

Student Registration

Student Name: _____ **Gender** **M** **F**
Last First Middle (Circle one) **Grade in Sept.**

Home Address: _____ **Home Phone** _____
Street City Zip
_____/_____/_____
Date of Birth (Month/Day/Year) **Birth Place:** _____
City and State/Country if other than USA

A. Is this student Hispanic or Latino*? Yes, Hispanic or Latino

B. Please continue to answer the following by marking one or more boxes to indicate what you consider the student's race to be.

<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Korean	<input type="checkbox"/> Tahitian
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Laotian	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Black / African American	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Other Asian	<input type="checkbox"/> White
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Hmong	<input type="checkbox"/> Other Pacific Islander	
<input type="checkbox"/> Chinese	<input type="checkbox"/> Japanese	<input type="checkbox"/> Samoan	

Child resides with: Both Parents Parent #1 Parent #2 Step Parent(s) _____ Foster Parent(s) _____

If there are specific custody, guardianship, or living arrangements that we should be aware of in case of emergency, please explain:

Parent/Guardian Information:

Parent #1 / Guardian: _____ Last First	Education Level* <input type="checkbox"/> Not a High School Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> Some College or AA degree <input type="checkbox"/> College Graduate <input type="checkbox"/> Graduate degree or higher
Address (if different than above): _____ Street City State Zip	
Work Phone _____ Cell Phone _____ Email _____	
Employer _____ Employer Address _____	
Parent #2 / Guardian: _____ Last First	Education Level* <input type="checkbox"/> Not a High School Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> Some College or AA degree <input type="checkbox"/> College Graduate <input type="checkbox"/> Graduate degree or higher
Address (if different than above): _____ Street City State Zip	
Work Phone _____ Cell Phone _____ Email _____	
Employer _____ Employer Address _____	

* For State of California required reporting

Has your child ever received Special Education services? Yes No
Has your child ever been enrolled in an English Language Development program? Yes No
How many years has your child been enrolled in any school district in the USA? _____
Has your child ever been retained or repeated a grade? Yes No **Grade level repeated:** _____
Has your child ever had an expulsion or been asked to leave school? Yes No

School Last Attended _____ **Address** _____ **City** _____ **State** _____ **Zip** _____

Signature of Parent or Guardian **Date**

Student Emergency Contact Information

Student Name: _____
Last First Middle Initial

Emergency Contact Information:

In the event of injury or illness, unless otherwise specified the parents will be contacted first. Please indicate the action you want the school to take if injury or illness is of a serious nature and you cannot be reached. If no action is specified, we will call the paramedics via 911 (Emergency).

Please provide (3) additional local contacts we may call in an emergency:

1. _____
Contact (1) Name Address / City Home Phone Cell Phone
May we place the child in the care of this person? _____
2. _____
Contact (2) Name Address / City Home Phone Cell Phone
May we place the child in the care of this person? _____
3. _____
Contact (3) Name Address / City Home Phone Cell Phone
May we place the child in the care of this person? _____

Please provide (1) additional Out-of-State contact we may call in an emergency:

Out-of-State Contact Name Address / City Home Phone Cell Phone
May we place the child in the care of this person? _____

Additional contact information or special instructions

Physician Name: _____		Dentist Name: _____	
Phone _____		Phone _____	
Is this student covered by a health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insurance Carrier _____	Policy Number _____	Hospital _____	
Please advise of any special health considerations, including allergies, medication and treatment requirements: Use additional pages if necessary. Please be specific.			
_____		Religious exemption? _____	

Other children in family:

1. _____
Name: School Grade
2. _____
Name: School Grade
3. _____
Name: School Grade
4. _____
Name: School Grade

Signature of Parent or Guardian

Date

Home Language Survey

California Department of Education Form HLS
Revised July, 2020

Directions to Parents and Guardians:

California Education Code contains legal requirements which direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. 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 these requirements. 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. If an error is made completing this home language survey, you may request correction before your student's English proficiency is assessed.

School

Name: Last First Middle Grade

1. Which language did your child learn when they first began to talk? _____
2. What language does your child most frequently speak at home? _____
3. Which language do you (the parents/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)

Portola Valley School District Use:

Which language would you like us to use when communicating with you? _____

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: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:	Child's race/ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other _____ <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No	Visible Decay Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Urgency: <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) <input type="checkbox"/> Urgent care needed (pain, infection, swelling or soft tissue lesions)
<div style="display: flex; justify-content: space-between; margin-top: 10px;"> _____ _____ _____ </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Licensed Dental Professional Signature CA License Number Date </div>			

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

Privacy law states that schools must keep student health information private: your child's name will not be part of any report. 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.