Welcome to the Fountain Valley School District!

New Student Enrollment Documentation Checklist

Student Name _____

Parent Name _____

School Year ☐ 2020-21 ☐ 2021-22

Grade _____ Birthdate _____

Please complete and bring the following documents with you to the school office to enroll your child in a Fountain Valley School District school.

- ☐ Permanent Record Card
- ☐ School History
- ☐ Parent Authorization for Release of School Records
- ☐ Aeries Pre-Enrollment Confirmation (Provided in the first part of the enrollment process)
- ☐ Student Health Concern Survey

Transitional Kindergarten/Kindergarten Documents

- ☐ Health Assessment
- ☐ Oral Health Assessment (may be submitted *after* child is enrolled)
- ☐ Report of Health Examination for School Entry (may be submitted *after* child is enrolled)

Please bring the following items with you to complete the enrollment process.

- ☐ Proof of Residence
- ☐ Immunization Records
- ☐ Verification of Age
- ☐ GATE Verification (if applicable)
- ☐ 4th – 8th Grades: most recent CAASPP results
- ☐ 6th – 8th Grades: most recent report card

FOUNTAIN VALLEY SCHOOL DISTRICT

Permanent Record Card

*****PLEASE USE BLACK or BLUE INK ONLY*****

LAST Name of Pupil (Legal)	**FIRST**	**MIDDLE**	Sex: ☐ **M** ☐ **F**
CHILD'S BIRTHDATE Month Day Year	City of Birth		State/Country
HOME ADDRESS Number	Street	City	Zip
HOME PHONE		**PREFERRED CONTACT NUMBER**	
MOTHER'S CELL		**FATHER'S CELL**	

FOR OFFICE USE ONLY

Perm ID # _____

SSID # _____

Person Verifying Age & Residency: _____

Verification of Age:

- ❑ Passport
- ❑ Health/Vital Statistic
- ❑ Birth Certificate
- ❑ Baptismal Certificate
- ❑ Affidavit

School: Level:

Date Entered:

Withdrawal Date:

Moved to (City/State):

Cum Records Sent To:

Date Sent: By:

				Circle Below	
Natural Father's Name	Home Address	Specific Occupation	Business Address & Telephone	Pupil Living With ☐ Yes ☐ No	Living? ☐ Yes ☐ No
Natural Mother's Name				Pupil Living With ☐ Yes ☐ No	Living? ☐ Yes ☐ No
Step-Parent or Guardian's Name				Pupil Living With ☐ Yes ☐ No	Living? ☐ Yes ☐ No
Authorized Caregiver / Foster/Group Home				Pupil Living With ☐ Yes ☐ No	

ARE THERE ANY COURT ORDERS PERTAINING TO THE CUSTODY OF THIS CHILD? ☐ **NO** ☐ **YES – IF YES, YOU MUST ATTACH**

BROTHERS and SISTERS:

Name	M	F	Birthdate
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

This information is accurate to the best of my knowledge.

_____

Signature of Parent or Guardian **Date**

FOUNTAIN VALLEY SCHOOL DISTRICT

School History

STUDENT'S NAME: _____ GRADE: _____

1. Has your child ever attended school before, including preschool?

   YES ☐ Name of School: _____
   NO ☐ Stop, there is no need to continue

2. Has your child ever attended a Fountain Valley School District school, including preschool?

   YES ☐ Name of School: When: _____
   NO ☐

3. Has your child ever received services from a special program?

   YES ☐ When: _____ NO ☐

   If YES, please check the appropriate program(s) below:

SPECIAL EDUCATION SERVICES	REGULAR EDUCATION SERVICES
☐ Resource Specialist Program (RSP)	☐ GATE (Gifted & Talented Education)
☐ Speech & Language Program	☐ Counseling
☐ Adaptive Physical Education	☐ Other (list below)
☐ Special Day Class (Learning Handicapped, Severely Handicapped, or Language Handicapped)	
☐ Individualized Education Program (IEP) (Please provide the most current copy)	

4. Expulsion (per AB 29) NO ☐ YES ☐ (If yes, when? _____)

5. Suspension (per AB 29) NO ☐ YES ☐ (If yes, when? _____)

6. Has your child been retained? NO ☐ YES ☐ (If yes, what grade? _____)

7. Comments :

Parent Signature: _____ Date: _____

FOUNTAIN VALLEY SCHOOL DISTRICT

PARENT AUTHORIZATION FOR RELEASE OF SCHOOL RECORDS

School/Facility where records/confidential information are presently on file:

School/Facility Name _____

Address _____

City_____ State_____ Zip Code _____

The schools commonly maintain two types of permanent records:

1. **Cumulative records** including grades, health information, subjects taken, required test results, and other information relative to the student's educational program. **Suspension and/or Expulsion records** (these must be forwarded as required by AB29).

2. **Confidential records** including reports from specialists such as the school psychologist, counselor or speech therapist.

The school district does not release information nor transfer student records concerning a child without parent consent or due process of law. Please check the appropriate space below indicating consent to release cumulative and/or confidential records. If both types of information are authorized for release, please check both boxes.

Name of Student(s)	Birthdate	Grade	Confidential Records	Cumulative Records
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

I hereby authorize the release of school records as indicated above.

Date _____ _____

Signature of Parent/Legal Guardian

FOR OFFICE USE ONLY

School/Facility where records/confidential information are to be sent:

School/Facility _____

Address _____

City, State & Zip Code _____

Date _____ _____

Principal/Authorized Representative

cc: School Cumulative Record/Confidential File
223-92-12

FOUNTAIN VALLEY SCHOOL DISTRICT

10055 Slater Ave. • Fountain Valley, CA 92708 • 714.843.3200 • www.fvsd.us

STUDENT HEALTH CONCERN SURVEY

Student's name (Last) _____ (First)_____ (MI)____ DOB _____
School _____ Grade _____

Please indicate if your child has any of the following health conditions and/or other health conditions so that we can keep your child as healthy and safe as possible while at school. Certain health conditions may require further discussion with the district nurse.

If no known health conditions, please indicate the appropriate box below.

- ☐ **NO KNOWN HEALTH CONDITIONS**
- ☐ Allergy: What kind? _____ Epi-pen Yes ☐ No ☐
- ☐ ADD/ADHD: Medication(s)_____ Required at school? Yes ☐ No ☐
- ☐ Autism: Comments_____
- ☐ Asthma: List medication(s) _____Required at school? Yes ☐ No ☐
- ☐ Blood/bleeding disorders: _____
- ☐ Bone/joint disorders: _____ Activity restriction? Yes ☐ No ☐
- ☐ Cancer (current or history of): What kind? _____
- ☐ Cerebral Palsy: Any limitations? _____
- ☐ Cystic Fibrosis: Medication(s)_____ Required at school? Yes ☐ No ☐
- ☐ Diabetes: Type 1 ☐ Type 2 ☐ Medication or blood testing required at school? Yes ☐ No ☐
- ☐ Down's syndrome or other chromosomal disorder:_____
- ☐ Eating disorders: _____
- ☐ Eczema or other skin condition: _____
- ☐ Epilepsy/seizure disorder: Medication(s) _____Required at school? Yes ☐ No ☐
- ☐ Gastrointestinal issue (GERD, Crohn's, feeding tube, etc):_____
- ☐ Hearing loss: Right ear ☐ Left ear ☐ Hearing aids? Right ear ☐ Left ear ☐
- ☐ Heart condition: Type? _____ Activity restriction? Yes ☐ No ☐
- ☐ Kidney or bladder problems: _____ Activity restriction? Yes ☐ No ☐
- ☐ Migraine headaches: Medication_____ Required at school? Yes ☐ No ☐
- ☐ Neurological or brain related issue: _____
- ☐ Psychiatric or emotional disorders: _____
  Medication(s)_____ Required at school? Yes ☐ No ☐
- ☐ Vision impairment: Glasses ☐ Contacts ☐ Other
- ☐ Any hospitalizations or surgeries? _____ Date: _____
- ☐ Other health conditions or medications needed: _____

Additional comments:

Signature of parent/guardian: _____ Date: _____

School Office Use Only: Entered in Aeries _____ (initials)

FOUNTAIN VALLEY SCHOOL DISTRICT

Transitional Kindergarten/Kindergarten Health Assessment

STUDENT'S NAME: _____ BIRTH DATE: _____

PARENT(S) NAME: _____ TELEPHONE: _____

We need your help in identifying kindergarten children that may need some assistance from our Speech and Language Therapist and/or our School Nurse. If you feel your child may be experiencing difficulty in any of the following areas, please indicate your area(s) of concern below. Your concerns will be forwarded to the appropriate specialist.

❑ VISION

- Squinting or rubbing eyes
- Eyes that wander or cross
- Holds books very close or far away
- Frequent headaches from possible eye strain
- Currently wearing glasses

❑ HEARING

- I have concerns about a possible hearing problem
- Frequent or lengthy ear infections
- Has been previously diagnosed with a hearing problem

❑ SPEECH/LANGUAGE

- Voice is harsh, hoarse, or breathy
- Repeats parts of words or whole words, "stuttering"
- Mispronounces sounds when talking, which makes it difficult for others to understand (Many kindergartners have difficulty with L, R, S, and TH)

❑ Previously worked with a speech therapist

- Where: _____
- When: _____

❑ OTHER?

❑ I have no concerns at this time.

FOUNTAIN VALLEY SCHOOL DISTRICT
10055 Slater Ave. • Fountain Valley, CA 92708 • 714.843.3200 • www.fvsd.us

Dear Parents,

California law requires all students to have a dental check-up by May 31 of their first year of public school. It is also required that your child receive a health examination upon school entry.

Attached you will find the **Oral Health Assessment for School Entry** form which should be filled out by a California licensed dental professional, along with your child's information and parent signature.

You will also find the **Report of Health Examination for School Entry** form with the top portion to be filled out by the parent and the bottom portion to be filled out by your child's health care professional. Please make sure that both the parent and health care professional sign and date this form.

Healthy children learn better!

Sincerely,

FVSD Nursing Staff

FOUNTAIN VALLEY SCHOOL DISTRICT

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Oral Health Assessment Requirement

To make sure your child is ready for school, California Law, *Education Code Section 49452.8*, requires that your child have an oral assessment (dental check-up) by May 31 in either kindergarten or first grade, whichever is his/her first year in public school. Assessments that have happened within the 12 months before your child enters school also meet this requirement. The law specifies that the assessment must be done by a licensed dentist or other licensed registered dental health professional.

Please take the attached Oral Health Assessment/Waiver Request form to your dental office, as it will be needed for your child's check-up. If you cannot take your child for this required assessment, please indicate the reason for this in Section 3 of the form. You can get more copies of the necessary form at your child's school or online from the California Department of Education web site at http://www.cde.ca.gov/ls/he/hn. California Law requires schools to maintain the privacy of student's health information. Your child's identity will not be associated with any report produced as a result of this requirement.

The following resources will help you find a dentist and complete this requirement for your child:

1. Medi-Cal/Denti-Cal's toll free number or web site can help you find a dentist who takes Denti-Cal: (800) 322-6384 or http://www.denti-cal.ca.gov. For help enrolling your child in Medi-Cal/Denti-Cal, contact your local social service agency at (855) 478-5386 or http://ssa.ocgov.com/health/.

2. Healthy Families' toll-free number or web site can help you to find a dentist who takes Healthy Families insurance or to find out if you can enroll in the program: (800) 880-5305 or http://www.mrmib.ca.gov/mrmib/HFP.shtml.

3. For additional resources that may be helpful, contact the local public health department at (855) 478-5386 or http://ssa.ocgov.com/health/.

Remember, your child is not healthy and ready for school if he or she has poor dental health! Here is important advice to help your child stay healthy:

- Take your child to the dentist twice a year.
- Choose healthy foods for the entire family. Fresh foods are usually the healthiest foods.
- Brush teeth at least twice a day with toothpaste that contains fluoride.
- Limit candy and sweet drinks, such as punch or soda. Sweet drinks and candy contain a lot of sugar, which causes cavities and replaces important nutrients in your child's diet. Sweet drinks and candy also contribute to weight problems, which may lead to other diseases, such as diabetes. The less candy and sweet drinks, the better!

Baby teeth are very important. They are not just teeth that will fall out. Children need their teeth to eat properly, talk, smile and feel good about themselves. Children with cavities may have difficulty eating, stop smiling and have problems paying attention and learning at school. Tooth decay is an infection that does not heal and can be painful if left without treatment. If cavities are not treated, children can become sick enough to require emergency room treatment, and their adult teeth may be permanently damaged.

Many things influence a child's progress and success in school, including health. Children must be healthy to learn, and children with cavities are not healthy. Cavities are preventable, but they affect more children than any other chronic disease.

If you have questions about the oral health assessment requirement, please contact Support Services at (714) 843-3281.

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: ☐ Male ☐ Female
Parent/Guardian Name:	Child's race/ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Multi-racial ☐ Other_____ ☐ Native Hawaiian/Pacific Islander ☐ 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) ☐ Yes ☐ No	Visible Decay Present: ☐ 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*** ***Date***

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.

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.

CHDP website: www.dhcs.ca.gov/services/chdp

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