Enrollment Form
Santa Cruz City Schools

Please Print All Information School of enrollment:_____

Student name on birth certificate: _____
Last First Middle

Grade: _____ Birth date: ____/_____/_____ Soc. Sec. #: _____ Gender: ▫ Male ▫ Female
M D Y

Street Address: _____
Number Street Name Apt. #

City: _____ Zip Code: _____ Phone Number: (_____)_____

Student Cell Phone: (_____)_____ Student email: _____

Mailing Address (if different): _____
Number Street Name Apt. #

City: _____ Zip Code: _____

Is this a permanent, regular, and adequate nighttime residence? (NOT a motel, campground, shelter or living with friends or family out of necessity, not by choice) □ *Yes* □ *No*

Is the student in foster care? □*Yes* □ *No*

Birthplace: _____
City State Country

Original entry *date* in US schools: ____/_____/_____ Original entry *date* in California schools: ____/_____/ _____
M D Y M D Y

Original entry *date* in this district: ____/_____/_____
M D Y

Has the student ever been retained? □ Yes □ No If yes, list grade repeated: _____

Prior Grade Completed:_____

Previous two schools attended (please complete fully):

School Name: _____ School Name: _____

Street Address: _____ Street Address: _____

City & State: _____ City & State:_____

Zip Code: _____ Phone: (_____) _____ Zip Code: _____ Phone: (_____) _____

Dates Attended: _____ Dates Attended:_____

Student Ethnicity: You must check at least one. (This is a federal and state requirement.)

□ Hispanic or Latino □ Not Hispanic or Latino

The above question is about ethnicity, not race. No matter what you selected above, please also answer the following by marking one or more boxes to indicate what you consider your race to be.

Student Race (Check all that apply. You must check at least one. This is a federal and state requirement)

Black or African American □ American Indian or Alaska Native □

Asian: □ Chinese □ Japanese □ Korean □ Vietnamese □ Asian Indian □ Laotian □ Cambodian □ Filipino

□ Hmong □ Other Asian

Native Hawaiian or other Pacific Islander: □ Hawaiian □ Guamanian □ Samoan □ Tahitian □ Other Pacific Islander

□ White: Hispanic or Latino □ White: Not Hispanic or Latino

For students entering after Kindergarten. Check any program in which student has participated.

□ GATE □ **Special Education: Date of Last IEP**: _____(please provide copy)

□ Speech. (attach copy of current IEP) □ Migrant □ **504 Accommodation Plan (provide copy)**

Has the student ever been referred to the School Attendance Review Board (SARB)? □ Yes □ No

Has the student ever been referred to a school disciplinary meeting? □ Yes □ No

List names, schools, and grade levels of all children living at home: _____

_____

Parent/Guardian Information (Complete one section for each adult. If legal guardian, attach documentation.)

Name (at primary residence): _____ Relationship: _____

Employer: _____ Does the student live with this Parent/Guardian? ☐ Yes ☐ No

Phone Numbers: _____ _____ _____
Home Work Message, Pager, or Cell

Email Address: _____ Language Preferred for Mailings __ English __ Spanish

Highest Educational Level:
☐ Not a High School Graduate ☐ High School Graduate ☐ Some College ☐ College Graduate ☐ Graduate School

Name: _____ Relationship: _____

Address (if different than student's primary residence): _____

If address is different, does this person request duplicate mailings? ☐ Yes ☐ No Language Preferred _English _ Spanish

Employer: _____Does the student live with this Parent/Guardian? ☐ Yes ☐ No

Phone Numbers: _____ _____ _____
Home Work Message, Pager, or Cell

Email Address: _____

Highest Educational Level:
☐ Not a High School Graduate ☐ High School Graduate ☐ Some College ☐ College Graduate ☐ Graduate School

Name: _____ Relationship: _____

Address (if different than student's primary residence): _____

If address is different, does this person request duplicate mailings? ☐ Yes ☐ No Language Preferred _English _ Spanish

Employer: _____Does the student live with this Parent/Guardian? ☐ Yes ☐ No

Phone Numbers: _____ _____ _____
Home Work Message, Pager, or Cell

Email Address: _____

Highest Educational Level:
☐ Not a High School Graduate ☐ High School Graduate ☐ Some College ☐ College Graduate ☐ Graduate School

Specify arrangements, if shared custody: _____

_____

Is there anything else about your child that you would like us to know? _____

_____

Signature of Parent/Guardian: _____ Date: ____/_____/ _____
M D Y

For Office Use Only: Student #: _____ Entry Date: _____

☐ BD verified ☐ Residence verified ☐ Immunizations ☐ CHDP ☐ Migrant ☐ Declaration of Residency

SAAZ zone _____ ☐ Caregiver Affidavit ☐ Open Enrollment ☐ Inter-district Transfer

Counselor/Teacher/Team: _____

SANTA CRUZ CITY SCHOOLS **HOME LANGUAGE SURVEY** **Date:** _____ **School** _____
Encuesta de idioma del hogar Fecha Escuela

School Year (año escolar) _____

Name of Student: _____ **Age** _____ **Birth date** _____ **Grade**_____
(Nombre del Estudiante): **Last** (Apellido) **First** (Primer Nombre) **Middle** (Segundo Nombre) (Edad) (Fecha de Nacimiento) (Grado)

Birthplace: _____ **Last School Attended:** _____
(Lugar de Nacimiento): **City** (Ciudad) **State/County** (Estado/País) (última escuela que asistió): **Name** (Nombre) **City/State/Country** (Ciudad/Estado/País)

A Home Language Survey (HLS) is used to determine a student's primary language and is on file for each student in the District, including Migrant, Special Education and continuation school enrollees. Your assistance in providing accurate information is requested.
Please answer all the questions and sign below.

1. Which language did your child learn when he/she first began to speak? _____
2. What language do you use most frequently to speak to your child? _____
3. What language does your child most frequently use at home? _____
4. Name the language most often spoken by the adults at home. _____
5. What year and in what state did your child enroll in a school in the USA for the first time? _____
6. Have you moved within the past 3 years, even for a short time? _____
7. Did you move so that you or a member of our family could find work in agriculture? _____

Each student whose home language is other than English as determined on this form will be assessed in English listening, speaking, reading and writing. You will receive a letter with your child's results and program placement recommendation.

Do you prefer communication from your school in: ☐ English ☐ Spanish ?

Una encuesta de idioma del hogar es usada para determinar el primer idioma y está archivada para cada estudiante en el distrito, incluyendo estudiantes inscritos como migrantes o en Educación Especial. Se solicita su ayuda en proveer la información correcta.
Por favor conteste todas las preguntas y firme abajo.

1. Cuando su hijo empezó a hablar. ¿cuál idioma aprendió primero? _____
2. Cuando usted habla con su hijo. ¿Qué idioma usa con más frecuencia? _____
3. En casa. ¿Qué idioma habla su hijo con más frecuencia? _____
4. Mencione el idioma que hablan los adultos con más frecuencia en la casa. _____
5. ¿En qué año y en qué estado inscribió a su hijo por primera vez en una escuela de los Estado Unidos? _____
6. ¿Se ha mudado de domicilio durante los últimos 3 años aunque sea por un período corto? _____
7. ¿Se mudó para que usted o algún miembro de su familia obtuviera trabajo en la agricultura? _____

Cada estudiante para quien su idioma del hogar es diferente al inglés por determinación de este formulario será evaluado en escuchar, hablar, leer y escribir en ingles. Ud. recibirá una carta con los resultados y la recomendación del programa en que se ubicara a su hijo.

¿Usted prefiere comunicación de la escuela en: ☐ Ingles ☐Español?

Parent/Guardian Signature: _____ Address: _____ Phone: _____
Firma De Padre/Tutores Domicilio Teléfono

CA Ed Code S52164.1(a) Distribution: ***Original Student's Cum*** Copy to: ***AECP*** sent on _____ Revised 2/5/15

STUDENT EMERGENCY INFORMATION

Student Last Name: **First:** **MI:** **M F Birthdate: / / Grd:**

Parent/Guardian ❍ Change of Address

Name_____
❍Mother ❍Father ❍Other_____

Home Address _____

_____
Does child live with this parent? ❍Yes ❍No

_____
Main/Daytime Contact Phone ❍Home ❍Cell ❍Work

_____
Other Contact Phone ❍Home ❍Cell ❍Work

_____
Email Address

_____
Employer

Parent/Guardian ❍ Change of Address

Name_____
❍Mother ❍Father ❍Other_____

Home Address _____

_____
Does child live with this parent? ❍Yes ❍No

_____
Main/Daytime Contact Phone ❍Home ❍Cell ❍Work

_____
Other Contact Phone ❍Home ❍Cell ❍Work

_____
Email Address

_____
Employer

Does parent/guardian speak English? ❍Yes ❍No Language Spoken at home? ❍English ❍Spanish ❍Other _____
Are there custody arrangements? ❍Yes (Please attach documents) ❍ No

List siblings attending any Santa Cruz City School:
Name _____ School _____ Grade _____
Name _____ School _____ Grade _____
Name _____ School _____ Grade_____

If we are unable to reach you, we MUST have 3 LOCAL contact persons who you authorize to pick your child up from school if: your child is ill, needs medical attention or must be evacuated due to a natural disaster.

Name _____ Relationship _____ Ph#s _____ _____ _____
Day Cell Pager

Name _____ Relationship _____ Ph#s _____ _____ _____
Day Cell Pager

Name _____ Relationship _____ Ph#s _____ _____ _____
Day Cell Pager

Does your child have any medical conditions? ˜ADHD ˜ Asthma ˜ Allergies ˜ Diabetes ˜ Hearing loss ˜ Heart condition
˜Depression ˜ PTSD ˜ Other _____ Describe _____

Primary Doctor _____ Ph# _____ Dentist _____ Ph# _____
Mental Health Practitioner _____ Ph# _____ Medication prescription? ˜ Yes ˜ No

Does your child currently have medical insurance? ˜ Yes ˜ No Insurance carrier _____
If none, would you like information on free and/or low-cost health insurance? ˜ Yes ˜ No

IN CASE OF AN EMERGENCY (serious illness or injury), when I cannot be reached, I hereby authorize SCCS personnel to obligate me for services of a local doctor/hospital for my child.

Release of information to Santa Cruz Educational Foundation (SCEF) The SCEF is a non profit group which conducts fundraising on behalf of the Santa Cruz City Schools. Your email will be released to the SCEF UNLESS you specify you want this information withheld.
o Do NOT release my email to the SCEF.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

< < Please notify the school immediately of any change in the above information > >

Revised 1/15

2015-16
Santa Cruz City Schools
Student Health History

_____ _____ ____ _____ _____ M ☐ F☐

Student's Last Name First Initial Birthdate Grade

Doctor:_____ Dentist:_____ Medical Insurance Provider _____

►►1.☐ CHECK THIS BOX IF STUDENT HAS NO KNOWN HEALTH PROBLEMS & SIGN BELOW.

2. *Check boxes below that apply to your student and sign below.*

☐ ***Diabetes** Type 1☐ Type 2☐ Medications? Oral☐ Injection☐ Pump☐ Given at school? Yes☐ No☐
Name of medication?_____ MD's Name/Phone#_____

☐ ***Allergic Reactions** To what?_____ Hives /rash? Yes☐ No☐
Difficulty breathing? Yes☐ No ☐ Has Epipen? Yes☐ No ☐
MD's Name/Phone#_____

☐ *** Seizure Disorder** Date of last seizure?_____ Requires Medication? Yes ☐ No☐
Name of Medication?_____ MD's Name/ Phone#_____

☐ **Orthopedic conditions** Any physical limitations? _____
Wheelchair? ☐ Corrective shoes/braces? ☐ Crutches?☐

☐ **Asthma** Requires medication/ inhaler? Yes☐ No☐ Name of medication_____
Given at school? Yes ☐ No☐ MD's Name/ Phone#_____

☐ **Heart Problems** Diagnosis: _____MD's Name/Phone#_____
Medications ? Yes ☐ No☐ Physical Restrictions Yes ☐ No☐

☐ **Mental Health** Anxiety, Depression PTSD Diagnosis:_____ Under care? Yes☐ No☐
Medications:_____ MD/Therapist Name/Phone#_____

☐ **ADHD** Requires medication Yes☐ No☐ Name of medication_____
Given at school? Yes☐ No ☐ MD's Name/Phone #_____

☐ **Hospitalizations** Explain:_____

☐ **Taking medication?** For what condition?_____ Name of medication_____
Given at school? Yes☐ No☐ MD Name/Phone#_____

☐ **Vision Problems** Wears glasses?☐ Contacts? ☐ Reading only?☐ All the time? ☐ Date of last exam_____

☐ **Hearing Problems** Permanent Hearing Loss? ☐ Hearing aid? Left☐ Right☐ Both☐ Date of last exam_____

Please list other important health or behavior information:_____

_____

These conditions require a Health Care Plan. Note: Any of the above conditions may require a Health Care Plan. All forms can be obtained from the School Health Office

Parent Name_____ **Parent signature**_____

Date_____ **Best phone number to reach parent**_____

405 Old San Jose Road, Soquel, California 95073 | (831) 429-3410 | www.sccs.santacruz.k12.ca.us

Kris Munro *Superintendent of Schools*
Molly Parks *Assistant Superintendent Human Resources*
Jim Monreal *Assistant Superintendent Business Services*
Angela Meeker *Assistant Superintendent Educational Services*

K-5th Grade School Entry Requirements – Health

Dear Parent or Guardian:
As your child prepares to enter school, it is also the time to take a look at your child's health. About 10% of children entering school have a health problem that is unknown to their parents. Below are the health requirements that California law requires for school entry.

1. **Health Examination Requirement (CHDP) Child Health and Disability Program**
A thorough health examination is required for all children entering school. This health check-up may be completed any time from 18 months before entering first grade to 90 days (and no later) after starting first grade. The **"Report of Health Check-up for School Entry"** form must be completed and signed by your child's doctor and returned to the school health office. In order to save time parents, are urged to have their child examined before starting kindergarten since immunization boosters are needed at this time.

NOTE: All children who are eligible for Medi-Cal are eligible for this health check-up at no cost. Some children are eligible to receive a CHDP health check-up at no cost to their family, depending on the family's size and income. If you want to find out if your child is eligible, call the Santa Cruz County Health Services Agency **(CHDP)** at **(831) 763-8100.**

2. **Oral Health Examination**: To make sure your child is ready for school, California law, *Education Code* Section 49452.8, now requires that your child have an oral health assessment (dental check-up) by May 31 in either kindergarten or first grade, whichever is his or her first year in public school. Assessments that have happened within the 12 months before your child enters school also meet this requirement. The law specifies that the assessment must be done by a licensed dentist or other licensed or registered dental health professional. The following resources will help you find a dentist and complete this requirement for your child:

- Medi-Cal/Denti-Cal's toll-free number or Web site can help you to find a dentist who takes Denti-Cal: 1-800-322-6384; http://www.denti-cal.ca.gov . For help enrolling your child in Medi-Cal/Denti-Cal, contact your local social service agency at (831) 454-4165.
- For additional resources that may be helpful, contact the local public health department at (831) 454-4000.

3. **Immunization Requirements**

At registration, you will need an **immunization record** showing that your child has received all the required immunizations to enroll.

4 Polio (3 doses if 3rd dose given on or after 4th birthday)
5 DPT (4 doses if 4th dose given on or after 4th birthday)
2 MMR (both doses must be given on or after 1st birthday)
3 Hepatitis B
1 Varicella or documentation of Chickenpox disease

Rev. 1/5/2015

State of California—Health and Human Services Agency
Primary Care and Family Health Division

Department of Health Services
Children's Medical Services Branch
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	BIRTHDATE—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
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.

State of California—Health and Human Services Agency
Primary Care and Family Health Division

Department of Health Services
Children's Medical Services Branch
Child Health and Disability Prevention (CHDP) Program

WAIVER OF HEALTH EXAMINATION FOR SCHOOL ENTRY

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

ADDRESS—Number/Street	City	ZIP Code	SCHOOL	Teacher

PARENT OR GUARDIAN:

Please fill out this form if you want to excuse your child from the health examination required by California law for school entry. ***SIGN AND RETURN THIS FORM TO THE SCHOOL*** where it will be maintained as confidential information.

NOTE: SIGNING THIS WAIVER ***DOES NOT*** EXCUSE YOUR CHILD FROM RECEIVING THE IMMUNIZATIONS REQUIRED BY CALIFORNIA LAW FOR CHILDREN IN SCHOOL. ALSO, SIGNING THIS WAIVER WILL NOT DENY YOUR CHILD THE VISION AND HEARING TESTS DONE BY THE SCHOOL.

I have been informed about the health examination recommended by health professionals and required by state law. I have been informed about where my child can receive a health examination and about the income levels for receiving it at no cost to me.

Please check one of the following:

❒ I choose not to have my child receive a health examination as a part of the school entry requirement.

❒ I would like my child to receive a health examination, but I am unable to obtain it.

Reason (see Health and Safety Code, Section 124085):

_____

Signature of parent or guardian — Date

INQUIRE AT THE SCHOOL OFFICE OR YOUR LOCAL HEALTH DEPARTMENT IF YOU WANT MORE INFORMATION.

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.

405 Old San Jose Road, Soquel, California 95073 | (831) 429-3410 | www.sccs.santacruz.k12.ca.us

Kris Munro
Superintendent of Schools

Molly Parks
Assistant Superintendent Human Resources

Jim Monreal
Assistant Superintendent Business Services

Angela Meeker
Assistant Superintendent Educational Services

New Enrollee: Immunization Personal Beliefs Waiver Update (not TK, KN, or 7th Grade)

Beginning January 2014, all students who are new to our district and

1. Are arriving from out of state or out of the country or from a non public school
2. And are in grades 1-6 or grades 8-12

who are requesting a Personal Beliefs Exemption to any immunization, must provide their child's school with:

- The California Department of Public Health form (CDPH 8262), signed and dated by a health care practitioner and parent indicating that the practitioner has provided, and the parent has received, information about the benefits and risks of immunizations and the risks of vaccine-preventable diseases.
- This form is available at your child's school and at most doctors' offices. No other forms will be accepted.
- This form must be signed no sooner than six months before a student first day of attendance. For example, if school begins on September 1, the documentation could be signed on or after March 1 but not before.
- This form, replaces the Tdap Personal Beliefs Waiver form.

PERSONAL BELIEFS EXEMPTION TO REQUIRED IMMUNIZATIONS

STUDENT NAME (LAST, FIRST, MIDDLE) GENDER ☐ M ☐ F	BIRTHDATE MONTH DAY YEAR __ __ / __ __ / __ __ __ __	TELEPHONE NUMBER
PARENT/GUARDIAN – NAME	ADDRESS	

A. AUTHORIZED HEALTH CARE PRACTITIONER LICENSED IN CALIFORNIA – FILL OUT THIS SECTION

I am a (check one): ☐ M.D./D.O. ☐ Nurse Practitioner ☐ Physician Assistant ☐ Naturopathic Doctor ☐ Credentialed School Nurse

Provision of information: I have provided the parent or guardian of the student named above, the adult who has assumed responsibility for the care and custody of the student, or the student if an emancipated minor, with information regarding 1) the benefits and risks of immunization and 2) the health risks to the student and to the community of the communicable diseases for which immunization is required in California (immunizations listed in Table below).

_____
Signature of authorized health care practitioner

_____
Date - within 6 months before entry to child care or school

Practitioner name, address, telephone number:

B. PARENT OR GUARDIAN – FILL OUT THESE SECTIONS

I. Check one of the boxes below:

☐ **Receipt of information:** I have received information provided by an authorized health care practitioner regarding 1) the benefits and risks of immunization and 2) the health risks to the student named above and to the community of the communicable diseases for which immunization is required in California (immunizations listed in Table below).

☐ **Religious beliefs**: I am a member of a religion which prohibits me from seeking medical advice or treatment from authorized health care practitioners. (Signature of a health care practitioner not required in Part A.)

_____ _____
Signature of parent or guardian **Date - within 6 months before entry to child care or school**

II. AFFIDAVIT

Immunizations already received: I have provided the child care or school with a record of all immunizations the student has received that are required for admission (California Health and Safety Code §120365).

Immunizations for which exemption is requested: An unimmunized student and the student's contacts at school and home are at greater risk of becoming ill with a vaccine-preventable disease. I understand that an unimmunized student may be excluded from attending school or child care during an outbreak of, or after exposure to, any of these diseases for the protection of the student and others (17 CCR §6060). I hereby request exemption of the student named above from the required immunizations checked below because such immunization is contrary to my beliefs.

School Category	Table of Required Immunizations – Check box(es) to request exemption.
Child Care Only	☐ ***Haemophilus influenzae* type b** (Hib meningitis)
Child Care and K-12th Grade	☐ **DTaP** (Diphtheria, Tetanus, Pertussis [whooping cough]) ☐ **Hepatitis B** ☐ **MMR** (Measles, Mumps, Rubella) ☐ **Polio** ☐ **Varicella** (Chickenpox)
7th Grade Advancement (or admission at 7-12th Grade)	☐ **Tdap** (Tetanus, reduced Diphtheria, Pertussis [whooping cough])

_____ _____
Signature of parent or guardian **Date**

The California Department of Public Health places strict controls on the gathering and use of personally identifiable data. Personal information is not disclosed, made available, or otherwise used for purposes other than those specified at the time of collection, except with consent or as authorized by law or regulation. The Department's information management practices are consistent with the Information Practices Act (Civil Code Section 1798 et seq.), the Public Records Act (Government Code Section 6250 et seq.), Government Code Sections 11015.5 and 11019.9, and with other applicable laws pertaining to information privacy.