

STUDENT INFORMATION	PARENT / GUARDIAN INFORMATION
Legal Last Name: _____	MOTHER/GUARDIAN/STEP PARENT (circle one)
Legal First Name: _____	Last Name: _____
Middle Name: _____	First Name: _____
Residence Address: _____	Address (if different from student): _____
Home Telephone: (_____)	Primary Phone Number: (_____)
<input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: _____	Additional Phone Number: (_____)
Birthplace : City: _____ State: _____ Country: _____	ACTIVE DUTY MILITARY: YES NO (circle one)
Date 1st enrolled in a U.S. school: _____	MILITARY VETERAN: YES NO (circle one)
Date 1st enrolled in a CA. public school: _____	Employer: _____
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic or Latino	Work Phone Number: (_____)
Race: <i>Mark primary with '1' and indicate others if needed.</i>	E-Mail Address: _____
<input type="checkbox"/> African American <input type="checkbox"/> Filipino <input type="checkbox"/> Native American <input type="checkbox"/> White	FATHER/GUARDIAN/STEP PARENT (circle one)
If Pacific Islander: <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Tahitian <input type="checkbox"/> Other Pacific Islander	Last Name: _____
If Asian: <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	First Name: _____
Grade Enrolling for: _____ Academic Year: _____ / _____	Address (if different from student): _____
School Enrolling for: _____	Primary Phone Number: (_____)
Has child ever attended a school in this District? <input type="checkbox"/> YES <input type="checkbox"/> NO	Additional Phone Number: (_____)
Name of prior school: _____	ACTIVE DUTY MILITARY: YES NO (circle one)
School Address (if other than CVESD): _____	MILITARY VETERAN: YES NO (circle one)
City: _____ State: _____ Zip: _____	Employer: _____
Phone or FAX Number: (_____)	Work Phone Number: (_____)
List names of other siblings in home (list oldest child first):	E-Mail Address: _____
1. _____ Birth Date: _____	Child lives with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother only <input type="checkbox"/> Father only
2. _____ Birth Date: _____	<input type="checkbox"/> Mother/Stepfather <input type="checkbox"/> Father/Stepmother <input type="checkbox"/> Grandparent(s)
3. _____ Birth Date: _____	<input type="checkbox"/> Foster Parent(s) <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Caregiver
4. _____ Birth Date: _____	Parent/Guardian Education Level Check the <u>one</u> response that describes the highest education level of either parent/guardian:
	<input type="checkbox"/> Graduate School / Post-graduate <input type="checkbox"/> High School Graduate
	<input type="checkbox"/> College Graduate <input type="checkbox"/> Not a High School Graduate
	<input type="checkbox"/> Some College (*includes AA degree)

I am responsible for notifying my child's school of any changes. I certify that all the information on this form is true and correct. Falsification of information may be grounds for immediate cancellation of enrollment.

Parent/Guardian Signature _____ Print Name _____ Date _____

THIS BOX FOR OFFICE USE ONLY		School: _____	Student ID: _____	Grade: _____
Enrollment Date/Time: _____	Teacher: _____	Room: _____	Pre-Reg: _____	
Birth Verification: _____	Residency Verification Source: _____	2 nd Family: _____		
SPED (circle one): YES NO IEP: _____	Date: _____	Services: _____		
Custody Issues: _____	Court Documents: _____	Caregiver Affidavit: _____		
Transfer (circle one): Interdistrict Zone _____	District/School of Residence: _____			

Legal Last Name of Student	First	Date of Birth	Grade	Teacher
Home Address		Zip Code	Home Telephone	
Mother's Name	Mother's Address	Employed By	Work Telephone	
Father's Name	Father's Address	Employed By	Work Telephone	

EMERGENCY INFORMATION: Provide name, address and telephone number of three adults other than parents who could take the child if he/she becomes ill at school and the parents are not available, preferably someone in the school area with a telephone and car. Your child will not be released to anyone except a parent / guardian or those adults listed below.

1.	Name (relationship)	Address	Telephone
2.	Name (relationship)	Address	Telephone
3.	Name of Person (Childcare Provider) who cares for child after school		Telephone

DISASTER PREPAREDNESS PLAN INFORMATION

In the case of a disaster (earthquake, fire, flood, bomb threat etc.) your child will not be released to anyone except those listed above.

Child's Doctor: _____

Name	Address	Telephone
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Medical Insurance Carrier: _____
 (HMO – MediCal – Private – None)

HEALTH INFORMATION

Does your child wear glasses or contacts? Yes No If yes, For close work only Distance only Both

Does your child have a hearing loss? Yes No If yes, For left ear only Right ear only Both

Does your child use hearing aids? Yes No

Does your child have a **Life Threatening Allergic Reaction**? Yes No

If yes, to what? Insect (type) _____ Food (type) _____ Other (type) _____

Does this life threatening allergy require an EpiPen (emergency injectable medication) that you will provide? Yes No

Has your child had **Asthma** within the past year?

Current medications: _____

Does your child need an inhaler at school? Yes No

Does your child **currently** have any of the following? (please check appropriate response)

<input type="checkbox"/> Yes <input type="checkbox"/> No Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Frequent ear infections
<input type="checkbox"/> Yes <input type="checkbox"/> No Seizure disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes
<input type="checkbox"/> Yes <input type="checkbox"/> No Activity limitations? If yes, please describe: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No Any operations? If yes, please describe: _____	

List any medications your child is taking on a regular basis: _____

Do any medications need to be administered at school? Yes No Name of medication: _____

Describe other health information that may affect your child at school: _____

PRIVACY AND COMMUNICATION INFORMATION

Preferred language for papers sent home?	<input type="checkbox"/> Spanish	<input type="checkbox"/> English
May the District use your e-mail address to provide you with emergency news and updates?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
May the District give your telephone number to the PTA or Parent Club?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your child have a current 504 Plan or an IEP (Individualized Education Plan)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
May your child's name or photo be released to the news media or for District publication purposes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I HAVE REVIEWED AND UPDATED THE ABOVE EMERGENCY AND HEALTH INFORMATION.

Parent / Guardian Signature	Print Name	Date
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PLEASE CALL THE SCHOOL NURSE IF YOUR CHILD HAS A CURRENT HEALTH PROBLEM



IMPORTANT HEALTH ISSUES

Please complete this form first

Student's Name:			School Enrolling for:
_____	_____	_____	Grade Enrolling for:
<i>Last</i>	<i>First</i>	<i>Middle Initial</i>	
Parent / Guardian Name: _____			Home phone: _____
E-mail address: _____			Cell phone: _____

Will your child require special assistance at school for any of the following reasons?

- Yes No *allergy requiring medication *Emergency medication:* _____
- Yes No *blood disorder *Student is severely allergic to:* _____
- Yes No *cancer (history of)
- Yes No *catheterization
- Yes No *diabetes
- Yes No *heart condition (current)
- Yes No *intravenous catheter or port
- Yes No *medical limitations to physical activities
- Yes No *seizures
- Yes No *swallowing difficulties
- Yes No *tube feeding
- Yes No *wears diapers
- Yes No *wets or soils clothing with urine or stool
- Yes No *wheelchair
- Yes No asthma
- Yes No requires respiratory assistance; such as the Nebulizer machine (Pulmo-Aide)
- Yes No arthritis
- Yes No braces or prosthetics (arms, legs)
- Yes No crutches
- Yes No Does your child have a current 504 Plan or an IEP?
- Yes No Does your child require ongoing medication? *Name of med* _____
Med given at home? _____ *Med to be administered at school?* _____
- Yes No Does your child have other health issues? *If yes, please explain:* _____

If you have indicated 'yes' to any of the above health issues marked with an asterisk(*), your child will not be allowed to start school until the School Nurse is consulted. Please complete and sign a HIPAA form, available in the school office, if you have checked yes to a health issue marked with an asterisk(*).

Parent / Guardian Signature _____ Date _____ School Nurse Signature _____



CHULA VISTA ELEMENTARY SCHOOL DISTRICT

HOME LANGUAGE SURVEY

Name of Student: _____
(Last Name) (First Name) (Middle Name)

Age of Student: _____ Grade Level: _____ School: _____

Directions to Parents and Guardians:

California Education Code, section 52164.3 contains legal requirements which directs schools and districts to assess the English proficiency of students if there is a language other than English spoken in the home. This information is critical in order to provide the instructional program, services and support for student success.

The process begins with parents completing the Home Language Survey. The Home Language Survey is completed only once for students in grades TK to 12 in California. If a Home Language Survey was previously completed, then schools and districts will honor the original Home Language Survey on file.

The Home Language Survey assists in determining the language(s) spoken in the home of each student, and it also determines if a student's proficiency in English should be tested. All students whose primary language is not English and who are obtaining a California student identification for the first time will take the Initial English Language Proficiency Assessment for California (Initial-ELPAC). *The goal is to provide students who are learning English as a second language the timely support and resources to be successful in school.*

We appreciate your support in accurately completing the Home Language Survey so we can effectively meet the learning needs of your child. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered.

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

2. Which language does your child most frequently speak at home?

3. Which language do you (the parents or guardians) most frequently use when speaking with your child?

4. Which language is most often spoken by adults in the home?
(parents, guardians, grandparents, or any other adults)

By signing this form, I understand my child may be assessed to determine English Language Proficiency and provide services that support my child's learning.

Print Name of Parent or Guardian

Signature of Parent or Guardian

Date

CHULA VISTA ELEMENTARY SCHOOL DISTRICT

RECORD OF PRIOR SCHOOL PROGRAMS AND SPECIAL SERVICES

Student's Name:	ID#:	Grade:
School:	Teacher:	
Relationship to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other (Specify) _____		

If your child is registering in the *Chula Vista Elementary School District* for the first time:

1. Does your child have a current IEP (Individualized Education Plan)? YES NO

If yes, please attach a copy of the most current IEP

2. Does your child have a current 504 Plan (Accommodations for Specific Disabilities)?

YES NO

If yes, please attach a copy of the most current 504 Plan

Special Education Program *(Please check boxes that apply, or box 7 to indicate that none apply)*

- 1) Speech/Language Therapy
- 2) RSP (Resource Specialist Program)
- 3) Special Education Special Day Class

Other Instructional Programs

- 4) Reading Support Program
- 5) Gifted and Talented Education (GATE)
- 6) Other Instructional Program Support:

7) None of the above

Parent / Guardian Signature

Date

E-mail address

Phone (cellular)

Immunization records are online!

Chula Vista Elementary School District uses the California Immunization Registry (CAIR) to store immunization records for many of their students. By using this system, the school can make sure that your children's immunization records can be easily located by a school nurse or health care provider when you change schools, doctors, or during a disease outbreak, or natural disaster. Once the record is in CAIR, then you will be able to access it in the future through an online registration process at <http://www.sandiegoimmunizationregistry.org/mraccess/login.jsp>

Chula Vista Elementary School District staff enter immunization records into the centralized, secure, and confidential database. Please return this completed form and a copy of the individual's immunization record to your school.

For more information, visit the SDIR Website at: www.sdiz.org/CAIR-SDIR/index.html or call the SDIR Help Desk at (619) 692-5656.

Please complete the information below. **Fill out additional form(s) if submitting more than one individual's immunization record.**

Please print clearly and include your phone number in case we need to call you!

PARENT/GUARDIAN	STUDENT
Name:	Last name:
Street Address:	First name:
City:	Date of Birth:
Zip Code:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Email:	Fields below will help locate the immunization record in the future:
Home Telephone:	
Relationship to student: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other [specify]	
	<input type="checkbox"/> Mother's maiden name: <input type="checkbox"/> Medical record # (optional)
	<div style="border: 1px solid black; padding: 2px;">Office use only</div> <input type="checkbox"/> ENTERED in SDIR DATE: ___/___/___ STAFF INITIALS: ___
Signature of Parent/Guardian: _____	

Immunization records are **only shared** with public health, participating health care providers, schools, childcare and other authorized programs that require the review of immunization records for enrollment. Check here only if you do not want the record to be shared. Initials: _____

Chula Vista Elementary School District

VERIFICATION OF RESIDENCY

In accordance with Title 5, California Code of Regulations section 432(F)(2), California school districts **must** verify student residency **annually**.

In order to verify residency within the Chula Vista Elementary School District, **one current document** from the following list must be provided. Said document must show parent/guardian/caregiver **name and address**, and **must be dated within 60 days prior to your child's first day of school**. Past due bills are not acceptable for verification. Post Office box numbers are not acceptable as residence addresses.

Address: _____

____ Mortgage book or statement ____ Homeowner's association billing statement

____ New rental contract/lease, or current payment receipt w/landlord contact info

____ Letter on apartment complex or mobile home park letterhead, signed by the landlord, stating that parent/guardian/caregiver/ lives there

____ Power Bill ____ Water/Sewer Bill ____ Trash Bill ____ Cable Bill ____ Landline Phone Bill

____ Pay stub ____ Voter registration ____ Property Tax payment receipt

____ Correspondence from a government agency

I, _____ the parent/guardian/caregiver/other*
(Print name)

of _____ declare under penalty of perjury that the above-named
(Print student's name)

student and his/her family reside at the address shown on the document indicated above and attached. I understand that **if residency changes, I must notify the school within two weeks, provide new proof of residency and sign an updated form**. If I move outside the school district, an Interdistrict Attendance Permit must be filed in order to request continued attendance for this student.

Warning: Falsification of any information or document required for residency verification or the use of the address of another person without actually residing there may result in revocation of student enrollment.

Parent/Guardian/Caregiver/Other*

Signature: _____ Date: _____

*"other" indicates persons living with another family, which requires a second verification form.

FOR SCHOOL USE ONLY:

The attached document shows the name and address of the person enrolling the above-named student. If not the parent, court papers are required for guardianship, foster placement documentation for foster parent, caregiver affidavit for caregiver.

School Official: _____ Date: _____
(Print name and provide signature)

School Year

Child's last name

Child's first name

Teacher

Room #

Grade