KEEGAN
THE KEEGAN ACADEMY

The Keegan Academy
28780 Single Oak Drive #242
Temecula, CA 92590
www.keeganacademy.org

Enrollment Instructions

To enroll your child at **The Keegan Academy** for the 2012-2013 school year, please complete and print the attached enrollment forms. Bring them along with the additional documentation, listed below, to your enrollment appointment.

If you prefer, forms can be completed and printed at our office. For questions or to schedule an enrollment appointment, please call 951.595.9095.

Enrollment Forms

The enrollment packet for **kindergarten and first grade students** contains the following forms:

- Parent Authorization for Release of School Records
- 2010-2011 Student Registration
- Home Language Survey
- Student Survey Form
- Student Health History
- Emergency Contact Information
- Report of Health Examination for School Entry*
- Oral Health Assessment Form*

* Please note this form is *not* required for **first grade students** who submitted this form upon entering kindergarten.

Additional Documentation

In addition to the completed packet, the following documentation must be submitted to the school office:

- Proof of age (documented by *one* of the following)
  - Original certified birth certificate (Students entering kindergarten must turn five years old on or before December 2, 2010.)
  - Visa
- Proof of residence (documented by *both* of the following)
  - *Current* original utility bill (gas, water, or electric) showing parent/guardian's name and service address
  - Parent/guardian's California driver's license or identification with current address
- Immunization record indicating all required immunizations have been administered and the dates of administration
- Custody information (if applicable)

Tips for Completing the Forms

- You might find it helpful to turn on the "Highlight Fields" button (usually located on the upper-right side of your screen) when completing the forms.
- **Digital signatures:** If you are able to use a digital signature, great. If not, simply sign all documents once the packet has been printed.
- **Printing:** If you prefer to have your packet printed in our office, we are happy to do so. If you are using Adobe Reader 7.0 or later, simply save the completed file, bring it along to your enrollment appointment, and we will print it at that time. Packets can also be emailed to sclause@keeganacademy.org.
- **Reset Button**: Use this button (located at the end of the packet) to clear information from all fields.

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Parent Authorization for Release of Student Records

This document serves as formal approval for the release of all official school records.

Student Information

Student's Full Name: ______________________________

First Middle Last

Student's Date of Birth: ____________ **Student's Home Phone:** ____________

Student's Address: ______________________________

Street City County State Zip

Prior School Information

Name of Prior School: ____________ **District:** ____________

School's Address: ______________________________

Street City County State Zip

School's Phone: ____________ **School's Fax:** ____________

In accordance with the Family Educational Rights and Privacy Act of 1974 and California State Law, I hereby authorize the release to **The Keegan Academy**, all records regarding the psychological, social, educational, and developmental information of the above-mentioned student.

Name of Parent or Legal Guardian: ______________________________

First Last

Signature of Parent or Legal Guardian: ____________ **Date:** ____________

SCHOOL USE ONLY:

Send student records to **The Keegan Academy**
28780 Single Oak Drive #242
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KEEGAN USE ONLY:

Date requested: ____________

Date received: ____________

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2010-2011 Student Registration

Student Information

Name: ______________________________ **2010-11 Grade Level:** ________
First Middle Last

Address: ______________________________ **School District of Residence:** ________
Street City Zip

Phone: ____________ **Date of Birth:** ____________ ◯ **Male** ◯ **Female**

Parent/Guardian Information

List the names of parent(s)/guardian(s) responsible for child's supervision and to whom we may release child.

Name: ____________ **Relationship:** ____________ **Lives with child?** ◯ Yes ◯ No

Address: ______________________________ **Email:** ____________
Street City Zip

Phone: ______________________________
Home Cell Work

Name: ____________ **Relationship:** ____________ **Lives with child?** ◯ Yes ◯ No

Address: ______________________________ **Email:** ____________
Street City Zip

Phone: ______________________________
Home Cell Work

Name: ____________ **Relationship:** ____________ **Lives with child?** ◯ Yes ◯ No

Address: ______________________________ **Email:** ____________
Street City Zip

Phone: ______________________________
Home Cell Work

Custody Information

Are there any custody, visitation, or other orders limiting access to this child? ◯ Yes ◯ No

If yes, specify orders: ______________________________

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Home Language Survey

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

Please respond to each of the questions below as accurately as possible.

Student's Full Name: ______________________________
First Middle Last

What language did your child first learn when he/she began to talk? ____________

What language does your child most frequently speak at home? ____________

What language do you most frequently speak to your child? ____________

What language is most often spoken by adults in the home? ____________

Please describe the language understood by your child. (Check only one.)

- ◯ Understands only the home language and no English.
- ◯ Understands mostly the home language and some English.
- ◯ Understands the home language and English equally.
- ◯ Understands mostly English and some of the home language.
- ◯ Understands only English.

Name of Parent or Legal Guardian: ______________________________
First Last

Signature of Parent or Legal Guardian: ____________________ **Date:** ____________

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Student Survey Form

The following information is required for federal and state testing reports.

Student Name: ____ **Grade:** ________
First Middle Last

Race and Ethnicity Survey

Ethnicity Is the student Hispanic or Latino? *(Select only one.)*

- ○ No, not Hispanic or Latino
- ○ Yes, Hispanic or Latino

Race What is the student's race? *(Select one or more.)*

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ White

Native Hawaiian or Other Pacific Islander

- ☐ Hawaiian
- ☐ Guamanian
- ☐ Samoan
- ☐ Tahitian
- ☐ Other Pacific Islander

Asian

- ☐ Chinese
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Laotian
- ☐ Cambodian
- ☐ Filipino
- ☐ Hmong
- ☐ Other Asian

Mobility Survey

1. Grade level for which you are enrolling your child: ________
2. Grade your child first attended TVUSD: ______________
3. When did your child first attend a public school in California?
   Month: ____________ Year: ________________

*If your child was **not** born in the United States, please answer questions 4-6.*

4. When did your child first enter the United States?
   Month: ____________ Year: ________________
5. From what country did your child enter the United States?
   ____
6. When did your child first attend school in the United States?
   Month: ____________ Year: ________________

Parent Education Survey

Please mark only one area that indicates the education level of the most educated parent or guardian.

- ○ Not a high school graduate
- ○ High school graduate
- ○ Some college (includes any college or AA degree)
- ○ College graduate (must have bachelor's degree)
- ○ Graduate school/post-graduate training (any units beyond bachelor's degree)
- ○ Decline to state or unknown

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Student Health History

Please check the appropriate box to indicate which, if any, of the following conditions apply for the student and give a brief explanation in the space provided below. List all health conditions, including those from previous years. Please notify the school of any changes in your child's health condition or change of medication.

Student's Full Name: ______________________________

First Middle Last

- A1 ☐ Allergy-**SEVERE; requires Epi-Pen/medication**
- A2 ☐ Allergy-bee sting; list symptoms below
- A3 ☐ Allergy-food; list symptoms below
- A4 ☐ Asthma-mild**; requires medication or inhaler**
- A5 ☐ Arthritis (rheumatoid)
- A6 ☐ Asthma-severe; **requires inhaler or daily medication**
- A7 ☐ Attention deficit disorder; **list medication below**
- A8 ☐ Autism
- B1 ☐ Birth defect/chromosome disorder; list below
- B2 ☐ Blind/visually impaired
- B3 ☐ Blood disorder; list below
- C1 ☐ Cancer/leukemia
- C2 ☐ Cerebral palsy
- C3 ☐ Color deficiency
- C4 ☐ Colitis/Crohn's disease
- C5 ☐ Confidential health problem; call school director
- C6 ☐ Cystic fibrosis
- D1 ☐ Deaf/profound hearing loss; list hearing aids if needed
- D2 ☐ Diabetes, insulin dependent; **requires meeting with school director**
- D3 ☐ Diabetes, Type II; call school director
- E1 ☐ Eating disorders/physician diagnosed
- E2 ☐ Endocrine disorder
- E3 ☐ Epilepsy/seizures; list medications below, describe symptoms
- E4 ☐ Growth disorder; explain below
- H1 ☐ Heart disease/defect; explain below
- H2 ☐ Hemophilia; call school director
- H3 ☐ Hydroglycemia/physician diagnosed
- K1 ☐ Kidney disorder/disease; explain below
- M1 ☐ Medication taken at home; explain below
- M2 ☐ Medication needed at school; **requires physician's note**
- M3 ☐ Menstrual problems (severe)
- M4 ☐ Migraine headaches/physician diagnosed; list medication
- M5 ☐ Muscular dystrophy
- N1 ☐ Nosebleeds-severe
- O1 ☐ Osgood-Schlatter disease; physician's note required if activity is restricted
- P1 ☐ Physical activity limitations; list below; **requires physician's note**
- R1 ☐ Rheumatic fever history
- S1 ☐ Scoliosis/physician diagnosed
- S2 ☐ Sickle cell anemia; explain below
- S3 ☐ Speech difficulties
- T1 ☐ Tuberculosis **or history of positive skin tests**; chest x-ray required with positive skin test; list medication
- U1 ☐ Ulcers; list type and medication
- V1 ☐ Vision-impaired/wears glasses/contacts
- Z1 ☐ Other health problems not listed (syndromes, etc.)
- Z2 ☐ **No known health problems**

All medications given at school (prescribed or over-the-counter) require a physician's note. Students carrying inhalers require a physician's note. (Forms are available in the school office.)

Explanation: ______________________________

Do you currently have health insurance? ◯ Yes ◯ No If yes, name of insurance company: ______________

Name of Parent or Legal Guardian: ______________________________

First Last

Signature of Parent or Legal Guardian: ______________ **Date:** ______________

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Emergency Contact Information

Please notify the school immediately if any information on this form changes.

Student Information

Name: ____________________
First Middle Last

Address: ____________________ **Home Phone:** ____________
Street City State Zip

Date of Birth: ____________ **Grade Level:** ____________ ◯ Male ◯ Female

Primary Emergency/Disaster Release Contacts

1. ____________________
Name (First Last) Relationship Home Phone Cell Phone Work Phone Employer
2. ____________________
Name (First Last) Relationship Home Phone Cell Phone Work Phone Employer
3. ____________________
Name (First Last) Relationship Home Phone Cell Phone Work Phone Employer

Additional Release Contacts

1. ____________________
Name (First Last) Relationship Home Phone Cell Phone Work Phone Employer
2. ____________________
Name (First Last) Relationship Home Phone Cell Phone Work Phone Employer
3. ____________________
Name (First Last) Relationship Home Phone Cell Phone Work Phone Employer
4. ____________________
Name (First Last) Relationship Home Phone Cell Phone Work Phone Employer

Custody Information

By court decree, _______________________ is restrained from picking up student from school grounds. (A copy of this decree must be on file in the school office for statement to be honored.)

Medical Release

In the event of an accident or other emergency, when a parent is unavailable, I hereby authorize a representative designated by **The Keegan Academy** to make arrangements as are considered necessary for my child, _________________________, born on __________________, to receive medical or hospital care, including necessary transportation. Under such circumstances I further authorize any licensed physician or surgeon to undertake such care and treatment of my child as he/she considers necessary. I hereby agree to bear all costs incurred as a result of the foregoing.

Name of Parent or Guardian **Signature of Parent or Guardian** **Date**

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.

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 [redacted] yellow California Immunization Record.
Note to School: Please record [redacted] lifornia 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