Sol Aureus College Preparatory

Required School Entry Documents

Dear Prospective S.A.C. Prep Parent,

Thank you for your interest in enrolling your student at Sol Aureus College Preparatory (S.A.C. Prep). Please be sure to complete the Online Application for the school year that you wish to apply for prior to submitting the following required school entry documents.

1. Birth Certificate *(Kindergarten - 8th grade)* ☐
2. Immunization Record *(Kindergarten - 8th grade)* ☐
3. Oral Health Assessment Form *(Kindergarten & 1st grade only)* ☐
4. Report of Health Examination *(Kindergarten & 1st grade only)* ☐
5. TB Skin Test *(Kindergarten only)* ☐
6. Home Language Survey *(Kindergarten/ Foreign Exchanged students)* ☐
7. Photo copy of parents Driver's License/ID *(Kindergarten - 8th grade)* ☐
8. Proof of California Residency ex. utility service statement or payment receipt, pay stub, rental property lease, or payment receipts *(Kindergarten – 8th grade)* ☐
9. Additional documents ex. court order, Medical Authorization Form, IEP, etc. *(Kindergarten – 8th)* ☐

Please Note: If your student is selected in the lottery and all required school entry documents are not submitted by the due date, ***June 29, 2020 by 4:00PM your students registration will be dismissed.*** *If your student is selected after the lottery, all documents are due prior to the first day of enrollment.*

If you have any questions please contact the school office at (916) 421-0600 or email registration@sacprep.org

FOR OFFICE USE ONLY:

Student Name: _____ Grade: _____

DOB: _____/_____/_____

Additional Comments:

_____

_____

_____

Date Submitted: _____ Received By: _____

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.

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	/ /
TB Risk Assessment and Test, if indicated	/ /
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 (e.g., TB Test, if indicated)					
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.

PM 171 A (09/07) (Bilingual)

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

HOME LANGUAGE SURVEY

Name of Student: _____ **Name of School:** _____

Grade: _____

Directions to Parents/ Guardians:

The California Education Code contains legal requirements which direct schools to determine the language(s) spoken in the home of each student. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with this legal requirement. 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) _____

If your child was not born in the United States, please answer the following questions.

1. Where was your child born? _____
2. What was his/her entry date to the first school in the United States? _____

_____ _____

Parent or Guardian Signature **Date**

Sol Aureus College Preparatory

AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION

PART I—TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize Sol Aureus College Preparatory personnel to administer prescribed medication as directed by the physician (Part II below). I agree to release, indemnify, and hold harmless any of their staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided S.A.C. Prep staff are following the physician's order as written in Part II below. I assume the responsibilities as required.

Student: _____ Birthdate: ____/____/____ School: _____

Prescription: ☐ Renewal ☐ New If new, the first full day's dosage was given at home on: ____/____/____

List all medication(s) student is taking:

_____

_____ _____-_____-_____ ____/____/____
Parent/Guardian Signature *Phone Number* *Date*

PART II—TO BE COMPLETED BY THE PHYSICIAN

Sol Aureus College Preparatory discourages the administration of medication to students in school during the school day. Any necessary medication that can possibly be administered before and after school should be prescribed. Only non-parenteral medications are administered. School personnel will, when it is absolutely necessary, administer medication to students during the school day and while participating in outdoor education programs and overnight field trips.

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication: _____ Diagnosis: _____
Trade name and/or generic

Dosage: _____ Time(s) To Be Given At School: _____
Ranges not accepted (i.e. 1 to 2 tabs or 2 to 4 puffs)

Route of Administration_____ Effective Dates: ____/____/____ to ____/____/____

Side Effects: _____

If PRN, specify:
When indicated (signs/symptoms) _____

Frequency of administration _____
Ranges not accepted (i.e. every 2 to 4 hours)

_____ _____ _____-_____-____ ____/____/____
Physician's Name (print) *Physician Signature* *Phone Number* *Date*

SELF-CARRY/SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of medication such as inhalers **must** be authorized by the prescriber and be approved by the school director according to the state medication policy.
Prescriber's authorization for self-carry/self-administration of medication: _____ ____/____/____
Signature *Date*

PART III—TO BE COMPLETED BY THE PRINCIPAL

☐Parts I and II above are completed, including signatures. (It is acceptable if all items of information in Part II are written on the physician's stationery/prescription blank.)
☐Prescription medication is properly labeled by a pharmacist.
☐Medication label and physician order are consistent.

_____ ____/____/____
Director of Operations Signature *Date*