



## New Student Enrollment Checklist 2022 - 2023

We are happy you will be joining the Learning By Design community! Please feel free to reach out to us with any questions and return this enrollment packet as soon as possible. We look forward to seeing you then!

The following documents are required for enrollment. All documents must be returned.

### **General Information**

- ☐ New Student Enrollment Form
- ☐ Student Emergency and Medical Card
- ☐ Health History Form
- ☐ Parent / Legal Guardian Publicity Authorization and Release

### **Verification of Parent/Guardian Identity (one of the following)**

- ☐ Current Driver's License or CA ID Card
- ☐ Company / Work ID
- ☐ Passport
- ☐ Government Issued ID with Photo

### **Verification of Student Date of Birth (one of the following)**

- ☐ Birth Certificate or Passport (original required)
- ☐ Adoption Papers / Court Documents
- ☐ Hospital Record
- ☐ Foster Placement Papers (if applicable)

### **Health and Wellness Verification**

- ☐ Physical Examination for:
  - ETK / Kindergarten Students - Needs to be less than 1 year prior to entering school
  - First Grade Students - Needs to be less than 18 months prior to first-grade entry
  - Students entering from out of the country
- ☐ Verification of Immunizations (Bring immunization record at time of enrollment)  
The following immunizations are required for school enrollment.
  - Polio Vaccine
  - Hepatitis B Vaccine
  - DTP: Diphtheria, Tetanus, Pertussis Vaccine
  - MMR: Measles, Mumps, Rubella Vaccine
  - Varicella (Doctor documented disease history)
- ☐ Oral Health Information Form for TK / Kindergarten only (or First Grade if it's the first year in public school)
- ☐ Health Examination for School Entry Form

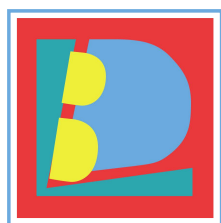
### **Student Housing Questionnaire**

#### **Proof of Residency - Must be in the Parent/Guardian's Name**

- Must be dated within the past 60 days. Included below is a list of acceptable documents:
  - ☐ Electric Bill
  - ☐ Water Bill
  - ☐ Utility Bill
  - ☐ Mortgage Statement
  - ☐ Gas Bill
  - ☐ Trash Bill
  - ☐ Property Tax Bill
  - ☐ Lease/Rental Agreement

#### **Additional Documentation (if applicable)**

- ☐ Prior School Records
  - Most recent Report Card or Transcript if the student attended school prior to enrollment at LBD
- ☐ Student Individualized Education Plan (IEP) and/or Student's Section 504 Plan
- ☐ Medical Statement to Request Special Meals and/or Accommodations Form
- ☐ Court Papers, Foster Placement, Restraining Orders



## Enrollment Form 2022-2023 School Year

Instructions: Please print using black or blue ink. If you have any questions, please ask for assistance.

### 1. STUDENT INFORMATION (Please write name EXACTLY as it appears on the birth verification)

Legal Last Name	Legal First Name	Middle Name	Grade
Home Address	Apt/Unit	City	Zip Code
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary <input type="checkbox"/> Female	Home Phone ( )	Date of Birth / /	Place of Birth
1. PLEASE INDICATE STUDENT'S ETHNICITY (CHECK ONE) Student is of Hispanic origin? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. PLEASE INDICATE STUDENT'S RACE (CHECK ALL THAT APPLY) <input type="checkbox"/> African American or Black <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Hmong <input type="checkbox"/> Japanese <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Samoan <input type="checkbox"/> Tahitian <input type="checkbox"/> Vietnamese <input type="checkbox"/> White			
RESIDENTIAL STATUS: <input type="checkbox"/> Single Family Permanent Residence (House, Apartment, Condo, Mobile Home) <input type="checkbox"/> Hotels/Motels <input type="checkbox"/> Temporarily Doubled Up <input type="checkbox"/> Temporary Shelters <input type="checkbox"/> Temporarily Unsheltered <input type="checkbox"/> Other _____			

### 2. FAMILY INFORMATION

Parent/Legal Guardian	
Last Name	First Name
Home Address (if different than student)	
Home Phone ( )	Cell Phone ( )
Work Telephone ( ) Ext.	Email Address
Relationship to Student	Lives with Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Highest Level of Education (CHECK ONE) <input type="checkbox"/> Not a High School Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> Some College or Associate's Degree <input type="checkbox"/> College Graduate <input type="checkbox"/> Graduate School <input type="checkbox"/> Decline to State	
Is an Armed Forces member, on active duty or serve on full-time National Guard Duty? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Parent/Legal Guardian	
Last Name	First Name
Home Address (if different than student)	
Home Phone ( )	Cell Phone ( )
Work Telephone ( ) Ext.	Email Address
Relationship to Student	Lives with Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Highest Level of Education (CHECK ONE) <input type="checkbox"/> Not a High School Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> Some College or Associate's Degree <input type="checkbox"/> College Graduate <input type="checkbox"/> Graduate School <input type="checkbox"/> Decline to State	
Is an Armed Forces member, on active duty or serve on full-time National Guard Duty? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Home Correspondence Language</b> – In which language do you wish to receive written communications from the school? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
---

### 3. HOME LANGUAGE SURVEY

Which language did the student learn when he/she first began to talk?	
Which language does the student most frequently use at home?	
Which language do you use most frequently to speak to this student?	
Which language is most often used by the adults at home?	
Has this student received any formal English language instruction?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### 4. STUDENT EDUCATIONAL INFORMATION

Special Services	
A. Was this student receiving special education services at his/her previous school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Did this student have an Individualized Education Program (IEP) at his/her previous school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, please provide a copy of the IEP.	
C. Did this student have a Section 504 Plan at his/her previous school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, please provide a copy of the Section 504 Plan.	

D. Does this student have difficulties that interfere with his/her ability to go to school or to learn?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Has this student been identified for gifted and talented educational services (GATE)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Previous School Information			
Has this student previously attended this school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?    /    /	
Date of first U.S. school enrollment?	Grade	Date	
Date of first California school enrollment?	Grade	Date	
Please list last two schools the student attended (include preschool, if applicable):			
School Name	City/State	Dates attended:	Which grade level(s)?
Is this student currently under an expulsion order? If yes, please provide name of the school district:			<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>5. ADDITIONAL HOUSEHOLD INFORMATION</b>	
Are there any court orders regarding legal custody, physical custody, educational rights or restricted contact with this child? If yes, please provide copy of the court order.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does student live with Foster Family? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Relative Caregiver <input type="checkbox"/> Non-Relative Caregiver If yes, please provide Notification of Placement Status Form	Children's Social Worker (CSW):  Telephone Number: (    )    ext.
Complete these three rows if student's address is a licensed children's institution/family foster agency/group home/adult residential facility	
Facility Name	Facility Type
Facility Telephone Number	License Number
Alternate Telephone Number	Contact Person
Facility Address: Number	City
Street	Zip Code
Apt./Unit	
Children's Social Worker (CSW)	Telephone Number and Extension
Does the student have any relatives who are all or part American Indian or Alaskan Native?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the student's parent or legal guardian worked in one or more of the following industries in the last three years: agriculture, dairy, fishery, food process/packing, or livestock?	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. ADDITIONAL SCHOOL AGED CHILDREN LIVING IN HOUSEHOLD WITH SAME PARENT(S)/LEGAL GUARDIAN(S)		
Last Name, First Name	Birth Date	Current School
	/    /	
Last Name, First Name	Birth Date	Current School
	/    /	
Last Name, First Name	Birth Date	Current School
	/    /	
Last Name, First Name	Birth Date	Current School
	/    /	

7. EMERGENCY CONTACT INFORMATION (Other than Parent/Legal Guardian authorized to pick up child. Must be 18 years of age or older)			
1. Legal Name	Home Phone	Work Phone	Cell Phone
Relationship to Student	Address		
2. Legal Name	Home Phone	Work Phone	Cell Phone
Relationship to Student	Address		
3. Legal Name	Home Phone	Work Phone	Cell Phone
Relationship to Student	Address		

8. SIGNATURE		
I verify that the information in this document is true and correct to the best of my knowledge.		
PRINT NAME	SIGNATURE	DATE
		/    /

RELATIONSHIP TO STUDENT:    ☐ Parent    ☐ Legal Guardian    ☐ Other \_\_\_\_\_



## Health History Form 2022 - 2023

### Student Information

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Gender: ☐ Female ☐ Male ☐ Non-Binary Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade Level: \_\_\_\_  
Home Language: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Blood type: \_\_\_\_\_

### Allergies

Does your child have any significant allergies? ☐ Yes ☐ No

If yes, list allergies, symptoms of allergic reaction, and treatment below:

---

---

---

---

Does your child have an EPIPen, EPIPen Jr. or Auvi - Q prescribed to treat the allergy? ☐ Yes ☐ No  
**(If yes, please contact the school before the first day of school to prepare an emergency action plan)**

### Daily Medications

Please note: All prescription medications to be given at school must be delivered by the parent to the school in a prescription bottle with the students' name and dosage clearly marked on the bottle.

Does your child take daily medications at home? ☐ Yes ☐ No

Does your child require medication to be given at school? ☐ Yes ☐ No If yes, list the current medications:

Name of Medication: \_\_\_\_\_ Time Given: \_\_\_\_\_

Reason Given: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Time Given: \_\_\_\_\_

Reason Given: \_\_\_\_\_

Does your child require any special medical procedures or emergency treatments during school hours? ☐ Yes ☐ No  
If yes, please describe: \_\_\_\_\_

Please note: All medical procedures or treatments required at school must have a doctor's medical order on file with the school before any procedures/treatments can be performed.

## Medical History

Does your child have any of the following medical conditions? Check all that apply:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> ADD/ADHD      | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> ASD (Autism)  | <input type="checkbox"/> Eating Disorder        | <input type="checkbox"/> Heart Condition  |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Emotional Concerns     | <input type="checkbox"/> Migraines        |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Genetic/Congenital     | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Bowel Bladder | <input type="checkbox"/> Glasses/Contacts       | <input type="checkbox"/> Sleep Disorder   |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Head Injury/Concussion | <input type="checkbox"/> Other: _____     |

List any recent hospitalization or treatments and explain (please include dates):

---

---

## Activity Restrictions

Does your child have any restrictions for physical activities? ☐ Yes ☐ No

If yes, a written note from your physician for the current school year, stating the restrictions is required and needs to be updated yearly.

## Emergency Care

***This information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health and safety of the student. In case of an emergency, if the school is not able to contact me, I give permission to take the student to the nearest hospital or appropriate facility for medical attention. This medical information may be shared with school personnel, EMTs, and hospital personnel as needed. If it is necessary to contact an ambulance, it will be the responsibility of the parent/guardian to pay for this service. I understand a copy of this information will be sent with my child to the hospital. If I cannot be reached by telephone in the event of an emergency involving: \_\_\_\_\_ (Student's Name), please send my child to \_\_\_\_\_ or any available medical service.***

***This information is current and correct; I understand that it is my responsibility as the parent/guardian to notify the school of new or existing health concerns or any changes in contact information. I understand that this health history form must be updated every school year.***

Parent / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Parent / Legal Guardian Name: \_\_\_\_\_



# LOS ANGELES UNIFIED SCHOOL DISTRICT STUDENT EMERGENCY INFORMATION FORM

Parent Information: Please fill out completely and sign where indicated. In a major emergency, it is school district policy to retain students at school for their safety. This form will be used by the school staff when students are released to go home. Please complete electronically or print clearly and return completed form to school.

STUDENT'S LAST NAME				FIRST NAME				M.I.		STUDENT'S LAST NAME			
BIRTH DATE		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		GRADE		HOME LANGUAGE							
STUDENT'S HOME ADDRESS -- NUMBER		STREET				APT #		CITY			ZIP CODE		
MAILING ADDRESS -- NUMBER (IF DIFFERENT FROM ABOVE)		STREET				APT #		CITY			ZIP CODE		
PARENT'S / LEGAL GUARDIAN'S LAST NAME			FIRST NAME			RELATIONSHIP TO STUDENT			LIVES WITH? <input type="checkbox"/> Yes <input type="checkbox"/> No			FIRST NAME	
WORK ADDRESS -- NUMBER		STREET				CITY			ZIP CODE				
CONTACT NUMBERS			Indicate which phone to call for each message type:*				EMAIL ADDRESS:						
HOME			EMERGENCY <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work										
CELL			ATTENDANCE <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work										
WORK			GENERAL INFO <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work										
TEXT			<input type="checkbox"/> I authorize receiving text messages and understand that I am responsible for all text related charges.									MIDDLE INITIAL	
PARENT'S / LEGAL GUARDIAN'S LAST NAME			FIRST NAME			RELATIONSHIP TO STUDENT			LIVES WITH? <input type="checkbox"/> Yes <input type="checkbox"/> No				
WORK ADDRESS -- NUMBER		STREET				CITY			ZIP CODE				
CONTACT NUMBERS			Indicate which phone to call for each message type:*				EMAIL ADDRESS:						
HOME			EMERGENCY <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work										
CELL			ATTENDANCE <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work										
WORK			GENERAL INFO <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work										
TEXT			<input type="checkbox"/> I authorize receiving text messages and understand that I am responsible for all text related charges.										
To the principal: In case you are unable to reach me during any emergency, you are authorized to contact and, if necessary, release my child to any of the following:													
NAME			RELATIONSHIP			HOME PHONE			CELL PHONE		WORK PHONE		DATE
NAME			RELATIONSHIP			HOME PHONE			CELL PHONE		WORK PHONE		
NAME			RELATIONSHIP			HOME PHONE			CELL PHONE		WORK PHONE		
List any other family members attending this school:													
LAST NAME			FIRST NAME			HOME ROOM		GRADE		RELATIONSHIP			
LAST NAME			FIRST NAME			HOME ROOM		GRADE		RELATIONSHIP			
MILITARY CONNECTED FAMILY: In efforts to provide resources and support to military connected students and their families, please respond to the following:			Immediate family member in the military (Active Duty, Guard, Reserve, or Veteran): <input type="checkbox"/> YES <input type="checkbox"/> NO Relationship to Student: _____				Currently Deployed: <input type="checkbox"/> YES <input type="checkbox"/> NO Military Branch: _____ Status: <input type="checkbox"/> Active Duty; <input type="checkbox"/> Guard; <input type="checkbox"/> Reserve; <input type="checkbox"/> Veteran; <input type="checkbox"/> Deceased						
<b>AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT</b>													
The undersigned, as parent/legal guardian of, _____ a minor, (Print name of the student here)													
hereby authorizes the principal or designee, into whose care the student has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to the student upon the advice of any licensed physician and/or dentist. It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the Los Angeles Unified School District ("District") to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary. This authorization is given in accordance with Section 49407 of the California Education Code, and shall remain effective until revoked in writing and delivered to the District. I understand that the District, its officers and its employees assume no liability of any nature in relation to the transportation of the student. I further understand that all costs of paramedic transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my sole responsibility as the student's parent/guardian.													
HEALTH ALERTS -- List any medical condition which restricts physical activity or requires special attention. Include conditions such as asthma and allergies such as peanut and bee stings. If none, please indicate "none".													
DOES THE STUDENT HAVE HEALTH INSURANCE? (Check One) <input type="checkbox"/> YES <input type="checkbox"/> NO* If "Yes": <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Healthy Families													
MEDI-CAL / HEALTHY FAMILIES ID Number:													
1. PRIVATE HEALTH INSURANCE NAME			GROUP NO.			2. PRIVATE HEALTH INSURANCE NAME (If covered under more than one plan)			GROUP NO.				
NAME OF DOCTOR / MEDICAL OFFICE						PHONE NUMBER OF DOCTOR / MEDICAL OFFICE							
*If the student currently does not have health insurance, information on free or low-cost health care programs is available by calling the District's toll-free HELPLINE 1(866)742-2273.													
MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS:													
MY CHILD CURRENTLY TAKES THE FOLLOWING MEDICATIONS:													
I CERTIFY THAT I HAVE READ AND UNDERSTOOD THIS FORM AND DO HEREBY GIVE MY AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT, AND THAT ALL OF THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND CORRECT.													
X										DATE			
SIGNATURE OF: _____ (CHECK ONE) <input type="checkbox"/> PARENT <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> CAREGIVER (AFFIDAVIT)													

\* Selected telephone number must be a direct dial number (no extensions).

Revised January 2014



## Parent / Legal Guardian Publicity Authorization and Release

Dear Parent/Guardian:

Learning By Design Charter School requests your permission to reproduce through printed, audio, visual, or electronic means activities in which your pupil has participated in his/her education program. Your authorization will enable us to use specially prepared materials to (1) train teachers, (2) increase public awareness and promote continuation and improvement of education programs, and/or (3) highlight accomplishments of students and educational programs including but not limited to honor roll, school awards, and culmination, through the use of mass media, displays, brochures, websites, social media, approved blogs and related School publications.

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

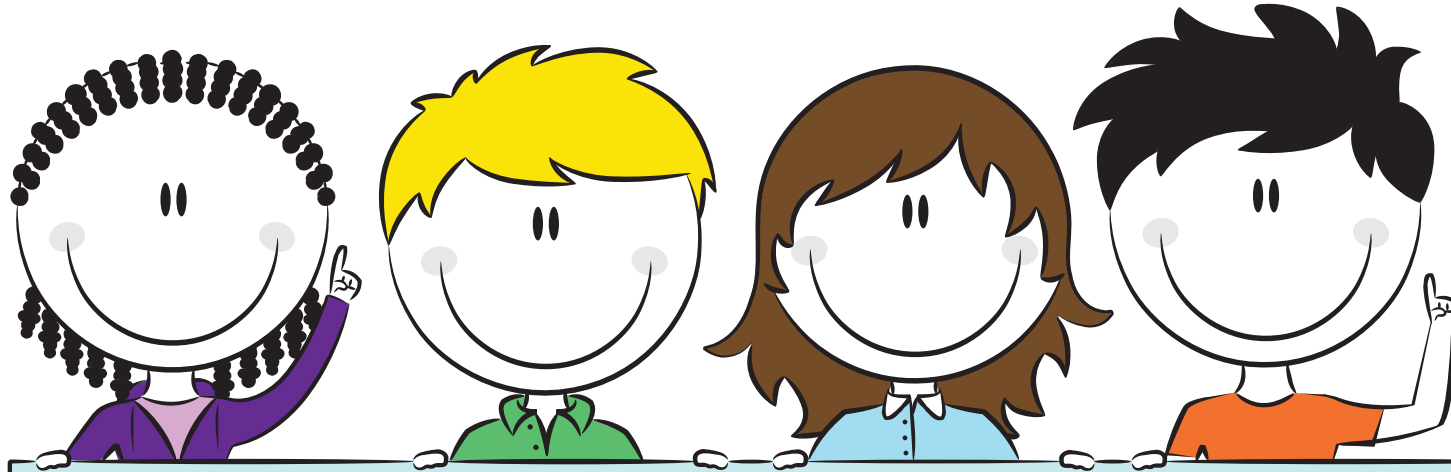
Name of Parent: \_\_\_\_\_

- a. I, as a parent or guardian of the above named student, fully authorize and grant Learning By Design Charter School and its authorized representatives, the right to print, photograph, record, and edit as desired, the biographical information, name, image, likeness, and/or voice of the above named pupil on audio, video, film, slide, or any other electronic and printed formats, currently developed, (known as "Recordings"), for the purposes stated or related to the above.
- b. I understand and agree that use of such Recordings will be without any compensation to the pupil or the pupil's parent or guardian.
- c. I understand and agree that Learning By Design Charter School and/or its authorized representatives shall have the exclusive right, title, and interest, including copyright, of the Recordings.
- d. I understand and agree that Learning By Design Charter School and/or its authorized representatives shall have the unlimited right to use the Recordings for any purposes stated or related to the above.
- e. I hereby release and hold harmless Learning By Design Charter School and its authorized representatives from any and all actions, claims, damages, costs, or expenses, including attorney's fees, brought by the pupil and/or parent or guardian which relate to or arise out of any use of these Recordings as specified above.

My signature indicates that I have read and understand the release and I agree to accept its provisions.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

# 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**



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

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

DTaP/Tdap = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine

Hep B = hepatitis B vaccine

MMR = measles, mumps, and rubella vaccine

Varicella = chickenpox vaccine

## INSTRUCTIONS:

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

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

- Receipt of immunization.
- A permanent medical exemption.\*
- A personal beliefs exemption (filed in CA prior to 2016); this is valid until enrollment in the next grade span, typically at TK/K or 7th grade.†

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

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

## CONDITIONAL ADMISSION SCHEDULE FOR GRADES K-12

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

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

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

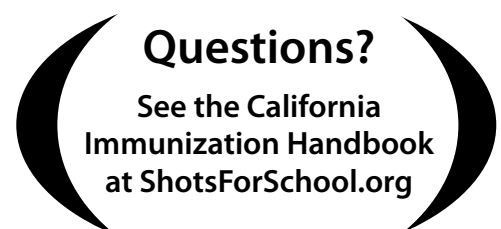
**Continued attendance** after conditional admission is contingent upon documentation of receipt of the remaining required immunizations. The school shall:

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

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

\* In accordance with 17 CCR sections 6050-6051 and Health and Safety Code sections 120370-120372.

† In accordance with Health and Safety Code section 120335.





## Oral Health Notification Letter

Dear Parent or Guardian:

To make sure your child is ready for school, California law, Education Code Section 49452.8, now requires that your child have an oral health assessment (dental check-up) by May 31st 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.

Take the attached 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's Website at <http://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; <http://www.denti-cal.ca.gov>. For help enrolling your child in Medi-Cal/Denti-Cal, contact your local social service agency, available at <http://www.denti-cal.ca.gov/WSI/Bene.jsp?fname=ProvReferral>.
2. Healthy Families' toll-free number or Website 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.benefitscal.com/>.
3. For additional resources that may be helpful, contact your local public health department: <http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx>.

Remember, your child is not healthy and ready for school if he or she has poor dental health! Here is important advice to help your child stay healthy:

- Take your child to the dentist twice a year.
- Choose healthy foods for the entire family. Fresh foods are usually the healthiest foods.
- Brush teeth at least twice a day with toothpaste that contains fluoride.

- Limit candy and sweet drinks, such as punch or soda. Sweet drinks and candy contain a lot of sugar, which causes cavities and replaces important nutrients in your child's diet. Sweet drinks and candy also contribute to weight problems, which may lead to other diseases, such as diabetes. The less candy and sweet drinks, the better!

Baby teeth are very important. They are not just teeth that will fall out. Children need their teeth to eat properly, talk, smile, and feel good about themselves. Children with cavities may have difficulty eating, stop smiling, and have problems paying attention and learning at school. Tooth decay is an infection that does not heal and can be painful if left without treatment. If cavities are not treated, children can become sick enough to require emergency room treatment, and their adult teeth may be permanently damaged.

Many things influence a child's progress and success in school, including health. Children must be healthy to learn, and children with cavities are not healthy. Cavities are preventable, but they affect more children than any other chronic disease.

If you have questions about the new oral health assessment requirement, please contact your child's school and speak to the School Operations Manager.

Sincerely,

Charla Harris  
Executive Director

# Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31st 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: <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 Present: <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)
<div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 40%; border-top: 1px solid black; padding-top: 5px;"> <b><i>Licensed Dental Professional Signature</i></b> </div> <div style="width: 30%; border-top: 1px solid black; padding-top: 5px;"> <b><i>CA License Number</i></b> </div> <div style="width: 30%; border-top: 1px solid black; padding-top: 5px;"> <b><i>Date</i></b> </div> </div>			

### 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 31st* of your child's first school year.**  
*Original to be kept in child's school record.*



LEARNING  
BY  
DESIGN

**Learning by Design Charter School  
INFORMED CONSENT FOR COVID-19 PERIODIC TESTING**

Individual Tested Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Emergency Phone Number: \_\_\_\_\_

**Please carefully read the following informed consent:**

1. I, on behalf of myself or my minor son/daughter/legal dependent (the “student”), have provided informed consent for Learning by Design Charter and/or an independent laboratory acting on Learning by Design’s behalf to conduct collection and testing for exposure to the 2019 Novel Corona Virus (COVID-19)
2. I understand that Learning by Design Charter School incorporates COVID-19 testing into regular school operations, and as part of the Return to School will provide periodic testing at school during the school day at a designated prearranged time
3. I acknowledge that testing will initially be provided on a weekly basis to all students subject to adjustments in frequency based on public health guidance and community prevalence.
4. I acknowledge that each minor child for whom I have provided consent to testing can be tested for COVID-19 during school hours without my presence

**ACCEPTANCE**

**I, the undersigned, hereby consent to the student participating in periodic COVID-19 testing as set forth herein.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_



LEARNING  
BY  
DESIGN

## STUDENT HOUSING QUESTIONNAIRE

*The McKinney-Vento Homeless Assistance Act, part of Every Student Succeeds Act (ESSA), entitles all school-aged children experiencing homelessness access to the same free, appropriate public education that is provided to non-homeless youth. Schools are required to remove barriers to enrollment, attendance, and academic success of students experiencing homelessness. To determine eligibility please complete this form. For additional information, please contact the main office at (323) 903-5712.*

Student First Name:		Student Last Name:	
Date of Birth:	Grade:	Gender:	
Address:	Apt#:	City:	Zip Code:
Is the student: (check all that apply) <input type="checkbox"/> a parenting teen? <input type="checkbox"/> an unaccompanied youth? <input type="checkbox"/> a runaway?			

**Is the student currently living in one of the nighttime residence options listed below?**

☐

Yes

☐

No



If you answered "No" to this question, please STOP and sign at the bottom of this form.

If you answered "YES," complete the remainder of this form.



CHECK ONE OF THE NIGHTTIME RESIDENCE OPTIONS THAT BEST DESCRIBES YOUR **CURRENT** LIVING SITUATION DUE TO LOSS OF HOUSING

<b>Shelter</b> (ex. homeless, domestic violence, etc.) Name of shelter:	<b>Motel or Hotel</b> Name:
<b>Garage</b> (unconverted)	<b>Car, trailer, or campsite</b>
<b>Temporarily in another family's house or apartment</b>	<b>Student temporarily with an adult that is not the parent or guardian</b>
<b>Transitional housing program</b> Name:	<b>Trailer/motor home on private property</b>
<b>Other place NOT designated for or ordinarily used as a regular sleeping accommodation for human beings</b> Explain:	

Is the student in need of services? ☐ YES ☐ NO

*If yes, please circle the services being requested.*

Backpack/School Supplies

Hygiene Kits

Transportation Assistance

Is the student in need of a referral for additional resource(s)? ☐ YES ☐ NO

*If yes, please circle the referral(s) being requested.*

Clothing/Shoe Assistance

Tutoring

Housing Referrals

Assistance for Parenting Teen

**\*\*\*Designated School Site Homeless Liaison must conference with family to facilitate the requested referral(s)\*\*\***

**Learning by Design Charter School's Designated Homeless Liaison: Charla Harris - (323) 903-5712 - [charris@lbschools.org](mailto:charris@lbschools.org)**

**AFFIDAVIT** – By signing this form, I declare under penalty of the laws in the State of California that the foregoing is true and correct. In addition, I understand that Learning by Design Charter School reserves the right to verify the above listed residence information.

**Signature of Parent/Legal Guardian/Caregiver:** \_\_\_\_\_ **Date:** \_\_\_\_\_