OSO GRANDE ELEMENTARY
"Home of the Grizzlies"
30251 Sienna Parkway, Ladera Ranch, CA 92694
(949) 234-5966
Fax: 949-365-1716

KINDERGARTEN REGISTRATION

Welcome to Kindergarten at Oso Grande Elementary! In order to initiate the registration process for your child, school's website at https://osogrizzlies.capousd.org/ click on "School Info" and begin the online process, be sure to select the *correct school year*.

Additional forms (see checklist below) which are required along with the online registration are located on our website at https://osogrizzlies.capousd.org/ (under "Registration Information").

Once these forms and the online registration are completed, please bring the following items to the school office Monday-Friday between the hours of 8:30-2:30 p.m. with the exception of when the office is closed for school holidays/breaks. If you are enrolling a student(s) for the next school year, we will accept registration packets beginning February 15th-March 29th. All documentation must be complete.

- ☐ **Online Registration Confirmation** - Please print, sign and bring to the school office. (The last page requires a signature.)
- ☐ **Verification of Age** (official or certified copy of the birth record; statement by the local registrar or county recorder certifying the date of birth; baptismal certificate or official hospital record of birth; passport; or Affidavit for Proof of Age of Minor signed by the student's parent/legal guardian)
- ☐ **Immunization record** with **ALL State of California mandatory** immunization requirements met.
- ☐ **Two SEPARATE Proofs of Residence dated within 30 days, current** utility bill [gas, electric or water] **AND** a current mortgage statement or rental agreement. *If you cannot provide these specific documents please contact the school office before coming in to register.*
- ☐ **Kindergarten Student Profile**
- ☐ **Report of Health Exam form (completed by physician after 2/20/2024)**
- ☐ **Home Language Survey**
- ☐ **Native American Title VII form (if applicable)**
- ☐ **Oral Assessment Form – check-up by May 31st, 2025**
- ☐ Please sign up for the Kinder Pre-Assessment:

https://docs.google.com/forms/d/e/1FAIpQLSd5eKffngfcE0feF9IwXN8ZaVPt2KLfMtnpOfoRsDGLIf4lVA/viewform?usp=sf_link

If you should have any questions regarding registration, please contact Nicola Hill at 949-234-5966 or nthill@capousd.org .

You're on your way to K!

The transition to kindergarten is respected as a major milestone not only for the child, but for his or her family as well. The attitude towards school and learning that the child carries with them for life is often determined by this very first experience with school. A smooth transition to kindergarten can help make sure your child is successful in school.

The information provided below is designed to help you prepare your children for their school experience.

You bet, I'm ready for K!

Personal Needs Without help, can they...
___ Put on and take off coat
___ Tie their own shoes
___ Wash their hands
___ Snap, button, zip, and buckle

Social Skills Can they ...
___ Listen to an adult & follow simple instructions
___ Cooperate with other children
___ Sit for short periods of time
___ Follow simple two-step directions

Intellectual Skills Do your children...
___ Sit and listen to a story
___ Hold a book upright and turn the pages
___ Know their first and last name
___ Tell and retell familiar stories
___ Know colors, shapes and sizes
___ Counts 0-10

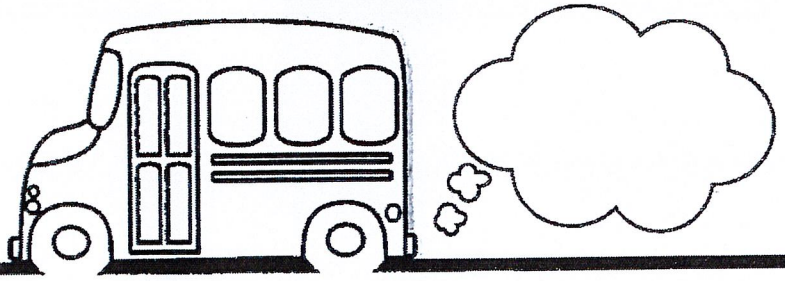
Intellectual Skills (continued)
___ Saying the ABC's
___ Holds scissors & pencil appropriately
___ Recognizes and writes first name (remember-use capital letter for the first letter in a name.) M-a-t-t, not M-A-T-T
___ Recognizes the letters within their name

To help with a smooth transition into kindergarten you can follow these additional helpful ideas; provide opportunities to play with other children, teach your children socially acceptable ways to disagree, and encourage social values such as helpfulness, cooperation, sharing and concern for others.

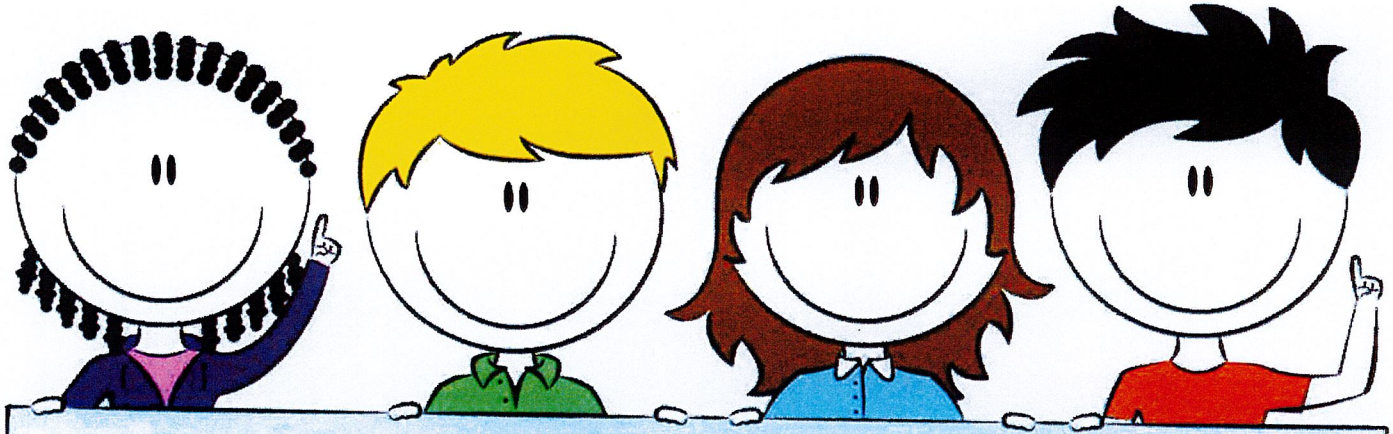
•Additional Resources•

The Leap Frog Letter Factory DVD is a fun and engaging way to teach children the letters and the sounds of the alphabet.

Starfall.com has several free educational videos and games for teaching children the letters of the alphabet, and more!



No Shots? No Records? No School.



Children will not be enrolled unless an immunization record is presented and immunizations are up-to-date.*

**If your child is unimmunized due to medical reasons, please notify us.*

Go to **ShotsForSchool.org** to access information about immunization requirements, an interactive school look-up tool, implementation materials for schools, and educational materials for parents. ShotsforSchool.org

IMM-1167 (5-16)

CAPISTRANO UNIFIED SCHOOL DISTRICT

33122 VALLE ROAD, SAN JUAN CAPISTRANO CA 92675
TELEPHONE: (949) 234-9200/FAX: 496-7681 www.capousd.org

January 2024

Dear Parent and Guardians of Incoming Transitional Kindergarten (TK.), Kindergarten and First Grade Students:

The beginning of school is a very important milestone in your child's life. We all share in the excitement, enthusiasm, and even a little anxiety that accompanies the beginning of school. Good health is a vital component in the quest for school success.

IMMUNIZATIONS

The California School Immunization Law requires that children be up-to-date on their immunizations to attend school. Per 2016 legislation (SB277), all students must provide proof of immunization or a medical exemption when registering, and prior to attending school.

Beginning January 1, 2021, only Medical Exemptions issued from California Immunization Registry (CAIR ME) meet requirements. We cannot accept doctor's notes NOT issued through CAIR ME, blood work or titers, or other documentation to medically exempt the required immunizations. The CAIR ME web site is a secure site for physicians to issue and manage standardized medical exemptions for children in school or child care. Parents use the same site to request medical exemptions from vaccination for their children. Schools and child care facilities can monitor and get updates for medical exemptions issued for children in attendance at their facility. For more details or to request an exemption from your child's physician, please visit https://cair.cdph,ca.gov/exemptions/home

Vaccine	4-6 Years Old Elementary School at Transitional-Kindergarten/Kindergarten and Above
Polio (OPV or IPV)	**4 doses** (3 doses OK if one was given on or after 4th birthday)
Diphtheria, Tetanus, and Pertussis {DTaP, DTP, DT, or Tdap)	**5 doses of DTaP, DTP, or DT** (4 doses OK if one was given on or after 4th birthday)
Measles, Mumps, and Rubella (MMR or MMR-V)	**2 doses** (Both doses given on or after 1st birthday. Only one dose of mumps and rubella vaccines are required if given separately.)
Hepatitis B (Hep B or HBV)	**3 doses**
Varicella (chickenpox, VAR, MMR-V or VZV)	**2 doses (new requirement as of July 1, 2019)**

HEALTH EXAMINATION FOR SCHOOL ENTRY

The State of California supports proactive steps toward a healthy start for its school children by requiring students to receive a Health Examination for School Entry by first grade. Capistrano Unified School District recommends this examination prior to entering kindergarten and first grade. **A health screening completed on or after February 20, 2024, will qualify children for school entrance on August 20, 2024.**

Attached is a copy of the "Health Examination for School Entry" form. Please take the form with you to your health care provider and return it to school when completed. If you have concerns about your child's health examination, please contact the health assistant or licensed vocational nurse at your school.

If you have any questions about these requirements, please do not hesitate to contact your school principal, the licensed vocational nurse, or the health assistant at your school. You may also visit http://www.shotsforschool.org for detailed immunization information. We wish you and your child well and look forward to a long and satisfying relationship with your family.

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Enero del 2024

Estimados padres y tutores de los estudiantes que estan ingresando al programa de transici6n al kinder {TK), kinder, y primer grado:

El comienzo de la escuela es un paso muy importante en la vida de su hijo. Nosotros compartimos con ustedes la emoci6n, el entusiasmo y aun hasta la ansiedad que acompaiia el comenzar un a:iio escolar. La buena salud es un componente vital en la conquista del exito academico.

VACUNAS

La Ley de Vacunaci6n del Estado de California requiere que todos los estudiantes esten al corriente con sus vacunas para poder asistir a la escuela. De acuerdo con legislatura (SB 277) del 2016, cada estudiante debe presentar un comprobante de inmunizaci6n o exenci6n medica al inscribirse y antes de asistir a clases.

A partir del 1 de Enero del 2021, solo las Excepciones Medicas emitidas por el Registro de Inmunizaci6n de California (CAIR ME) cumplen los reguisitos. No podemos aceptar notas del medico NO emitidas a traves de CAIR ME, analisis de sangre o titulos de anticuerpos, u otra documentaci6n para eximir medicamente las vacunas requeridas. El sitio web CAIR ME es un sitio seguro para que los medicos emitan y gestionen exenciones medicas estandarizadas para ni:iios en la escuela o en guarderias. Los padres utilizan el mismo sitio para solicitar exenciones medicas de vacunaci6n para sus hijos. Las escuelas y guarderias pueden supervisar y obtener actualizaciones de las exenciones medicas emitidas para los niiios que asisten a sus instalaciones. Para mas detalles o para solicitar una exenci6n al medico de su hijo, visite https://cair.cdph.ca.gov/exemptions/home.

Vacuna	4 - 6 aflos de edad Escuela primaria (al nivel de kinder de transici6n/ kinder o mas arriba)
Polio (OPV o IPV)	**4 dosis** (3 dosis cumplen con el requisite si una se aplic6 al cumplir las 4 anos de edad o despues).
Difteria, tetanos y tos ferina	**5 dosis de DTaP, DTP o** OT (4 dosis cumplen con el requisito si una se aplic6 al cumplir los 4 arios de edad o despues).
Sarampi6n, paperas y rubeola {MMR O MMR-V)	**2 dosis** (Ambas aplicadas al cumplir 1 ano de edad o despues. Solo se requiere una dosis de las vacunas contra las paperas y la rubeolas se aplican por separado).
Hepatitis B (Hep B o HBV)	**3 dosis**
Varicela (chickenpox, VAR, MMR-V o VZV)	**2 dosis** (nuevo requisito desde el 1 de Julio, 2019)

EL "EXAMEN DE SALUD" RECOMENDADO PARA INGRESAR A LA ESCUELA

El estado de California apoya y toma la iniciativa para un comienzo escolar saludable al requerir un "Examen de Salud Para Ingreso Escolar" antes del primer grado. El Distrito Escolar Unificado de Capistrano recomienda que los estudiantes tengan un examen fisico antes de comenzar el kinder y primer grado. Un examen de salud que se lleve a cabo durante o despues del 20 de febrero del 2024, le permitira a su hijo/a ingresar a la escuela el 20 de Agosto, 2024.

Adjunto encontrara una copia de la forma que se requiere para el "Examen de Salud Para Ingreso Escolar." Por favor llevela a su proveedor de salud y devuelvala a la escuela una vez que este completa. Si usted tiene alguna pregunta referente al examen de salud de su hijo, por favor comuniguese con la asistente de salud o la enfermera de la escuela.

Si usted tiene preguntas sobre estos requisitos, por favor comuniquese con el director/a, la enfermera de la escuela, o la asistente de salud de su escuela. Tambien puede visitar http://www.shotsforschool.org para informaci6n detallada sobre vacunas. Les deseamos bienestar y esperamos poder llevar una larga y satisfactoria relaci6n con su familia.

Oso Grande Elementary
Kindergarten Student Profile

Student's Name_____

Date of Birth _____/_____/_____

Parent(s) Name(s) _____

Address _____

Home Phone _____ Work _____

Cell Phone:_____/_____E-mail:_____
(Mom) (Dad)

Did your child attend preschool? _____ Yes _____ No If yes, for how long? _____

Name of Preschool:_____ City & State:_____

Did your child attend Transitional Kindergarten? ____Yes____No

Name of Transitional School:_____City:_____

Is there a language other than English spoken in the home? _____Yes _____ No

If yes, which language? _____

Does your child have any custody, special needs or behavioral issues? _____ Yes _____ No

If "Yes" please explain (For custody issues a copy of the complete court decree MUST be attached):

_____

Please check the appropriate boxes if your child is currently participating in any of the following programs or if applicable:

- ☐ Special Education
  Your child must have a current Individualized Educational Plan (IEP). Please attach a copy.
- ☐ RSP ☐ Speech ☐ Special Day Class (SDC)
- ☐ 504Plan (Comments:_____)
  A copy of the 504 must be attached.
- ☐ My child was retained in _____ grade. Comments:_____
- ☐ Medical Conditions/Allergies:_____

If it is necessary to build a kindergarten/first grade combination class, would you be interested in having your child in that class? _____ Yes _____ No

Child Care (if any)

_____ None _____ YMCA (on campus): _____ BusyBees

Other (please be specific) _____

If you child is a twin, would you prefer that they be placed in the same class? ___Yes ____No

Additional comments/information:

_____

_____

_____

CAPISTRANO UNIFIED SCHOOL DISTRICT

HOME LANGUAGE SURVEY

Name of Student _____ _____ _____ _____

Last Name First Name Middle Grade Date of Birth Age

_____ _____ _____ _____

Today's Date Entering School (CUSD) Prior School Name Prior School District Name

The California *Education Code* contains legal requirements which direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. 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 these requirements. 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. If an error is made completing this home language survey, you may request correction before your student's English proficiency is assessed.

1. Which language(s) did your child learn when he/she first began to talk? _____
2. Which language(s) does your child most frequently speak at home? _____
3. Which language do you (parents or guardians) most frequently use when speaking with your child? _____
4. Which language is most often spoken by adults in the home? _____

_____ _____

Signature of Parent/Guardian Date

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 Services
Child Health and Disability Prevention (CHDP) Program

INFORME DEL EXAMEN DE SALUD PARA EL INGRESO A LA ESCUELA

Para proteger la salud de los niños, la ley de California exige que antes de ingresar a la escuela todos los niños tengan un examen médico de salud. Por favor, pidale al examinador de salud que llene este informe y entregelo a la escuela—este informe sera archivado por la escuela en forma confidencial.

PARTE I PARA SER LLENADO POR EL PADRE/LA MADRE O EL GUARDIÁN

NOMBRE DEL NIÑO/NIÑA—Apellido	Primer Nombre	Segundo Nombre	FECHA DE NACIMIENTO—Mes/Día/Año

DOMICILIO—Número y Calle	Ciudad	Zona Postal	Escuela

PARTE II PARA SER LLENADO POR EL EXAMINADOR DE SALUD

EXAMEN DE SALUD

AVISO: Todas las pruebas y evaluaciones excepto el análisis de sangre para el plomo deben ser hechas después de la edad de 4 años y 3 meses.

PRUEBAS Y EVALUACIONES REQUERIDAS	FECHA(mm/dd/aa)
Historia de Salud	/ /
Examen Físico	/ /
Evaluación de Dientes	/ /
Evaluación de Nutrición	/ /
Evaluación del Desarrollo	/ /
Pruebas Visuales	/ /
Pruebas con Audiómetro (auditivas)	/ /
Evaluacion de Riesgo y prueba Tuberculosis*	/ /
Análisis de Sangre (para anemia)	/ /
Análisis de Orina	/ /
Análisis de Sangre para el plomo	/ /
Otra	/ /

REGISTRO DE INMUNIZACIONES

Aviso al Examinador: Por favor dé a la familia, una vez completado, o a la fecha, el Registro de Inmunización de California en papel amarillo.
Aviso a la Escuela: Por favor apunte las fechas de inmunización sobre el Registro de Inmunización de la escuela de California en papel azul.

VACUNA	FECHA EN QUE CADA DOSIS FUE DADA				
	Primero	Segundo	Tercero	Quarto	Quinto
POLIO (OPV o IPV)					
DTaP/DTP/DT/Td (difteria, tétano y [acellular] pertusis [tos ferina]) O (tétano y difteria solamente)					
MMR (sarampión, paperas, rubéola)					
HIB MENINGITIS (Hemófilo, Tipo B) (Requerida para centros de cuidado para niños y centros preescolares solamente)					
HEPATITIS B					
VARICELLA (Viruelas locas)					
OTRA (e.g. prueba TB, de ser indicado)					
OTRA					

PARTE III INFORMACIÓN ADICIONAL DEL EXAMINADOR DE SALUD *(optional)* y PERMISO PARA DIVULGAR (DISTRIBUIR) EL INFORME DE SALUD

RESULTADOS Y RECOMENDACIONES

Llene esta parte si el padre/la madre o el guardián ha firmado el consentimiento para divulgar (distribuir) la información de salud de su niño/niña.

☐ El examen reveló que no hay condiciones que conciernen las actividades de los programas escolares.

☐ Las condiciones encontradas en el examen o después de una evaluación posterior que son de importancia para la actividad escolar o física son: (por favor explique)

***de ser indicado**

Yo le doy permiso al examinador de salud para que comparta con la escuela la información adicional de este examen como es explicado en la Parte III.

☐ Por favor marque esta caja si Ud. no desea que el examinador llene la Parte III.

Firma del padre/madre o guardián _____ Fecha _____

Firma del examinador de salud _____ Fecha _____

Si su niño o niña no puede obtener el examen de salud llame al Programa de Salud para la Prevención de Incapacidades de Niños y Jovenes (Child Health and Disability Prevention Program) en su departamento de salud local. Si Ud. no desea que su niño(a) tenga un examen de salud, puede firmar la orden (PM 171 B), formulario que se consigue en la escuela de su niño(a).
CHDP website: www.dhcs.ca.gov/services/chdp

OMB Control No. 1810-0021 (Exp. 01/31/2024)

ED 506 Form
Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

Student Information

Name of the Child _____ Date of Birth _____ Grade level _____

Name of School _____ School District _____

Tribal Membership

The individual with Tribal membership is the (select only one): ○ child ○ child's parent ○ child's grandparent

If the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: _____

Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name _____ Address _____

City _____ State _____ Zip Code _____

The Tribe or Band is (select only one):

- ○ Federally Recognized Tribe
- ○ State Recognized Tribe
- ○ Terminated Tribe
- ○ Alaska Native
- ○ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

- ○ Membership or enrollment number establishing membership (if readily available) or
- ○ Other evidence establishing membership in the Tribe listed above (describe and attach)

Membership or enrollment number establishing membership (if readily available) or other evidence establishing membership in the Tribe listed above (describe and attach). _____

Attestation Statement
I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian _____ Signature _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email _____ Date _____

For Parent/Guardians:

Definitions:
Indian means an individual who is (1) A member of an Indian Tribe or Band, as membership is defined by the Indian Tribe or Band, including any Tribe or Band terminated since 1940, and any Tribe or Band recognized by the State in which the Tribe or Band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, Aleut, or other Alaska Native; or (5) A member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect on October 19, 1994.

Student Information: Write the name of the child, date of birth, grade level, name of school and school district. Only name one child per form.

Tribal Membership: Write the name of the individual with the tribal membership, if it is not the child listed. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one identifier: the child, child's parent or grandparent, for whom you can provide membership information.

Write the name and address of the organization that maintains updated and accurate membership data for such Tribe or Band of Indians. The name does not need to be the official name as it appears exactly on the Department of Interior's list of federally recognized Tribes, but the name must be recognizable and be of sufficient detail to permit verification of the eligibility of the Tribe. Check only one box indicated whether it is a Federally Recognized, State Recognized, Terminated Tribe or Organized Indian Group. Write the enrollment number establishing the membership for the child, parent or grandparent, if readily available, or other evidence of membership.

Attestation Statement: Provide the printed name of parent/guardian and signature, address, phone number and email of the parent or guardian of the child. The signature of the parent or guardian of the child verifies the accuracy of the information supplied.

Paperwork Burden Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3W238, Washington, D.C. 20202-6335

CAPISTRANO UNIFIED SCHOOL DISTRICT

33122 VALLE ROAD, SAN JUAN CAPISTRANO CA 92675
TELEPHONE: (949) 234-9200/FAX: 496-7681 www.capousd.org

January 2024

Dear Parent or Guardian:

To make sure your child is ready for school, California law, Education Code Section 49452.8, 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.

Please take the Oral Health Assessment/Waiver Request form to the dental office, as it will be needed for 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 website https://www.cde.ca.gov/ls/he/hn. 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.

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 website can help you to find a dentist who takes Denti-Cal: 1-800-322- 6384 or https://dental.dhcs.ca.gov. For help enrolling your child in Medi-Cal/Denti-Cal, contact your local social service agency at 1-800-281-9799 or https://ssa.ocgov.com.
2. Healthy Families' toll-free number or website can help you 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 https://benefitscal.com.
3. For additional resources that may be helpful, contact your local public health department at the Department of Health Care Services website https://www.dhcs.ca.gov.

Many things influence a child's development and success in school, including health. If you have questions about the oral health assessment requirement, please contact your school nurse.

CAPISTRANO UNIFIED SCHOOL DISTRICT

33122 VALLE ROAD, SAN JUAN CAPISTRANO CA 92675
TELEPHONE: (949) 234-9200/FAX: 496-7681 www.capousd.org

Estimado padre o representante legal:

Para asegurarse de que su hijo está listo para la escuela, la ley de California, Código de Educación Sección 49452.8, requiere que su hijo tenga una evaluación de salud dental (chequeo dental) antes del 31 de mayo en el kindergarten o primer grado, ***cualquiera que sea su primer año en una escuela pública.*** Las evaluaciones realizadas en los 12 meses antes de que su hijo entre en la escuela también cumplen este requisito. La ley especifica que la evaluación debe realizarla un dentista con licencia u otro profesional de la salud dental con licencia o registrado.

Lleve al consultorio dental el formulario adjunto de evaluación de la salud dental o solicitud de exención, ya que será necesario para la revisión de su hijo. Si no puede llevar a su hijo para esta evaluación requerida, indique el motivo en la sección 3 del formulario. Puede obtener más copias del formulario necesario en la escuela de su hijo o por Internet en el sitio web de California Department of Education (https://www.cde.ca.gov/ls/he/hn/). La ley de California exige que las escuelas mantengan la privacidad de la información médica de los estudiantes. La identidad de su hijo no se asociará a ningún informe elaborado como resultado de este requisito.

Los siguientes recursos le ayudarán a encontrar un dentista y a completar este requisito para su hijo:

1. El número gratuito de Medi-Cal/Denti-Cal o el sitio web pueden ayudarle a encontrar un dentista que acepte Denti-Cal: 1-800-322- 6384 o https://dental.dhcs.ca.gov/. Si necesita ayuda para inscribir a su hijo en Medi-Cal/Denti-Cal, póngase en contacto con su agencia local de servicios sociales llamando al 1-800-281-9799 o https://ssa.ocgov.com/.
2. El número gratuito o el sitio web de *Healthy Families* pueden ayudarle a encontrar un dentista que acepte el seguro de *Healthy Families* o a averiguar si su hijo puede inscribirse en el programa: 1-800-880-5305 o https://benefitscal.com/.
3. Para obtener recursos adicionales que pueden ser útiles, póngase en contacto con su departamento local de salud pública en el sitio web Department of Health Care Services (https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx).

Muchas cosas influyen en el desarrollo y el éxito escolar de un niño, incluyendo la salud. Si tiene preguntas sobre el requisito de evaluación de la salud dental, póngase en contacto con la enfermera escolar.

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.

Oral Health Assessment Form (Dec. 2007) Spanish

Formulario de evaluación de la salud bucal

La ley de California (Sección 49452.8 del *Código de Educación*) exige que su hijo se haga un chequeo dental antes del 31 de mayo de su primer año en una escuela pública. Un profesional de la salud dental matriculado de California que trabaje dentro de su área de especialización debe realizar el chequeo y completar la Sección 2 de este formulario. Si su hijo tuvo un chequeo dental en los 12 meses anteriores al comienzo del año escolar, pídale a su dentista que complete la Sección 2. Si no puede conseguir un chequeo dental para su hijo, complete la Sección 3.

Sección 1. Información del menor (debe ser completada por el padre, la madre o el tutor)

Primer nombre del menor:	Apellido:	Inicial del segundo nombre:	Fecha de nacimiento del menor:
Domicilio:			Dpto.:
Ciudad:			Código postal:
Nombre de la escuela:	Maestro:	Grado:	Sexo del menor: □ Masculino □ Femenino _____
Nombre del padre/madre/tutor:	Raza/origen étnico del menor: □ Blanco □ Negro/Afroamericano □ Hispano/Latino □ Asiático □ Indio nativo americano □ Multirracial □ Otro □ Nativo de Hawai/islas del Pacífico □ Desconocido		

Sección 2. Información de salud dental: debe ser completada por un profesional de la salud dental matriculado de California ***[Oral Health Data (To be completed by a California licensed dental professional)]***

NOTA IMPORTANTE: Considere cada casilla por separado. Marque cada casilla.
[IMPORTANT NOTE: Consider each box separately. Mark each box.]

Fecha de la evaluación: *[Assessment Date:]*	Incidencia de caries *[Caries Experience]* (Caries visibles y/o empastes presentes) *(Visible decay and/or fillings present)]* □ Sí *[Yes]* □ No *[No]*	Caries visibles presentes: *[Visible Decay Present:]* □ Sí *[Yes]* □ No *[No]*	Urgencia de tratamiento: *[Treatment Urgency:]* □ Ningún problema obvio *[No obvious problem found]* □ Se recomienda atención dental temprana (caries sin dolor o infección o el niño se beneficiará del sellador dental o de una evaluación adicional) *[Early dental care recommended (Caries without pain or infection or child would benefit from sealants or further evaluation)]* □ Se necesita atención urgente (dolor, infección, inflamación o lesiones del tejido blando) *[Urgent care needed (pain, infection, swelling or soft tissue lesions)]*

_____	_____	_____
Firma del profesional de salud dental matriculado	***Número de matrícula de CA***	***Fecha***
[Licensed Dental Professional Signature	***CA License Number***	***Date]***

Sección 3. Exención del requisito de evaluación de salud dental
Debe ser completado por el padre, la madre o el tutor que solicita que su hijo/a sea eximido de este requisito.

Solicito que mi hijo sea eximido de este chequeo dental porque: (marque la casilla que describa el motivo)

□ No puedo encontrar un consultorio dental que acepte el plan de seguro dental de mi hijo.
□ Medi-Cal/Denti-Cal □ Healthy Families □ Healthy Kids □ Otro _____ □ Ninguno

El plan de seguro dental de mi hijo es:

□ No puedo pagar el chequeo dental de mi hijo.

□ No quiero que a mi hijo se le haga un chequeo dental.

Opcional: otras razones por las cuales mi hijo no pudo obtener un chequeo dental:_____

Si pide ser eximido de este requisito:_____
Firma del padre, madre o tutor ***Fecha***

La ley establece que las escuelas mantengan la privacidad de la información médica de los estudiantes. El nombre de su hijo no formará parte de ningún informe que se realice como resultado de esta ley. Esta información sólo puede ser utilizada para fines relacionados con la salud de su hijo. Si tiene alguna pregunta, comuníquese con la escuela.

Regrese este formulario a la escuela *antes* del 31 de mayo del primer año escolar de su hijo. *El original de este formulario será guardado en el registro escolar del menor.*

Oso Grande Elementary School

2024-2025

Suggested Optional Kindergarten Supply List

KINDERGARTEN CLASS

QTY	ITEM
1 each	**Canvas Tote/Book Bag (Must be at least 14x14-if smaller the mouth of the bag is not large enough.) NO BACKPACKS!**
NO JUMBO, ROSE-ART or Crayola Washable	3- **large size** 16 count Crayola 2- regular size 16 count Crayola crayons **(Please- Crayola Brand Only)**
1	8oz Hand sanitizer & 1 packet hand wipes
2 box	12 count Crayola Markers
6 Large	Elmer glue sticks
1	Crayola 16 Watercolor paint set

KINDERGARTEN GIRLS ONLY

QTY	ITEM
1 ream	Astro Bright paper (any single color-please no white)
1	75 pack of Clorox Wipes
1	8oz hand soap (pump)
1 pkg	Avery Labels#8163 (2x4)

KINDERGARTEN BOYS ONLY

QTY	ITEM
1 ream	Astro bright (any single color-please no white)
1 pack	Expo Dry Erase Makers
1 box	Ziploc Baggies (Quart size)
1 boxes	Tissue