Copperopolis Elementary School
217 School St.
Copperopolis, CA 95228
209-785-2236 ph / 209-785-4309 fax

Parent Check List:

Please make sure that you have supplied us with the following documents. We will need all of these forms in order to process your child's file.

- **Copy of Original Birth Certificate**
- **Current Immunization Record**
- **Proof of Residence**

} We ***must*** have these for enrollment

Other forms

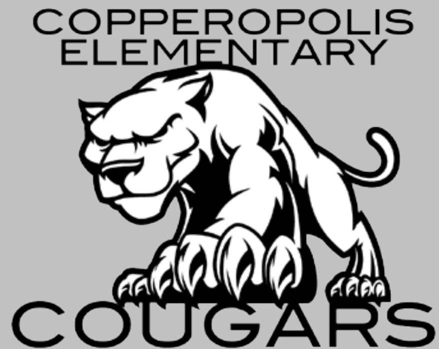
- Copy of Current IEP or 504 Plan *(if applicable)*
- Copy of Custody Papers *(if applicable)*
- Care Giver Form *(if not the parent)*

Thank you!

For office use only:

Enrollment Folder Checklist

- ☐ Registration Form
- ☐ Emergency Card
- ☐ Student Handbook Acknowledgment
- ☐ Photo Release Form
- ☐ Calendar/Bell Schedule
- ☐ Computer/Internet Form
- ☐ Cumulative Record Request Form
- ☐ Care Giver Form (if not the parent)
- ☐ Bus Form (if needed)
- ☐ Lunch Form (if needed)
- ☐ Special Education Forms (if needed)
- ☐ Custody Form



Mark Twain Union Elementary School District

[ ] **Copperopolis Elementary**
[ ] Classroom [ ] Independent Study

[ ] **Mark Twain Elementary**
[ ] Classroom [ ] Independent Study

For Office Use
Student ID #:____________________
State ID # :____________________
Birth Verification: ____________________
Address Verification: ____________________
Immunizations: ____________________

Teacher: ____________________ Grade:__________
Date Records Requested: ____________________

REGISTRATION DATE:	FIRST DAY:			
STUDENT'S LEGAL LAST NAME	FIRST NAME	MIDDLE NAME	NICKNAME	GRADE
DATE OF BIRTH / /	PLACE OF BIRTH: CITY & STATE	STUDENT'S SOCIAL SECURITY NUMBER ___ ___ ___ - ___ ___ - ___ ___ ___ ___	[ ] MALE [ ] FEMALE	

MAILING ADDRESS	CITY	ZIP
PHYSICAL ADDRESS	CITY	ZIP

HOME PHONE	MOTHER'S CELL	FATHER'S CELL
STUDENT'S CELL	EMAIL	EMAIL

MOTHER RESIDES W/STUDENT [ ] YES [ ] NO IF NO, IS CONTACT WITH STUDENT ALLOWED? [ ] YES [ ] NO		FATHER RESIDES W/STUDENT [ ] YES [ ] NO IF NO, IS CONTACT WITH STUDENT ALLOWED? [ ] YES [ ] NO	
NAME		NAME	
ADDRESS IF DIFFERENT FROM STUDENT		ADDRESS IF DIFFERENT FROM STUDENT	
WORK PLACE	WORK PHONE	WORK PLACE	WORK PHONE
EDUCATION LEVEL: [ ] HS GRAD [ ] NON HS GRAD [ ] SOME COLLEGE [ ] COLLEGE GRAD [ ] POST GRAD		EDUCATION LEVEL: [ ] HS GRAD [ ] NON HS GRAD [ ] SOME COLLEGE [ ] COLLEGE GRAD [ ] POST GRAD	
IF MOTHER DOES NOT LIVE WITH STUDENT, SHOULD SHE GET STUDENT MAILINGS? [ ] YES [ ] NO		IF FATHER DOES NOT LIVE WITH STUDENT, SHOULD HE GET STUDENT MAILINGS? [ ] YES [ ] NO	

IF STUDENT DOES NOT LIVE WITH PARENT(S) COMPLETE THE FOLLOWING ALONG WITH A CAREGIVER AFFIDAVIT

FEMALE GUARDIAN STUDENT LIVES WITH RELATIONSHIP: [ ] STEP MOTHER [ ] FOSTER PARENT [ ] LEGAL GUARDIAN [ ] OTHER __________		MALE GUARDIAN STUDENT LIVES WITH RELATIONSHIP: [ ] STEP FATHER [ ] FOSTER PARENT [ ] LEGAL GUARDIAN [ ] OTHER __________	
NAME		NAME	
CELL PHONE	WORK PHONE	CELL PHONE	WORK PHONE

EMERGENCY INFORMATION - IF PARENT/GUARDIAN CAN'T BE REACHED *PLEASE PROVIDE AT LEAST TWO CONTACTS*

#1 NAME:	RELATIONSHIP:	HOME PHONE	CELL PHONE:
#2 NAME:	RELATIONSHIP:	HOME PHONE	CELL PHONE:
#3 NAME:	RELATIONSHIP:	HOME PHONE	CELL PHONE:
#4 NAME:	RELATIONSHIP:	HOME PHONE	CELL PHONE:
#5 NAME:	RELATIONSHIP:	HOME PHONE	CELL PHONE:
#6 NAME:	RELATIONSHIP:	HOME PHONE	CELL PHONE:

LAST SCHOOL ATTENDED

SCHOOL NAME: ____ LAST DAY ATTENDEND: ________________________

PHONE NUMBER: _____________________________________ FAX NUMBER: ________________________________

IF OUT OF THE COUNTY: CITY, STATE, COUNTRY ____

MEDICAL HISTORY: STUDENT HAS…

[ ] HEART DISEASE [ ] EPILEPSY [ ] DIABETES [ ] MIGRAINES [ ] ASTHMA: CARRIES INHALER [ ] YES [ ] NO

[ ] ADD/ADHD: IF YES, MEDICATIONS ____

SEVERE ALLERGIC REACTIONS TO: ____

A PHYSICAL DISABILITY: ____

IF STUDENT HAS HEALTH RELATED CONCERNS THAT WOULD AFFECT THEIR SCHOOL PERFORMANCE, PLEASE DESCRIBE BELOW:

____

IS STUDENT TAKING ANY PRESCRIPTION MEDICATIONS? PLEASE NAME: ____________________________________

IN CASE OF EMERGENCY, MY STUDENT CAN BE TAKEN TO THE EMERGENCY HOSPITAL [ ] YES [ ] NO

STUDENT'S DOCTOR ____PHONE NUMBER: __________________________

SIBLINGS/STUDENTS IN SAME HOUSEHOLD

Name:______________________	Relationship to student:____________________	Date of Birth:____________
Name:______________________	Relationship to student:____________________	Date of Birth:____________
Name:______________________	Relationship to student:____________________	Date of Birth:____________
Name:______________________	Relationship to student:____________________	Date of Birth:____________
Name:______________________	Relationship to student:____________________	Date of Birth:____________

RESIDENTIAL STATUS

THE FOLLOWING BEST DESCRIBES OUR CURRENT LIVING CONDITIONS: [ ] OUR FAMILY, SINGLE RESIDENCE [ ] MORE THAT ONE FAMILY IN HOME
[ ] SHELTER, GROUP HOME, TRANSITIONAL [ ] TEMPORARILY WITH FRIENDS OR FAMILY [ ] CAR, CAMPSITE, TRAILER, VACANT BUILDING [ ] HOTEL, MOTEL

SARB

HAS STUDENT EVER BEEN REFERRED TO SARB? [ ] YES [ ] NO
(STUDENT ATTENDANCE REVIEW BOARD)

PROBATION

IS STUDENT CURRENTLY ON PROBATION? [ ] YES [ ] NO
IF YES, WHO IS THE PROBATION OFFICER?

PARENT PERMISSION & MEDICAL RELEASE

I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT, AND I AM THE PARENT AND/OR LEGAL GUARDIAN OF THE NAMED STUDENT.

YOUR SIGNATURE BELOW INDICATES YOU HAVE GIVEN PERMISSION FOR EMERGENCY MEDICAL CARE UNDER THE SUPERVISION OF MARK TWAIN UNION ELEMENTARY SCOOL DISTRICT

X ____ ____________________

PARENT/GUARDIAN SIGNATURE DATE I

IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO NOTIFY THE SCHOOL IMMEDIATELY OF ADDITIONS OR CHANGES TO THIS INFORMATION. I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION PROVIDED IN THIS REGISTRATION FORM IS TRUE AND CORRECT.

STUDENT ETHNIC/RACE BACKGROUND

***IS STUDENT HISPANIC OR LATINO ? [ ] YES [ ] NO**
***STUDENT RACE: (CHECK ALL THAT APPLY)**
[ ] AMERICAN INDIAN – ALASKAN NATIVE
[ ] BLACK OR AFRICAN AMERICAN
[ ] OTHER PACIFIC ISLANDER

[ ] CHINESE	[ ] FILIPINO	[ ] JAPANESE
[ ] KOREAN	[ ] HAWAIIAN	[ ] VIETNAMESE
[ ] GUAMANIAN	[ ] ASIAN INDIAN	[ ] SAMOAN
[ ] LAOTIAN	[ ] TAHITIAN	[ ] CAMBODIAN
[ ] HMONG	[ ] OTHER ASIAN	[ ] WHITE

***CIRCLE THE RACE YOUR CHILD MOST IDENTIFIES WITH.**

ADDITIONAL SERVICES

PLEASE INDICATE IF STUDENT HAS OR RECIEVES ANY OF THE FOLLOWING:

[ ] SPEECH
[ ] 504
[ ] SPECIAL ED (SDC / RSP)
DATE OF LAST IEP___________
[ ] ESL
[ ] WAS RETAINED IN GRADE _____
[ ] G.A.T.E.

LANGUAGE SURVEY

WHICH LANGUAGE…

DID STUDENT FIRST LEARN?
[ ] ENGLISH [ ] SPANISH [ ] OTHER _________
DID STUDENT SPEAK AT HOME?
[ ] ENGLISH [ ] SPANISH [ ] OTHER _________
IS SPOKEN TO STUDENT AT HOME:
[ ] ENGLISH [ ] SPANISH [ ] OTHER _________
IS SPOKEN BY ADULTS AT HOME:
[ ] ENGLISH [ ] SPANISH [ ] OTHER _________

Mark Twain Union Elementary School District
Custody Issues

[ ] Copperopolis Elementary [ ] Mark Twain Elementary

If you have a custody issue that you feel the school staff needs to be aware of, please complete this form. If there are no custody issues, please disregard this form.

Child's Name:______________________________ Grade: _____

Who has legal custody of the above named child?

_______ Mother
_______ Father
_______ Both
_______ Other: ____

Is there a current restraining order on file with the court system? _________
(yes/No)

Custody Issues

The courts must handle custody disputes. The school has NO LEGAL JURISDICTION to refuse a biological parent access to their child and/or school records. The only exception is when a signed restraining order or proper divorce papers, specifically stating court ordered visitation, limitations, are on file in the school office. Should any such situation become a disruption to the school, the Police Department will be contacted and an Officer will be requested to intervene.

PARENTS ARE ASKED TO NOT INVOLVE THE SCHOOL SITE IN CUSTODY MATTERS.

The school will make every attempt to reach the custodial parent when another parent or any person not listed on the Emergency Card attempts to pick up your child. **Please attach most recent court orders.**

______________________________ ____________________
Signature of Parent/Guardian Date

HEALTH HISTORY REPORT

Date: ____________________

Child's Name: Last_________________________First________________________Middle______ ________________

Birth Date: ________________Pre School____

Name of person completing form: _______________________________________Relationship_____________________

Family Members (including parents)

Name	Sex	Birthdate	Relationship to Child

Problems early in life can sometimes cause later difficulties. Please answer the following questions:

1. Were there any problems during pregnancy?

   ____

2. Was the pregnancy full term? ________ If not, premature by ________ weeks.
3. Were there any complications during labor or delivery? ________ If yes, explain ________________________

   ____

4. Baby's condition at birth: Normal ________ Abnormal ________ (Please explain) ____________________

   ____

5. Any difficulties during the first 30 days? ____

Developmental Growth: (give age, if known, or state "slow", "average", or "fast")

1. Sat alone _____________________________
2. Crawled ______________________________
3. Walked _______________________________
4. Said words__________________________________
5. Said sentences______________________________
6. Toilet trained_______________________________

Health History

Please list for below, "good", "fair", or "poor" and explain:

1. Vision ____
2. Hearing ____
3. Large muscle coordination (ability to run, hop, jump, etc.) ____
4. Small muscle coordination (use of eating utensils, manipulating small toys, etc.)________________________

   ____

5. Speech ____
6. Other chronic or current health problems:

   _____Head Injury _____ADD or ADHD _____Enuresis/Encopresis

   _____Fainting spells _____Bone or Joint problems _____Bleeding disorder

   _____Kidney problem _____Frequent ear infections _____Seizures

   _____Autism Spectrum Disorder

   _____Anaphylaxis – from what? _________________________ Type: ____________________

Complete Both Sides

Explain items checked above: ______________________________

____

____

List any serious accidents, operations, or hospitalizations: (date, situation, etc.)

____

____

____

____

Last complete physical exam: Date: ______________________________

Physician's Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

Last dental exam: Date: ______________________________

Was dental work needed? ________ Completed? ______________

Dentist's name: ______________________________

Address: ______________________________

____

Phone: ______________________________

General Information:

1. Is your child taking any medication? If so, please identify drug, dosage, and time(s):______________________________

   ____

   ____

2. Does your child have any special dietary needs: Please explain ______________________________

   ____

   ____

3. Is there a history of learning difficulties in the family? ______________________________
4. Are there current sleep problems? ______________________________
5. Are there current eating problems? ______________________________
6. Do you have concerns about your child's health (especially in relation to his/her school performance)?

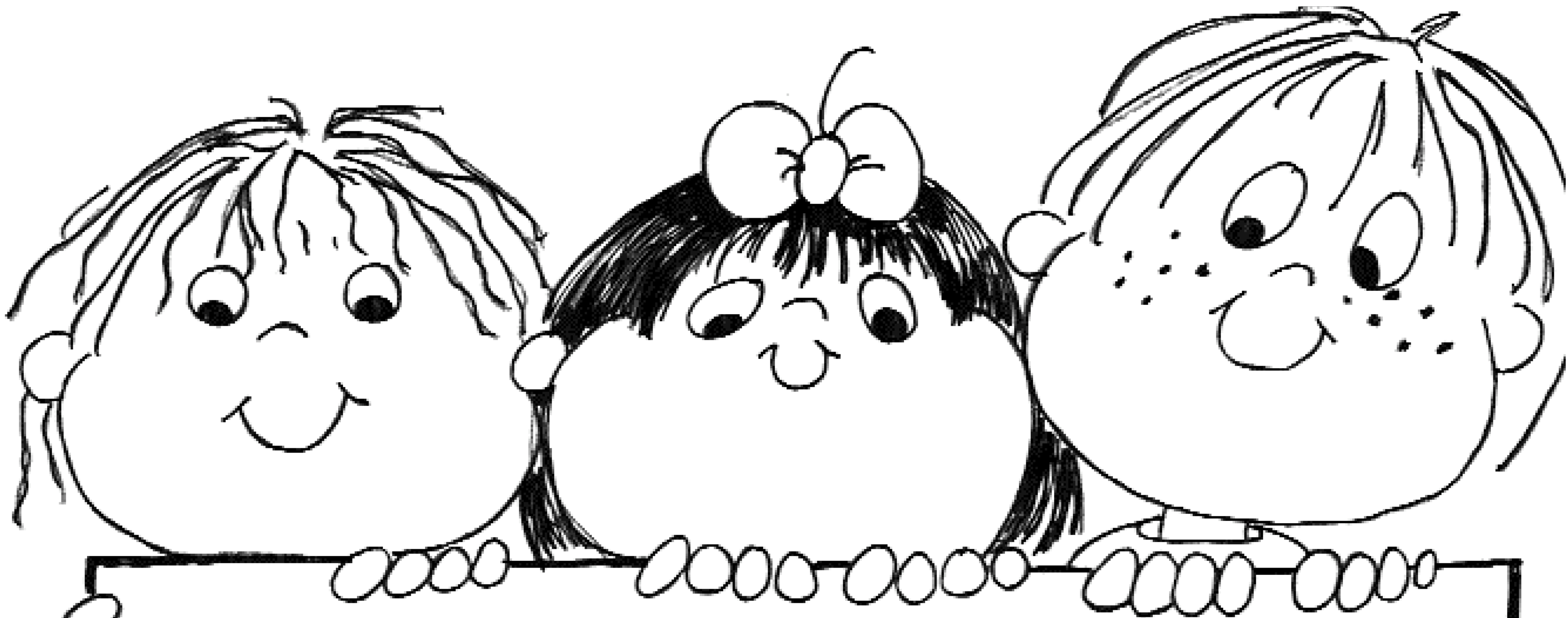
   ____

   ____

   ____

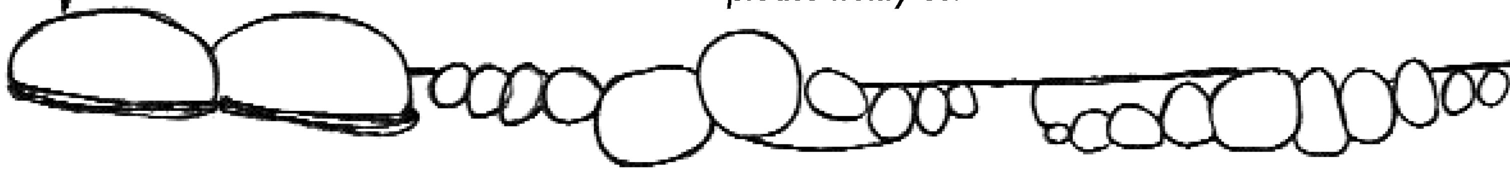
   ____

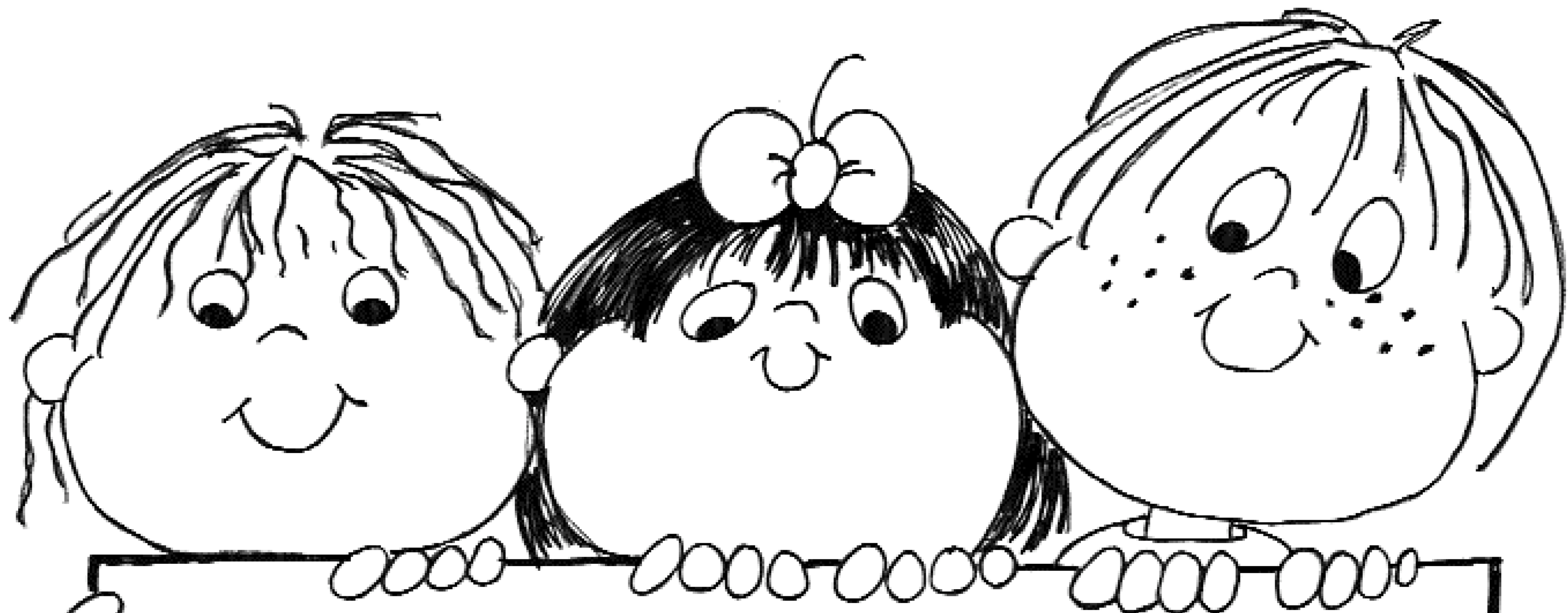
   ____



Children will not be enrolled unless an immunization record is presented and immunizations are up-to-date.*

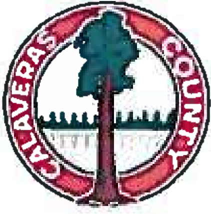
*If your child is unimmunized due to religious, personal, or medical reasons, please notify us.





No se inscribirá a los niños a menos que se presente el comprobante de vacunación y las vacunas estén al día.*

**Avísenos si su hijo no está vacunado por motivos religiosos, personales o médicos.*



Calaveras Health and Human Services Agency

Mary Sawicki, Director

509 East St. Charles Street
San Andreas, CA 95249

To: Parent/Guardian of a child entering kindergarten in summer 2016
From: Dean Kelaita, M.D., Health Officer
RE: Changes to School Immunization Law
Date: January 4, 2016

Dear Parent and/or Guardian,

Every child should be able to attend school without the threat of contracting a preventable contagious disease. Chronically ill and immunocompromised students who are unable to be vaccinated are therefore protected from significant health risks through the community-minded efforts of others who do not have a medical contraindication to vaccination.

On June 30, 2015, Governor Brown signed Senate Bill 277 requiring all students entering kindergarten and 7th grade to show proof of immunization in order to enroll in school, public or private. Most notably, while the law still allows for exemptions with proper documentation, the new law no longer permits immunization exemptions based on personal beliefs (PBE) for children in child care programs and in public and private schools. Beginning, July 1, 2016, child care programs, public schools and private schools shall not unconditionally admit to any of those institutions for the first time, or admit or advance any pupil to 7th grade level, unless the pupil has been immunized for his or her age as required by this law.

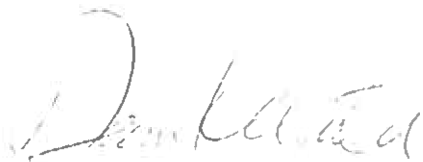
If you are not sure if your child's vaccine records are up to date, you can contact your child's school directly. All the required immunizations are approved for the routine schedule to be administered at 4 years of age, and typically are part of a routine 4 year old well child visit. There will be no exceptions made for parents who choose to delay vaccines unless a physician has signed a medical exemption.

Students Admitted to Kindergarten/Transitional Kindergarten (at ages 4-6 years) Must Have These Immunizations:

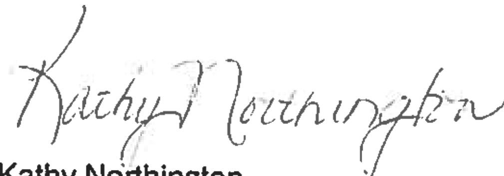
- **Diphtheria, Tetanus, and Pertussis (DTaP, DTP, or DT)** – 5 doses
  (4 doses OK if one was given on or after 4th birthday)
- **Polio (OPV or IPV)** – 4 doses
  (3 doses OK if one was given on or after 4th birthday)
- **Hepatitis B** – 3 doses

- **Measles, Mumps, and Rubells (MMR)** – 2 doses
  (both given on or after 1st birthday)
- **Varicella (Chickenpox)** – 1 dose

California schools are required to check immunization records for all new student admissions at Kindergarten/TK through 12th grade and all students advancing to 7th grade before entry. Parents/Guardians must show their child's Immunization Record as proof of immunization as a condition of enrollment. Students without proof of immunization will not be allowed to attend school. Furthermore, if your child is unvaccinated, including for medical reasons, and there is a disease outbreak, the school may be ordered by the Health Department to temporarily exclude your child for his/her protection.



Dean Kelaita, MD
Calaveras County Public Health Officer



Kathy Northington
Calaveras County Superintendent of Schools

State of California—Health and Human Services Agency

Department of Health Care Services
Child Health and Disability Prevention (CHDP) Program

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTH DATE—Month/Day/Year

ADDRESS—Number, Street	City	ZIP code	SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	/ /
Physical Examination	/ /
Dental Assessment	/ /
Nutritional Assessment	/ /
Developmental Assessment	/ /
Vision Screening	/ /
Audiometric (hearing) Screening	/ /
Tuberculin Test (Mantoux/PPD)	/ /
Blood Test (for anemia)	/ /
Urine Test	/ /
Blood Lead Test	/ /
Other	/ /

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER *(optional)* *and* RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

☐ Examination shows no condition of concern to school program activities.

☐ Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: *(please explain)*

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

☐ Please check this box if you ***do not*** want the health examiner to fill out Part III.

Signature of parent or guardian — Date

Name, address, and telephone number of health examiner

Signature of health examiner — Date

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.

CHDP website: www.dhcs.ca.gov/services/chdp

State of California—Health and Human Services Agency

Department of Health Services
Child Health and Disability Prevention (CHDP) Program

INFORME DEL EXAMEN DE SALUD PARA EL INGRESO A LA ESCUELA

Para proteger la salud de los niños, la ley de California exige que antes de ingresar a la escuela todos los niños tengan un examen médico de salud. Por favor, pidale al examinador de salud que llene este informe y entregelo a la escuela—este informe sera archivado por la escuela en forma confidencial.

PARTE I PARA SER LLENADO POR EL PADRE/LA MADRE O EL GUARDIÁN

NOMBRE DEL NIÑO/NIÑA—Apellido	Primer Nombre	Segundo Nombre	FECHA DE NACIMIENTO—Mes/Día/Año

DOMICILIO—Número y Calle	Ciudad	Zona Postal	Escuela

PARTE II PARA SER LLENADO POR EL EXAMINADOR DE SALUD

EXAMEN DE SALUD

AVISO: Todas las pruebas y evaluaciones excepto el análisis de sangre para el plomo deben ser hechas después de la edad de 4 años y 3 meses.

PRUEBAS Y EVALUACIONES REQUERIDAS	FECHA(mm/dd/aa)
Historia de Salud	___/___/___
Examen Físico	___/___/___
Evaluación de Dientes	___/___/___
Evaluación de Nutrición	___/___/___
Evaluación del Desarrollo	___/___/___
Pruebas Visuales	___/___/___
Pruebas con Audiómetro (auditivas)	___/___/___
Pruebas con Tuberculina (Mantoux/PPD)	___/___/___
Análisis de Sangre (para anemia)	___/___/___
Análisis de Orina	___/___/___
Análisis de Sangre para el plomo	___/___/___
Otra	___/___/___

REGISTRO DE INMUNIZACIONES

Aviso al Examinador: Por favor dé a la familia, una vez completado, o a la fecha, el Registro de Inmunización de California en papel amarillo.

Aviso a la Escuela: Por favor apunte las fechas de inmunización sobre el Registro de Inmunización de la escuela de California en papel azul.

VACUNA	FECHA EN QUE CADA DOSIS FUE DADA				
	Primero	Segundo	Tercero	Quarto	Quinto
POLIO (OPV o IPV)					
DTaP/DTP/DT/Td (difteria, tétano y [acellular] pertusis [tos ferina]) O (tétano y difteria solamente)					
MMR (sarampión, paperas, rubéola)					
HIB MENINGITIS (Hemófilo, Tipo B) (Requerida para centros de cuidado para niños y centros preescolares solamente)					
HEPATITIS B					
VARICELLA (Viruelas locas)					
OTRA					
OTRA					

PARTE III INFORMACIÓN ADICIONAL DEL EXAMINADOR DE SALUD *(optional)* *y* PERMISO PARA DIVULGAR (DISTRIBUIR) EL INFORME DE SALUD

RESULTADOS Y RECOMENDACIONES

Llene esta parte si el padre/la madre o el guardián ha firmado el consentimiento para divulgar (distribuir) la información de salud de su niño/niña.

☐ El examen reveló que no hay condiciones que conciernen las actividades de los programas escolares.

☐ Las condiciones encontradas en el examen o después de una evaluación posterior que son de importancia para la actividad escolar o física son: (por favor explique)

Yo le doy permiso al examinador de salud para que comparta con la escuela la información adicional de este examen como es explicado en la Parte III.

☐ Por favor marque esta caja si Ud. no desea que el examinador llene la Parte III.

Firma del padre/madre o guardián ____________ Fecha ________

Nombre, domicilo, y teléfono del examinador

Firma del examinador de salud ____________ Fecha ________

Si su niño o niña no puede obtener el examen de salud llame al Programa de Salud para la Prevención de Incapacidades de Niños y Jovenes (Child Health and Disability Prevention Program) en su departamento de salud local. Si Ud. no desea que su niño(a) tenga un examen de salud, puede firmar la orden (PM 171 B), formulario que se consigue en la escuela de su niño(a).
CHDP website: www.dhcs.ca.gov/services/chdp

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 his 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 started 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.

CCOE's
CHILD DEVELOPMENT PROGRAM
KINDERGARTEN PROGRAM

COPPEROPOLIS ELEMENTARY
217 SCHOOL STREET – COPPEROPOLIS 785-8741
FAC#053613137

We offer a variety of activities that will support your child's development and academic growth during the school year. We provide a safe, fun place to be during the after school hours.

Structured curriculum includes:

Circle Time activities

Music/Movement

Story Time (reading appreciation)

Reinforcement of kindergarten curriculum

Art and Science activities

Social skills development

Development of motor skills and healthy living activities

Our centers provide care from the kindergarten release until 6:00 p.m. during school days.

We are open from 7:00 a.m. until 6:00 p.m. on school in-service days.
We are open at Mark Twain Elementary 7:30-5:30 during the summer.

Program Cost: (for the 2016/2017 year)

Early slot (kindergarten release - 2:00 p.m.) is $100.00 per child, per week.

Early slot + primary slot (kindergarten release -6:00 p.m.) is $135 per child, per week.

In-service/full day is $37.00 per child, per day.

-Summer prices -

3 days per week is $111 per child

4 days per week is $148 per child

5 days per week is $185 per child

Children who will start kindergarten/TK in the fall are eligible for the summer program.