

**Kindergarten Registration Form  
MILL VALLEY SCHOOL DISTRICT**

For School Year \_\_\_\_\_

Legal Student Name (Last)	(First)	(Middle)	Boy/Girl
Primary Address (Street)	(City & Zip if not Mill Valley)		Home Telephone
Birthdate (Month/Date/Year)	Birthplace (City and State)	(Lives with: Mother, Father, etc)	

**IMPORTANT: Although the District cannot guarantee preferred school placement please list your first two preferences for school attendance.**

1. \_\_\_\_\_

2. \_\_\_\_\_

PARENTAL INFORMATION

Father/Guardian Name	Residence Phone	Residence Address (if different from student)
Business/Employer	Business Phone	Business Address
Mother/Guardian Name	Residence Phone	Residence Address
Business/Employer	Business Phone	Business Address

Other Children at Home: Name, Date of Birth, School, Grade

Name and address of last school attended by student	Father's e-mail
	Mother's e-mail

➔ Does your child have a current Individual Education Program (I.E.P.) for special education? \_\_\_\_\_ **If yes, please provide a copy of the I.E.P.**

➔ Does your child have any physical conditions of which we should be aware (e.g.. diabetes)?

I declare that the address of the student given above is the true and correct residence of the child and that I will immediately inform the District of any change in address which subsequently occurs. I hereby grant permission to the Mill Valley School District to contact my child's prior school regarding recommendations for placement.

Date \_\_\_\_\_ Signature of Parent or Guardian \_\_\_\_\_

<b>OFFICE USE ONLY</b>		IEP _____	ELL _____
Proof of Age _____	Residency Complete _____	Residency follow-up _____	
Date Entered to Database _____	All Forms Completed _____	Wait List _____	
Interim Placement _____ Date _____	Final Placement _____	Date _____	

**HOME LANGUAGE SURVEY  
ENGLISH VERSION**

Name of Student: \_\_\_\_\_

Surname / Last Name \_\_\_\_\_ First Given Name \_\_\_\_\_ Second Given Name \_\_\_\_\_

School: \_\_\_\_\_ Age: \_\_\_\_\_ Grade Level: \_\_\_\_\_ Teacher Name: \_\_\_\_\_

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**Directions to Parents and 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)

Please sign and date this form in the spaces provided below, then return this form to your child's teacher. Thank you for your cooperation.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

Mill Valley School District  
 Standardized Testing and Reporting (STAR)  
 Student & Parent Demographic Information

To establish our records, please complete a form for each child.

Student: \_\_\_\_\_  
                     Last name                    First name                    Middle Initial                    Grade

Part A: Is this student Hispanic or Latino (*Select only one*)

No, not Hispanic or Latino  
 Yes, Hispanic or Latino

The above part of the question is about ethnicity, now race. No matter what you selected above, **please continue to answer the following** by marking one or more boxes to indicate what you consider the student's race to be.

Part B: What is the race of this student? (*Select one or more*)

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

Black or African American  
 White

Parent Level of Education:

<u>Father</u>	<u>Mother</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Not a high school graduate
<input type="checkbox"/>	<input type="checkbox"/>	High school graduate
<input type="checkbox"/>	<input type="checkbox"/>	Some college
<input type="checkbox"/>	<input type="checkbox"/>	College graduate
<input type="checkbox"/>	<input type="checkbox"/>	Graduate school/post graduate training

The information requested on this form is required to comply with the mandates of the statewide student assessment program known as the Standardized Testing and Reporting (STAR) system. In the spring of each year, the California Standards Test is administered to all second through tenth grade students in the state of California. Individual student test results are made available to parents. School and districtwide assessment results are reported to the public on an annual basis by various means: administrative reports to the Board of Trustees; administrative reports to school parent groups; publication in local newspapers; publication on the World Wide Web; etc.

Marin County Report of Health Examination for School Entry

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Medi-Cal # \_\_\_\_\_  
 Reason for referral if other than pre-school physical: \_\_\_\_\_ School Nurse \_\_\_\_\_ Phone \_\_\_\_\_

**HEALTH EXAMINATION MUST INCLUDE AREAS NOTED IN BOLD.** (Please check if done and note results as appropriate)

Date of Exam: \_\_\_\_\_ Is child  New?  Established to your care? \_\_\_\_\_

		Follow-Up / Referral Please indicate who will follow up																
		HEALTH PROVIDER	SCHOOL NURSE															
_____ Health and Developmental History																		
_____ <b>Nutritional Assessment</b>	Height _____ Weight _____ B/P _____																	
_____ <b>Physical Examination</b>	Dental Assessment:     <b>Normal</b>     <b>Possible caries</b>																	
_____ <b>Blood Test for Anemia</b>	Blood Test for Lead:     <b>No</b>     <b>Yes</b> Result: _____																	
_____ <b>Urine Test</b>	Exposure to second hand smoke?     <b>No</b>     <b>Yes</b>																	
_____ <b>Vision Testing: Acuity Test Used:</b>	<b>Snellen</b>     <b>Titmus</b> <b>VISION</b>																	
Right: 20/ _____ Left: 20/ _____	Eye muscle testing:     <b>Normal</b>     <b>Abnormal</b>																	
_____ <b>Referred?</b>	<b>Yes</b>     <b>No</b> <b>Student should wear eye glasses</b>     <b>Yes</b>     <b>No</b>																	
_____ <b>Audiometry Screening</b>	_____ <b>Tympanograms (Optional)</b> <b>AUDIO</b>																	
	Right _____ Left _____																	
	Referred?     <b>Yes</b>     <b>No</b>																	
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Right																		
Left																		
Comments: _____																		

**ADDITIONAL INFORMATION FROM HEALTH EXAMINER:** \_\_\_\_\_ **OTHER** \_\_\_\_\_

Does this child have any conditions that might concern the school?  Yes  No

If yes, explain condition(s) and recommendations for follow-up: \_\_\_\_\_

Are there any restrictions from physical activities?  Yes  No

If yes, explain \_\_\_\_\_

Does this child take any medications?  Yes  No Explain: \_\_\_\_\_  
 (If child must take medication at school, please request and complete a medication form.)

Stamp or print examiner's name, address, phone number  _____ Examiner's Signature  TB skin test (PPD or clearance) required for school entry <i>regardless</i> of BCG. ___ TB assessment completed, not at risk, deferred PPD. PPD: Date given _____ Date read _____	<b>ENTER IMMUNIZATION DATES- Shaded areas indicate minimum for admittance.</b>					
	Polio (OPV or IPV)					
	DTP / DtaP					
	DT / Td					
	HIB Meningitis					
	MMR					
	Hepatitis B					
	Varicella					
	Other					

Induration \_\_\_\_\_ mm \_\_\_\_\_ Negative \_\_\_\_\_ Positive \_\_\_\_\_ If any required immunizations were not given, list reason: \_\_\_\_\_

Chest X-Ray required if positive

Date: \_\_\_\_\_  
ST34; 2/05

Normal

Abnormal

Exemption Expiration Date: \_\_\_\_\_

## Mill Valley School District

Dear Parent or Guardian:

Please be advised in order to make sure your child is ready for school, California law, *Education Code* Section 49452.8, now requires:

- That your child has 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.
- That dental exams must have been completed within 12 months before your child enters school, in order to meet this requirement.
- That a licensed dentist or other licensed or registered dental health professional provides the assessment (dental exam).

Baby teeth are very important, as children need their teeth to eat properly, talk, smile and feel good about themselves. Children with cavities may have difficulty eating, may stop smiling, and may have problems paying attention and learning at school. Tooth decay is an infection that does not heal and can be painful if untreated. It is important to treat tooth decay to prevent possible permanent damage.

The following steps are important to meet this requirement:

**\*Take the Oral Health Assessment/Waiver Request form (on reverse) to the dental office, so it can be completed at the time of your child's check-up.** If you cannot take your child for this required assessment, please indicate the reason for this in Section 3 of the form. You can get more copies of the necessary form at your child's school or online from the California Department of Education's Web site at <http://www.cde.ca.gov/ls/he/hn/>.

**Return the completed form to the school.**

The following resources will help you find a dentist and complete this requirement for your child:

1. 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, you may contact Marin County Dental Services at (415) 473-5450 (English/Spanish).

2. Healthy Families' toll-free number or Web site can help you to find a dentist who takes Healthy Families insurance or to find out if your child can enroll in the program: 1-800-880-5305 or <http://www.healthyfamilies.ca.gov/hfhome.asp>.

3. For additional resources that may be helpful, contact the local public health department at Children's Oral Health Project at (415) 473-4248 (English) and (415) 473-6941 (Spanish). If you have questions about the new oral health assessment (dental exam) requirement, please contact District nurse, Martha Parker at (415) 389-7768 or [mparker@mvschools.org](mailto:mparker@mvschools.org)

Sincerely,

Kerri M. Mills, Ed.D.  
Assistant Superintendent

California law requires schools to maintain the privacy of students' health information. Your child's identity will not be associated with any report produced as a result of this requirement.

## Oral Health Assessment/Waiver Request Form

California law, *Education Code* Section 49452.8, now requires that your child have an oral health assessment by May 31 in kindergarten or first grade, whichever is his or her first year of public school. The law specifies that the assessment must be performed by a licensed dentist or other licensed or registered dental health professional. Oral health assessments that have happened within the 12 months before your child enters school also meet this requirement. If you cannot take your child for this assessment, you may be excused from this requirement by filling out Section 3 of this form.

### Section 1

#### To be completed by the 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 Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:			

### Section 2

#### Oral Health Data Collection

#### To be completed by the dental professional conducting the assessment

Assessment Date:	<u>Visible caries and/or fillings present:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Visible caries present:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Treatment Urgency:</u> <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended <input type="checkbox"/> Urgent care needed
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\_\_\_\_\_  
*Dental professional's signature*

\_\_\_\_\_  
*Date*

### Section 3

#### Waiver of Oral Health Assessment Requirement

#### To be completed by a parent or guardian requesting to be excused from this requirement

I request that my child be excused from the oral health assessment requirement for the following reason: (Please check the box that best describes the reason.)

- I am unable to find a dental office that will take my child's insurance plan.  
My child is covered by the following insurance plan:  
 Medi-Cal/Denti-Cal     Healthy Families     Healthy Kids     None  
 Other \_\_\_\_\_

- I cannot afford an oral health assessment for my child.  
 I do not wish my child to receive an oral health assessment.

Optional: other reasons my child could not get an oral health assessment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

California law requires schools to maintain the privacy of students' health information. Your child's identity will not be associated with any report produced as a result of this requirement. If you have any questions about this requirement, please contact your school office.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date



Administrative Office  
411 Sycamore Avenue  
Mill Valley, California 94941  
tel (415) 389-7700  
fax (415) 389-7773

## DECLARATION OF RESIDENCY

I, \_\_\_\_\_ declare under the penalty of  
*(Parent Guardian Name)*

perjury under the laws of the State of California that the residency  
information provided below is true and correct.

STUDENT NAME \_\_\_\_\_

HOME STREET ADDRESS \_\_\_\_\_  
*(P.O. boxes not accepted.)*

GRADE \_\_\_\_\_

HOME TELEPHONE \_\_\_\_\_

PARENT WORK TELEPHONE \_\_\_\_\_

This declaration is made and entered on the \_\_\_\_\_ day of \_\_\_\_\_  
*(day) (month)*

of \_\_\_\_\_ in \_\_\_\_\_ California.  
*(year) (city)*

I agree to notify the Mill Valley School District within 30 days if I move  
from my current residence as listed above.

\_\_\_\_\_  
*(Relationship to Student)*

\_\_\_\_\_  
*(Parent/Guardian Signature)*

**\*\*Mill Valley School Board Administrative Regulation 5111.1**  
**"If the superintendent/or designee, upon investigation, determines that a  
student's enrollment is based on false evidence of residency, he/she shall  
revoke the student's enrollment."**