

## BOFGUSD STUDENT REGISTRATION 2024-2025

GRADE

Student Last Name:

First Name:

Permanent ID:

► Has your student ever attended \_\_\_\_BOFGUSD\_\_\_\_ public schools before? ☐ Yes ☐ No

PLEASE PRINT – STUDENT'S LEGAL NAME

Legal First Name	Legal Middle Name	Legal Last Name	Other Legal Name (if applicable)
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<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date:	Month	Day	Year
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Parent/Guardian First Name	Last Name	Home/Cell Phone	Work Phone
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Parent/Guardian First Name	Last Name	Home/Cell Phone	Work Phone
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Mailing Address	Apt#	City	State	Zip
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Residence Address (house # & street name) (IF DIFFERENT)	Apt #	City	State	Zip
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(P.O Box or house # &amp; street name)

**WHAT IS YOUR CHILD'S ETHNICITY? (Please check one):** ☐ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race) ☐ Not Hispanic or Latino

**WHAT IS YOUR CHILD'S RACE? (Please check up to five racial categories)**

*The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be.*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> American Indian or Alaskan Native(100)<br>(Persons having origins in any of the original people of North, Central or South America ) | <input type="checkbox"/> Laotian (206)     | <input type="checkbox"/> Tahitian (304)  |
| <input type="checkbox"/> Chinese (201)  | <input type="checkbox"/> Cambodian (207)   | <input type="checkbox"/> Other Pacific Islander (399)  |
| <input type="checkbox"/> Japanese (202)   | <input type="checkbox"/> Hmong (208)       | <input type="checkbox"/> Filipino/Filipino American (400)  |
| <input type="checkbox"/> Korean (203)   | <input type="checkbox"/> Other Asian (299) | <input type="checkbox"/> African American or Black (600)   |
| <input type="checkbox"/> Vietnamese (204)   | <input type="checkbox"/> Hawaiian (301)    | <input type="checkbox"/> White (700) (Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East) |
| <input type="checkbox"/> Asian Indian (205)   | <input type="checkbox"/> Guamanian (302)   |  |
|   | <input type="checkbox"/> Samoan (303)      |  |

**PARENT EDUCATION – Please indicate level for both parents.**

**Parent/Guardian 1:**

- ☐ Graduate Degree or Higher (10)  
☐ College Graduate (11)  
☐ Some College or Associate's Degree (12)  
☐ High School Graduate (13)  
☐ Not a High School Graduate (14)

**Parent/Guardian 2:**

- ☐ Graduate Degree or Higher (10)  
☐ College Graduate (11)  
☐ Some College or Associate's Degree (12)  
☐ High School Graduate (13)  
☐ Not a High School Graduate (14)

**PARENT EMAILS (required for communication):**

Parent/Guardian 1:

Parent/Guardian 2:

**PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THE FORM (REV 7/24)**

**HOME LANGUAGE SURVEY: Indicate only one language (most frequently used) per line:**

1. What language/dialect does your child most frequently use at home? \_\_\_\_\_
2. Which language/dialect did your child learn when he/she first began to talk? \_\_\_\_\_
3. What language/dialect do you most frequently speak to your child? \_\_\_\_\_
4. Has your child ever been given the CELDT Test (Calif English Language Development Test)? ☐ Yes ☐ No ☐ I don't know

**Residence – where is your child/family currently living? (federally mandated by NCLB) – Please check appropriate box:**

- ☐ In a single family permanent residence (house, apartment, condo, mobile home) ☐ In a motel/hotel (09)  
☐ Doubled-up (sharing housing with other families/individuals due to economic hardship or loss) (11) ☐ Unsheltered (car/campsite) (12)  
☐ In a shelter or transitional housing program (10) ☐ Other (15) (please specify) \_\_\_\_\_

**Parent/Guardianship Information (with whom the student lives) – check all that apply**

- ☐ Father ☐ Mother ☐ Both ☐ Step-Father ☐ Step-Mother ☐ Guardian ☐ Foster/Group Home ☐ Other \_\_\_\_\_  
Is the above (checked) person (s) the student's LEGAL guardian? ☐ Yes ☐ No If No, please complete a "Caregiver Affidavit"  
If there is a legal custody agreement regarding this student, please check one: ☐ Joint Custody ☐ Sole Custody ☐ Guardian

**PLEASE COMPLETE INFORMATION BELOW FOR PARENT(S)/GUARDIAN WITH WHOM THE STUDENT LIVES:**

1. ☐ Father ☐ Step Father/Guardian (check one) Full Name: \_\_\_\_\_  
Employer: \_\_\_\_\_ City: \_\_\_\_\_ Daytime Phone # (\_\_\_\_) \_\_\_\_\_
2. ☐ Mother ☐ Step Mother/Guardian (check one) Full Name: \_\_\_\_\_  
Employer: \_\_\_\_\_ City: \_\_\_\_\_ Daytime Phone # (\_\_\_\_) \_\_\_\_\_

**DUPLICATE MAILING** – If divorced/separated & joint custody allows duplicate mailing/information to be given to other parent, Please include their name, address, and phone number:

Full Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

**MOST RECENT SCHOOL ATTENDED:**

School	Address/City/State/Zip	Grade(s)	Date(s)

Are there psychological or confidential reports available from your child's former school? ☐ Yes ☐ No

Has your child been suspended? ☐ Yes ☐ No Has your child ever been expelled? ☐ Yes ☐ No

What special services has your child received? (please check all boxes that apply)

**Special Education:** ☐ Resource (RSP) ☐ Special Day Class (SDC) ☐ Speech/Language ☐ 504

**Other:** ☐ Gifted (GATE) ☐ Remedial Math ☐ Remedial Reading ☐ Counseling ☐ English Language Development

☐ Help to Improve Attendance/ Behavior ☐ Other (Specify) \_\_\_\_\_

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

BELOW FOR SCHOOL USE ONLY

Proof of Birth: Type: _____ Verified by: _____	Proof of Residence: Type: _____ Verified by: _____	Proof of Immunization: Type: _____ Verified by: _____	Entry Reason:	Enroll Date:	Assigned Grade:	Permanent ID:	Blank <input type="checkbox"/> ET <input type="checkbox"/> RC
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**PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THE FORM (REV 7/24)**

Student Last Name:

First Name:

Permanent ID:

# TENAYA EMERGENCY CONTACT FORM 2024-25

May be used for multiple students with same data

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THE FOLLOWING INDIVIDUAL(S) ARE AUTHORIZED TO PICK UP MY STUDENT IN AN EMERGENCY IF I CANNOT BE REACHED.

Name of Contact/Relationship	Home Number	Cell Number	Work Number
Name of Contact/Relationship	Home Number	Cell Number	Work Number
Name of Contact/Relationship	Home Number	Cell Number	Work Number
Signature of Parent/Guardian	Relationship to Student		Date

NOTE: If there is a custodial agreement in place, please make sure the office has a copy on file (including any updates).

Teacher \_\_\_\_\_

Grade \_\_\_\_\_

**MEDICAL INFORMATION FOR SCHOOL YEAR: 2024-2025**

Student's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Parent's Name \_\_\_\_\_ Home Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Telephone \_\_\_\_\_

Allergies to: \_\_\_\_\_ Symptoms \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Bee Sting Allergies: Symptoms \_\_\_\_\_

Treatment/Medication Needed \_\_\_\_\_

Has your child ever had an allergic reaction requiring a visit to the emergency room or hospital?

Yes \_\_\_\_\_ No \_\_\_\_\_ Please explain: \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Asthma: Medication/Inhalers \_\_\_\_\_ Peak Flow \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Diabetes: Treatment \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Convulsions/Seizure Disorder: Medication \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Heart condition Medication/Restriction \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Orthopedic Problems: Limitations \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Hyperactivity/ADD: Medication/Treatment \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Head Injury: Medication/Treatment \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Frequent Colds: Medication/Treatment \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Skin Problems: Medication/Treatment \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Tires Easily: Medication/Treatment \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Stomachaches: Medication/Treatment \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Speech Problems: Medication/Treatment \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Kidney Disease: Medication/Treatment \_\_\_\_\_

Other Current health problems: \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Are any medications taken on a regular basis? Names of medications: \_\_\_\_\_

Child's Physician/Clinic \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Glasses: Distance only \_\_\_\_\_ Reading only \_\_\_\_\_ All the time \_\_\_\_\_ Date of last exam \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Hearing Problems: Hearing Aid: Yes \_\_\_\_\_ No \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ History of Earaches/Infections: Number per year \_\_\_\_\_

Doctor Providing care for Ears \_\_\_\_\_ Date of Last Infection \_\_\_\_\_

**CURRENT HEALTH STATUS**

Has your child been examined by:

Yes \_\_\_\_\_ No \_\_\_\_\_ Dentist? Name \_\_\_\_\_ Date of exam \_\_\_\_\_

Recommendation: \_\_\_\_\_

If there is a change in the child's health which affect his/her ability to participate in school activities, or if he/she is placed on a regular medication, it is the parent's responsibility to notify the school. Please request forms as needed if either condition exists.

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

**Please attach a copy of your child's immunization record to this form.**

# **STUDENT TRANSPORTATION RULES: 2024-2025**

THE FOLLOWING RULES APPLY TO ALL STUDENTS RIDING SCHOOL BUSES:

1. Students transported on a school bus shall be under the authority of and responsible to the driver of the bus.
2. No student will be denied school bus transportation unless he/she consistently behaves in a disorderly manner or refuses to submit to the authority of the bus driver.
3. Students must remain seated while the bus is in motion.
4. Students must remain in their own seats unless allowed by the bus driver to change.
5. A QUIET BUS is a SAFER BUS, so students are expected to conduct their conversation in a quiet manner.
6. Guide Dogs are the only animals allowed on a School Bus.
7. Any containers on the bus must be of unbreakable material, i.e. wood, metal, plastic.
8. No knives, dangerous objects, or weapons of any sort may be transported on a school bus.
9. Students are not permitted to throw anything out the window of a school bus. Throwing or shooting anything within the school bus is not permitted.
10. For safety, students must sit in the seats assigned to them by the bus driver. They are to face forward and keep legs and feet out of the aisle.
11. Horseplay and scuffling are inappropriate bus behavior.
12. All students are to keep their hands off other people.
13. Control of lowering and raising the windows shall be under the supervision of the bus driver. Windows shall never be lower than 3 notches.
14. Students will keep all parts of their bodies inside the bus whether the vehicle is stopped or in motion.
15. Tampering with bus equipment is illegal.
16. All students who have red light stops shall wait to be escorted across the street or highway in front of the bus.
17. Students are to be respectful and obedient to the bus driver.
18. Students are to have a note from their parents or guardian on each occasion they are to ride a bus or go to a bus stop that is not their own.
19. It is a suspendable offense to willingly deface or destroy any part of a bus.
20. Chewing gum or eating is not allowed on the bus.
21. Students are to be at the bus stop 10 minutes before their scheduled pickup time.
22. Spitting is inappropriate behavior and will not be permitted.

## **WARNING/LETTER ORDER:**

**1<sup>st</sup> offense: Warning letter sent home**

**2<sup>nd</sup> offense: 3 days off the bus- letter sent home (High school 5 days)**

**3<sup>rd</sup> offense: 5 days off the bus – letter sent home (High School 10 days)**

**4<sup>th</sup> offense: 10 days off the bus – letter sent home (High School Remainder of the Semester or 3 Months – whichever is longer)**

**5<sup>th</sup> offense: Student will be off the bus remainder of the trimester or 3 months whichever is longer (High School off bus remainder of the year or 3 months, whichever is longer)**

**Please discuss these rules with your child. Sign and return to the bus driver.**

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

## **BUS TRANSPORTATION/EMERGENCY FORM FOR SCHOOL YEAR 2024-2025**

Since the Big Oak Flat-Groveland Unified School District is dominated by Highway 120, and all of the stops are along roads with traffic, every effort has been made to select stops which, in the opinion of bus drivers and trustees, are most protective for the children. However, parents in each stop area must instruct their children, and check on their children's behavior on the way to and from the stops and while waiting at the stop.

1. Pupils shall not cross main traveled roads at the bus stop except with the driver's assistance.
2. Pupils shall not play at the edge of the road or play running ball games which might lead to darting into the road.
3. Teach children to understand and observe all of the rules for behavior on the bus.
4. Students are to ride their assigned routes only. The routes are formed after considering home location, bus capacity, and student safety. The transportation department appreciates your support and understanding.

PARENTS: Please have your child return this slip to his or her bus driver.

1. I have read the policy regarding pupil transportation in the student handbook.
2. In case of accident or serious illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below, and to follow his instructions. If it is impossible to contact this physician, I hereby authorize the school to obtain medical care and medical treatment.

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Students Name, Grade Level and Teacher

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Street Address

Phone Number

---

Lot & Unit Number

Nearest Cross Street or Landmark

---

Brothers & Sisters Names & Grade Level

---

Any Health or Allergy Problems

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Local Physician's Name

Address

Phone Number

---

Parent Signature

Date

## FINGERPRINTING OF VOLUNTEERS

If you have fingerprints on file with the district please initial the line at the right. \_\_\_\_\_

You must be fingerprinted through the TCSOS office in Sonora to participate in field trips or volunteer for any event/classroom activity. You may obtain a form in your school office.

### PHOTO, AUDIO, OR VIDEO RELEASE FOR SCHOOL YEAR: **2024-2025**

Big Oak Flat Groveland Unified School District requests permission to reproduce, through photograph, audio, or video activities related to this student's educational program.



I hereby grant to the Big Oak Flat Groveland Unified School district and to its employees the right to use my child's image or voice for publication process, whether electronic, print, digital or electronic publishing via the Internet.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

## AUTHORIZATION FOR MEDICAL TREATMENT

As legal custodian of the student named below, and in my absence or if unable to contact me, I hereby authorize the principal or his/her designee, into whose care the aforementioned minor student has been entrusted, to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and/or dentist.

I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) 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 shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand the Big Oak Flat-Groveland Unified School District, its employees and its Board assume no liability of any nature in relation to the transportation or treatment of the said minor. 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 responsibility. I understand that the Big Oak Flat-Groveland Unified School District does not provide accident medical insurance for students for school related.

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
School & Grade

\_\_\_\_\_  
Health Insurance Provider

\_\_\_\_\_  
Policy/Plan Number

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## ANNUAL NOTICE OF YOUR RIGHTS AND RESPONSIBILITIES

SCHOOL YEAR: 2024-2025

Dear Parent or Guardian:

As required by law, I wish to notify you, as the parents/or guardians of students enrolled in our schools, of your rights and responsibilities. I ask, therefore, that you please take a moment of your time to carefully review the Parent Rights Booklet. After your review, please sign the parent/guardian acknowledgement below indicating you have received and reviewed these materials. If you have any questions regarding this information, please feel free to contact our District Office.

### PARENT/GUARDIAN ACKNOWLEDGEMENT

Education Code Section 48982 requires parents or guardians to sign and return this acknowledgment. By signing below, I am neither giving nor withholding consent for my child to participate in any program. I am merely indicating that I have received and read the booklet with notices regarding my rights relating to activities which might affect my child.

\_\_\_\_\_  
Student Name (printed)

\_\_\_\_\_  
School and Grade

### FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA) NOTICE FOR DIRECTORY INFORMATION

A federal law called The Family Educational Rights and Privacy Act (FERPA) requires that Big Oak Flat Groveland Unified School District, with certain exceptions, obtain your written consent before we release any personal information about your child. However, Big Oak Flat Groveland Unified School District may release basic information about your child, without your consent to certain organizations. For example: your student's name may be listed in the yearbook, and his or her name and weight may be listed in sporting event information. We also give student names and addresses to companies selling class rings and graduation items as well as to scholarship organizations and colleges.

\_\_\_\_\_  
Student Name (printed)

\_\_\_\_\_  
Student's Phone #

\_\_\_\_\_  
Student's Address

☐

I do NOT authorize Big Oak Flat Groveland Unified School District to release any directory information about my child.

\_\_\_\_\_  
Parent/Guardian Name (printed)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



**ACCEPTABLE USE POLICY FOR ON-LINE SERVICE**  
**FOR SCHOOL YEAR 2024-2025**

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Student Name (printed)

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Teacher and Grade

Use of the Internet provides great educational benefits to students. Unfortunately, however, some material accessible via the Internet may contain items which are illegal, defamatory, or potentially offensive to some people. Access to the Internet is a privilege for students who must act in a considerate and responsible manner. We require that students and parents/guardians read, accept and sign the following guidelines for acceptable on-line behavior before Internet use will be allowed.

- \* Students are responsible for good behavior on the Internet, just as they are in a school building. All school rules for behavior and communication apply.

- \* Downloading non-academic files from the Internet, especially, but not limited to, shareware programs, browsers and audio or video files will not be permitted.

- \* Network areas will be monitored on a regular basis. Network Administrators, the staff and other faculty may review files to maintain system integrity and ensure students are using the system responsibly. At times, surveillance will be used and students should not expect that files will be private.

- \* Internet use is for academic purposes and scheduled classes will have priority over coming into the Computer Lab individually for Internet use.

- \* The following are not permitted:

- \* The use of anonymous proxy servers or anything else that bypasses the firewall.

- \* Sending or displaying offensive messages or pictures.

- \* Using obscene language.

- \* Harassing, insulting, or attacking others.

- \* Damaging computers, computer system or network files.

- \* Other student files.

- \* Violating copyright laws.

- \* Employing the network for commercial purposes.

- \* Intentionally wasting limited resources, including the use of "chain letters" and messages broadcast to mailing lists or individuals.

- \* Revealing the personal address, phone number or e-mail address of any other person without permission.

- \* Violations will result in loss of access and other school discipline as outlined in the school code.

I have read the rules for acceptable on-line behavior, understand the rules, and agree to comply with the above stated rules. Should I violate the rules, I understand that I may lose my computer privileges, may be removed from class, may be suspended, may be expelled and may be referred to the police and will have to pay restitution for damages.

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Student Signature

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Date

As a parent or legal guardian of the minor student signing above, I grant permission for this student to access networked computer services. I understand that some materials on the Internet may be objectionable, and I accept responsibility for providing guidance to the above student on the Internet use, both inside and outside of the school setting and for conveying standards for this student to follow when selecting or exploring information and media.

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Parent/Guardian (or Student 18-years or older) Signature

---

Date

Alternative Income Form

(Complete ONE Application per Household)

SECTION A. CHILDREN INFORMATION

All Households Complete This Section. Enter all children's personal (earned) gross income, by amount, and how often received by placing a circle around the correct income codes: W=Weekly, E=Every 2 Weeks, T=Twice a Month, M=Monthly, Y=Yearly.

Racial and Ethnic Identities (optional) 1. Circle one or more racial identities: (Regardless of ethnicity) A=Asian, W=White, B=Black or African American, I=American Indian or Alaska Native, P=Native Hawaiian or other Pacific Islander

LAST NAME, FIRST NAME	SCHOOL (Write "NONE" if not in school)	GRADE	Date of Birth (Optional)	Racial and Ethnic Identities (Optional) Circle One Ethnic Identity	Circle one or more	MARK "X" if Foster Child	Mark "X" if No Income	Child's Personal Earned Income	Source of Income (Work)?	Paid How Often? (Circle)	ENTER Benefit Type: CalFresh, CalWORKS, Kin-GAP, FDPIR	ENTER Benefit Case Number
①				N OR H	A W B I P	<input type="checkbox"/>	<input type="checkbox"/>	\$		W E T M Y		
②				N OR H	A W B I P	<input type="checkbox"/>	<input type="checkbox"/>	\$		W E T M Y		
③				N OR H	A W B I P	<input type="checkbox"/>	<input type="checkbox"/>	\$		W E T M Y		
④				N OR H	A W B I P	<input type="checkbox"/>	<input type="checkbox"/>	\$		W E T M Y		
⑤				N OR H	A W B I P	<input type="checkbox"/>	<input type="checkbox"/>	\$		W E T M Y		

If the child you are applying for is Homeless, Migrant, or Runaway, contact the school and CIRCLE appropriate letter: H M R

Households submitting an application with a Benefit Case Number for CalFresh/CalWORKS for EACH child or an Adult household member, please skip to Section C and complete.

A Foster Child is under the legal responsibility of a foster care agency or court.

SECTION B. ALL OTHER HOUSEHOLD MEMBERS:

Enter Gross Income Under Each Income Type each Household Member Receives and "How Often" the Income is Received by using the following Income Codes: W=Weekly, E=Every 2 Weeks, T=Twice a Month, M=Monthly, Y=Yearly. If No Income, You MUST Mark the "No Income box." DO NOT Leave Blank.

Adult's Full Name (Do not repeat names from Section A)	MARK "X" if No Income	Gross Earnings from Work Before Deductions, Include All jobs	Paid How Often?	Indicate Pay from Pensions, Retirement, Social Security, VA benefits	Income Source?	Paid How Often?	Welfare Benefits, Child Support, Alimony Payments	Income Source?	Paid How Often?	Any Other Income, Including Temporary Income	Income Source?	Paid How Often?	Enter Benefit Type: CalFresh, CalWORKS, Kin-GAP, FDPIR	Enter Benefit
Richard, Larath	<input type="checkbox"/>	\$ 199.98	W	\$ 141.65	Pension	Y	\$ 99.99	Child Support	M	\$ 550.00	Rental Income	M		
①	<input type="checkbox"/>	\$		\$			\$			\$				
②	<input type="checkbox"/>	\$		\$			\$			\$				
③	<input type="checkbox"/>	\$		\$			\$			\$				
④	<input type="checkbox"/>	\$		\$			\$			\$				
⑤	<input type="checkbox"/>	\$		\$			\$			\$				

SECTION C. CONTACT INFORMATION, CERTIFICATIONS, AND SIGNATURE:

This form may be submitted at any time during a school day.

I certify (promise) that all of the above information is true and correct and that all income is reported. I understand that this information is given in connection with the receipt of state funds and school officials may verify the information on the application at any time, and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and federal laws.

Printed name of adult household member completing this form \_\_\_\_\_ Signature of adult household member completing this form \_\_\_\_\_ Date \_\_\_\_\_

Street Address, Apt #, etc. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

Application Status: \_\_\_\_\_ HSLD Size: \_\_\_\_\_ HSLD Annual Income: \$ \_\_\_\_\_

- ☐ Approved based on:  
☐ Income
- ☐ Denied based on:  
☐ Income Too High  
☐ Incomplete

Annual Income Conversion Factors: Weekly X 52, Every 2 Weeks X 26, Twice A Month X 24, Monthly X 12

Determining Official's Signature & Date \_\_\_\_\_  
Confirming Official's Signature & Date \_\_\_\_\_  
Verification Official's Signature & Date \_\_\_\_\_



SECCIÓN A. INFORMACIÓN DE NIÑOS

Todas las Familias Completen Esta Sección. Anote el ingreso bruto (ganado) personal de todos los niños, por cantidad, y qué tan seguido es recibido al colocar un círculo alrededor de los Códigos de Ingresos correctos: S=Semanal, C=Cada 2 semanas, D=Dos veces al mes, M=Mensualmente, A=Anualmente. Identidades Raciales y Étnicas (opcional) 1. Encierre en un círculo una Identidad Étnica: N=No Hispano/Latino o H=Hispano/Latino 2. Encierre en un círculo una o más identidades raciales: (Independientemente de la etnia) A=Asiático, B=Blanco, N=Negro o Afroamericano, I=Indígena Americano o Nativo Alaska, P=Native Hawaiano u otro Isleño Pacífico

APELLIDO, NOMBRE	ESCUELA (Escriba "NINGUNA" si no está en la escuela)	AÑO EN LA ESCUELA	Fecha de Nacimiento (Opcional)	Identidades Raciales y Étnicas: (Opcional)		MARQUE "X" si Niño Acogido	MARQUE "X" si No Hay Ingreso	Ingreso Ganado Personal del Niño	Fuente del Ingreso ¿(Trabajo)?	¿Qué Tan Seguido Se Le Paga? (Encierre)	Anoté el Tipo de Beneficio: CalFresh, CalWORKs, Kin-GAP, FDIPIR	Anoté el Número de Caso del Beneficio
				Encierre en un círculo Una Identidad Étnica	Encierre en un círculo una o más identidades Raciales							
①				N o H	A B N I P	<input type="checkbox"/>	<input type="checkbox"/>	\$		S C D M A		
②				N o H	A B N I P	<input type="checkbox"/>	<input type="checkbox"/>	\$		S C D M A		
③				N o H	A B N I P	<input type="checkbox"/>	<input type="checkbox"/>	\$		S C D M A		
④				N o H	A B N I P	<input type="checkbox"/>	<input type="checkbox"/>	\$		S C D M A		
⑤				N o H	A B N I P	<input type="checkbox"/>	<input type="checkbox"/>	\$		S C D M A		

Si el niño por quien solicita Carece de Hogar, Migrante, o Fugitivo, contacte la escuela y ENCIERRE en un círculo letra apropiada: C M F

Familias presentando una solicitud con un Número de Caso del Beneficio para CalFresh/CalWORKs para CADA niño o un miembro Adulto de la familia, por favor brinque a la Sección C y complete.

Un Niño Acogido está bajo la responsabilidad legal de una agencia de cuidado de crianza temporal o del tribunal.

SECCIÓN B. TODOS LOS OTROS MIEMBROS DE FAMILIA:

Anote el Ingreso Bruto Bajo Cada Tipo de Ingreso Cada Miembro de la Familia Recibe y "Qué Tan Seguido" se Recibe el Ingreso al usar los siguientes Códigos de Ingreso: S=Semanal, C=Cada 2 semanas, D=Dos veces al mes, M=Mensualmente, A=Anualmente. Si No Hay Ingreso, Usted TIENE QUE Marcar la "caja Sin Ingreso". NO la Deje en Blanco.

Nombre y Apellido Completo del Adulto (No repita nombres de la Sección A)	MARQUE "X" Si No Hay Ingreso	Ganancias Brutas del Trabajo Antes de Deducciones, Incluya Todos los Trabajos	¿Qué Tan Seguido Se Le Paga?	Indique Pago de Pensiones, Jubilación, Seguro Social, Beneficios VA	¿Fuente del Ingreso?	¿Qué Tan Seguido Se Le Paga?	Beneficios de Asistencia Social, Manutención de Niños, Pagos de Pensión Alimenticia	¿Fuente del Ingreso?	¿Qué Tan Seguido Se Le Paga?	Cualquier Otro Ingreso Incluyendo Ingreso Temporal	¿Fuente del Ingreso?	¿Qué Tan Seguido Se Le Paga?	Anoté el Tipo de Beneficio: CalFresh, CalWORKs, Kin-GAP, FDIPIR	Anoté el Número de Caso del Beneficio
Richard, Larath	<input type="checkbox"/>	\$ 199.98	S	\$ 141.65	Pensión	A	\$ 99.99	Manutención de Niños	M	\$ 550.00	Ingreso por herencia	M		
①	<input type="checkbox"/>	\$		\$			\$			\$				
②	<input type="checkbox"/>	\$		\$			\$			\$				
③	<input type="checkbox"/>	\$		\$			\$			\$				
④	<input type="checkbox"/>	\$		\$			\$			\$				
⑤	<input type="checkbox"/>	\$		\$			\$			\$				

SECCIÓN C. INFORMACIÓN DE CONTACTO, CERTIFICACIONES, Y FIRMA:

Este formulario puede ser entregado a cualquier hora del día escolar.

Yo certifico (prometo) que toda información antedicha es verídica y correcta y que todo ingreso es reportado. Tengo entendido que esta información se da en conexión con el recibir fondos estatales y los funcionarios escolares pueden verificar la información en la solicitud a cualquier hora, y que falsedad intencionada de la información me puede sujetar a enjuiciamiento bajo las leyes aplicables Estatales y Federales.

Nombre y apellido escrito en letra de molde del miembro adulto de la familia completando este formulario

Fecha

X

Domicilio de Calle, # Apt., etc.	Ciudad	Estado	Zona Postal	Núm. Tel. de Casa	Núm. Tel. Celular	Domicilio Electrónico

Estado de Solicitud:

- ☐ Aprobada basado en:
  - ☐ Ingreso
- ☐ Negada basado en:
  - ☐ Ingreso muy elevado
  - ☐ Incompleta

No. de personas en fam.: \_\_\_\_\_ Ingreso anual de la fam.: \$ \_\_\_\_\_

Factores de Conversión del Ingreso Anual: Semanal X 52, Cada 2  
semanas X 26, Dos veces al mes X 24, Mensualmente X 12

Firma del Funcionario Determinando y Fecha

\_\_\_\_\_

Firma del Funcionario Confiando y Fecha

\_\_\_\_\_

Firma del Funcionario Verificando y Fecha

\_\_\_\_\_

# Smile Keepers Dental Disease Prevention Program

Consent Form 2024-2025



Dear Parents/Guardians,

Your child's class will be participating in the Smile Keepers Dental Disease Prevention Program this school year. Children in this program will:

1. Learn to prevent cavities and gum disease
2. Learn to brush and floss their teeth
3. Have a basic dental screening
4. Receive fluoride varnish applications during the school year

There is no fee to participate in this program; **PLEASE SIGN THIS FORM** for your child to participate with the rest of the class. Please have your child return this form immediately.

## 1. Your Childs Information:

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Grade: \_\_\_\_\_  
Name of School: Tenaya Elementary Teacher: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Parent/Guardian/Relation to Child: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Siblings(Name/Age/Grade): \_\_\_\_\_

## 2. Dental History, Health History & Health Coverage:

Does your child currently have a dentist they see **every 6 months**? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of your child's regular dentist(If applicable): \_\_\_\_\_

Dental Insurance? (please mark one) None \_\_\_\_\_ Medi-cal \_\_\_\_\_ Private Insurance \_\_\_\_\_

Do you need help finding a dentist? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child have any medical conditions/allergies we should be aware of? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

## 3. Consent for Dental Services:

I give consent for my child to receive dental services by the providers at Smile Keepers Dental Disease Prevention Program. These dental services include limited oral evaluation and protective fluoride treatment. I understand a limited oral evaluation is only a very basic assessment and does not take the place of a full dental exam. I understand I would need to secure the service of a dentist in order for my child to receive a complete dental exam necessary to establish and maintain oral health. As stated in CA ED code section 35330, I agree to hold the TCSOS, it's officers, agents, and employees harmless from any liability claims which may arise out of, or in connection with my child's participation in this activity.

## 4. Consent to Share Information:

Your child's information will be kept confidential. Tuolumne County Public Health Department uses health screenings to link children who need treatment to providers and plan and evaluate countywide public health programs. Tuolumne County Public Health Department may report screening results to government agencies and policymakers in terms of total number of children served. Your child's personal information will not be shared with other agencies or anyone other than your child's school without your written permission.



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

**Parent/Guardian Signature:** \_\_\_\_\_

**For more information, please contact Ocean Arellano , RDHAP (209)536-2072,  
or Erika Hagstrom-Dossi, RDA (209)536-2014**



# Dental Report:

## First Visit:

Date: \_\_\_\_\_

Examiner: \_\_\_\_\_

## Treatment:

Varnish: \_\_\_\_\_

## Class:

I \_\_\_\_\_

II \_\_\_\_\_

III \_\_\_\_\_

## History:

Yes \_\_\_\_\_

No \_\_\_\_\_

## Ortho:

In Tx. \_\_\_\_\_

Tx. History \_\_\_\_\_

## Sealant:

Yes \_\_\_\_\_

Rec. \_\_\_\_\_

## OHI

Rev: \_\_\_\_\_

## Second Visit:

Date: \_\_\_\_\_

Examiner: \_\_\_\_\_

## Treatment:

Varnish: \_\_\_\_\_

## Class:

I \_\_\_\_\_

II \_\_\_\_\_

III \_\_\_\_\_

## History:

Yes \_\_\_\_\_

No \_\_\_\_\_

## Ortho:

In Tx. \_\_\_\_\_

Tx. History \_\_\_\_\_

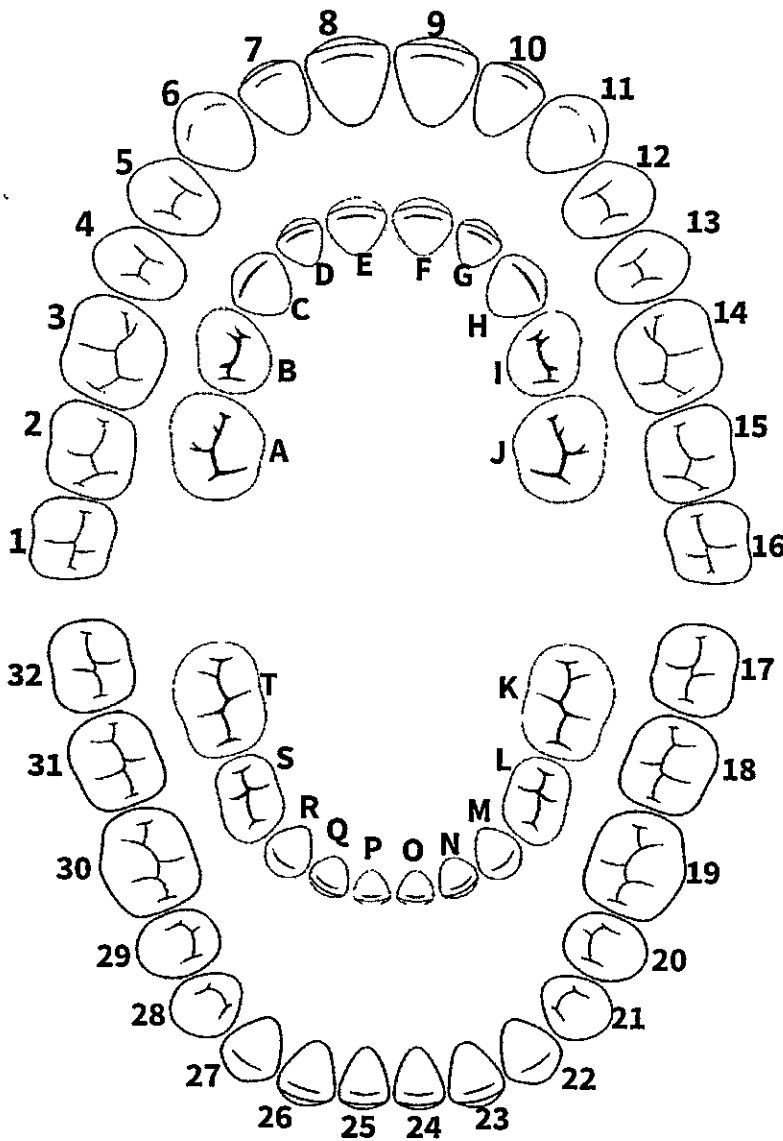
## Sealant:

Yes \_\_\_\_\_

Rec. \_\_\_\_\_

## OHI

Rev: \_\_\_\_\_



Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



2024/2025 School Year

School/Site: \_\_\_\_\_

Amador Tuolumne Community Action Agency (ATCAA)  
(209) 984-3960 x101

## KIDS CLUB PROGRAM APPLICATION

**\*Please only fill out if you are eligible and want this program\***

If your children don't attend the same school, you must fill out a separate application for each child.

PRINT LEGIBLY

Student Name \_\_\_\_\_ Age \_\_\_\_\_ Teacher \_\_\_\_\_

Student Name \_\_\_\_\_ Age \_\_\_\_\_ Teacher \_\_\_\_\_

Student Name \_\_\_\_\_ Age \_\_\_\_\_ Teacher \_\_\_\_\_

Student Name \_\_\_\_\_ Age \_\_\_\_\_ Teacher \_\_\_\_\_

Parent or Guardian \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone or Message Number \_\_\_\_\_

### Household Member Information -Include everyone in household

Name	Age	Name	Age
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Number of Household Members:      1      2      3      4      5      6      7      8      9+

**Did you know that your family may qualify for other ATCAA Programs?**

Would you like someone to contact you from one of our other programs? **Yes** or **No** (please circle one)

Please circle all that you would like information about:

Head Start Programs    Youth Programs    Family & Adult Programs    Housing    Weatherization    Other Food Distributions

### Verification of Eligibility

I certify under penalty of perjury that my household income does not exceed the monthly guidelines listed below or for the past 12 months does not exceed the annual income guidelines listed below and those foods received will be for personal home use and will not be sold, traded, or given away.

Number in Household	Total Monthly Income	Max. Yearly Income	Number in Household	Total Monthly income	Max. Yearly Income
1	\$2,855.25	\$34,263.00	6	\$7,888.17	\$94,658.00
2	\$3,861.83	\$46,342.00	7	\$8,894.75	\$106,737.00
3	\$4,868.42	\$58,421.00	8	\$9,901.33	\$118,816.00
4	\$5,875.00	\$70,500.00	Over 8	Add \$1,006.59 each	Add \$12,079.00 each
5	\$6,881.58	\$82,579.00			

I certify that my income does not exceed \$ \_\_\_\_\_ for a family of \_\_\_\_\_ persons.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Provided by California Department of Social Services Emergency Food Assistance Program, U.S. Department of Health and Human Services Community Food and Nutrition Program, California Emergency Foodlink, and the Amador Tuolumne Community Action Agency Food Bank. No person shall be discriminated against in participating, due to