Welcome to Carrillo Elementary School 2018/2019

Welcome to Carrillo Elementary School, home of the COLTS (Community of Learners Target Success). We are pleased that you will be joining our school family. Carrillo Elementary first opened its doors in 1999 with 234 students. Although we have grown to over 1,000 students, we continue to design and implement programs which provide your children with experiences and opportunities that challenge, motivate and lead to success.

School Hours

Grades 1-5	8:45-3:10, every Wednesday 8:45-2:10
AM Kindergarten	8:15-11:50, every Wednesday 8:15-10:50
PM Kindergarten/TK	11:50-3:25, every Wednesday 11:50-2:25

School Calendar

Please visit our District website for the most up to date calendar
www.smusd.org

Communication

Sign up for text messages from our Principal on the Remind App. Send text to 81010 and enter @carparents

Sign up for emails from our PTO on the PTO website:
http://www.myvlink.org/carrillopto/

Carrillo Elementary School

COLTS: Community of Learners Target Success

Registration Check-Off List

Required Forms for 1st - 5th Graders

_____ Enrollment form

_____ Student Emergency Card

_____ State Certified Original Birth Certificate (a copy will be made and the original returned immediately)

_____ Original Immunization Record (the original returned immediately)

_____ Oral Screening Assesment form (1st graders only- must be signed and dated by dentist or a copy from last school)

_____ School Entry Health Checkup form (1st graders only- must be signed and dated by doctor or a copy from last school)

_____ Student Health History Information

_____ Student Placement Data Form

_____ Residency Verification Form and 2 Proofs of Residency*

**NOTE: These items must have your name and address on them*

engaging students...inspiring futures

Res Verif. _____ ELLRC Ref. _____
TRACT Code: _____

Start Date _____ School _____ Perm ID# _____

Student Information

Legal-*Last Name* | Legal-*First Name* | Legal-*Middle Name* | ☐ Female ☐ Male | Grade

Birth City | State | Country | Date of Birth (mm/dd/yyyy) / /

Student's Ethnicity

As mandated by federal and state law, please answer the following questions to identify this student's ethnicity and race. This information will only be used for reporting total counts of pupils, and will not be released in a personally-identifiable form.

Is this student's ethnicity Hispanic or Latino? ☐ Yes ☐ No

Please check one or more of the following to indicate your student's race:

☐ American Indian/Alaskan Native
☐ Asian – Korean
☐ Asian – Laotian
☐ Asian – Other
☐ Pacific Islander – Samoan
☐ Filipino
☐ Asian – Chinese
☐ Asian – Vietnamese
☐ Asian – Cambodian
☐ Pacific Islander – Hawaiian
☐ Pacific Islander – Tahitian
☐ African American/Black
☐ Asian-Japanese
☐ Asian-Indian
☐ Asian-Hmong
☐ Pacific Islander – Guamanian
☐ Pacific Islander – Other
☐ White

Home Language Survey

The California Education Code requires schools to determine the language(s) spoken at home by each student. This information is essential in order for the school to provide adequate instructional programs and services.

1. Which language did your child learn when he or she first began to speak? _____
2. What language does your child most frequently use at home? _____
3. What language do you use most frequently to speak to your child? _____
4. Name the language spoken most often by the adults at home. _____

Household Information

1. Parent/Guardian Full Name | Email Address:

Student's Home Address (Street) (City) (Zip Code) | Primary Phone Number ( )

☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Guardian | ☐ Cell ☐ Work ☐ Home ( ) | ☐ Cell ☐ Work ☐ Home ( )

☐ Lives with ☐ Contact Allowed ☐ Ed. Rights ☐ Has Custody ☐ Mailings Allowed | ☐ Graduate Degree ☐ College Degree ☐ Some College ☐ High School ☐ Not High School Graduate ☐ Decline to State

2. Parent/Guardian Full Name | Email Address:

Address (Street) (City) (Zip Code) | Primary Phone Number ( )

☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Guardian | ☐ Cell ☐ Work ☐ Home ( ) | ☐ Cell ☐ Work ☐ Home ( )

☐ Lives with ☐ Contact Allowed ☐ Ed. Rights ☐ Has Custody ☐ Mailings Allowed | ☐ Graduate Degree ☐ College Degree ☐ Some College ☐ High School ☐ Not High School Graduate ☐ Decline to State

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4. Parent/Guardian Full Name | Email Address:

Address (Street) (City) (Zip Code) | Primary Phone Number ( )

☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Guardian | ☐ Cell ☐ Work ☐ Home ( ) | ☐ Cell ☐ Work ☐ Home ( )

☐ Lives with ☐ Contact Allowed ☐ Ed. Rights ☐ Has Custody ☐ Mailings Allowed | ☐ Graduate Degree ☐ College Degree ☐ Some College ☐ High School ☐ Not High School Graduate ☐ Decline to State

Primary Residency Information - Please select the option that best describes your housing situation:

☐ Single Family Dwelling ☐ Mobile Home ☐ Duplex ☐ Apartment/Condo ☐ Auto/RV or RV Park ☐ Hotel/Motel
☐ Shelter ☐ Campground ☐ Foster Home ☐ Other: _____

Are you temporarily sharing housing with another family? ☐ Yes ☐ No
Is this due to loss of housing, economic hardship or similar reason? ☐ Yes ☐ No

Questionnaire

- Does anyone in your household work, or has anyone ever worked in seasonal or temporary work related to agriculture (such as fieldwork), food processing (such as canneries or packing houses), fishing, lumbering, or dairy work in the last three years? ..... ☐ No ☐ Yes (Complete Migrant Education Card)
- Is student part of a Military Family? ..... ☐ No ☐ Yes ☐ Active Duty ☐ DOD Employee ☐ National Guard ☐ Reserves (Check all that apply)
- Has student ever received Special Education Services? ..... ☐ No ☐ Yes
- Has student ever received 504 Accommodations? ..... ☐ No ☐ Yes
- Has student ever received English Learner Services? ..... ☐ No ☐ Yes
- Has student ever been received retained or advanced a grade? ☐ No ☐ Yes What Grade: _____
- Has student ever attended San Marcos schools before? ..... ☐ No ☐ Yes School Name: _____
- Has the student been previously suspended or expelled or is he/she currently recommended for expulsion? ..... ☐ No ☐ Yes School Name: _____

Last School Attended

Name of Last School Attended

Address of Last School (Street) (City) (State) (Zip Code)

(Phone Number) (Fax Number)

Please complete only if your student is enrolling in Kindergarten

Please select the program in which your student was primarily participating in prior to Kindergarten.
(check one)

☐ Educational Enrichment Systems (EES) Preschool Program at San Marcos Unified in School: _____
☐ Head Start Program or other State/Federal subsidized care.
☐ Private or Center-Based childcare program (e.g. KinderCare, or a Faith-Based Preschool)
☐ Other: _____
☐ No Preschool

- How many months did the student participate in the program selected above? _____months
- How long did the student attend the program selected above? ☐ Half-Day ☐ Full-Day
- How often did the student attend the program selected above?
  ☐ 1-Day per week ☐ 2-Days per week ☐ 3-Days per week ☐ 4-Days per week ☐ 5-Days per week

Certification

I certify that all the information on this form is true and correct. Falsification of any information or document required for the enrollment of your child in the San Marcos Unified School District may result in denial of this application.

X _____ _____
Parent/Guardian Signature *Date*

Year:_____ Grade:_____

Teacher:_____ ID#:_____

SAN MARCOS UNIFIED SCHOOL DISTRICT
STUDENT EMERGENCY CARD

X _____ _____ _____ _____

Last Name **First Name** **Middle Name** **Birthdate**

X _____ _____ _____

Home Address **Home Phone** **Parent E-Mail Address**

IN CASE OF AN EMERGENCY, IT IS IMPORTANT FOR THE SAFETY OF YOUR CHILD THAT WE HAVE INFORMATION REQUESTED BELOW.

1._____ _____ _____ _____

Name (Parent) Employer Cell Phone Work Phone

2._____ _____ _____ _____

Name (Parent) Employer Cell Phone Work Phone

IT IS VERY IMPORTANT, IN CASE PARENTS CANNOT BE REACHED, THAT TWO (2) ADDITIONAL NAMES AND TELEPHONE NUMBERS BE LISTED BELOW:

3._____ _____ _____

Alternate Local Contact Name Relationship Phone

4._____ _____ _____

Alternate Local Contact Name Relationship Phone

IF NONE OF THE ABOVE IS AVAILABLE, YOUR CHILD WILL BE TRANSPORTED BY AMBULANCE TO THE HOSPITAL.

Siblings in school:

_____ _____ _____ _____ _____ _____

Name School Grade Name School Grade

_____ _____ _____ _____ _____ _____

Name School Grade Name School Grade

HEALTH CONDITION(S)- Check all that apply
IF NO HEALTH PROBLEMS check here ☐
☐ ADHD
☐ Asthma, needs Inhaler at school: ☐Yes ☐No
☐ Diabetes, needs Insulin at school: ☐Yes ☐No
☐ Heart Problem, explain:_____
☐ Seizure Disorder, explain:_____
☐ Known Hearing Loss , wears hearing aide(s): ☐ R ☐ L
☐ Vision Problem ☐ Wears Glasses ☐ Wears Contact Lenses
☐ Other Health Problem, explain:_____
☐History of concussion, date(s):_____

ALLERGIES- Check all that apply
IF NO KNOWN ALLERGIES check here ☐
☐ Bee Sting Allergy
☐ Food Allergy, list foods:_____
_____
☐ Medication Allergy, explain:_____
☐ Other Allergy, explain:_____
☐ **Check here if your child has had an Anaphylactic Reaction**
Does your child require medication to treat allergies: ☐Yes ☐No
IF MEDICATIONS ARE REQUIRED TO TREAT AN ALLERGIC REACTION, PLEASE CONTACT THE SCHOOL HEALTH OFFICE OR CHECK THE SCHOOL WEB SITE TO OBTAIN THE REQUIRED FORMS.

MEDICATION(S)- List medications below. IF NONE, Check Here ☐
Medication name/dose/time taken:_____
Are any of the listed medications taken at school? ☐Yes ☐No
IF MEDICATIONS ARE REQUIRED AT SCHOOL, A SIGNED PARENT PERMISSION FORM AND PHYSICIANS ORDER IS REQUIRED. PLEASE CONTACT THE SCHOOL HEALTH OFFICE OR CHECK THE SCHOOL WEB SITE TO OBTAIN THE REQUIRED FORMS.

MEDICAL CARE PROVIDER PHONE NUMBERS-
Physician Name/Phone:_____ Dentist Name/Phone:_____
Does your child have Health Insurance? ☐Yes ☐No Name of Insurance Provider:_____

THE HEALTH INFORMATION PROVIDED IN THIS FORM MAY BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL ON A NEED-TO-KNOW BASIS IN ORDER TO PROVIDE FOR YOUR CHILD'S SAFETY AND WELL-BEING.
PLEASE CONTACT THE SCHOOL NURSE WITH ANY CONCERNS OR QUESTIONS IN THIS REGARD.

Signature(s) of Parent(s) or Guardian(s):_____ Date:_____
I hereby certify the above information to be true and correct to the best of my knowledge.

Rev. 1/3/2017

DISTRITO ESCOLAR UNIFICADO DE SAN MARCOS
TARJETA DE EMERGENCIA DEL ESTUDIANTE

Year :_____ Grade:_____
Teacher :_____ ID #:_____

X _____ _____ _____
Apellido Nombre Fecha de Nacimiento

X _____ _____ _____
Domicilio Teléfono de casa Dirección de Correo Electrónico

EN CASO DE EMERGENCIA, ES IMPORTANTE PARA LA SEGURIDAD DE SU NIÑO QUE TENGAMOS LA INFORMACÍON SOLICITADA EN ESTA TARJETA.

1._____ _____ _____ _____
Nombre (Padres) Empleador Teléfono Celular Teléfono del Trabajo

2._____ _____ _____ _____
Nombre (Padres) Empleador Teléfono Celular Teléfono del Trabajo

ES MUY IMPORTANTE, EN CASO QUE LOS PADRES NO PUEDAN SER CONTACTADOS, QUE (2) DOS NOMBRES Y NUMEROS DE TELEFONO ADICIONALES SE PROPORCIONEN. POR FAVOR INDIQUE A CONTINUACION:

3._____ _____ _____
Nombre del contacto alternativo (local) Relacíon Teléfono

4._____ _____ _____
Nombre del contacto alternativo (local) Relacíon Teléfono

SI NINGUNA DE LAS PERSONAS EN LA LISTA ESTÁ DISPONIBLE, SU NIÑO/A SERÁ TRANSPORTADO POR AMBULANCIA AL HOSPITAL.
Hermanos en la escuela:

_____ _____ _____ _____ _____ _____
Nombre Escuela Grado Nombre Escuela Grado

_____ _____ _____ _____ _____ _____
Nombre Escuela Grado Nombre Escuela Grado

CONDICIONES MÉDICA(S)- Marque todo que aplica
SI NADA APLICA marque aquí ☐
☐ ADHD
☐ Asma, necesita inhalador en la escuela: ☐sí ☐no
☐ Diabetes, necesita insulina en la escuela: ☐sí ☐no
☐ Enfermedades cardiacas:_____
☐ Historia de ataques epilépticos:_____
☐ Pérdida de la audición, usa audífono(s): ☐ R ☐ L
☐ Problemas de la vista ☐ usa lentes ☐ usa lentes de contacto
☐ Otro problema de salud:_____
_____
☐Historia de traumatismo craneoencefálico fechas:_____
_____
_____

ALERGIAS- Marque todo que aplica
Si no hay alergias conocidas marque aquí ☐
☐ Reacción a picaduras de abeja
☐ Alergia de comida o otra alergia (por favor lista):
_____
☐ Alergia de medicina,
explique:_____
☐ Otra alergia explique:_____
☐ **Marque aquí si su hijo/a ha tenido una reacción anafiláctica**
Requiere su hijo/a medicamentos para tratar las alergias:
☐sí ☐no
SI SE REQUIEREN MEDICAMENTOS PARA TRATAR UNA REACCION ALERGICA, POR FAVOR COMUNIQUESE CON LA OFICINA DE LA ESCUELA O VISITE EL SITIO WEB DE LA ESCUELA PARA OBTENER LAS FORMULARIOS NECESARIOS.

MEDICAMENTOS- Lista de medicamentos. Si no toma ninguno marque aquí: ☐
Nombre de medicamento/dosis/tiempo de uso:_____
Es alguno de las medicamentos indicados usado en la escuela? ☐sí ☐no
SI LOS MEDICAMENTOS SON NECESARIOS EN LA ESCUELA UNA FORMA DE PERMISO DE LOS PADRES FIRMADO Y PARA LOS MÉDICOS ES NECESARIO, PÓNGASE EN CONTACTO CON LA OFICINA DE SALUD ESCOLAR PARA OBTENER LAS FORMAS NECESARIAS.

Números telefónicos de proveedores médicos:

Nombre del medico/teléfono:_____ Nombre de dentista/teléfono:_____

Tiene su hijo/hija seguro medico? ☐sí ☐no Nombre del proveedor de seguro:_____

LA INFORMACION DE SALUD PROPOCIONADA EN ESTE FORMULARIO PUEDE COMPARTIRSE CON EL PERSONAL EXCOLAR APROPIADO CUANDO SEA REQUERIDA CON EL FIN DE GARANTIZAR LA SEGURIDAD Y BIENESTAR DE SU HIJO/A.
POR FAVOR PONGASE EN CONTACTO CON LA ENFERMERA DE LA ESCUELA SI TIENE ALGUNA DUDA O PREGUNTA AL RESPECTO.

Firma de los padres o tutores:_____ Fecha:_____
Yo certifico, bajo mi conocimiento, que la información mencionada arriba es correcta y verdadera.

Carrillo Elementary School

COLTS: Community of Learners Target Success

Student Health History

Name_____ Birthdate_____ Grade_____
Last Name First Name

1. **Medical History:** (Check if child has had a history of disease or condition)

☐ ADD or ADHD	☐ Tuberculosis	☐ frequent ear infections
☐ Head injury	☐ Bone & Joint Problems	☐ Hepatitis
☐ Fainting Spells	☐ Heart Condition	☐ Kidney Problems
☐ Seizures	☐ Blood Condition	

☐ Asthma (Do you intend to have an inhaler in the Health Office?) ☐Yes ☐No

☐ Other_____

2. Please use this space to explain items checked above.

_____

_____

3. Does your child have allergies? ☐Yes ☐No If "Yes" explain:

_____

_____

4. Does your child have any health problems now? ☐Yes ☐No If "Yes" explain:

_____

_____

5. Is your child taking any medication? ☐Yes ☐No
If "Yes," name of medication:_____
Reason for medication_____

Will your child taking medication at school? ☐Yes ☐No

Would you like a district nurse to contact you? ☐Yes ☐No

Parent/Guardian
Signature_____Date_____

County of San Diego

Child Health and Disability Prevention (CHDP) Prog

Report of Medical Examination for School Entry

California law requires a medical examination for school entry to protect the health of all children.

Please return this report to the school. All personal information will be kept confidential.

PART I TO BE FILLED OUT BY PARENT OR GUARDIAN Español al dorso

CHILD'S NAME—Last	First	Middle Initial	School
ADDRESS—Number, Street	**City**	**ZIP Code**	**Birth Date—Month/Day/Year**

☐ I want the medical provider to complete **Part II and Part III**

☐ I want the medical provider to complete **Part II only**

_____ / _____

Signature of Parent or Guardian **Date**

PART II TO BE FILLED OUT BY THE MEDICAL PROVIDER

Tests and Evaluations			Date
Child's Height inches	Child's Weight lbs ozs	Child's BMI Percentile %	
Health/Development History			
Physical Examination			
Nutritional Evaluation			
Vision Screening			
Audiometric Screening			
Blood Test for Anemia			
Urine Dipstick			
Dental Screening			
Tuberculin (TB) Skin Test (Recommended for ALL children entering first grade)			

Medical Provider Information

Name, Address, and Telephone Number:

/

Signature of Medical Professional Date

CHILD HAS A COMPLETED OR UPDATED YELLOW CALIFORNIA IMMUNIZATION RECORD ☐ **YES** ☐ N

PART III TO BE FILLED OUT BY THE MEDICAL PROVIDER

Other Health Information (*Optional*): For the child's welfare—and with the permission of the parent or guardian—it is recommended that significant health information be shared with the school. *Please contact the school nurse if the child needs h with medication at school.*

☐ Parent requests Part III not be filled out ☐ The examination revealed no conditions of importance to school or physical activ

☐ Conditions that need further evaluation or that can affect school or physical activity are (*please explain*):

WAIVER OF MEDICAL EXAMINATION

Note: Your child must have immunizations required by State law, even if no health examination is given.

I have been told about the medical examination recommended by health professionals and required by State law. I have been told where and how my child can receive medical examinations at no cost, if such assistance is needed.

___ **I do not want** my child to receive a medical examination

___ **I do want** my child to receive a medical examination, but **I am unable to get it because** _____

_____

/

Signature of Parent or Guardian Date

County of San Diego Health and Human Services Agency, 3851 Rosecrans Street, Suite 522, MS: P511-H, San Diego, CA 92110

For more information, please call 619-692-8808

MCFHS-77 ES 4/08

SAN MARCOS
UNIFIED SCHOOL DISTRICT
engaging students...inspiring futures

Student Services
255 Pico Avenue, Suite 250
San Marcos, CA 92069

T 760.752.1299
F 760.752.1215
www.smusd.org

Dear Parent or Guardian:

To make sure your child is ready for school, California law, Education Code Section 49452.8, now requires that your child have an oral health assessment (dental check-up) in kindergarten or first grade, whichever is his or her first year in public school. Dental assessments completed up to 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 or registered dental health professional.

Please take the attached Oral Health Assessment/Waiver Request form to the dental office, as it will be needed for your child's check-up. 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: 1-800-322-6384; http://www.denti-cal.ca.gov
2. Covered California's toll free number or Web site can help your find a dentist or find out if your child can enroll in the program: 1-800-300-1506; http://www.coveredca.com
3. For help in enrolling in either Medi-Cal/Denti-Cal or Targeted Low Income Children's Program you may call the San Diego Maternal, Child and Family Health Services toll free help line at 1-800-675-2229. Listen for the SD-KHAN option.
4. For additional resources to find a provider:
    a. San Diego Kids Health Assurance Network @ 1-800-675-2229. http://www.sdkhan.org
    b. 2-1-1 San Diego (If you are unable to reach 2-1-1 from your cell phone or you are calling from outside San Diego County, please call 858-300-1211.
    c. San Diego Dental Society 619-275-0244.

Remember, if your child has poor dental health, your child is not healthy and ready for school. 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.
- 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 Type 2 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.

Your cooperation with this new law is very much appreciated. If you have questions about the oral health assessment requirement, please contact your school nurse.

If you cannot take your child for this required assessment, please indicate the reason for this in Section 3 of the form.

California law requires schools to maintain the privacy of students' health information. Your child's identity will not be associated with any report produced as a result of this requirement.

Sincerely,

Melissa Hunt
District Superintendent

Attachment

SAN MARCOS
UNIFIED SCHOOL DISTRICT
engaging students...inspiring futures

Student Services
255 Pico Avenue, Suite 250
San Marcos, CA 92069

T 760.752.1299
F 760.752.1215
www.smusd.org

Estimado padre o tutor:

Para asegurarse de que su hijo/a este listo para la escuela, una ley de california, Código de Educación Sección 49452.8, ahora requiere que su hijo tenga una evaluación de salud oral (examen dental) en kindergarten o primer grado, cualquiera que sea su primer año en la escuela pública. Las evaluaciones dentales completadas hasta 12 meses antes de que su hijo entre a la escuela también cumplen con este requisito. La ley especifica que la evaluación debe ser hecha por un dentista con licencia u otro profesional con licencia en salud dental.
Por favor lleve el formulario adjunto de Evaluación de Salud Oral/Renuncia a la oficina del dentista ya que se necesitará para el examen dental de su hijo.
La siguiente información le ayudará a encontrar un dentista y a completar con este requisito para su hijo.

1. El número de teléfono gratuito de Medi-Cal/Denti-Cal o el sitio Web le puede ayudar a encontrar un dentista que acepte Denti-Cal: 1-800-322-6384; http://www.denti-cal.ca.gov
2. El número de teléfono gratuito de Covered California o el sitio Web le puede ayudar a encontrar un dentista que acepte el seguro de Covered California o para informarse si su hijo/a puede inscribirse en el programa: 1-800-300-1506; http://www.coveredca.com.
3. Si necesita ayuda para inscribirse a Medi-Cal/Denti-Cal o Covered California usted puede llamar al número gratuito de ayuda 1-800-675-2229 de San Diego Maternal, Child and Family health. Escuche la opción SD-KHAN.
4. Recursos adicionales para encontrar un proveedor:
    a. San Diego Kids Health Assurance Network @ 1-800-675-2229. http://www.sdkhan.org
    b. 2-1-1 San Diego (Si no puede llamar al 2-1-1 de su teléfono celular o si llama desde fuera del Condado de San Diego, por favor llame al 858-300-1211.
    c. San Diego Dental Society 619-275-0244.
    d. Contacte a la enfermera de su escuela.

Recuerde, si su hijo/a tiene mala salud dental, su hijo/a no está listo para la escuela. Aquí hay unos consejos importantes que ayudarán a su hijo/a a mantenerse saludable:

*Lleve a su hijo/a al dentista dos veces por año. *Escoja comidas saludables para toda la familia. Los alimentos frescos por lo general son los más saludables *Cepille los dientes al menos dos veces al día con una pasta dental que contenga fluoruro. *Limite el consumo de caramelos y bebidas dulces, como el ponche o la soda. Las bebidas dulces y los caramelos contienen mucha azúcar que causa las caries dentales y remplaza nutrientes importantes en la dieta de su hijo/a. Las bebidas dulces y los caramelos también contribuyen a los problemas de peso, lo que puede conducir a otras enfermedades, tales como la diabetes tipo 2. ¡Mientras menos se consuman los caramelos y las bebidas dulces, mejor!

Los dientes de leche son muy importantes. No son sólo los dientes que se caerán. Los niños necesitan sus dientes para comer apropiadamente, hablar, sonreír y sentirse bien consigo mismos. Los niños con caries pueden tener dificultades para comer, dejar de sonreír y tienen problemas de atención y aprendizaje en la escuela. Las caries dentales son infecciones que no sanan y pueden ser dolorosas si se dejan sin tratamiento. Si las caries no son tratadas, los niños pueden enfermarse y hasta pueden requerir tratamiento en la sala de emergencia, y sus dientes adultos pueden dañarse permanentemente.

Muchas cosas influyen en el progreso y éxito en la escuela, incluyendo la salud del niño. Los niños deben estar saludables para aprender, y los niños con caries no están sanos. Las caries se pueden prevenir, pero afectan a más niños que cualquier otra enfermedad crónica.

Apreciamos mucho su colaboración con esta nueva ley. Si usted tiene preguntas sobre el requisito de evaluación de salud oral, póngase en contacto con la enfermera de la escuela.

Si no puede llevar a su hijo/a a esta evaluación requerida, por favor indique el motivo en la sección 3 del formulario.

La ley de California requiere que las escuelas mantengan la privacidad de la información de la salud de los estudiantes. La identidad de su hijo/a no será asociada con ningún reporte producido como resultado de este requisito.

Sinceramente,

Melissa Hunt
Superintendente del Distrito

Adjunto

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 their 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 starts 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.

School Site Only-*Place Label here*
Grade _____
D.O.B. _____
Stu # _____
New Student _____

SAN MARCOS UNIFIED SCHOOL DISTRICT
engaging students...inspiring futures

Please check here if:
☐ New Address
☐ New Phone Number(s)

2018-19 ANNUAL RESIDENCY VERIFICATION AND CHECKLIST

In accordance with District policy, all students in the San Marcos Unified School District must provide TWO residency verifications (proof of where you live) each year in order to register. Proof of where you live must be provided at registration or your child will not be able to register (one from each Category-see below). Proof must show Parent/Guardian/Caregiver name and address. If you want to keep your original document(s), you must provide us with a copy to keep. Parent/Guardian/Caregiver must show a picture identification at registration (driver's license, passport)

STUDENT NAME: _____ **ID#:** _____
Last, First Middle

Student living with (check one): ☐ PARENT(S) ☐ LEGAL GUARDIAN/FOSTER PARENT (need court papers)
☐ CAREGIVER (need SMUSD affidavit)) ☐ OTHER _____
☐ SHARED HOUSING (homeowner/renter must complete Affidavit of Residency Form)

PARENT/GUARDIAN NAME(S) (PRINT): 1. _____ **2.** _____

Names of Students living in the home: _____ _____ _____

I AFFIRM THAT THE STUDENT RESIDES AT THE ABOVE STREET ADDRESS:

_____
Street Address

_____
City **Zip Code** **Home Phone#** **Cell Phone# for** _____

_____ _____
Signature of Person Establishing Residency **Date**

WARNING: INCORRECT INFORMATION WILL RESULT IN YOUR STUDENT BEING DISENROLLED IMMEDIATELY

Check off one proof of residency in each category below. Proof must be current (dated within last 60 days). Each Proof must show Parent/Guardian name and address unless shared housing (complete Affidavit of Residency Form).

****IF YOU ARE IN A TRANSITIONAL LIVING CIRCUMSTANCE, PLEASE ASK THE SCHOOL SITE FOR ASSISTANCE.**

CATEGORY ONE:
- ☐ **MORTGAGE STATEMENT or PAYMENT RECEIPT** (with address of residency)
- ☐ **RENTAL AGREEMENT or PAYMENT RECEIPT** (with address of residency)
- ☐ **PROPERTY TAX STATEMENT or RECEIPT** (with address of residency)
- ☐ **GRANT DEED** (with address of residency)
- ☐ **ESCROW PAPERS** (with address of residency)

AND

CATEGORY TWO:
- ☐ **CURRENT UTILITY BILL** (SDG&E, WATER, TRASH OR CABLE)
- ☐ **CORRESPONDENCE FROM A GOVERNMENT AGENCY**
- ☐ **VOTER REGISTRATION**
- ☐ **CURRENT PAY STUB W/ADDRESS**
- ☐ **AFFIDAVIT OF RESIDENCY (needed if shared housing-Parent/ Guardian not listed on proof of residency)**
- ☐ **OTHER**

_____ _____
Verifying School Official **Date**

rev.1/2017

School Site Only-*Place Label here*
Grade _____
D.O.B. _____
Stu # _____
New Student _____

SAN MARCOS UNIFIED SCHOOL DISTRICT
engaging students...inspiring futures

Por favor marque aquí sí:
☐ Nueva dirección
☐ Nuevo teléfono(s)

2018-19 VERIFICACIÓN ANUAL DE RESIDENCIA Y LISTA DE REQUISITOS

De acuerdo con las reglas del Distrito, todos los estudiantes en el Distrito Escolar Unificado de San Marcos deben proporcionar DOS comprobantes de residencia (prueba de donde viven) cada año para poder inscribirse. Si no entrega la prueba de residencia al momento de la inscripción, su hijo/a no podrá inscribirse (uno de cada categoría- ver a en la parte de abajo). La prueba debe mostrar el nombre y dirección del Padre/Guardián/Cuidador. Si desea conservar su documento(s) original(es), debe proporcionarnos copias. Padre/Tutor tiene que mostrar identificación con foto (licencia para manejar/pasaporte/credencial con fotografía) para completar la registración.

NOMBRE DEL ESTUDIANTE _____ **ID#:** _____
APELLIDO, NOMBRE SEGUNDO NOMBRE

El estudiante vive con **(marque uno):** ☐ PADRE(S) ☐ TUTOR LEGAL/PADRE ADOPTIVO TEMPORAL (proporcionar documentos legales)
☐ CUIDADOR (necesita un Affidávit de SMUSD) ☐ OTRO _____
☐ RESIDENCIA COMPARTIDA (el dueño debe completar el formulario Affidávit de Residencia)

NOMBRE(S) DE PADRE/TUTOR (letras de imprenta): 1. _____ **2.** _____

Nombres de los estudiantes que viven en casa: _____

YO CERTIFICO QUE EL ESTUDIANTE VIVE EN LA SIGUIENTE DIRECCIÓN

_____
Dirección

_____
Ciudad **Código Postal** **Teléfono de casa#** **Celular# para** _____

_____ _____
Firma de la persona que establece residencia **Fecha**

ADVERTENCIA: ***SU ESTUDIANTE SERÁ DESAPUNTADO INMEDIATAMENTE SI PROPORCIONA INFORMACIÓN INCORRECTA***

Marque a continuación una prueba de residencia de cada categoría. El documento debe estar al corriente (de no más de 60 días de antigüedad). Cada documento debe mostrar el nombre del padre/Tutor y la dirección a no ser que la residencia sea compartida (llene el formulario Affidávit de Residencia).

****SI SE ENCUENTRA EN CIRCUNSTANCIAS DE VIVIENDA TRANSITORIA, POR FAVOR PIDA ASISTENCIA EN LA ESCUELA.**

CATEGORÍA UNO:
- ☐ **RECIBO DE PAGO DE LA HIPOTECA O RECIBO DE PAGO** (con la dirección de la residencia)
- ☐ **CONTRATO DE ARRIENDAMIENTO O RECIBO DE PAGO** (con la dirección de la residencia)
- ☐ **DOCUMENTO DE IMPUESTOS DE LA PROPIEDAD O RECIBO** (con la dirección de la residencia)
- ☐ **ESCRITURA DE SUBVENCIÓN** (con la dirección de la residencia)
- ☐ **DOCUMENTOS DE PLICA** (con la dirección de la residencia)

Y

CATEGORÍA DOS:
- ☐ **RECIBO ACTUAL DE SERVICIOS PÚBLICOS** (SDG&E, AGUA, BASURA O CABLE)
- ☐ **CORRESPONDENCIA DE UNA AGENCIA GUBERNAMENTAL**
- ☐ **REGISTRO DE VOTANTES**
- ☐ **TALON ACTUAL DE PAGO CON LA DIRECCIÓN**
- ☐ **AFFIDÁVIT DE RESIDENCIA** (se necesita si la residencia es compartida-Padre/Tutor no se encuentra en la lista de prueba de residencia)
- ☐ **OTRO**

_____ _____
Verificación de un oficial de la escuela **Fecha**

rev 1/2017

Carrillo Elementary School

COLTS: Community of Learners Target Success

Student Placement Data

Student Name:_____ Date:_____

Birth Date:_____ Grade:_____

_____ My child has not participated in any special programs.

_____ My child has participated in the program(s) listed below:

_____ 1. Counseling/Contract Behavior

_____ 2. GATE (Gifted and Talented Education)

_____ 3. Hearing Impaired

_____ 4. Visually Impaired

_____ 5. Speech/Language Therapy

_____ 6. Adapted Physical Education

_____ 7. Resource Specialist Program

_____ 8. Special Day Class

_____ 9. Other Information:_____