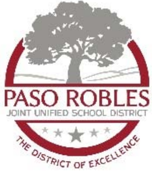

Kindergarten & Transitional Kinder (TK)

Preschool Experience

Student's Name ______________________________________ Gender _____________

Date of Birth ____ Age ______________

Parent's Name _______________________________________

Does your child have an IEP? ☐ Yes ☐ No

My child has preschool experience: ☐ Yes ☐ No

If yes, please indicate which:

☐ Head Start
☐ First 5 Preschool
☐ Family Day Care
☐ Early Learning Academy
☐ Private Preschool
☐ Co-op Preschool
☐ TK-GB WP PB BS or Other

County/State/PRJUSD:

☐ CDC
☐ Bauer Speck
☐ Georgia Brown
☐ Winifred Pifer

Transitional Kindergarten (TK) Only:

All transitional kindergarten classes are balanced number of boys and girls. If you have circumstances that would require your child to be placed in a particular session, please indicate below.

Unfortunately, not all requests for specific times can be accommodated.

____ No preference needed

____ AM TK class 8:10 am – 11:30 am (estimate)

____ PM TK class 10:45 am – 2:30 pm (estimate)

Reason for request (please be specific):

____

____

HEALTH & DEVELOPMENTAL HISTORY FOR KINDERGARTEN ENTRANCE

Student Name:____
Last First Middle

Birth Date:________________
Gender:

Health Care provider/Physician________________
Date of last physical examination________________
Family Dentist________________
Date of last dental examination________________
Child taking any medication?
*Name of medicine:*________________
*Amount*__________ *Frequency* __________
Physical Activities limited
Reason for limitation:
Does child currently receive any of the following?
Speech therapy?
Physical therapy?
Occupational therapy?

CHILD'S ILLNESS/PROBLEMS (Past or present)

	Yes	No		Yes	No
Allergies-Seasonal			Chronic Stomach Aches		
Allergies-Food			Constipation		
Allergies-Medication			Urinary / Kidney Problems		
Hives/Eczema			Immune Deficiency		
Asthma Mild			Cancer		
Asthma Inhaler			Overweight/ Obesity		
Pneumonia			Parasites		
Febrile Seizure			Eye Health Problems		
Epilepsy/ Seizures			Wears Glasses		
Fainting			Heart Problem		
Diabetes/ Insulin			High Blood Pressure		
Diabetes/ without Insulin			Blood Disease		
Physical Disability			Brain Injury		
Syndrome			Chronic Ear Infections		
Speech Problems			Hearing Loss		

Other serious accidents or illness________________
(Describe all YES answers)________________

FAMILY HEALTH

	Name	Please list any Health Issues
Father		
Mother		
Step-Parent		
Others:		
Brothers		
Sisters		

BIRTH HISTORY:

Mother's Pregnancy

	Yes	No
Infections		
Unusual bleeding		
High Blood Pressure/Toxemia		
Diabetes		
Cigarettes, alcohol, or drugs		
Twin or more		

Mother's age at delivery________________
Type of delivery________________
Child's birth weight: ______ pounds ______ ounces
Child's birth condition
Explain any other complications:

DEVELOPMENTAL HISTORY

At what age did your child:

Sit alone__________ Say words__________
Crawl__________ Use sentences__________
Stand alone__________ Toilet train__________
Walk__________ Feed self__________

Does your child:

	Yes	No		Yes	No
Enjoy learning			Jump, run		
Like school			Use scissors OK		
Like other children			Wet bed		
Eat well			Seem shy		
Eat breakfast			Bite nails		
Sleep well			Suck thumb		
Follow directions			Seem overactive		
			Temper tantrums		

What time does your child go to bed?__________
Please list any questions or concerns about your child's health:
____
____
Reactions to discipline________________
____
Has your child been involved with a counselor or therapist?

ILLNESS DURING FIRST <u>30 DAYS</u> OF LIFE

	Yes	No
Trouble breathing		
Seizures		
Cyanosis (blue color)		
Jaundice (yellow color)		
Feeding problems/colic		
Anemia		
Required incubator		
Went home with mother		
Infections: (list)__________		
Birth defect: (list)__________		

________________ Parent/Guarian Signature
________________ Date
________________ Name of School

Paso Robles Joint Unified School District

ENROLLMENT FORM/EMERGENCY CONTACT 20 ___ - 20 ___

STUDENT DEMOGRAPHICS

Student's Legal Last Name	Student's Legal First Name	Student's Middle Name
Alias Last Name	Alias First Name	Student's Nickname

Residence Address	City, State Zip Code
Mailing Address (if different from above)	City, State, Zip Code

Birthdate	Age	Gender	Student's Cell Phone

Is the student Hispanic or Latino? ☐ Yes, Hispanic / Latino ☐ No, Not Hispanic / Latino

Please indicate students Primary Race (1) and Secondary Race (2):

__American Indian/Alaskan Native __Asian Indian __Black or African American __Cambodian __Chinese __Filipino __Guamanian
__Hawaiian __Hmong __Japanese __Korean __Laotian __Other Asian __Other Pacific Islander
__Samoan __Tahitian __Vietnamese __White

STUDENT EDUCATIONAL HISTORY

Has the student ever been previously enrolled at Paso Robles Joint Unified School District (if yes, school:______________________________)?	☐ YES	☐ NO

Please list 3 schools previously attended (if applicable), beginning with the most recent.

1. School/District	City, State	Grade	Public/Private/Cont/Comm
2. School/District	City, State	Grade	Public/Private/Cont/Comm
3. School/District	City, State	Grade	Public/Private/Cont/Comm

Is the student currently enrolled in a **Special Education Program or have an IEP** (if yes, please indicate: _______________________________)?	☐ YES	☐ NO

What special services, if any, does your student receive: ☐ None ☐ Resource (RSP) ☐ Special Day Class (SDC) ☐ Speech & Language ☐ Gifted (GATE) ☐ Migrant Education ☐ Dual Immersion ☐ English Language Development (ELD) ☐ 504 Plan ☐ Other:

Has the student ever been retained or accelerated a grade (if yes, please circle **RETAINED** or **ACCELERATED** and indicate which grade: ______)?	☐ YES	☐ NO
Is the student currently going through the expulsion process or under an expulsion contract (if yes, please attach)?	☐ YES	☐ NO

OTHER SCHOOL AGED CHILDREN IN STUDENT'S FAMILY

Full Name	Birthdate	School/District (if not PRJUSD)	Grade
Full Name	Birthdate	School/District (if not PRJUSD)	Grade
Full Name	Birthdate	School/District (if not PRJUSD)	Grade
Full Name	Birthdate	School/District (if not PRJUSD)	Grade

PARENT/GUARDIAN/CAREGIVER INFORMATION & NOTIFICATIONS

☐ Check here if student is an unaccompanied youth

PRIMARY HOUSEHOLD. Please circle relationship to student: Parent (Mother /Father) / Stepparent / Foster / Guardian / Caregiver / Other:	Are you in the military? YES / NO Branch:	Home Telephone
Full name	Email	Work Telephone
Address	City, State, Zip Code	Cell Phone
SECONDARY HOUSEHOLD. Please circle relationship to student: Parent (Mother / Father) / Stepparent / Foster / Guardian / Caregiver / Other:	Are you in the military? YES / NO Branch:	Home Telephone
Full name	Email	Work Telephone
Address	City, State, Zip Code	Cell Phone

Circle the highest level of student's most educated parent/guardian/caregiver:
Master's/Doctorate Graduate • College/Bachelor's Graduate • Some College/Associate's Degree • High School Graduate • Not a High School Graduate • Decline to state

Communication Language Check the language in which you would like to receive school notifications: ☐ English ☐ Spanish ☐ Other:

Are there any court orders regarding legal custody, physical custody, restricted contact with school or child (if yes, please attach)?	☐ YES	☐ NO
I give the school/district permission to send text messages to my cell phone.	☐ YES	☐ NO
I give the school/district permission to publicly share newspaper and/or internet articles and photos related to the achievements of my child.	☐ YES	☐ NO
I give the school/district permission to share my student's information with military recruiters (high school only).	☐ YES	☐ NO
I have received, read, & agree with the Computer & Network Info. Resource Acceptable use Agreement for Student.	☐ YES	☐ NO
I have read the Annual Parent & Student Rights Notification available on our District website (www.pasoschools.org).	☐ YES	☐ NO
I have received and read the Pesticide Notification.	☐ YES	☐ NO

HEALTH & EMERGENCY INFORMATION

☐ **Check if student has NO KNOWN medical conditions.**

☐ **Check here if student HAS KNOWN MEDICAL CONDITIONS AND complete section below.**

Medical Conditions (circle all that apply and attach a doctor's note): **Seasonal Allergies/Food • Allergies • Diabetes • Heart Problem • Epilepsy • Asthma • Inhaler Required • Orthopedic Limitations • P.E. Limitations • Special Diet/Restrictions •Other conditions** (please specify):

Medications including name(s) & dosage(s):

*In case of illness/emergency only, if parent/guardian cannot be reached, the following people may be called in the order listed below and/or may pick up student from school or activities. Listing an individual below **does not** authorize that individual to call for off-campus permits.*

Full Name	Relationship to student	Primary Number	Secondary Number
Full Name	Relationship to student	Primary Number	Secondary Number
Full Name	Relationship to student	Primary Number	Secondary Number

Paso Robles Joint Unified School District may bill Medi-Cal for LEA services provided to Medi-Cal eligible students. These billings will not result in any cost to your family. If you do not want the district to bill Medi-Cal or other third parties for LEA services provided to your child, please notify the district in writing.

Medical Doctor	Telephone	Insurance Company	Policy No.

As a parent/guardian/caregiver I understand that Paso Robles Joint Unified School District DOES NOT provide medical insurance covering students for accidents or school related injuries. I authorize the Paso Robles Joint Unified School District's authorized personnel to obtain emergency medical care for this student in the event of an accident /injury. I verify that the above information is accurate.

Parent/Guardian/Caregiver Signature	Date	Parent/Guardian/Caregiver Signature	Date
Student Signature (if student is over 18 years old or an unaccompanied youth)	Date		

PASO ROBLES

MIGRANT EDUCATION PROGRAM
PROGRAMA DE EDUCACIÓN MIGRANTE
STUDENT SURVEY - ENCUESTA ESTUDIANTIL

For more information and details about the program please read the back of this form.
Para información más detallada sobre este programa favor de leer la parte de atrás de esta forma.

To determine if your family qualifies for the services of Migrant Education Program please answer the following questions. ***Para determinar si su familia califica para recibir los servicios de Programa de Educación Migrante por favor conteste las siguientes preguntas:***

1. Have you moved within the past 3 years, even for a short time? Yes_______ No______
   ¿Usted se ha mudado en los últimos (3) años aunque sea por un corto tiempo? ***Si_______ No______***

2. When you moved, did you move from one school district to another Yes_______ No______
   ¿Cuándo usted o su familia se mudaron fue de un distrito escolar a otro? ***Si_______ No______***

3. Did you move so that a member of your family could find work in agriculture, livestock or fishing? Yes_______ No______
   ¿Usted o su familia se mudaron para que un miembro de su familia pudiera encontrar trabajo en la agricultura, (el campo), ganadería o pesca? ***Si_______ No______***

4. Where do you presently work?____
   ¿Dónde trabaja usted ahora?____

5. Have you ever worked in agriculture, livestock or fishing? Yes_______ No______
   ¿Usted o su pareja han trabajado en agricultura, (el campo) ganadería o pesa? ***Si_______ No______***

Student Name ____ Day____________________
Nombre del Alumno ***Fecha***

Parent/Guardian ____ Grade ________________
Padre o Tutor ***Grado***

Address ______________________________ Phone __________________ Cell____________________
Domicillo ***Teléfono*** ***Celular***

Siblings ______________________________ ______________________________
Hermanos
______________________________ ______________________________

Completed by migrant office staff

Action taken by____

_______Enrolled Date of Interview______________________________________
_______Not Enrolled Reason ______________________________________
____

Comments:____

Migrant Education Program: Migrant Education is a federal program for eligible migrant children. The purpose of the program is to provide high quality educational programs and services for migratory students and their families. The program focuses mainly on the educational needs of migrant children and tries to reduce barriers to successful educational achievement. For more information, call the local office of the migrant program at (805) 769-1380 or the district office (805) 769-1000.

A child is considered “migrant” if the parent or guardian is a migratory worker in the agricultural, dairy, or fishing industries and whose family has moved during the past three years. A “qualifying” move can range from moving across school district boundaries or from one state to another for the purpose of finding temporary or seasonal employment. A young adult may also qualify if he/she has moved on his/her own for the same reason.

Programa de educación migrante: Educación Migrante es un programa federal para niños migrantes elegibles. El propósito del programa es proporcionar a los estudiantes migrantes programas educativos de alta calidad y servicios para estudiantes migratorios y sus familias. El programa se centra principalmente en las necesidades educativas de los niños migrantes y trata de reducir las barreras para logar el exitoso educativo. Para obtener más información, llame a la oficina local del programa migrante al (805) 769-1380 o a la oficina del distrito al (805) 769-1000.

Un niño se considera "migrante" si el padre o tutor es un trabajador migratorio en las industrias lácteos, agricultura, o de la pesca y cuya familia ha mudado durante los últimos tres años. Un movimiento de “calificación” puede variar de movimiento a través de los límites del distrito escolar o de un estado a otro con el propósito de encontrar un empleo temporal o estacional. Un joven adulto puede también calificar si él o ella se han movido por la cuenta por la misma razón.

Paso Robles Joint Unified School District
Home Language Survey

Student's Last Name__________________ First Name __________________

Last Alias__________________ First Alias __________________

Grade ____________ Date of Birth ____________Gender ____________

Name of Last School Attended__________________________________

District __________________ City/State __________________

Parent/Guardian__________________________________

Address__________________________________

Home Telephone__________________ Cell Phone__________________

California Education Code § 52164.1(a) requires schools to determine the language(s) spoken in the home of each student. This information is essential in order for schools to provide meaningful instruction for all students. ***If a language other than English is spoken in the home the district is required to do further assessment of your student.*** *<u>Please respond with one language per question.</u>*

1. Which language did your son/daughter learn when he/she first began to speak?__________________
2. What language does your son/daughter most frequently speak at home? __________________
3. What language do you most frequently speak to your son/daughter?__________________
4. What language do the adults in your home most frequently speak? __________________

If applicable, please indicate number of years in U.S.

☐ 1 year or less ☐ 3 years or less ☐ 4 years or more

As a parent/guardian, I verify that the above information is accurate.

Signature __________________________ Date __________________

PASO ROBLES JOINT UNIFIED SCHOOL DISTRICT

CONFIDENTIAL FORM

Student Residency Questionnaire

This document is intended to comply with the McKinney-Vento Assistance Act 42 USC § 11434a. The answers help determine the services that your student may be eligible to receive.

Student Name:____Gender: ____________

School:_______________________________Grade: ________ DOB: _______________ Age: __________

Name of Parent / Guardian:_____________________________ Phone: (______) ______________________

Address / Current Location: ____

Siblings (name, school, grade, DOB, age): ____

____

____

____

Student lives with:

☐ Parent(s) / Legal Guardian ☐ Relative ☐ Adult who is NOT the parent/legal guardian
☐ Foster Parent ☐ Friend ☐ Unaccompanied minor (not in custody of legal guardian)

Do you and your student live in a permanent home or apartment? ☐ Yes ☐ No

Do you or your student meet one of the following conditions for the McKinney Vento Homeless Assistance Act:

☐ Lack a fixed, regular nighttime residence
☐ Live with a friend or relative due to loss of housing and/or economic hardship
☐ Live in a motel/hotel (provide name: ____________________________________)
☐ Live in an emergency shelter, transitional shelter, domestic violence shelter, or group home (name of program: ______________________________________)
☐ Live in a car, recreational vehicle/trailer, park, or campground
☐ Other: ____

Students experiencing homelessness will not be removed from parent/guardian solely because the family is experiencing homeless.

Our District may be able to provide assistance in the following areas. Please check areas of need, if any:

☐ School Supplies ☐ Backpacks ☐ Hygiene Kits
☐ Early Childhood Education/Pre-school ☐ Education Advocacy ☐ Food Pantries
☐ Counseling (emotional, substance abuse) ☐ School Clothing Assistance ☐ Housing Assistance
☐ Free Breakfast/Lunch Program ☐ Transportation Assistance ☐ Medical/Dental/Health
☐ Other: (please indicate) ____

May we provide your name and contact information to outside resources or groups that may be able to provide additional services? ☐ Yes ☐ No

Parent / Guardian: ____ Date:_______________________

Please return this form to your student's school office or the District Office.

For District Office Use Only:

☐ Foster Youth

☐ Student DOES qualify for McKinney-Vento ☐ Student DOES NOT qualify for McKinney-Vento

Approved By:_____________________________ Date ______________________________________