



NEW STUDENT APPLICATION

All proper documentation must be submitted prior to enrollment. Incomplete applications will not be accepted.

Student Name _____ Entering Grade _____

Forms provided in this packet:

- Application for Admission
- Enrollment Contract
- Financial Agreement
- Liability Form
- Parent's Rights *LIC 995*
- Personal Rights *LIC613A*
- Identification and Emergency Information *LIC700*
- Consent for Emergency Treatment *LIC627*
- Child's Preadmission Health History *LIC702* - (PS, PK, KG Only)
- Emergency Contact Form (1 per family)
- Home Language Survey (KG-Grade 8 Only)

Must be provided by the parent/guardian:

- Birth Certificate (Copy)
- Immunization Record (Copy)
- Annual Physical - Use the form according to your child's grade level
 - Montessori (PS, PK, KG): Physician's Report LIC 701
 - Grades 1-8: Health Examination for School Entry Form

FOR OFFICE USE ONLY	
Accepted by School Admin: _____	Enrollment Date: _____
Registration Payment Type: <input type="checkbox"/> Check # _____ <input type="checkbox"/> Cash \$ _____	



NEW STUDENT APPLICATION FOR ADMISSION

Please print clearly and complete all sections of this form.

School Year Applying for: _____

Entering Grade: _____

STUDENT INFORMATION

Full Name _____ Male Female

Date of Birth _____ Place of Birth _____ Ethnicity _____

Home Address _____ City _____ State _____ Zip _____

Allergies or Medical Condition: Yes No _____

If yes, please list any medications _____

What language does your child speak at home? Primary _____ Secondary _____

FAMILY INFORMATION

Father/Guardian

Name _____

Cell Phone _____

Home Phone _____

Email _____

Address (if different from above) _____

City _____ State _____ Zip _____

Occupation _____

Employer _____

Work Address _____

Work Phone _____

Highest Level of Education: (circle)

Some High School High School AS/AA

BS/BA MS/MA PhD Other _____

Mother/Guardian

Name _____

Cell Phone _____

Home Phone _____

Email _____

Address (if different from above) _____

City _____ State _____ Zip _____

Occupation _____

Employer _____

Work Address _____

Work Phone _____

Highest Level of Education: (circle)

Some High School High School AS/AA

BS/BA MS/MA PhD Other _____

Student lives at the address above with: (circle) Both Parents Mother Father Other _____

The Applicant's Parent(s) are: (circle) Married Separated Divorced Widowed Single

Siblings

Name _____ Gender _____ Grade _____ School Attending _____

Name _____ Gender _____ Grade _____ School Attending _____

EDUCATIONAL HISTORY

Last School Attended _____ Grade Completed _____

Type of School: Public Private Reason for leaving _____

School Address _____

School Phone _____ Email _____

Other School Attended _____ Dates Attended _____

STUDENT DEVELOPMENT INFORMATION

Does any of the following apply to your child? (Circle all that apply) If yes, give description and provide any physician reports.

Health/Physical limitations affecting school attendance Yes No _____

Psychiatric/Psychosocial Problems Yes No _____

Behavioral Problems Yes No _____

Hearing/Visual Problems Yes No _____

REASONS FOR SELECTING MINARET ACADEMY

Please check all that apply to your school selection process:

Islamic and Quran Curriculum

Strong Academics

Convenient Location

Islamic Environment

Quality of Teachers

Quality of Facility

Arabic Curriculum

Individualized Instruction

Affordable Tuition

PARENTAL PERMISSION REQUIRED

I hereby give permission for my child to be photographed/video recorded for the purpose of:

School Events Marketing Materials Social Media (Instagram & Facebook)

Yes, permission for all of the above.

I DO NOT give permission

I certify that all information given in the application is complete and accurate. I understand that failure to disclose information about the applicant may affect the completion of the application process and will not guarantee enrollment in the upcoming school year. Information provided in the application is confidential and intended for school use only.

Parent/Guardian's Name

Parent/Guardian's Signature

Date

Parent/Guardian's Name

Parent/Guardian's Signature

Date

Student Name: _____ Date of Birth: _____ Grade Level: _____

ENROLLMENT POLICY

Parent Initials _____

I/we understand that to fulfill the enrollment requirements, I/we must complete and sign this contract and return it to the school with the non-refundable registration fee according to the current fee schedule.

I understand that I must pay the entire 2022-2023 year tuition, in full, regardless of my child(ren)'s attendance. In the event that a student's withdrawal is deemed necessary, a written request for withdrawal must be submitted to the school administration for approval. (See Parent Handbook for detailed Financial Policy)

I/we adhere to the guidelines and policies stated in the parent handbook, support the school mission, standards of discipline, the rules of behavior, academic policies and the uniform code adopted by the school. I/we understand that continuous breach of such guidelines would result in disciplinary actions with the possibility of an enrollment termination of your child.

I/we understand that it is my/our responsibility to notify the school office promptly of any change in my/our address, telephone number and place of employment.

PARENT HANDBOOK ACKNOWLEDGMENT

Parent Initials _____

-Please view the Parent Handbook on the school website at www.minaretacademy.net-

I acknowledge that I have read the Minaret Academy Parent Handbook and will follow the COVID-19 protocols, procedures, and guidelines set forth by the school. I agree to abide with all policies established by the school. I understand that the handbook is subject to change for the safety and security of my child(ren) and will be notified.

TARDY POLICY

Parent Initials _____

Minaret Academy is devoted to maintain an educational environment where students can learn with enjoyment and minimal distractions. All teachers need 100% attendance in every period in order to proficiently educate your child. Multiple absences hinder the students' academic potential and will most likely lower their performance level. In order to teach our students the value of time management and respect for others, it is necessary to follow the following tardy policy:

- **Kindergarten through 5th Grade students arriving at school after 8:05 a.m. are considered tardy.**
 - **Middle School Students (6th, 7th and 8th Grade) arriving after 7:55 a.m. are considered tardy.**
- The following program will be implemented at the school to facilitate promptness in our students and families.
- Students who are late must check in at the main office before going to class. We appreciate the parent or an adult accompanying the student to the office when he/she is late.
 - Only illness, family emergency, inclement weather and major traffic conditions will be considered as an excused tardy.
 - Attendance records, including tardies, are maintained in our **Gradelink** Records System.
 - **If a student is tardy 2 or more times during the trimester, each tardy following the 2nd tardy will be assessed a tardy fee of \$10.00 per tardy and will be applied to your account.**
 - Parents of students with excessive tardies will be required to meet with the Principal.
- If the issue becomes chronic and without regard, then disciplinary action may be taken including contract termination.

I/we have read, understand and agree to all of the terms and conditions of this enrollment contract. By signing this contract, I/we represent and warrant that I/we have full authority to sign this contract. I/we are fully authorized to enter into this agreement.

Signature of Parent/Guardian: _____

Date: _____

Signature of Parent/Guardian: _____

Date: _____

Family Last Name: _____ Email to Receive Invoices: _____

Fill in the appropriate amounts for your child(ren)'s tuition. Add the sibling discount for each additional child. Total the amount of monthly tuition per child and then add each child's tuition together to give the **TOTAL MONTHLY TUITION** to be paid at the beginning of each month.

Monthly Tuition by Grade		Sibling Discount
Montessori (PS, Pre-K, KG)	\$875	\$50 discount for each additional full time sibling \$100 discount for the 4th full time sibling
Part-Time Preschool (3 days a week)	\$700	
Grades 1-8	\$795	

Child 1 Tuition _____	Child 2 Tuition _____	Child 3 Tuition _____	Child 4 Tuition _____
Monthly Total _____	Sibling Discount _____	Sibling Discount _____	Sibling Discount _____
Total _____		Total _____	

Total Monthly Tuition: \$ _____ -This amount will be due August 1, 2022-

*Please note that ALL Annual Fees are **NON-REFUNDABLE**

PAYMENT PLAN OPTIONS

Plan A - Full Payment

This plan gives you the option of paying the entire year's tuition in one installment and a 3% discount will be applied. The full amount will be due August 1, 2022.

Montessori: \$8,487.50 **Grades 1-8:** \$7,711.50

Plan B - Bi-Annual Payments

This plan gives you the option of paying the entire year's tuition in two installments and a 2% discount will be applied. The first installment is due August 1, 2022 and the second due January 1, 2023.

Montessori: Two installments of \$4,287.50 **Grade 1-8:** Two installments of \$3,895.50

Plan C - Ten-Month Payment Plan

This plan gives you the option of paying tuition on a monthly basis with 10 installments total. Installment #1 will be **due August 1, 2022** and the last Installment #10 **due May 1, 2023**. A monthly invoice will be sent to the email address provided above.

FINANCIAL POLICY AGREEMENT

I understand that I must pay the entire 2022-2023 year tuition, in full, regardless of my child(ren)'s attendance. In the event a student withdrawal is deemed necessary, a written request to withdraw must be submitted to the school administration for approval. I also understand that the annual fees and first month's tuition is due according to the current fee schedule and prior to my child(ren)'s attendance at the school.

*I agree to pay the "Monthly Total," indicated above, during the first full week of each month throughout the school year. If I am late in making the payment, I understand that I will be charged a late payment of \$20.00. If I am late in picking up my child(ren), I understand I must pay a late pick-up fee of \$20.00 (after 15 minutes grace). *A \$25.00 handling fee for any returned checks will be charged.*

Parent Signature _____ Date _____



**RELEASE OF LIABILITY AND PARENT/GUARDIAN PERMISSION
-FOR FIELD TRIPS AND SCHOOL ACTIVITIES-**

I, _____, am the parent/guardian of _____, a student at Minaret Academy, give my permission for my son/daughter to participate in all school activities, including sports and field trips during the academic school year enrolled.

I/we waive and release Minaret Academy or any of its officers, agents or employees from all claims of liability for any injury, loss, or damages to the student, as well as, to other individuals or property incurred by the student at school or during any school activity except for any injury caused by willful malfeasance by the school or any of its agents.

In the event that I, or the other parent cannot be reached in an emergency, I hereby give permission to the school staff to secure proper treatment for my child. I do hereby consent to any x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of the medical staff of the hospital or facility furnishing medical or dental services.

I have read, understand and accept all of the statements recited above and accept full responsibility as described.

Parent Signature

Date

Parent Name

Date

CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: CALIFORNIA DEPT OF SOCIAL SERVICES

Licensing Office Address: 750 CITY DRIVE, ORANGE, CA 92868

Licensing Office Telephone #: 714-703-2800

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender" database, go to www.meganslaw.ca.gov

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS (Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

MINARET ACADEMY

Name of Child Care Center

Signature (Parent/Authorized Representative)

Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.

For the Department of Justice "Registered Sex Offender" database go to www.meganslaw.ca.gov

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

- (a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:
- (1) To be accorded dignity in his/her personal relationships with staff and other persons.
 - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
 - (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.
 - (4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.
 - (5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.
 - (6) Not to be locked in any room, building, or facility premises by day or night.
 - (7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME		
California Dept. of Social Services		
ADDRESS		
750 City Drive		
CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Orange, CA	92868	(714) 703-2800

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

PLACE IN CHILD'S FILE

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)
Minaret Academy	1220 N State College Blvd, Anaheim, CA 92806
(PRINT THE NAME OF THE CHILD)	

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ()
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
BIRTHDATE					
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					
PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ()	BUSINESS TELEPHONE ()

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

CALL EMERGENCY HOSPITAL OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE
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TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT
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CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

MINARET ACADEMY

FACILITY NAME

TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

NAME

. THIS CARE MAY BE GIVEN UNDER

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD

NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE

()

WORK PHONE

()

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST	WHAT ARE USUAL EATING HOURS? BREAKFAST _____ LUNCH _____ DINNER _____
	LUNCH	
	DINNER	

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?
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IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE?*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*
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PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE
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EMERGENCY CONTACT INFO

1 per family – Indicate each child’s name attending the school

Family Last Name _____

Student Information

Name: _____ DOB: _____ Sex: M F Grade: _____

Allergies: _____

Name: _____ DOB: _____ Sex: M F Grade: _____

Allergies: _____

Name: _____ DOB: _____ Sex: M F Grade: _____

Allergies: _____

Name: _____ DOB: _____ Sex: M F Grade: _____

Allergies: _____

Name: _____ DOB: _____ Sex: M F Grade: _____

Allergies: _____

Address

Street: _____ City: _____ State: _____ Zip: _____

Father/Guardian

Name: _____

Cell: _____

Home: _____

Email: _____

Address: *(if different from above)*

Mother/Guardian

Name: _____

Cell: _____

Home: _____

Email: _____

Address: *(if different from above)*

Emergency Contact (authorized to take child(ren) from facility)

Primary

Name: _____

Cell: _____ Relation: _____

Secondary

Name: _____

Cell: _____ Relation: _____

Persons authorized to take child(ren) from facility

Name: _____ Relation: _____

Medical Information

Hospital Preference: _____

Insurance Company: _____

Policy #: _____

Physician’s Name: _____

Phone: _____

Dentist’s Name: _____

Phone: _____

Authorization for Emergency Medical Treatment

I, _____ (parent/guardian) understand that in the case of illness or injury to my child(ren) listed above, the school will try to notify me or the person(s) listed as the emergency contact. In case of medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to the school to 1) Arrange for the transportation of my child(ren), whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor’s office or a medical clinic; and 2) Sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgement of medical authorities at the facility.

Parent/Guardian Signature: _____ Date: _____

HOME LANGUAGE SURVEY

**PLACENTIA-YORBA LINDA USD
FAMILY RESOURCE CENTER**

SCHOOL: _____ **GRADE:** _____

yes ___ no ___

The California Education Code requires school districts to determine the language(s) spoken at home by each student. This information is essential in order for the Placentia-Yorba Linda Unified School District to provide appropriate instruction for all students.

NAME: _____ / _____ / _____
Last First MI Age Date of Birth

1. What language did your son/daughter learn when he/she began to talk? _____
2. What language does your son/daughter most frequently speak at home? _____
3. What language do you use most frequently to speak to your son/daughter? _____

Notice: *Privacy and confidentiality will be observed. A numerical count of students is the only information that will be sent outside the district.*

4. What country was your son/daughter born in? _____
5. If he/she was born outside the U.S., when did he/she first enter the United States? _____ / _____ / _____
6. What language is spoken most often by the adults in the home? _____

Please sign and date this form upon completing questions 1-6. Your signature indicates you have understood the above questions.

Signature of Parent/Guardian

_____/_____/_____
Today's Date

PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____. This Child Care Center/School provides a program which extends from _____ : _____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

(TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: _____ Allergies: medicine: _____

Vision: _____ Insect stings: _____

Developmental: _____ Food: _____

Language/Speech: _____ Asthma: _____

Dental: _____

Other (Include behavioral concerns): _____

Comments/Explanations: _____

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: _____

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	/ /
HEPATITIS B	/ /	/ /	/ /	/ /	/ /
VARICELLA (CHICKENPOX)	/ /	/ /	/ /	/ /	/ /

SCREENING OF TB RISK FACTORS (listing on reverse side)

- Risk factors not present; TB skin test not required.
- Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have have not reviewed the above information with the parent/guardian.

Physician: _____

Address: _____

Telephone: _____

Date of Physical Exam: _____

Date This Form Completed: _____

Signature _____

Physician Physician's Assistant Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

- * Have a family member or contacts with a history of confirmed or suspected TB.
- * Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
- * Live in out-of-home placements.
- * Have, or are suspected to have, HIV infection.
- * Live with an adult with HIV seropositivity.
- * Live with an adult who has been incarcerated in the last five years.
- * Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- * Have abnormalities on chest X-ray suggestive of TB.
- * Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

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.