Shaffer Elementary School

"Excellence In Education"
P.O. Box 320
Litchfield, CA 96117
(530) 254-6577 FAX (530)-254-6126
www.shafferschool.com

"Shaffer ROCKS"

Terri Daniels
Superintendent/Principal

WELCOME TO OUR INCOMING KINDERGARTEN STUDENTS AND FAMILIES

Hello. I am very excited to know that your child will be enrolling in Shaffer Elementary School for the 2016-2017 school year. We are a community of students, teachers, parents and staff who value education and support the development of the whole child. We provide a family atmosphere where each child is honored and recognized as a valued member of the community. At Shaffer School we say: "Shaffer ROCKS". This acronym stands for Respectful; On Tasks; Cooperative; Kind; and Safe. These are the Shaffer School rules which shape the culture of our campus.

At Shaffer Elementary School students develop strong personal ethics and character. We invite parents and the community to visit our school and see all the great things we are doing for children and the wonderful things the students are accomplishing.

We believe that every child can succeed in reaching their full potential. Our goal is to help students reach their goals. Communication is important and I encourage parents to contact me with any questions or concerns that you may have regarding the educational experience for your child. Providing your child a safe and enriching academic experience is at the heart of why we are here.

The Shaffer School Mission Statement: "Shaffer School establishes a positive and safe environment where students' creativity is encouraged, their talents valued, and their accomplishments celebrated." We are very happy to have you as part of our Shaffer School Family.

Sincerely,

Terri Daniels

Mrs. Terri Daniels
Superintendent/Principal

NAME _____ M___F___ Birth date & Place _____

Address (Physical) _____P.O. Box_____, Zip _____

Language Spoken at Home _____

Last School Attended _____

City & State _____

OFFICE USE ONLY
Inter District: Yes No
Grade: _____
Teacher: _____
Date Entered: _____
Birth Certificate: _____
Immunization: _____
Dental Screening: _____
Physical: _____

Place of Employment _____
Father

_____
Mother

PARENTS & GUARDIANS

Relationship	Name	Living with Pupil	Home Phone	Work Phone
Father				
Mother				
Guardian				

BROTHERS & SISTERS

Name	Grade	School	Birth date

IF UNABLE TO CONTACT PARENT IN AN EMERGENCY, A FRIEND OR RELATIVE, THE SCHOOL CAN CONTACT:

Name	Relationship	Phone Number

VISION 1. Does your child have vision or eye problem? Yes ___ No ___
2. Does your child need to wear glasses? Yes ___ No ___
If yes, just for reading _____ all the time _____

HEARING 1. Does your child have a history of earache or ear infection? Yes ___ No ___
2. Does your child have a hearing problem? Yes ___ No ___
3. If yes, explain: _____

SHAFFER ELEMENTARY SCHOOL

STUDENT NAME _____ TEACHER _____ (office only)

GENDER _____ GRADE _____ DATE OF BIRTH _____

*ETHNICITY – (Please check one)

African/African American _____
American Indian or Alaskan Native _____
Asian/Asian American _____
Filipino/Filipino American _____
Hispanic/Latino _____
Pacific Islander _____
White (not of Hispanic origin) _____

*PARENT EDUCATION LEVEL – Parent with higher education level – (Please check one)

Not a High School graduate _____
High School graduate _____
Some College _____ (No degree earned)
Some College _____ (AA/AS degree earned)
College graduate _____
Graduate school/post graduate training _____

*HOME LANGUAGE – (Please check one)

English _____
Armenian _____
Cantonese _____
Hmong _____
Khmer _____
Korean _____
Lao _____
Philipino _____
Russian _____
Spanish _____
Vietnamese _____
Other _____

*Mobility – What is the grade you child first attended **this** school: _____

(We are requesting the above information to assist us in paperwork required by the State of California. This is not mandatory.)

MEDICAL HISTORY

Has You Child Had ---

Allergies	Yes ___	No ___
Heart Disease	Yes ___	No ___
Asthma	Yes ___	No ___
Orthopedic Problem	Yes ___	No ___
Convulsive Disorders (Seizures)	Yes ___	No ___
Diabetes	Yes ___	No ___

If yes on any of the above, please explain:

_____

_____

_____

_____

PAST SCHOOL HISTORY

Has Your Child ----

Repeated a grade?	Yes ___	No ___
Attended a Special Education Program?	Yes ___	No ___

If yes, please indicate which type ----

___ Educationally Handicapped (EH)
___ Learning Disabilities (LDG)
___ Educable Mentally Retarded (EMR)
___ Speech
___ Gifted
___ Other – Explain _____

_____

_____

_____

_____ _____

Parent/Guardian Signature Date

COMMENTS –

_____

_____

_____

_____

ENGLISH

Date _____ School _____

Teacher _____

HOME LANGUAGE SURVEY

The California Education Code requires schools to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students.

Your cooperation in helping us met this important requirement is requested. Please answer the following questions and have your son/daughter return this form to his/her teacher. Thank you for your help

Name of student: _____ _____ _____
Last First Middle Grade Age

1. Which language did your son or daughter learn when he or she first began to talk? _____
2. What language does your son or daughter most frequently use at home? _____
3. What language do you use most frequently to speak to your son or daughter? _____
4. Name the languages in the order most often spoken by the adults at home:
   a. _____
   b. _____
   c. _____

State of California
Department of Education
OPER – LS 77

_____
Signature of parent or guardian

Oral Health Assessment/Waiver Request Form

(Return this form to the school by May 31)

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/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 completing Section 3 of this form.

SECTION 1 (To be completed by the parent or guardian)

Child's Last Name:	First Name:	Middle Initial:	Child's birthdate:
Address:			Apt. or Space No.:
City:			Zip Code:
School Name:	Teacher:	Grade:	Child's Gender: ☐ Male ☐ Female
Parent/Guardian Name (Print):	Child's race/ethnicity: ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ Hispanic/Latino ☐ American Indian ☐ Alaskan Native ☐ Multi-racial ☐ Asian ☐ Unknown		

By signing this form, I am consenting for the child named above to receive a basic oral health assessment/dental screening. I understand this screening is only a very basic evaluation. Dental screenings only find obvious dental problems and are meant to identify children who need dental care. No x-rays were taken, and this screening does not replace a thorough dental examination by a dentist. Also, I will not hold the dentist or those performing this assessment responsible for the oral health consequences or results should I choose NOT to follow the Treatment recommendation(s) listed below.

_____

Parent/Guardian/Representative Signature *Date*

SECTION 2 - Oral Health Data Collection

To be completed by the dental professional conducting the assessment

Assessment Date:	Visible fillings present? ☐ Yes ☐ No	Visible caries present? ☐ Yes ☐ No	Treatment urgency: ☐ No obvious dental problem found. ☐ Further evaluation needed. Contact a dentist for an exam as soon as possible. ☐ Some dental problems. Contact a dentist immediately.

_____

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.

Other reasons my child could not get an oral health assessment (optional): _____

_____

_____

Signature of Parent or Guardian *Date*

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.

Distribution: White – School; Yellow – Dental Health Professional; Pink – Parent/Guardian

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	/ /
Tuberculin Test (Mantoux/PPD)	/ /
Blood Test (for anemia)	/ /
Urine Test	/ /
Blood Lead Test	/ /
Other	/ /

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER *(optional)* *and* RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

☐ Examination shows no condition of concern to school program activities.

☐ Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: *(please explain)*

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

☐ Please check this box if you ***do not*** want the health examiner to fill out Part III.

➤ _____ _____
Signature of parent or guardian — Date

Name, address, and telephone number of health examiner

➤ _____ _____
Signature of health examiner — Date

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.

CHDP website: www.dhs.ca.gov/chdp

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SHAFFER ELEMENTARY SCHOOL

KINDERGARTEN QUESTIONNAIRE

DATE_____

FAMILY BACKGROUND

Child's Name_____ Name to be used in school_____

Birth date_____ Home phone_____

Address (mailing) _____

Address (physical) _____

Mother's Name _____ Occupation _____

Work #_____

Father's Name _____ Occupation _____

Work #_____

Other Children in Family	Yr of Birth	Age	Grade Level
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

Has there been a divorce, death, or illness in the family which might affect your child?
_____

SOCIAL EXPERIENCES

1. Circle the places your child has visited:

grocery store ocean zoo dairy factories mountains

farm airport downtown museum county fair city

2. Where has your child traveled? _____

3. How has your child traveled? _____

4. Has your child attended Nursery School? _____ Which one? _____

5. Does your child play quietly or actively? _____

6. With whom does your child play? _____ Alone_____, with older children _____, with younger children _____, spends most of their time around adults_____.

7. Does your child play mostly By him/her self_____, with other children of the same age_____, with boys_____, with girls_____

8. Would you say your child is a leader or a follower? _____

9. What activities does your child enjoy outdoors? _____

_____

10. Does your child enjoy watching television?_____

11. What programs are his/her favorite (s)? _____

12. Does your child enjoy books? _____

13. Do you read to your child? _____ How often? _____

14. Is your child able to remember songs or rhymes? _____

15. Has your child had experiences with paints and crayons? _____

16. Does your child select the clothing he/she wears? _____

17. Does your child celebrate traditional holidays? _____

18. Do you celebrate birthdays in your home? _____

If so, please explain_____

19. Does your child remember special events of the past? _____

DEVELOPMENT

1. At what age did your child: walk alone_____, feed him/her self_____, talk in sentences _____

2. Is your child right or left handed? _____

3. Does your child dress him/her self? _____

4. Please circle the items your child can do: button zip tie shoes lace shoes snap fasten

5. Is your child able to skip? _____

6. Is your child able to print his/her first name? _____

7. Is your child aware of dangers such as fire, electricity, traffic, and strangers? _____

8. Is your child able to be in a new or strange situation without an undue show of fear? _____

9. Does your child respond well to correction? _____

10. Can your child take care of his/her own toilet needs? _____

11. Does your child wet the bed? _____ never occasionally rarely

12. Circle the characteristics that apply to your child:

cries easily temper tantrums fearful in new situations sulks daydreams

destructive whines bites nails eating problems sucks thumb

easily angered doesn't like to share jealous none of these

13. Describe your child: _____

_____

14. What would you say are your child's strengths? _____

_____

15. What would you say is your child's weakness? _____

_____

SCHOOL ADJUSTMENT

1. Is your child able to sit still and listen to a story for 5-10 minutes? _____
2. Does your child listen without interrupting when someone else is talking? _____
3. Is your child able to share and take turns? _____
4. Will your child be able to find his/her way home from the bus stop? _____
5. Does your child know his/her phone # _____ or home address _____
6. What do you expect your child to acquire in the kindergarten experience? _____
7. What else would you like your child's teacher to know about your child? _____

_____

8. Would you be interested in helping in the classroom? _____
   If yes, what day is best for you? _____
9. Would you be interested in occasionally sending a food ingredient for the classroom cooking program?_____
10. When is the best time to meet with you? (Please circle)

Mother:	morning	afternoon	evening
Father:	morning	afternoon	evening