

Student LEGAL Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Grade: \_\_\_\_  Male  Female Birth Date: \_\_\_\_\_ City of Birth: \_\_\_\_\_ 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 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: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Secondary Parent/Guardian Last: \_\_\_\_\_ First: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Non-parent Emerg Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Non-parent Emerg Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

What special services has your child received at the previous school? (Please check all boxes that apply)

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: \_\_\_\_\_

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: \_\_\_\_\_ Grade: \_\_\_\_  Current Enrollment  Pre Enrollment CWA: \_\_\_\_\_

School Assigned \_\_\_\_\_ Student ID: \_\_\_\_\_  Inter  OLD SDC/RSP/SI Staff Enrolled: \_\_\_\_\_ Input \_\_\_\_\_ Email: \_\_\_\_\_

Proof of Address Provided: \_\_\_\_\_ Staff Verified: \_\_\_\_\_ 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's Ethnicity/Race:** The Federal Government requires an ethnic designation for each student.

**Directions:** Check the one category... which best describes your student - **OPTIONAL**

**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
- American Indian/Alaska Native     Asian     Filipino     Black     White/Not Hispanic     Hispanic     Pacific Islander     Other

**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)<br>(Person having origins in any of the original people of North and South America (including Central America) | <input type="checkbox"/> Chinese (201)      | <input type="checkbox"/> Hawaiian (301)               |
| <input type="checkbox"/> African American/Black (600)                                                                                                                           | <input type="checkbox"/> Japanese (202)     | <input type="checkbox"/> Guamarian (302)              |
| <input type="checkbox"/> White (700)<br>(Persons having origins in any of the original peoples of Europe,                                                                       | <input type="checkbox"/> Korean (203)       | <input type="checkbox"/> Samoan (303)                 |
|                                                                                                                                                                                 | <input type="checkbox"/> Vietnamese (204)   | <input type="checkbox"/> Tahitian (304)               |
|                                                                                                                                                                                 | <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)  |                                                       |

**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)

When did your student start 9<sup>th</sup> grade: Month: \_\_\_\_\_ Year: \_\_\_\_\_ (Tag SG9)

**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** \_\_\_\_\_

**For Office Use Only - TAGS information**

**Resident Category: Primary Residence Status (PRC)**

210 Foster Family/Kinship Placement	220 Licensed Children Institution
240 Health Institution (Home Hospital)	300 Other (approved PO BOX – Domestic Violent)

**Birth Country Special Circumstances (BCO)**

**Birth Country Special circumstances:** overseas to United States diplomatic or military personnel or other US citizens

1 Military	2. Diplomatic	3 Other Us Citizen
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**Other Tags:** BTH EUS ESJ MPE MPS MPV (RC1 RC2 RC3 RC4 RC5) PRC BCO IME SG9  
SIB SLS (SDC) SLR (RSP) SI (Speech) FNM(name change) PRI(private school) OL\_\_(overload)

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?**

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? \_\_\_\_\_

**Has your child attended school in Santa Clara County within the last 12 month?**  Yes  No

Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_

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

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