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

_____Gas & Elec _____Water _____Sewer _____Trash _____Cable _____ Landline Phone

_____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-
(Print student's name)

named student and his/her family reside at the address shown on the document indicated above and attached. I understand that **if my 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)

830205 (01/16)

School Year ______
Child's last name ______
Child's first name ______
Teacher ______
Room # ______
Grade ______

CHULA VISTA ELEMENTARY SCHOOL DISTRICT
STUDENT DISASTER INFORMATION CARD

PLEASE PRINT

School:____________________ Teacher:__________

Child's Name:____________________ Birthdate:__________

Home Address:____________________ Telephone:__________

____

Mother's (Guardian's) Name:____________________ Day Phone:__________

Place of Employment:____________________

Father's (Guardian's) Name:____________________ Day Phone:__________

Place of Employment:____________________

Persons other than Parent (Gaurdian) or adult who may pick up child:

1.____________________ Day Phone:__________

2.____________________ Day Phone:__________

3.____________________ Day Phone:__________

List any health problems:____________________

____

List any medications taken on a regular basis:____________________

Doctor's Name:____________________ Telephone:__________

Date:__________ Parent's (Guardian's) Signature:____________________

(infocard.doc) 814107 (1-91)

AUTHORIZATION FOR TREATMENT OF MINORS

PARENTS: This form signed by you authorizes emergency medical treatment for a minor child in case of necessity. Should it be necessary for you to be away from home, this form can authorize the person charged with the care of your child to act for you.

PLEASE PRINT

(I)(We), the undersigned, Parent(s)/Guardian(s) of

____________________ a minor, do hereby authorize employees of **Chula Vista Elementary School District and/or any hospital located in San Diego County** as agent(s) for the undersigned, in advance of any specific diagnosis, to any x-ray examinations, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of any hospital in San Diego County, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California and shall remain in effect, unless sooner revoked in writing to said agent(s), until the end of the current school year.

It is further understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, and we hereby do give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician or surgeon in the exercise of his best judgement may deem advisable. We understand that neither Chula Vista Elementary School District, physician, surgeon, nor hospital involved assumes any financial responsibility for exercising this action.

____

Parent/Guardian (Printed Name)

____________________ Date Signed:__________

Signature

It is helpful to have the following information in order to expedite paperwork necessary for treatment:

Insurance Carrier:____________________

Name of Insured:____________________

Policy Number:____________________ Social Security Number:__________

Additional Information

Child's Name: ____________________________

Best eMail address to reach you: ____

Child lives with:

___Both Parents ___Mother Only ___Father Only ___Foster Parent

___Caregiver ___Legal Guardian ___ Mother/Stepfather ___Father/Stepmother

Ethnicity: (please check 1) ___Hispanic/Latino ___Not Hispanic/Latino

Race: (Mark primary with a "1" and indicate others if needed) ___African American ___Filipino ___Native American ___White

If Pacific Islander: ___Guamanian ___Hawaiian ___Samoan ___Tahitian ___Other

If Asian: ___Cambodian ___Chinese ___Indian ___ Japanese ___Korean ___ Laoatian ___Vietnamese ___Other

Información Adicional

Nombre del estudiante: ____________________________

Correo electrónico : ____

Vive con:

___Ambos padres ___Sólo con la madre ___Sólo con el padre ___Padres Foster

___Tutor Legal ___Persona que lo cuida ___ Madre/padrastro ___Padre/madrastra

Etnicidad: (escoge 1) ___Hispánica/Latina ___No Hispánica ni Latina

Raza: (Marque la principal con "1" marque otras si corresponde)___Afro- Americana ___Filipina

___Indígena Americana ___Blanca

Si es de las islas del Pacifico: ___Guameña ___Hawaiana ___Samoana ___Tahitiana ___Otra

Si es Asiática: ___Camboyana ___China ___India ___ Japonesa ___Coreana ___ Laosiana ___Vietnamita ___Otra

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

CAIR California Immunization Registry
Connected & Protected

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: ☐ Male ☐ Female
☐ Email:	**Fields below will help locate the immunization record in the future:**
Home Telephone:	
Relationship to student: ☐ Parent ☐ Guardian ☐ Other [specify]	☐ Mother's maiden name: ☐ Medical record # (optional) Office use only ☐ 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

84 East J Street • Chula Vista • CA 91910
Phone (619) 425-9600 • Fax (619) 427-0463 • www.cvesd.org

VOLUNTARY AUTHORIZATION FOR RELEASE OF INFORMATION

To the Parents of:		
School:		Teacher:
Grade:	Date of birth:	

From time to time, the Chula Vista Elementary School District has the opportunity to participate in promotional and other activities featuring students, schools, and/or District programs. Please review and sign this form to authorize your child's participation as described below. Indicate your acceptance or rejection by checking the appropriate box located next to the two separate types of disclosures described below.

☐ I AUTHORIZE the District to **duplicate or reproduce my child's work** in multiple media formats, including but not limited to, print, electronic, or web-based publications as part of any District event, activity, or promotion.

☐ I DO NOT authorize the District and/or media agencies to duplicate or reproduce my child's work as part of any District event, activity, or promotion.

☐ I AUTHORIZE the District and/or media agencies to **interview, photograph, videotape, and/or publish** information about my child in multiple media formats, including but not limited to, print, electronic, or web-based publications as part of any District, event, activity, or promotion.

☐ I DO NOT authorize the District and/or media agencies to interview, photograph, videotape, and/or publish information about my child as part of any District event, activity, or promotion. I understand this means my child may not be included in any District event, activity, or promotion planned specifically for publication purposes.

I understand that I and my student shall have no intellectual property or other right in or arising from the distribution of any media relating to my child. To the extent that any of the information described above constitutes a pupil or student record under the Family Educational Rights and Privacy Act ("FERPA") and/or the California Education Code, I authorize the release and disclosure of said information relating to my child.

I also agree to release and hold harmless the District from and against all actions, claims, damages, and liabilities of every kind or nature arising out of any media relating to my child.

I understand that I can revise my permission(s) and/or withdraw my consent at any time with written notice to the District. I further understand that this release shall only be valid for the school year in which it is submitted.

Please complete this form and return it to your child's teacher at your earliest convenience.

I, THE PARENT/GUARDIAN OF THE CHILD NAMED HEREIN, HAVE READ THE INFORMATION PRINTED ABOVE AND AUTHORIZE THE RELEASE OF INFORMATION/WORK/PHOTOS CONCERNING MY CHILD UNDER THE CONDITIONS OUTLINED ABOVE.

Printed Name: ______________________ Relationship to Child: ______________________

Signature: ______________________ Date: ______________________

Address: ____

Phone Number(s): ______________________ Email address: ______________________

For additional information, contact your school or District Communications Officer at (619) 425-9600 Ext. 1328

Chula Vista Elementary School District
84 East J St • Chula Vista, CA 91910 • (619) 425-9600

IMPORTANT HEALTH ISSUES

Please complete this form first

Student's Name: ____________________ *Last* *First* *Middle Initial*	School Enrolling for:
	Grade Enrolling for:
Parent / Guardian Name: ____________________ E-mail address: ____________________	Home phone: __________ 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 <u>health issues marked with an asterisk(*)</u>, your child will <u>not</u> 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 ____________________

DO NOT REMOVE FROM CUMULATIVE FOLDER

844012 (Rev. 06/12)

Child Medical History Questionnaire

Child's Name: ______________________________ Male Female Birth Date: __________

Name of Person Answering Questionnaire:____________________Relationship to the Child:________

Phone Number: H ( ) C ( ) W ( )

Were there any complications with the pregnancy? No Yes If yes, please describe
:____
____

Birth History:

Length of pregnancy: __________ weeks Child's birth weight: _______ lbs _______ oz

Was this delivery a C-section No Yes, reason for C-section________________________

Child's condition at birth ____

Mother's condition at birth ____

Was the child admitted to the NICU No Yes, if yes how long was the child in the hospital after delivery?
____

Did he/she require: __ oxygen ___ tube feedings ___ breathing tube _____ other ______________

Child's Development:

At what age did the child first do the following? Please indicate age in months

______ Sit alone ______ Stand alone ______Speak first words (other than mama/dada

______Crawl ______Walk alone

Can the child _____walk ____run ____ jump with both feet off the ground and _____climb easily? Please check item that apply

Can he/she walk up stairs alternating feet (one foot on each stair)? No Yes down stairs alternating? No Yes

Is the child breast-feeding? No Yes Is the child taking a bottle? No Yes

Is the child toilet trained? No Yes At what age? ____

Can the child feed him/herself with a fork and spoon? No Yes if yes ____with spillage ____without spillage

Can the child drink from a cup without a lid? No Yes if yes ____with spillage ____without spillage

Does this child take any medication regularly? No Yes If yes, please list medication dosage and reason why

Medication Dosage Reason

Has the child been diagnosed with or experienced any of the following problems? If yes, please describe.

Walking or running difficulty No Yes ______________________________

Asthma/Breathing No Yes ______________________________

Feeding problem No Yes ______________________________

Under/Overweight No Yes ______________________________

Sleep problems No Yes ______________________________

ADHD/Autism No Yes ______________________________

Vision or hearing problems No Yes ______________________________

Diabetes No Yes______________________________

Other ____

Has your child been examined by a dentist or dental hygienist? No Yes Any dental problems found? No Yes

If yes, has the dental problem(s) been corrected (example: cavities were filled) No Yes

Does your child have his teeth brush daily? No Yes, how many times a day? ________________

Medical History:

How would you describe your child's current health? (circle one) Poor Fair Good Excellent

Any allergies? No Yes, please describe:______________________________ Epi-Pen No Yes

Has your child received a medical diagnosis (i.e. heart or kidney problems, autism, CP, etc.? No Yes, please describe

____

____

Please describe any serious childhood illnesses or injuries and indicate the age

____

____

Is there any family history (ie: parents, siblings, grandparents, first cousins) of learning disorders, speech delays Developmental delays or genetic disorders? No Yes If yes, please state relationship to child and diagnosis.:

____

____

Please describe any additional information you would like the classroom to know, not previously discussed

____

____

____

For Nurse Use:

Weight: Height: Immunizations: Vision: Hearing:

CHULA VISTA ELEMENTARY SCHOOL DISTRICT

Department of Special Education & Pupil Services and Instruction & Support

Preschool Speech and Language Questionnaire

Child's Name: ______________________________ **Date of Birth:** _______________

______________________________ ______________________________

Name of Person Completing form (Please Print) Relationship to Child

The following information will provide a speech-language pathologist with important information regarding your child's speech, language and social skills. Please answer as accurately as possible.

1. When did your child:
   a. Speak his/her first words (age) ______________________________
   What were the first words: ______________________________
   b. Approximately how many words does your child speak? ______________________________

2. Does your child use?

1 word in a sentence (Ex: Water.)	Yes / No
2 words in a sentence (Ex: Want water)	Yes / No
3 words in a sentence (Ex: I want water)	Yes / No
4 or more words (Ex: Can I have water, please?)	Yes / No

Please provide 2 examples: 1. ______________________________
2. ______________________________

3. Is your child able to answer the following questions?

a. What are you doing?	Yes / No
b. Who's that?	Yes / No
c. Where are you going? (Sample answer: To my room.)	Yes / No

4. Does your child ask questions? Yes / No
   (Ex: What's that? Where are we going? Why?)

5. Does your child follow directions **without** being given a gesture such as:

a. Put this in the trash.	Yes / No
b. Go get your shoes.	Yes / No
c. Get your cup and put it on the table.	Yes / No

6. Does your child:

a. Drool	Yes / No
b. Mouth Objects	Yes / No
c. Thumb or finger suck	Yes / No
d. Use a pacifier	Yes / No
e. Use a sippy cup	Yes / No

7. Does your child stutter (repeat sounds, words, and/or phrases)? Yes / No
   If yes, when do you notice the stuttering?
   ____
   ____

8. Do you have concerns about your child's voice (ex: scratchy voice, sounds like a cold, sounds like they are talking through their nose)? Yes / No
   If yes, please describe: ______________________________

9. Does your child produce the following sounds:
   a. **/m/** (mom, hammer, boom) Yes / No Example:_________
   b. **/n/** (no, money, win) Yes / No Example:_________
   c. **/b/** (boy, baby, tub) Yes / No Example:_________
   d. **/p/** (pie, happy, top) Yes / No Example:_________
   e. **/d/** (duck, body, bed) Yes / No Example:_________
   f. **/t/** (tie, guitar, boat) Yes / No Example:_________
   g. **/g/** (go, tiger, bug) Yes / No Example:_________
   h. **/k/** (key, monkey, back) Yes / No Example:_________
   i. **/v/** (van, over, love) Yes / No Example:_________
   j. **/f/** (fan, waffle, leaf) Yes / No Example:_________
   k. **/w/** (what, towel, bow) Yes / No Example:_________
   l. **/h/** (hot, behind) Yes / No Example:_________
   m. **/y/** (yes, yo yo) Yes / No Example:_________

10. How much of your child's speech do you understand? All____ Half____ Little to None____

11. Does your child do the following:
   a. Make eye contact with peers and adults regularly Yes / No
   b. Respond to greetings from peers and adults Yes / No
   c. Attend to non-preferred structured tasks Yes / No
   d. Stay on topic in a conversation Yes / No

12. Is your child able to easily adjust to changes in his/her daily routine? Yes / No

13. Does your child have opportunities to play with peers (other than siblings)? Yes / No
   If yes, Where? ____

14. When playing with peers my child:
   a. Prefers to play alone Yes / No
   b. Plays next to/near other children Yes / No
   c. Plays a game with a peer that requires turn taking Yes / No
   (Ex: kicking a ball back and forth or building a block tower together)

15. Has your child had his/her hearing evaluated recently? Yes / No
   If yes, did they pass the screening? Yes / No
   If no, do you have any concerns with his/her hearing? Yes / No

16. Does your child have a history of ear infections? Yes / No

17. Does your child have a history of:
   a. Sinus infections/sinusitis Yes / No
   b. Tonsillitis/enlarged tonsils Yes / No
   c. Allergies Yes / No
   d. Asthma Yes / No

18. Has your child ever had a speech and language evaluation/therapy Yes / No
   before? If yes, where? When?)______________________________________

19. What are your concerns?____
   ____
   ____

______________________________ ______________________________
Signature Date