

# LOS MOLINOS UNIFIED SCHOOL DISTRICT

## GRADES TK-8 ENROLLMENT FORM

Office Use Only:

\_\_ B/C \_\_ IZ



CIRCLE GRADE LEVEL: TK\* K 1 2 3 4 5 6 7 8

\*TK students turn 5 between Sept. 2 - Dec. 2

### STUDENT INFORMATION

Full Last Name	Full First Name	Full Middle Name	Gender Male / Female
Birth Date	City of Birth	State of Birth	Country (if other than USA)
Physical Address		<b>Student's Primary Residence</b> <input type="checkbox"/> Mother and Father <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____	
City/State/Zip Code			
Mailing Address (if different from physical address)			
Please provide us with your email address. Email may be used for school communication from teacher, administration, or office staff regarding class schedules, school newsletters, reminders, and special announcements.			
Primary E-mail Address		Secondary E-Mail Address	
<b>What is your child's Ethnicity?</b> (circle one)      Hispanic or Latino      Not Hispanic or Latino			
<b>What is your child's Race?</b> No matter what you selected above, please indicate what you consider your race to be.			
American Indian or Alaskan Native	White	Chinese	Samoan
Black or African American	Cambodian	Korean	Japanese
Vietnamese	Asian Indian	Laotian	Hmong
Guamanian	Filipino	Other Asian	Other Pacific Islander
<b>MILITARY</b> - Is the parent or guardian an active member of the military?    Yes    No    If so, which branch?			

### PREVIOUS SCHOOL EXPERIENCE

Last School Attended	City/State of Previous School
Any Special Education Services needed?    Yes    No	Is there a current IEP?    Yes    No
Any Speech Services needed?    Yes    No	Is there a current IEP?    Yes    No
Circle any services your child is or has taken at previous schools.	
Speech	Special Day Classes    Resource    Bilingual/ELD Program

### PARENT / GUARDIAN PERMISSIONS

I give permission for my child to be photographed or audio/video taped for school publications, newspaper, and local news channels	Y    N
I give permission for LMUSD to display my child's school related academics, athletics, music, and or work on the district website.	Y    N

**MOTHER'S INFORMATION (or guardian)**

If not mother, what is your relation to student? Step Parent Foster Parent Other: \_\_\_\_\_

First Name	Last Name			
Cell Phone	Physical Address			
Home Phone	Mailing Address			
Work Phone	Note: If physical or mailing address is outside of our school district, verification of address must be provided and an inter district transfer may need to be completed before your student can attend school.			
Place of Employment				
<b>What is your Ethnicity?</b> (cicle one)      Hispanic or Latino      Not Hispanic or Latino				
<b>What is your Race? No mater what you selected above, please indicate what you consider your race to be.</b>				
American Indian or Alaskan Native	White	Chinese	Samoan	Japanese
Black or African American	Cambodian	Korean	Japanese	Tahitian
Vietnamese	Asian Indian	Laotian	Hmong	Hawaiian
Guamanian	Filipino	Other Asian	Other Pacific Islander	
<b>Highest level of education completed:</b>				
<input type="checkbox"/> Not a high school graduate		<input type="checkbox"/> High School Graduate		<input type="checkbox"/> Associate's Degree
<input type="checkbox"/> College Graduate		<input type="checkbox"/> Graduate Degree or Higher		

**FATHER'S INFORMATION (or guardian)**

If not father, what is your relation to student? Step Parent Foster Parent Other: \_\_\_\_\_

First Name	Last Name			
Cell Phone	Physical Address			
Home Phone	Mailing Address			
Work Phone	Note: If physical or mailing address is outside of our school district, verification of address must be provided and an inter district transfer may need to be completed before your student can attend school.			
Place of Employment				
<b>What is your Ethnicity?</b> (cicle one)      Hispanic or Latino      Not Hispanic or Latino				
<b>What is your Race? No mater what you selected above, please indicate what you consider your race to be.</b>				
American Indian or Alaskan Native	White	Chinese	Samoan	Japanese
Black or African American	Cambodian	Korean	Japanese	Tahitian
Vietnamese	Asian Indian	Laotian	Hmong	Hawaiian
Guamanian	Filipino	Other Asian	Other Pacific Islander	
<b>Highest level of education completed:</b>				
<input type="checkbox"/> Not a high school graduate		<input type="checkbox"/> High School Graduate		<input type="checkbox"/> Associate's Degree
<input type="checkbox"/> College Graduate		<input type="checkbox"/> Graduate Degree or Higher		

**LEGAL / CUSTODY INFORMATION**

Is the above person(s) the student's LEGAL guardian?	Yes	No (must complete a caregiver affidavit)	
Are parents separated or divorces?	Yes	No	If yes, who has physical custody? _____
Are there any restraining orders or custody paperwork affecting this child?	Yes***	No	
***If yes, you must provide copies to the school office.			

If, in case of an accident of illness requiring medical attention, or sugery, the school cannot reach parent or guardian, I hereby give my permission for any available doctor or medical facility to attend to my child.

\_\_\_\_\_  
Signature of Parent/Guardian\_\_\_\_\_  
Date



# LOS MOLINOS UNIFIED SCHOOL DISTRICT

## HEALTH & EMERGENCY INFORMATION

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_

DISEASE HISTORY	YEAR	DISEASE HISTORY	YEAR	DISEASE HISTORY	YEAR
Chicken Pox		Pneumonia		Meningitis	
Mumps		Infectious Hepatitis		Ear Infections	
Scarlet Fever		Tuberculosis		Other	
Whooping Cough		Rheumatic Fever		Date of last tetanus shot	

### General Health

1. Have the following conditions:
- Asthma ☐
  - Arthritis ☐
  - Diabetes ☐
  - Heart Condition ☐
  - Seizures ☐
  - Fainting ☐
  - Migraines ☐
  - Epilepsy ☐
  - ADHD ☐
  - Physical Handicap ☐
- Other: \_\_\_\_\_
2. List medication(s) prescribed: \_\_\_\_\_
- Current dosage: \_\_\_\_\_
- For (diagnosis): \_\_\_\_\_
- Prescribed by Dr. \_\_\_\_\_
- Dr. Phone Number \_\_\_\_\_
- Does the drug need to be taken during school hours? \_\_\_\_\_
3. Does your child have a physical condition that limits participation in classroom activities or physical education? \_\_\_\_\_
- If yes, please explain: \_\_\_\_\_

### Eyes

Wears Glasses ☐

Wears Contacts ☐

To be worn at all times ☐

Date of last exam \_\_\_\_\_

Eye Dr. \_\_\_\_\_

Ph. Number: \_\_\_\_\_

### Ears

Has a hearing problem ☐

Uses a hearing aide ☐

Has tubes in ears ☐

Preferential seating ☐

Primary Care Physician: \_\_\_\_\_

Dr. Phone Number: \_\_\_\_\_

Comments: \_\_\_\_\_

Please list any surgery, injuries, or illnesses your child may have had: \_\_\_\_\_

Please explain: \_\_\_\_\_

☐ Check here if there are no known health problems.

### Name of local person that your child may be released to in case you can not be reached:

1. Name: \_\_\_\_\_ Relation to student: \_\_\_\_\_ Lives with student: \_\_\_\_\_
- Primary Ph: \_\_\_\_\_ Alt. Ph: \_\_\_\_\_
2. Name: \_\_\_\_\_ Relation to student: \_\_\_\_\_ Lives with student: \_\_\_\_\_
- Primary Ph: \_\_\_\_\_ Alt. Ph: \_\_\_\_\_
3. Name: \_\_\_\_\_ Relation to student: \_\_\_\_\_ Lives with student: \_\_\_\_\_
- Primary Ph: \_\_\_\_\_ Alt. Ph: \_\_\_\_\_
4. Name: \_\_\_\_\_ Relation to student: \_\_\_\_\_ Lives with student: \_\_\_\_\_
- Primary Ph: \_\_\_\_\_ Alt. Ph: \_\_\_\_\_
5. Name: \_\_\_\_\_ Relation to student: \_\_\_\_\_ Lives with student: \_\_\_\_\_
- Primary Ph: \_\_\_\_\_ Alt. Ph: \_\_\_\_\_

If you would like to add additional names, please attach a separate paper to this form.

## EMERGENCY / ALLERGY INFORMATION

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_

### TYPE OF ALLERGY

Check the box for any allergy your child has experienced.

<input type="checkbox"/> Medication (describe)	<input type="checkbox"/> Food (describe)
<input type="checkbox"/> Environmental Allergens (describe) (Dust, mites, mold, pets, grass, etc.)	<input type="checkbox"/> Insect Bites/Stings (describe)

*If dietary changes are medically necessary, a doctor's order with diagnosis is required.*

Comment: \_\_\_\_\_

### SYMPTOMS OF ALLERGY - Check the box for each symptom your child has experienced.

<input type="checkbox"/> Hives or giant hives	<input type="checkbox"/> Swelling of:
<input type="checkbox"/> Difficulty in breathing - wheezing	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Shock	<input type="checkbox"/> Other (describe):
<input type="checkbox"/> Fainting, dizziness	

Please circle yes or no to the following questions.

1. Has your child seen a doctor for any the allergies indicated above? Yes or No
2. Has your child ever been hospitalized for any allergic event? Yes or No
3. Is medication required immediately after exposure to any allergy producing substance? Yes or No

*If yes, we must have both the medication and an authorization form signed by a physician.*

### Please read and initial:

\_\_\_\_\_ California Ed Code 49408 indicates that for the protection of the pupils health and welfare, the governing board of a school district may require the parent/guardian of a pupil to keep current at the pupil's school of attendance, emergency information including the home address and telephone number, business address and telephone number of the parent/guardians, and the name, address and telephone number of a relative or friend who is authorized to care for the pupil in any emergency situation if the parent/guardian cannot be reached.

### PARENT MUST INITIAL ONE

#### Emergency Situations

\_\_\_\_\_ In the event of an emergency, when a parent/guardian is unavailable, I authorize school personnel to make arrangements for my child to receive medical/hospital care, including the necessary transportation, in accordance with their best judgment. I authorize such care and treatment to be performed by a licensed physician or surgeon. I agree to pay all costs incurred as a result of the foregoing.

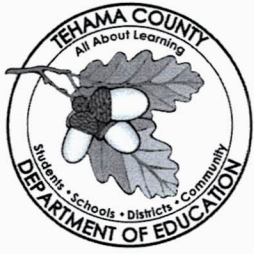
\_\_\_\_\_ I do NOT choose the above statement and desire the following action in the event of an emergency. \_\_\_\_\_

I understand that the Los Molinos Unified School District does NOT provide accident medical insurance for students for school related injuries but does offer student accident insurance for voluntary purchase. I also understand that I may request this information and application for this program from the school office at any time.

\_\_\_\_\_  
Print Parent/Guardian's Name

\_\_\_\_\_  
Parent/Guardian's Signature





### STUDENT RESIDENCY QUESTIONNAIRE/AFFIDAVIT

This document is intended to address the McKinney-Vento Assistance Act. Your answers will help determine documents necessary to enroll your child quickly.

Student: \_\_\_\_\_ Birthdate: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

1. Do you and the student live in:

- ☐ shelter (PATH Winter Shelter, Sale House, etc.)
- ☐ motel/hotel
- ☐ temporarily with another family due to economic hardship
- ☐ in a car or RV
- ☐ at a campsite
- ☐ single family dwelling (house, mobile home, or apartment)
- ☐ other location \_\_\_\_\_

2. Are you currently homeless or living with another family due to a natural disaster? ☐Yes ☐No  
(If yes name of disaster: \_\_\_\_\_)

3. The student lives with:

- ☐ one or both parents
- ☐ legal guardian(s) *(please attach court documentation)*
- ☐ foster Parent(s) *(please attach court documentation)*
- ☐ an adult relative (Relationship: \_\_\_\_\_)
- ☐ friend(s)
- ☐ an adult that is not the legal guardian
- ☐ alone with no adult(s)

4. I am:

- ☐ the parent/legal guardian of the above-named student
- ☐ the student
- ☐ an adult relative of the above-named student  
(Relationship: \_\_\_\_\_)

***I declare under penalty of perjury under the laws of this state that the information provided here is true and correct and of my own personal knowledge.***

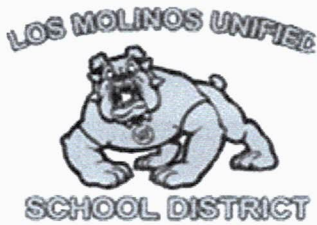
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Your Name: \_\_\_\_\_

Residence: \_\_\_\_\_  
Street City Zip

Mailing Address: \_\_\_\_\_  
Street City Zip

Telephone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_



Student Name \_\_\_\_\_

DOB \_\_\_\_\_ Student ID# \_\_\_\_\_

School \_\_\_\_\_

Grade \_\_\_\_\_ Date \_\_\_\_\_

## Los Molinos Unified School District Home Language Survey – English

The California *Education Code 52164.1(a)* requires schools to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students.

As parents or guardians, your cooperation is requested in complying with the legal requirement. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name of the language that applies 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) \_\_\_\_\_

State of California  
Department of Education

\_\_\_\_\_  
Signature of Parent or Guardian/Date

### INITIAL IDENTIFICATION – FOR SCHOOL USE ONLY

1\_\_ English Only

Initial CELDT/ELPAC Assessment

Date: \_\_\_\_\_

Score: B EI I EA A

Language Classification:

2\_\_ Initially Fluent English Proficiency (IFEP)

3\_\_ English Learner (EL)

4\_\_ Reclassified (RFEP) Date \_\_\_\_\_

Primary Language Assessment

Date: \_\_\_\_\_

District Language Assessment Score: \_\_\_\_\_



Butte County Office of Education  
MIGRANT EDUCATION – REGION 2  
OROVILLE AREA OFFICE  
1870 Bird St., Oroville, CA 95965

Office: (530) 532-5738 /Cell: (530) 370-1814/Fax: (530) 532-3096

ME-1



## FORMULARIO DE REFERENCIA REFERRAL FORM

ESTA INFORMACIÓN ES CONFIDENCIAL/THIS INFORMATION IS CONFIDENTIAL

**¿Le gustaría seguir apoyando a su hijo/a para que tengan éxito en la escuela? ¿El Programa de Educación Migrante es un excelente recurso!**

Would you like to continue assisting your child in school? The Migrant Education Program is an excellent resource!

**1. ¿Ha trabajado algún miembro de su familia en la agricultura, la ganadería, la pesca o la industria forestal en los últimos tres años?**

Has any member of your family worked in agriculture, livestock, fishing or logging in the last three years?

YES NO  
☐ ☐

**2. ¿Se mudó su familia al pueblo/ciudad donde viven en los últimos tres años?**

Did your family move to the town/city where you live in the last three years?

YES NO  
☐ ☐

**Si contestó “SÍ” a ambas preguntas, su hijo/a podría ser elegible para recibir servicios educativos. Por favor anote los siguientes datos y entregue este formulario. ¡Gracias!**

If you answered “YES” to both questions, your child could be eligible to receive educational services. Please provide the following information and return this form. Thank you!

Fecha/Date: \_\_\_\_\_

Nombre de los Padres/Parents' Name: \_\_\_\_\_

Número de Teléfono/Telephone Number: \_\_\_\_\_

Dirección /Address: \_\_\_\_\_  
Número /Number Calle/Street Ciudad/City

Nombre del Estudiante/Student's Name: \_\_\_\_\_

Fecha de Nacimiento/Date of Birth: \_\_\_\_\_

Referred by (Agency/School): \_\_\_\_\_ Telephone Number/E-mail: \_\_\_\_\_

**FOR MIGRANT EDUCATION RECRUITMENT STAFF USE ONLY**

Date: \_\_\_\_\_ Notes: \_\_\_\_\_

Date: \_\_\_\_\_ Notes: \_\_\_\_\_

Please mail completed surveys to the address above, fax to (530) 532-3096, or e-mail to [cespinoz@bcoe.org](mailto:cespinoz@bcoe.org).