUSTODIAL PARENT(S) OR GUARDIAN(S):**

Father's Full Name \_\_\_\_\_ Living with pupil?  Yes  No

Father's Mailing Address \_\_\_\_\_  Receive separate Mailings?

Occupation/Employer \_\_\_\_\_ Work phone \_\_\_\_\_ Cell \_\_\_\_\_

Highest level of education (demographic use) \_\_\_\_\_ Degree?  Yes  No

Mother's Full Name \_\_\_\_\_ Living with pupil? Yes  No

Mother's Mailing address \_\_\_\_\_  Receive separate Mailings?

Occupation/Employer \_\_\_\_\_ Work phone \_\_\_\_\_ Cell \_\_\_\_\_

Highest level of education (demographic use) \_\_\_\_\_ Degree?  Yes  No

Step Parent or **Legal** Guardian's Full Name \_\_\_\_\_ Living with pupil?  Yes  No

Occupation/Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Highest level of education (demographic use) \_\_\_\_\_ Degree? Yes  No

**IF NOT THE LEGAL GUARDIAN: Do you have a current Caregiver's Authorization Affidavit on file?**  Yes  No

**IF NO PLEASE OBTAIN A "CAREGIVER'S AUTHORIZATION AFFIDAVIT" FROM THE SCHOOL OFFICE**

Any other adults living in the pupil's home: \_\_\_\_\_

**CURRENT LEGAL DOCUMENTS (file annually in office):** \_\_\_\_\_

Custody/Visitation \_\_\_\_\_ Restraining Order \_\_\_\_\_ Date Issued \_\_\_\_\_ County \_\_\_\_\_

**EMERGENCY MEDICAL, ALLERGY AND MEDICATION INFORMATION**

	Condition	Start Date	End Date (for temp. conditions)	Severity (mild, moderate, severe, life threatening)
Medical Alert #1				
Medical Alert #2				

INSURANCE CO & # OR MEDI-CAL # \_\_\_\_\_

**EMERGENCY CONTACTS** (include parents)

Only these persons will be able to pick up your student during a disaster.

	Name	Address	Phone Number & Extension	Relationship	Alerts (voice, text, all)
1 <sup>st</sup>					
2 <sup>nd</sup>					
3 <sup>rd</sup>					
4 <sup>th</sup>					
Doctor					
Hospital					

**ADDITIONAL SCHOOL AGE CHILDREN LIVING IN HOUSEHOLD WITH SAME PARENT(S)/LEGAL GUARDIAN**

First Name	Last Name	Current School	Grade	Age	Sex (M,F,X)	Birth Date	Relationship

**WHERE IS YOUR CHILD/FAMILY CURRENTLY LIVING?**

- In a single family permanent residence   
  With friends or other family members   
  In or awaiting foster care placement  
 With more than one family in an apt. or house   
  in a shelter or transitional housing program   
  in a motel, car or campsite  
 Your family does not have access to running water/heat/electricity   
  sleeping outside or in a public location  
 Runaway or unaccompanied youth

Does the student live outside our attendance area?     Yes     No

If yes, do you have an inter district agreement?     Yes     No (contact the district office in which the student resides for application)

Please indicate any of the following programs that this child has participated in:   
 Resource Specialist Program  
 Special Day Classes   
 Speech/Language   
 Student Study Team   
 Gifted/Gate   
 Counseling

**Are any of the student's immediate relatives (Mother, Father, Brother, Sister) currently active in the United States Military?**     Yes     No

Please add any information you feel could help us to better serve your student.

\_\_\_\_\_

My child has permission to walk home (student must live nearby) need physical address \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_ Relationship to student \_\_\_\_\_ Date \_\_\_\_\_

\* Your signature gives consent for the school and its representatives to contact your physician and/or to transport your student for treatment in the event the school is unable to reach you during an emergency.

<p><b>SOUTH FORK HIGH SCHOOL ONLY:</b>                  Did your student take the California High School Exit Exam?    <input type="checkbox"/> Yes    <input type="checkbox"/> No                  If yes, name of the high school: _____</p>
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## 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
<b>POLIO</b> (OPV or IPV)					
<b>DtaP/DTP/DT/Td</b> (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
<b>MMR</b> (measles, mumps, and rubella)					
<b>HIB MENINGITIS</b> (Haemophilus Influenzae B) (Required for child care/preschool only)					
<b>HEPATITIS B</b>					
<b>VARICELLA</b> (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) 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)
<div style="display: flex; justify-content: space-between; margin-top: 10px;"> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span><b>Licensed Dental Professional Signature</b></span> <span><b>CA License Number</b></span> <span><b>Date</b></span> </div>			

#### 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.*