

Tustin Connect School
Grades K - 8
15400 Lansdowne Road
Tustin, CA 92782
(714) 730-7395

The following items must be presented to complete the registration process:

- 1. Current lease/rental agreement, escrow paper, or mortgage statement**

- 2. Utility bill - gas, electric, or water only** (We do not accept telephone bills, wireless telephone bills, or cable TV bills)

- 3. California Drivers License or California Identification Card**

- 4. Birth Certificate**

- 5. Proof of Immunizations**

After the enrollment packet is complete and the above documents are received, a Master Agreement Meeting will be scheduled with the teacher.



TUSTIN UNIFIED SCHOOL DISTRICT ENROLLMENT FORM

Has your student ever attended Tustin Unified School District schools before? Yes No Dates Enrolled: _____ to _____

STUDENT INFORMATION

Legal Last Name:	Legal First Name:	Middle Name:	Birthdate:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Grade:
Residence Address:	City/State:	Zip Code:	Home Phone: ()		
Mailing Address:	City/State:	Zip Code:	<input type="checkbox"/> Same as Residence Address		
Correspondence Language:	Home Language:	Student Email Address:			
Ethnicity: (Please check one per Federal requirement) <input type="checkbox"/> NOT Hispanic or Latino <input type="checkbox"/> Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)					
Race/Nationality: The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following (per Federal requirement) by marking the box(es) to indicate what you consider your child's race or nationality to be, as you see applicable.					
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Chinese	<input type="checkbox"/> Japanese	<input type="checkbox"/> Korean	<input type="checkbox"/> Vietnamese	
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Laotian	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Hmong	<input type="checkbox"/> Other Asian	
<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Samoan	<input type="checkbox"/> Tahitian	<input type="checkbox"/> Other Pacific Islander	
<input type="checkbox"/> Filipino	<input type="checkbox"/> Black/African American	<input type="checkbox"/> White			
Birth City:	Birth State:	Birth Country:			
Name of Most Recent School Attended:	Address/City/State:	Grade(s):	Date(s):		
Services Received: (Check all that apply)					
<input type="checkbox"/> Special Education (IEP) <input type="checkbox"/> Resource Specialist Program (RSP)/SAI <input type="checkbox"/> Speech/Language <input type="checkbox"/> Special Day Classes <input type="checkbox"/> 504 Plan <input type="checkbox"/> SARB <input type="checkbox"/> Counseling <input type="checkbox"/> English Language Dev. (ELD) <input type="checkbox"/> Help to Improve Attendance/Behavior <input type="checkbox"/> GATE <input type="checkbox"/> Retention Grade: _____ <input type="checkbox"/> Other _____					

Home Language Survey: The California Education Code requires schools to determine the language(s) spoken at home by each student. The information is essential in order for schools to provide meaningful instruction for all students. Your cooperation in helping us meet this important requirement is requested. Indicate only one language (most frequently used) per line:

1. What language/dialect did your child learn when he/she first began to speak? _____
2. What language/dialect does your child most frequently use at home? _____
3. What language/dialect do you most frequently speak to your child? _____
4. What language/dialect is most often spoken by adults at home? _____
5. Has your child ever been given the CELDT Test (California English Language Development Test)? Yes No I don't know

U.S Entry Date:	U.S. School Entry Date:	California School Entry Date:
Health Problems / Medications / Allergies / Other: _____ Please check if NONE <input type="checkbox"/>		

In case of SERIOUS ILLNESS or EMERGENCY, I acknowledge that my child may be taken by ambulance to the nearest hospital.
Parent Initials: _____

FAMILY INFORMATION

Other Children in the Home	Birthdate:	School:	Relationship:
First and Last Name:			
First and Last Name:			
First and Last Name:			
First and Last Name:			

Foster Youth Services: Yes No

Relative Caregiver Name: _____ Relationship: _____

Non-Relative Caregiver Social Worker Name: _____ Contact Number: () _____

Residence: Where is your child/family currently living? (Federally mandated by NCLB/ESEA)

In a permanent residence (house, apartment, condo, mobile home) In a shelter or transitional housing program
 Temporarily doubled-up (sharing housing with other families/individuals due to economic hardship or loss) In a motel/hotel
 Other (please specify): _____ Temporarily unsheltered (car/campsite)

PARENT/GUARDIAN INFORMATION

***By law, if parents are legally separated or divorced, each parent has equal rights to the custody of the children unless there is a signed court order indicating otherwise. Without a copy of this court order on file at school, the school has no legal right to refuse biological parents' access to their children and/or their children's school records.**

Current Court Orders? (Custody, Restraining Orders, etc.) Yes No Most Recent Court Order Date: _____

Student lives with: (Circle One)

Father/Mother / Stepfather/Stepmother / Legal Guardian / Foster Parent / Caregiver / Other _____

Parent/Guardian Name (1): _____

Email Address: _____

Address: _____ City/State: _____ Zip Code: _____

Employer: _____ Home Phone: () Cell Phone: () Work Phone: ()

Parent Education Level:
 Not a high school graduate (Less than 12th grade) High school graduate (Completed 12th grade) Some college College graduate
 Graduate school/Post graduate training Decline to state

Military Service: Has the parent/step-parent/guardian served in the military?
 Active Duty / Deployed Guard Veteran Active Duty / Full Time Reserve Deceased Branch of Service: _____

Student lives with: (Circle One)

Father/Mother / Stepfather/Stepmother / Legal Guardian / Foster Parent / Caregiver / Other _____

Parent/Guardian Name (2): _____

Email Address: _____

Address: _____ City/State: _____ Zip Code: _____

Employer: _____ Home Phone: () Cell Phone: () Work Phone: ()

Parent Education Level:
 Not a high school graduate (Less than 12th grade) High school graduate (Completed 12th grade) Some college College graduate
 Graduate school/Post graduate training Decline to state

Military Service: Has the parent/step-parent/guardian served in the military?
 Active Duty / Deployed Guard Veteran Active Duty / Full Time Reserve Deceased Branch of Service: _____

EMERGENCY CONTACT INFORMATION

IN CASE OF AN EMERGENCY (bomb threat, earthquake, flooding, etc.) STUDENTS WILL BE KEPT AT SCHOOL OR EVACUATED TO A SAFE LOCATION. List individuals to whom student may be released in case of illness, injury, or emergency, if parent/guardian is not available. Student will **ONLY** be released to parents/guardians or authorized individuals listed below.

First and Last Name (Contact 1):		First and Last Name (Contact 2):	
Relationship:	Contact Number: ()	Relationship:	Contact Number: ()
First and Last Name (Contact 3):		First and Last Name (Contact 4):	
Relationship:	Contact Number: ()	Relationship:	Contact Number: ()
First and Last Name (Contact 5):		First and Last Name (Contact 6):	
Relationship:	Contact Number: ()	Relationship:	Contact Number: ()

RELEASE OF INFORMATION

I give permission to release my child's information, photographs and/or videos to the following:

Media/Press Yes No Classroom Web sites Yes No PTO Yes No School Directory Yes No
 School Web sites Yes No School Yearbook Yes No Military Yes No College Yes No
 School Social Media Yes No Posting of Class List at Beginning of School Year Yes No

TUSD TECHNOLOGY ACCEPTABLE USE POLICY

As a parent/guardian, I have read and understand the TUSD Acceptable Use Policy (the complete TUSD Acceptable Use Policy and Parent Technology Meeting Video is available at www.tustin.k12.ca.us under the TUSD Technology Devices quick links). I accept full responsibility for loss, damage, or harm that results from my student(s) misuse of District technology.

Parent/Legal Guardian Signature: _____ Date: _____



Student Health Inventory

School Year: _____

Student Name: _____ School: _____ Grade: _____
 Birthdate: ___/___/___ Male Female Best phone # during school hours: () _____
 Medical Insurance? Private Medi-Cal CalOptima Emergency Medi-Cal None
 Primary Doctor's Name/City: _____
 Medical Specialists: (List Names/Specialty) _____

Dental Insurance: Yes No Vision Insurance: Yes No

Has your child had any problems with?

	Yes	No	Explain any "Yes" responses: (more space below if needed)
Allergies: Life threatening? EpiPen needed at School? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Food(List) _____ <input type="checkbox"/> Insect bites (List): _____ <input type="checkbox"/> Medication. (List): _____ <input type="checkbox"/> Seasonal <input type="checkbox"/> Latex <input type="checkbox"/> Other (List): _____ Reaction (Explain): _____
Allergies: Non-Life threatening?			<input type="checkbox"/> Food(List) _____ <input type="checkbox"/> Insect bites (List): _____ <input type="checkbox"/> Medication. (List): _____ <input type="checkbox"/> Seasonal <input type="checkbox"/> Latex <input type="checkbox"/> Other (List): _____ Reaction (Explain): _____
<input type="checkbox"/> ADD <input type="checkbox"/> ADHD Date of Diagnosis: _____ By Whom: _____			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No
Asthma <input type="checkbox"/> Mild <input type="checkbox"/> Severe Date of Diagnosis: _____ By Whom: _____			Last episode: _____ Triggers: _____ Inhaler at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No Nebulizer at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No
Autism: Date of Diagnosis: _____ By Whom: _____			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No
Blood Disorder: (Explain)			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No Special precautions needed at school:
Bone/Joint Problems Under doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No			Explain:
Brain injury: <input type="checkbox"/> Acquired <input type="checkbox"/> Traumatic			Date of injury: _____ Explain:
Cancer: Type:			<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Remission <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation <input type="checkbox"/> Central line
Cerebral Palsy			<input type="checkbox"/> Upper extremities <input type="checkbox"/> Lower extremities <input type="checkbox"/> Right <input type="checkbox"/> Left
Cystic Fibrosis			
Developmental Delay			
Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II			<input type="checkbox"/> Insulin injections at school* <input type="checkbox"/> Insulin Pump* <input type="checkbox"/> Oral medication
Down Syndrome			
Ear Infections-frequent			PE tubes <input type="checkbox"/> Current <input type="checkbox"/> Past
Endocrine Disorder: (Explain)			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No
Fainting/Blackouts, frequent Under doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No			Last episode: _____ Triggers:
Gastrointestinal Disorder			Explain:
Genetic Disorder			Explain:
<input type="checkbox"/> Head Injuries <input type="checkbox"/> Concussions			How many? _____ Age/s: _____ How did they occur?
Hearing Loss Date of last hearing test:			If yes: <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear Hearing aids: <input type="checkbox"/> Right <input type="checkbox"/> Left Cochlear Implant: <input type="checkbox"/> Right <input type="checkbox"/> Left



Student Health Inventory

School Year: _____

	Yes	No	Explain any "Yes" responses: (more space below if needed)
Heart Condition Under doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No			Explain:
Immune Disorder			Explain:
Kidney/Bladder Condition			Explain:
Lung Condition			Explain:
Mental Health Condition: <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar Other: (Explain)			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No Date of Diagnosis: _____ By Whom:
<input type="checkbox"/> Migraine <input type="checkbox"/> Headaches			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No
Neurological Condition			Explain:
Neuromuscular Condition			Explain:
Nose Bleeds-frequent			
Seizures/Epilepsy: List seizure type: _____ Date of last seizure: _____			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No Diastat: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No
Skin Condition (Explain)			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No
Vision Problems			<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Night-only Contacts Patching: <input type="checkbox"/> Right <input type="checkbox"/> Left
Activity Restrictions: Do any of these conditions affect the student's ability to participate in routine school activities, programs or PE?			If yes, provide a note from the healthcare provider indicating the restrictions or special needs and how long they will be needed.
Medical Procedures/Equipment (List)			At: <input type="checkbox"/> Home <input type="checkbox"/> School* If needed at school, you will be contacted for further information.
Medication: List <u>all</u> DAILY medication:			
<u>Medication/Purpose</u>			<u>Dose/Frequency</u>
_____			<input type="checkbox"/> Home <input type="checkbox"/> School*
_____			<input type="checkbox"/> Home <input type="checkbox"/> School*
_____			<input type="checkbox"/> Home <input type="checkbox"/> School*
*Contact the school health office for <u>ANY</u> Medication or Medical Procedures to be given or done during school hours.			
Any serious medical condition not listed above? Explain:			
Any "yes" answer above that requires more explanation:			
Please provide any additional information that might impact this student's education or safety:			

No current known Medical Problems.

The above information may be shared with appropriate school staff to ensure the student's health and safety at school. It is the parent/guardian responsibility to inform the school health office of any changes in this student's health status.

Signature of Parent/Guardian: _____ **Date:** _____
 Relationship: _____

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31 of their first year in public school. A California licensed dental professional operating within their 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 they start school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:	Child's race/ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other _____ <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown		

Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box.

Assessment Date:	Caries Experience (Visible decay and/or fillings present) <input type="checkbox"/> Yes <input type="checkbox"/> No	Visible Decay <u>Present:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Urgency: <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended (Caries without pain or infection or child would benefit from sealants or further evaluation) <input type="checkbox"/> Urgent care needed (pain, infection, swelling or soft tissue lesions)
_____ <i>Licensed Dental Professional Signature</i>		_____ <i>CA License Number</i>	_____ <i>Date</i>

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.

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.