CUTTEN ELEMENTARY SCHOOL DISTRICT
Ridgewood School · 2060 Ridgewood Drive · 441-3930 · Grades TK - 2

Ridgewood School
Transitional Kindergarten and Kindergarten Registration

Let the learning adventure begin . . . with paperwork!
Thank you for your attention to these details.

Return pages 1, 2 and 3, proof of age (all students).

Provide proof of residency (in district only) as soon as possible.

Verification of immunizations must be received by the school office prior to the first day of attendance.

☑ **Pages 1, 2 and 3** These three pages ask for important information such as your address and phone numbers, home language, emergency contacts, and health needs.

☑ **Proof of residency – 2 items** Original utility bill with parent / guardian name and address (other specified documents, if these are unobtainable) to show Cutten Elementary School District residency. Parents/guardians employment within the district boundaries for ten hours a week or more establishes district residency. Please submit an official document that verifies the employment. If you live outside the Cutten Elementary School District, please complete the **Application for Interdistrict Transfer Permit** and take it to your school district of residence. Once approved or denied, the permit returns to the Cutten School District office.

☑ **Proof of age** – birth certificate, duly attested baptismal certificate or passport

TK	Children whose fifth birthday falls on or between September 2 and December 2, 2021.
Kindergarten	Children who are five years of age on or before September 1, 2021.

☑ **Verification of Immunizations** – required prior to the first day of school attendance

Polio	At least three doses. If the third one was given before the child's fourth birthday, a fourth one is required.
DPT	At least four doses. If the fourth one was given before the child's fourth birthday, a fifth one is required.
MMR	(Measles, mumps & rubella) Two doses required, on or after the child's first birthday.
Hepatitis B	Three doses required for kindergarten entry.
Varicella	(Chickenpox) One dose required, or documentation from a health care provider that the child has had the disease.

☑ **Physical examination** completed within the six-month period before entering school. Take the attached form to your health care provider and return the completed form to school.

☑ **Oral health assessment** completed within the twelve-month period before entering school, and May 31 of the TK / K year. Take the attached form to your dentist or licensed dental health professional and return the completed form to school.

For your calendar . . .

Wednesday, February 10
Parent Orientation
Virtual Zoom Event
We will share all about our school!
6:30 p.m. to 7:30 p.m.
RSVP 441 – 3930

Wednesday, May 12 or
Thursday, May 13
(2 sessions) *
Spring into TK & Kindergarten!
Stories, Crafts, Games & Music
6:30 p.m. to 7:45 p.m.
RSVP 441 – 3930

TBA
Ridgewood School Open House
Visit the Entire School
6:30 p.m. to 7:30 p.m.
No need to RSVP

*We hope we can host this event on campus but will arrange for an alternative, if necessary.

2021-22
Cutten Elementary School District
4182 Walnut Drive, Eureka, CA 95503

Ridgewood School Grades TK – 2 (707) 441-3930
Cutten School Grades 3 – 6 (707) 441-3900

①

- **Submit immunization record and birth certificate at time of registration.**
- **IN DISTRICT ONLY: Submit TWO documents that show proof of residency at time of registration.**
- **Student's legal name:** _____
  Please print — last name — first name — middle name

  Grade entering: _____ ☐ Female ☐ Male ☐ _____ Date of birth: ___ ___ / ___ ___ / ___
  month day year

  Name student goes by if different than above: _____

  Home address: _____

  Mailing address: _____

- **Mother**: _____ Home phone: _____
  Address: _____ Cell phone: _____
  Employer: _____ Occupation: _____ Work phone: _____
  Email address: _____

- **Father**: _____ Home phone: _____
  Address: _____ Cell phone: _____
  Employer: _____ Occupation: _____ Work phone: _____
  Email address: _____

- **Stepparent / Guardian**: _____ Home phone: _____
  Address: _____ Cell phone: _____
  Employer: _____ Occupation: _____ Work phone: _____
  Email address: _____

- **Stepparent / Guardian**: _____ Home phone: _____
  Address: _____ Cell phone: _____
  Employer: _____ Occupation: _____ Work phone: _____
  Email address: _____

- **Student lives with:** Check all that apply.
  ☐ Both parents ☐ Father ☐ Mother ☐ Stepparent(s)
  ☐ Guardian(s) ☐ Other relative(s) ☐ Caregiver ☐ Other adult

- **Is there a legal custody agreement or court order regarding this student? Agreement MUST be provided if other than joint custody.**
  ☐ Joint custody ☐ Sole custody ☐ Guardianship ☐ Other

- **Living situation that currently applies to the student** (depending upon the box checked, services may be available):
  ☐ Single family permanent residence (house, apartment, mobile home)
  ☐ Living with friends or relatives due to economic hardship, or housing loss
  ☐ Shelter or transitional housing program
  ☐ Foster or group home
  ☐ Motel or hotel
  ☐ Campground, park, or vehicle
  Other _____

< For school use only >
DOR: _____
Date received in office:

- **Student's name:** _____ **Grade entering:** _____

- **Last school attended:** _____ City / State: _____

- **Services received:** ☐ Speech ☐ Special Ed. ☐ 504 Plan ☐ Medical Plan
  ☐ Gifted Ed. ☐ Special Day Class ☐ Counseling

  Other: _____

- Has the student been expelled or is the student in the process of being expelled? ☐ Yes ☐ No

- Has the student been retained? ☐ Yes ☐ No
  If *yes*, in what grade? _____

- **Emergency contacts** – If you cannot be reached, who may the school call, and to whom may your child be released?

1st _____
Printed name | cell / home phone | work phone | relationship to student

2nd _____
Printed name | cell / home phone | work phone | relationship to student

3rd _____
Printed name | cell / home phone | work phone | relationship to student

- **Other children in the family**

First & Last Names	Female / Male	Relationship to Student	Date of Birth
_____	F M	_____	__ __ / __ __ / __ __
_____	F M	_____	__ __ / __ __ / __ __
_____	F M	_____	__ __ / __ __ / __ __
_____	F M	_____	__ __ / __ __ / __ __
_____	F M	_____	__ __ / __ __ / __ __

- **Student birthplace:** _____
  City | State | Country

- **If your student was not born in the U.S., when did your student first:**
  Enter the U.S.? ____ / ____ Month & Year
  Enroll in a U.S. school? ____ / ____ Month & Year
  Enroll in a California school? ____ / ____ Month & Year

- **Home language survey** Education Code requires schools to determine the language(s) spoken at home by each student. If a language other than English is indicated, the student will be tested for English proficiency.
  - What language did your child learn when he / she first began to talk? _____
  - What language does your child use most frequently at home? _____
  - What language do you use most frequently to speak to your son / daughter? _____
  - What language is most often spoken by the adults at home? _____

- **Is this student Hispanic or Latino?**
  ☐ Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)
  ☐ Non-Hispanic or Latino

- **What is the student's race? Check one or more.**
  ☐ American Indian or Alaska native Having origins in any of the original people of North, Central or South America
  ☐ Black or African American
  ☐ White - Having origins in any of the original people of Europe, North Africa, or the Middle East
  ☐ Hawaiian
  ☐ Guamanian
  ☐ Samoan
  ☐ Tahitian
  ☐ Other Pacific Islander
  ☐ Chinese
  ☐ Japanese
  ☐ Korean
  ☐ Asian Indian
  ☐ Laotian
  ☐ Cambodian
  ☐ Filipino
  ☐ Hmong
  ☐ Other Asian

- **Student's name:** _____ **Grade entering:** _____ ③

- **Parent / guardian highest education level:** ☐ Not a high school graduate ☐ High school graduate ☐ Some college (includes AA degree) ☐ College graduate ☐ Graduate school / post graduate training
  Level checked is for _____ (name)

- **Parent(s) / guardian(s) on active military duty** -- print name: _____
  ☐ Army ☐ Navy ☐ Coast Guard ☐ Marine Corps ☐ Air Force ☐ Full-time National Guard

- **Please check below if your child experiences any of the following:**
  ☐ Asthma ☐ Bleeding disorder ☐ Vision issues/glasses ☐ Seizures
  ☐ Allergies ☐ Hearing loss ☐ Frequent ear infections ☐ Other

Additional medical information (please list allergies if checked above): _____

_____

- **Medication taken at home** ☐ No If *yes*, please describe: **Medication taken at school** ☐ No **If *yes***, please describe:

_____ _____

_____ _____

Note - if medication is taken at school, a form signed by the doctor must be on file in the school office, and the medication must be in the original container.

- **Does your child have any physical activity limitations?** ☐ No If *yes*, please describe: _____

_____

_____

- **Does your child have emotional or behavioral needs which could affect learning?** ☐ No

If *yes*, please describe: _____

_____

- **Is there anything else you wish to share about your child?** _____

_____

_____

- **Proof of residency** – Two of the following documents must be provided at time of registration:
  Property tax payment receipts
  Rent payment receipts
  Mortgage statement
  Utility service payment receipts
  Pay stub

- **Proof of age** – birth certificate, duly attested baptismal certificate, or passport

To the best of my knowledge, the information provided in this application is true and accurate.

- **Parent / guardian signature**: _____ **Date**: _____

- **Printed parent / guardian name**: _____

● Student's name: _____ Grade entering: _____ ④

Complete this section only if your child is entering KINDERGARTEN or TRANSITIONAL KINDERGARTEN (TK)
Please provide as much detail as possible to help us best meet your child's needs.

Describe some of the qualities you especially appreciate in your child.

Do you have any special concerns about your child (behavior, social, physical, developmental, etc.)?

What activities does your child like to do at home?

How would you describe your child's energy level?

What time does your child go to bed? Does s/he sleep through the night?

What responsibilities does your child have at home?

Does your child tend to be anxious in new situations or have any big fears?

If your child has had preschool experience, how would you describe it (positive, neutral, negative)?

What areas do you think your child needs to work on?

My child follows directions:

☐ **Rarely** ☐ **After multiple reminders** ☐ **Inconsistently** ☐ **Often** ☐ **Always**

Social group experiences: Other than daycare or preschool? _____

Daycare	Hrs. per wk.: _____	Ages: _____ to _____	Provider: _____
	Hrs. per wk.: _____	Ages: _____ to _____	Provider: _____
Preschool	Hrs. per wk.: _____	Ages: _____ to _____	Provider: _____
	Hrs. per wk.: _____	Ages: _____ to _____	Provider: _____

Does your child:

Look forward to TK or kindergarten?	☐ Yes	☐ No	☐ Sometimes	Comment: _____
Play cooperatively with other children?	☐ Yes	☐ No	☐ Sometimes	_____
Manage frustration/disappointment calmly?	☐ Yes	☐ No	☐ Sometimes	_____
Separate from parents without being upset?	☐ Yes	☐ No	☐ Sometimes	_____
Listen attentively to a story for 10-15 minutes?	☐ Yes	☐ No	☐ Sometimes	_____
Engage in self-chosen activities for 20-30 minutes?	☐ Yes	☐ No	☐ Sometimes	_____

Delivery: Premature: ☐ Yes ☐ No Birth weight: _____ Oxygen given: ☐ Yes ☐ No

Is there anything else you think we should know about you or your child? Please note it on the back of this sheet. If there is any information you would like to share in a more confidential manner, please feel free to set up an appointment with the principal.

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.

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

State of California—Health and Human Services Agency

Department of Health Care Services
Child Health and Disability Prevention (CHDP) Program

WAIVER OF HEALTH EXAMINATION FOR SCHOOL ENTRY

CHILD'S NAME—Last	First	Middle	DATE OF BIRTH—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 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.
CHDP website: www.dhcs.ca.gov/services/chdp

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.

Child Health and Disability Prevention (CHDP) Program

Humboldt County – Department of Health and Human Services
Public Health Branch
908 7th Street, Eureka, CA 95501
(707) 445-6210 Toll Free (800) 698-0843 Fax: (707) 476-4960

The following is a list of offices that provide CHDP examinations, including camp/sports physicals and school entry or pre-school examinations. Please note some of these offices may not accept your Medi-Cal card for other services. **When you call for an appointment, be sure to tell the office you are requesting a CHDP examination, pre-school or school examination, camp or sports physical for your child.**

Lo Siguiente es una lista de oficinas que provienen exámenes por CHDP, los exámenes incluyen físicos de deportes/campos y exámenes de entrada de escuela o pre-escuela. Por favor note que algunas de estas oficinas, puedan aceptar su tarjeta de Medi-cal por otros servicios. **Cuando llame por una cita, asegurase de decir a la oficina que usted está solicitando un examen de CDHP, sea pre-escuela examen de escuela, o un físico de deportes/campo para su hija/hijo.**

*Clinics with a Pediatrician

EUREKA

Eureka Community Health Center	441-1624
Eureka Community Health Ctr. Peds*	269-7051
Redwood Community Health Clinic	443-4593

MCKINLEYVILLE

McKinleyville Community Health Ctr.	839-3068

ARCATA

Humboldt Open Door Clinic*	826-8610
North Country Clinic (NCC)	822-2481
United Indian Health Services	825-5000
Perinatal Services of NCC	822-1385
Mad River Healthcare Clinic*	825-4938

FERNDALE/FORTUNA / RIO DELL/SCOTIA

Fortuna Family Medical Group	725-3334
Fortuna Community Health Center	725-6101
Ferndale Community Health Center	786-4028
St. Joseph Health Rural Health Clinic	725-3318
Redwood Pediatric Medical Group*	725-9355
Scotia Bluffs Community Health Center—Ste A	764-5617
UIHS/Fortuna	725-7988

WILLOW CREEK/HOOPA/ORLEANS WEITCHPEC

Six Rivers Medical Clinic	(530) 629-3116
Willow Creek Comm. Health Ctr.	(530) 629-3111
K'IMA:W Medical Center*	(530) 625-4261
Karuk Tribal Clinic - Orleans	(530) 627-3452
UIHS/Weitchpec	(530) 625-4300

REDWAY/GARBERVILLE

Redwoods Rural Health Center	923-2783
Southern Humboldt Community Clinic	923-3925

MOBILE SERVICES

Mobile Medical Office (for locations & appointments)	443-4666

Humboldt County CHDP Dental Provider List

All the dentists and clinics below can do a Kindergarten Oral Health Assessment

***Offices Accepting Medi-Cal**

OFFICE	PHONE	ADDRESS	HELPFUL INFO
Arcata			
United Indian Health Services *	825-5040	1600 Weott Way	Tribal enrollment required
Eureka			
Burre Dental Health Center*	442-7078	959 Myrtle Avenue	Spanish
Growing Smiles Dentistry-Randy Heckert, DMD	443-6481	2787 Harris Street	
College of the Redwoods	476-4250	7351 Tompkins Hill Rd.	Low cost exams
Kerisa Elloway, MD, DDS	442-1140	1519 2nd Street	
Fortuna			
Kerissa Elloway, MS DDS	725-1303	1730 Main Street	
Garberville/Redway			
Redwoods Rural Dental Clinic*	923-4313	71 West Coast Road	
Hoopa			
K'IMA:W Dental Clinic *	530-625-4261 x311	1201 Airport Road	Open to all insurances no tribal enrollment required
Willow Creek			
Willow Creek Dental Center-Paul Jung, DDS	530-629-2155	40618 Highway 299	
Mad River			
Southern Trinity Health Services*	574-6616	321 Van Duzen Road	
Laytonville			
Long Valley Dental Clinic*	984-8222	51 Branscomb Road	Sliding scale

WHEN MAKING AN APPOINTMENT REMEMBER TO ASK IF THE OFFICE IS ACCEPTING YOUR INSURANCE

Kindergarten Oral Health Assessment

One of the goals of the Kindergarten Oral Health Assessment is to help you find a dental home for your child. A dental home is where you take your child for regular care and the dentist or clinic knows you. **All the dentists and clinics on the other side of this page can provide a dental home and the Kindergarten Oral Health Assessment.**

The following dentists can provide a free Kindergarten Oral Health Assessment, but most take only private dental insurance

Dr. Elloway	1730 Main Street, Suite A, Fortuna CA	725-1303
	1519 2nd Street, Eureka	442-1140

Please call to make an appointment for a free KOHA. Dr. Elloway accepts private insurance only.

Dr. Hunt	707 I Street, Eureka	443-1390

Please call to make an appointment for a free KOHA. Dr. Hunt accepts private insurance only.

Dr. Heckert	2787 Harris Avenue, Eureka	443-6781

Please call to make an appointment for a free KOHA. Dr. Heckert *accepts private insurance only.*

TIPS FOR MAKING A DENTAL APPOINTMENT.....

- Explain that your child has been referred to see a dentist from your pediatrician, family doctor, or through a CHDP exam.
- If your child has a toothache or is in pain be sure to tell the dental office.
- If the dental office isn't making appointments for new patients and you have transportation and can make a "last minute" appointment, ask if you may have your child placed on a cancellation list to see the dentist in the event of a cancellation.
- If you make an appointment, be sure to go to the dentist at that time. If it is necessary to cancel your appointment please call as early as possible, so that your appointment can be filled by someone else. Your "no show" wastes the dentist's time and may prevent you or a family member from getting service in the future.
- The Medi-Cal beneficiary toll free number is 1-800-322-6384. They may be able to help you find a dentist or orthodontist who accepts Medi-Cal.

CALIFORNIA IMMUNIZATION REQUIREMENTS FOR

K – 12TH GRADE (including transitional kindergarten)

CDPH

GRADE	NUMBER OF DOSES REQUIRED OF EACH IMMUNIZATION[1,2,3]				
K-12 Admission	4 Polio[4]	5 DTaP[5]	3 Hep B[6]	2 MMR[7]	2 Varicella
(7th-12th)[8]	K-12 doses	+ 1 Tdap			
7th Grade Advancement[9,10]		1 Tdap[8]			2 Varicella[10]

1. Requirements for K-12 admission also apply to transfer pupils.
2. Combination vaccines (e.g., MMRV) meet the requirements for individual component vaccines. Doses of DTP count towards the DTaP requirement.
3. Any vaccine administered four or fewer days prior to the minimum required age is valid.
4. Three doses of polio vaccine meet the requirement if one dose was given on or after the 4th birthday.
5. Four doses of DTaP meet the requirement if at least one dose was given on or after the 4th birthday. Three doses meet the requirement if at least one dose of Tdap, DTaP, or DTP vaccine was given on or after the 7th birthday (also meets the 7th-12th grade Tdap requirement. See fn. 8.)
6. For 7th grade admission, refer to Health and Safety Code section 120335, subdivision (c).
7. Two doses of measles, two doses of mumps, and one dose of rubella vaccine meet the requirement, separately or combined. Only doses administered on or after the 1st birthday meet the requirement.
8. For 7th-12th graders, at least one dose of pertussis-containing vaccine is required on or after the 7th birthday. One or two doses of Td vaccine given on or after the 7th birthday count towards the K-12 requirement.
9. For children in ungraded schools, pupils 12 years and older are subject to the 7th grade advancement requirements.
10. The varicella requirement for seventh grade advancement expires after June 30, 2025.

DTaP/Tdap = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine
Hep B = hepatitis B vaccine
MMR = measles, mumps, and rubella vaccine
Varicella = chickenpox vaccine

INSTRUCTIONS:

California schools are required to check immunization records for all new student admissions at TK /Kindergarten through 12th grade and all students advancing to 7th grade before entry. Students entering 7th grade who had a personal beliefs exemption on file must meet the requirements for TK/K-12 and 7th grade. See shotsforschool.org for more information.

UNCONDITIONALLY ADMIT a pupil whose parent or guardian has provided documentation of any of the following for each immunization required for the pupil's age or grade as defined in table above:

- Receipt of immunization.
- A permanent medical exemption in accordance with 17 CCR section 6051.
- A personal beliefs exemption (filed in CA prior to 2016) in accordance with Health and Safety Code section 120335; this is valid until enrollment in the next grade span, typically at TK/K or 7th grade.

CONDITIONALLY ADMIT any pupil who lacks documentation for unconditional admission if the pupil has:

- Commenced receiving doses of all the vaccines required for the pupil's grade (table above) and is not currently due for any doses at the time of admission (as determined by intervals listed in Conditional Admission Schedule, column entitled "EXCLUDE IF NOT GIVEN BY"), or
- A temporary medical exemption from some or all required immunizations (17 CCR section 6050).

CONDITIONAL ADMISSION SCHEDULE FOR GRADES K-12

Before admission a child must obtain the first dose of each required vaccine and any subsequent doses that are due because the period of time allowed before exclusion has elapsed.

DOSE	EARLIEST DOSE MAY BE GIVEN	EXCLUDE IF NOT GIVEN BY
Polio #2	4 weeks after 1st dose	8 weeks after 1st dose
Polio #3[1]	4 weeks after 2nd dose	12 months after 2nd dose
Polio #4[1]	6 months after 3rd dose	12 months after 3rd dose
DTaP #2	4 weeks after 1st dose	8 weeks after 1st dose
DTaP #3[2]	4 weeks after 2nd dose	8 weeks after 2nd dose
DTaP #4	6 months after 3rd dose	12 months after 3rd dose
DTaP #5	6 months after 4th dose	12 months after 4th dose
Hep B #2	4 weeks after 1st dose	8 weeks after 1st dose
Hep B #3	8 weeks after 2nd dose and at least 4 months after 1st dose	12 months after 2nd dose
MMR #2	4 weeks after 1st dose	4 months after 1st dose
Varicella #2	Age less than 13 years: 3 months after 1st dose	4 months after 1st dose
	Age 13 years and older: 4 weeks after 1st dose	8 weeks after 1st dose

1. Three doses of polio vaccine meet the requirement if one dose was given on or after the fourth birthday. If polio #3 is the final required dose, polio #3 should be given at least six months after polio #2.
2. If DTaP #3 is the final required dose, DTaP #3 should be given at least six months after DTaP #2, and pupils should be excluded if not given by 12 months after second dose. Three doses meet the requirement if at least one dose of Tdap, DTaP, or DTP vaccine was given on or after the seventh birthday. One or two doses of Td vaccine given on or after the seventh birthday count towards the requirement.

Continued attendance after conditional admission is contingent upon documentation of receipt of the remaining required immunizations. The school shall:

- review records of any pupil admitted conditionally to a school at least every 30 days from the date of admission,
- inform the parent or guardian of the remaining required vaccine doses until all required immunizations are received or an exemption is filed, and
- update the immunization information in the pupil's record.

For a pupil **transferring** from another school in the United States whose immunization record has not been received by the new school at the time of admission, the school may admit the child for up to 30 school days. If the immunization record has not been received at the end of this period, the school shall exclude the pupil until the parent or guardian provides documentation of compliance with the requirements.

Questions?

See the California Immunization Handbook at ShotsForSchool.org

all in HEALTH CARE FOR ALL FAMILIES

A PROJECT OF THE CHILDREN'S PARTNERSHIP

Enroll. Get Care. Renew.
Health Coverage All Year Long

The COVID-19 pandemic has made it clear that the health of each one of us is deeply interconnected with that of every Californian. The current public health emergency has re-emphasized the importance of having accessible health care coverage and a well-funded safety-net available for our most vulnerable communities.

Health Coverage Options

Medi-Cal:

- Children—regardless of immigration status—foster youth, pregnant women, and legally present individuals—including those with DACA status—may be eligible for no- or low-cost Medi-Cal.
- Medi-Cal covers immunizations, checkups, specialists, vision and dental services, and more for children and youth at no or low cost.
- Medi-Cal enrollment is available year round.
- During COVID-19, Medi-Cal plans began offering more services using telehealth. Ask your provider about accessing care over video or telephone.

Covered California:

- Covered California is where legal residents of California can compare quality health plans and choose the one that works best for them.
- Based on income and family size, many Californians may qualify for financial assistance.
- Enroll during Open Enrollment or any time you experience a life-changing event, like losing your job or having a baby. You have 60 days from the event to complete enrollment.

Immigrant Families visit: **www.allinforhealth.org/immigrantfamilies** *Immigration status information is kept private, protected, and secure. It will not be used by any immigration agency to enforce immigration laws, but only to determine eligibility for health programs.*

You and your family may qualify for financial help:

Household Size	If 2020 household income is less than...		If 2020 household income is between...
1	$17,609	$33,942	$17,609 - $49,960
2	$23,792	$45,859	$23,792 - $67, 640
3	$29,974	$57,776	$29,974 - $85,320
4	$36,156	$69,692	$36,156 - $103,000
5	$42,339	$81,609	$42,339 - $120,680
6	$48,521	$93,526	$48,521 - $138,360
	Adults may be eligible for **Medi-Cal**	Children may be eligible for **Medi-Cal**	May be eligible for financial help to purchase insurance through **Covered California**

Enroll.

Three ways to enroll in Medi-Cal and Covered California:

www.coveredca.com

1(800) 300-1506

Find in-person help: ***www.coveredca.com/get-help/local/***

Get Care.

- Find a primary care doctor in your network.
- Schedule an annual checkup for you and your family.
- Make sure to take your child to the dentist.
- Pay your monthly premium if your plan requires it.

Renew.

- Medi-Cal must be renewed every year. If you receive a renewal notice, complete and return. You can also renew online or by phone. For help, contact your local Medi-Cal office.
- Health plans through Covered California must be renewed every year. Renewal information will be mailed at the end of the year, or contact Covered California at: 1 (800) 300-1506.

For more information go to:
www.allinforhealth.org
July 2020

The Children's Partnership · csba · California School-Based Health Alliance · health happens aqui · Covered California