

Student LEGAL Last Name: _____ First Name: _____ Middle Name: _____

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HOUSEHOLD MEMBERS:

Student resides with (Check boxes): Parents Birth mother Birth father Legal guardian Other: _____

Primary Parent/Guardian Last: _____ First: _____ Relationship: _____

FYI: Home address is the location where the student sleeps each night. P.O. Boxes will not be accepted as a mailing address.

Home Address: _____ Apt: _____ City: _____ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____ E-Mail: _____

Step Father/Mother Last: _____ First: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work Phone: _____ E-Mail: _____

Secondary Parent/Guardian Last: _____ First: _____ Relationship: _____

Home Address: _____ Apt: _____ City: _____ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____ E-Mail: _____

Step Father/Mother Last: _____ First: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work Phone: _____ E-Mail: _____

NON HOUSEHOLD MEMBERS – EMERGENCY CONTACTS:

Non-parent Emerg Contact: _____ Relationship: _____ Phone: _____

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PARENT EDUCATION LEVEL: Check the response that describes the highest education level of parent/guardian(s):
 Not a high school graduate (A) Some College (C) Graduate school/post graduate training (E)
 High school graduate (B) College graduate (D) Decline to state or unknown (F)

I/We have reviewed this two-page document and to the best of my/our knowledge, the information contained herein is true and complete. The undersigned declares under penalty of perjury that they are the parents or legal guardians of the above-named student and grant the authorizations

Parent/Guardian signature: _____ Date: _____

Office Use Only: Attendance Area: _____ Inter OLD SDC/RSP/SI Staff Enrolled: _____ Input _____ Email: _____
Proof of Address Provided: _____ Staff: Verify: _____ Due dates: _____
Please be advised if SJUSD does not receive additional proof by due date we will **drop** your child from assigned school. Parent initial _____

Student Enrollment and Demographic (Page 2) - School Assigned _____ Student ID: _____

Student LEGAL Last Name: _____ First Name: _____ Middle Name: _____

Grade: _____ Male Female Birth Date: _____ City of Birth: _____ State: _____ Birth Country _____

Previous School: _____ City: _____ State/Country: _____ Date left: _____

Is there an active Court **Order** which **affects this student**? Yes No If yes, please provide document.

Student's Ethnicity/Race: The Federal Government requires an ethnic designation for each student.

ETHNICITY: Mark the ethnicity with which the student most closely identifies: Please check one:

(1) Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)

(2) Not Hispanic or Latino

WHAT IS YOUR CHILD'S RACE (Please check up to five racial categories) The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be.

<input type="checkbox"/> American Indian or Alaskan Native (100)	<input type="checkbox"/> Chinese (201)	<input type="checkbox"/> Hawaiian (301)
<input type="checkbox"/> Hispanic (500)	<input type="checkbox"/> Japanese (202)	<input type="checkbox"/> Guamanian (302)
<input type="checkbox"/> African American/Black (600)	<input type="checkbox"/> Korean (203)	<input type="checkbox"/> Samoan (303)
<input type="checkbox"/> White (700)	<input type="checkbox"/> Vietnamese (204)	<input type="checkbox"/> Tahitian (304)
(Persons having origins in any of the original peoples of Europe,	<input type="checkbox"/> Asian Indian (205)	<input type="checkbox"/> Other Pacific Islander (399)
	<input type="checkbox"/> Laotian (206))	<input type="checkbox"/> Filipino (400)
	<input type="checkbox"/> Cambodian (207)	
	<input type="checkbox"/> Hmong (208)	
	<input type="checkbox"/> Other Asian (299)	

Check if student was receiving special services in the following program at the previous school:

Special Education: Resource (RSP) Special Day Class (SDC) Speech/Language 504 Accommodation Plan

Did you provide an Individualized **Education Plan (IEP)**? Yes No

Has this student attended a **Continuation/Alternative School**? Yes No

Is the student listed above **expelled**, being **considered for expulsion** or has been given a **suspended expulsion** from another school District? Yes No If **Yes** Name of school: _____ City: _____

HOME LANGUAGE SURVEY:

1. Which language did your son/daughter learn when he/she first began to talk? _____

2. What language do you use most frequently to speak to your son/daughter? _____

3. What language does your son/daughter most frequently use at home? _____

4. Name the language most often spoken by the adults at home: _____

In what language do you wish to receive school information: (Check Boxes) English Spanish Vietnamese

When did this student first attend school in the United States? Month: _____ Date: _____ Year: _____

What month and year did this student first attend California public School? Month _____ Year: _____

When did your student start 9th grade (**High School student Only**): Month _____ Year: _____

Emergency Dismissal Procedures and Emergency Care:
In case of a **Declared Emergency** by the Superintendent during school hours, all students will be required to remain at school or at an alternate safe site under the supervision of District personnel until a safe dismissal time is determined or until an authorized adult picks up the student. In case of major disaster during the school day, students will be kept at school or an alternate safe site and will be released only to parents, to legal guardians, or to emergency contacts listed on emergency card at school site. I understand that, if emergency medical or dental treatment is needed and the listed emergency contacts cannot be reached **911 will be called at my expense**. I realize the school district cannot assume responsibility for the payment of medical fees for expenses incurred. I understand that it is my responsibility to inform the school of any changes regarding the information on this form. **Parent Initial** _____

San Jose Unified
Student Health Information

Dear Parent,

Your answers to the following questions will provide valuable information that will assist SJUSD nurses and staff to plan your child's school program and identify Health Services needs. If your child does not have health insurance, free/low cost insurance is available through Medi-Cal, Healthy Families, Healthy Kids and Kaiser's Child Health Plan. Call 535-6798 for assistance.

Student's Name _____ **Grade** _____ **DOB:** _____

Student # _____ **Assigned School:** _____ **Parent's Language:** _____

Mother/Guardian _____ **Daytime Phone** _____

Father/Guardian _____ **Daytime Phone** _____

PLEASE CHECK ALL THAT APPLIES TO YOUR CHILD:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Freq. Ear Infections | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Frequent Nosebleeds |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Joint Pains | <input type="checkbox"/> Tires Easily |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Weight problems | <input type="checkbox"/> Severe Allergy |
| | <input type="checkbox"/> Seasonal Allergy | <input type="checkbox"/> "Epi-Pen" | |

LIST ALL MEDICATION, WITH DOSE, TAKEN BY YOUR CHILD

AT HOME _____

AT SCHOOL _____

Does student wear glasses or contact lenses YES NO

Does student wear hearing aids or have a history of hearing problems? YES NO

DOES YOUR CHILD HAVE HEALTH INSURANCE? YES NO

If yes, please check type: Medi-Cal Healthy Families Healthy Kids Kaiser Child Program Private insurance

Does your child have a health care provider they visit regularly? Yes No

Primary Physician or Health Clinic: _____ Date of Last Physical Exam _____

Dentist: _____ Date of Last Dental Exam _____

When your child is sick, where do you take him/her?

Doctor's Office Emergency Room Healer Keep child home Other, please explain _____

During the past year, has your child ever experienced any asthma symptoms such as coughing, wheezing, shortness of breath, chest tightness or phlegm?

Not at all Less than every month Every month Every week Every day Not sure

HAS YOUR CHILD HAD ANY SERIOUS ILLNESS, OPERATIONS OR ACCIDENTS? ? Yes No

If yes, when did this occur? _____ Was she/he admitted to the hospital? Yes No

WAS YOUR CHILD SEEN AT A HOSPITAL EMERGENCY ROOM DURING THE LAST YEAR?

Yes No If yes was it for: Injury Asthma Diabetes Other How many times? _____

Parent Signature _____ **Date:** _____

Status Requirement: All requirements are met _____ Record Verified: _____ Date: _____ Staff Initial _____

Attended school in Santa Clara County within the last 12 month? Yes No (TB Test)

Attended school in California before July, 2001? Yes No (Varicella)

Currently, up-to-date, but more doses are due late: _____ TB test needed _____ MV _____ 30 day letter _____

Exemption granted for (circle): Personal belief Medical Permanent Temporary: VAR MMR DTP Polio PPD