



FOUNTAIN VALLEY SCHOOL DISTRICT

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

Welcome to the Fountain Valley School District!

New Student Enrollment Documentation Checklist

Student Name _____

Parent/Guardian Name _____

School Year 2023-24 2024-25

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

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

- Proof of Residence
- GATE Verification (if applicable)
- Immunization Records
- 4th – 8th Grades: most recent CAASPP results
- Verification of Age
- 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: <input type="checkbox"/> M <input type="checkbox"/> 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: _____	
<u>Verification of Age:</u>	
<input type="checkbox"/> Passport	<input type="checkbox"/> Birth Certificate
<input type="checkbox"/> Health/Vital Statistic	<input type="checkbox"/> Baptismal Certificate
<input type="checkbox"/> Affidavit	
School: _____	Level: _____
Date Entered: _____	
Withdrawal Date: _____	
Moved to (City/State): _____	
Cum Records Sent To: _____	
Date Sent: _____	By: _____

	Home Address	Specific Occupation	Business Address & Telephone	Circle Below	
				Pupil Living With <input type="checkbox"/> Yes <input type="checkbox"/> No	Living? <input type="checkbox"/> Yes <input type="checkbox"/> No
Natural Father's Name				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Natural Mother's Name				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Step-Parent or Guardian's Name				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Authorized Caregiver / Foster/Group Home				<input type="checkbox"/> Yes <input type="checkbox"/> 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



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School History

Student Name: _____ Grade: _____

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

YES Name of School: _____ When: _____

NO Stop

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
<input type="checkbox"/> Individualized Education Program (IEP) (Please provide the most current copy) <input type="checkbox"/> Resource Specialist Program (RSP) <input type="checkbox"/> Speech & Language Program (SLP) <input type="checkbox"/> Adaptive Physical Education (APE) <input type="checkbox"/> Special Day Class (SDC)	<input type="checkbox"/> GATE (Gifted & Talented Education) <input type="checkbox"/> Counseling <input type="checkbox"/> 504 Plan <input type="checkbox"/> Other (list below)

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: _____



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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 parental 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

Location where records/confidential information are to be sent:

School/Facility Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

Date

Principal/Authorized Rep. Signature



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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)