TENAYA ELEMENTARY SCHOOL

PLEASE UPDATE YOUR CHANGE OF EMERGENCY CONTACT INFORMATION.

IF WE ARE UNABLE TO REACH YOU, PLEASE LIST WHO HAS PERMISSION TO PICK UP YOUR CHILD AT THE END OF THE SCHOOL DAY, OR IN THE EVENT OF ILLNESS OR INJURY.

Name of Student_____ Teacher_____

_____

Name of Contact/Phone Number of Contact - Indicate "H" for home, "C" for cell, "W" for work

_____

Name of Contact/Phone Number of Contact - Indicate "H" for home, "C" for cell, "W" for work

_____

Name of Contact/Phone Number of Contact - Indicate "H" for home, "C" for cell, "W" for work

Parent/Guardian Name_____

Address_____

Phone #_____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to obtain medical care and medical treatment for my child.

_____ _____ _____

Signature of Parent/Guardian Relationship to Student Date

BUS TRANSPORTATION/EMERGENCY FORM

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.

_____

Students Name, Grade Level and Teacher

_____

Street Address Phone Number

_____

Lot & Unit Number Nearest Cross Street or Landmark

_____

Brothers & Sisters Names & Grade Level

_____

Any Health or Allergy Problems

_____

Local Physician's Name Address Phone Number

_____

Parent Signature Date

STUDENT TRANSPORTATION RULES

THE FOLLOWING RULES APPLY TO ALL STUDENTS RIDING SCHOOL BUSES:

1. Students transported in 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 buys.
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 persons.
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 parent 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 suspension 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.

1st offense: Warning letter sent home
2nd offense: 3 days off the bus- letter sent home (High school 5 days)
3rd offense: 5 days off the bus – letter sent home (High School 10 days)
4th offense: 10 days off the bus – letter sent home (High School Remainder of the Semester or 3 Months – whichever is longer)
5th offense: Off 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_____

Date _____
Teacher _____
Grade _____

MEDICAL INFORMATION

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 medicaitons 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

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

Smile Keepers Dental Disease Prevention Program

Consent Form

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 two fluoride varnish applications during the school year

There is no cost to participate in this program, however **YOU MUST SIGN THIS FORM** for your child to participate with the rest of the class.

1. Your Child's Information

Child's Name _____ Age _____

Name of School *Tenaya Elementary School* Grade _____

Child's Birth Date Month Day Year Teacher/Room # _____

Home Phone Number _____ Cellular Number _____

Emergency Contact: Name _____ Phone _____

2. Dental History & Health Coverage

Does your child currently have a dentist they see every 6 months? ❒ Yes ❒ No

Does your child have dental insurance? ❒ Yes ❒ No If yes, which type of dental insurance? ❒ Medi-Cal ❒ Private ❒ Other

Name of child's regular dentist (if applicable): _____

Would you like help finding a dentist for your child? ❒ Yes ❒ No

3. Health History

Does your child have any medical conditions we should be aware of? ❒ Yes ❒ No

Please explain: _____

4. 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.

5. 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.

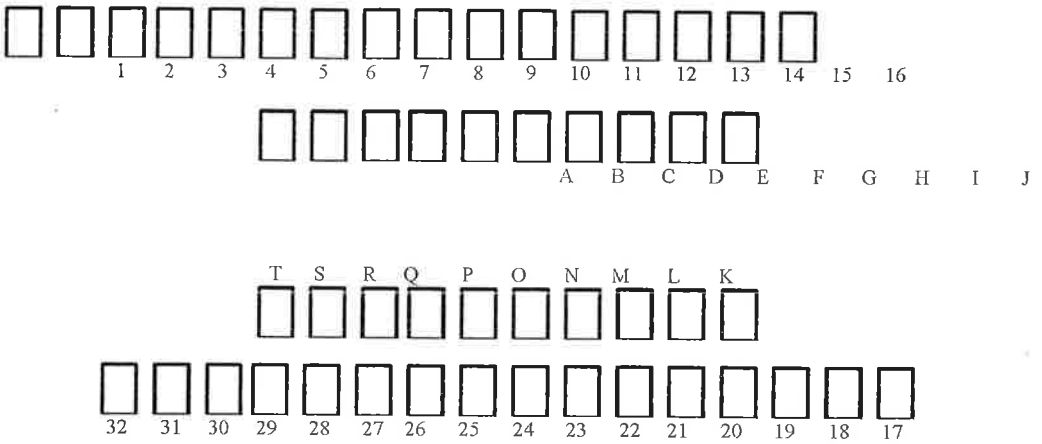
Parent/Guardian Signature : _____ Date: ____/____/____

For more information, please contact Erika Hagstrom Dossi, RDA or Ocean Arellano, RDHAP, at (209)536-2014. Please have your child return this form to his/her teacher immediately.

SMILE KEEPERS SCHOOL BASED DENTAL PROJECT

FIRST VISIT: DATE: _____ EXAMINER: _____

SCREENING

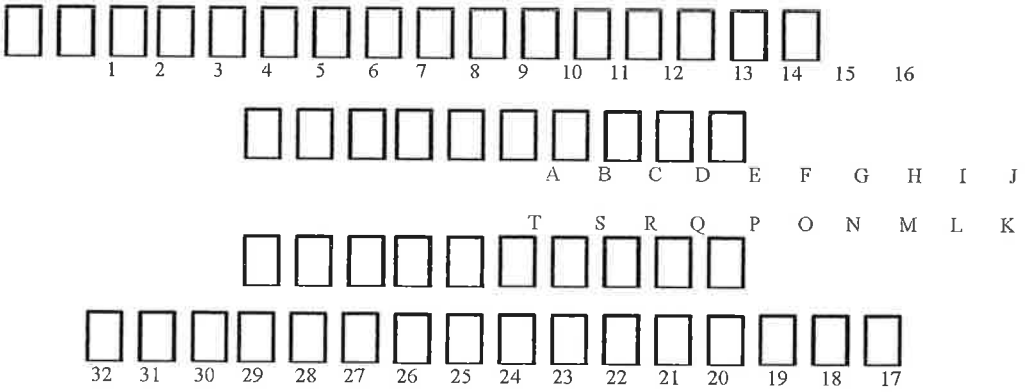


TREATMENT: **SCREEN ONLY** **PROPHY** **VARNISH #1**

CLASS: I II III **CARIES FREE** **HISTORY:** Y N **ALREADY SEALED**: Y N

SECOND VISIT: DATE: _____ EXAMINER: _____

SCREENING



TREATMENT: **SCREEN ONLY** **PROPHY** **VARNISH #2**

CLASS: I II III **CARIES FREE** **HISTORY:** Y N **ALREADY SEALED**: Y N

School Year 2020–2021 Big Oak Flat Groveland USD Application for Free and Reduced-Price Meals Complete one application per household.

Please read the instructions on how to apply. Print clearly with a pen. This institution is an equal opportunity provider.

California *Education Code* Section 49557(a): Applications for free and reduced-price meals may be submitted at any time during a school day. Children participating in the federal National School Lunch Program will not be overtly identified by the use of special tokens, special tickets, special serving lines, separate entrances, separate dining areas, or by any other means.

STEP 1 – STUDENT INFORMATION

Children in **Foster Care** and children who meet the definition of **Homeless**, **Migrant**, or **Runaway** are eligible for free meals.

Print the name of **EACH STUDENT** (First, Middle Initial, Last) **EXAMPLE: Joseph P Adams**	Enter **school name** and **grade level**		Enter **student's birthdate**	Check the applicable box if the student is **foster, homeless, migrant,** or **runaway**			
	Lincoln Elementary	**1st**	**12-15-2010**	Foster	Homeless	Migrant	Runaway

STEP 2 – ASSISTANCE PROGRAMS: CalFresh, CalWORKs, or FDPIR

Do ANY household members (child or adult) currently participate in CalFresh, CalWORKs or FDPIR? **If NO**, skip STEP 2 and continue to STEP 3.

If YES, check the applicable program box, enter one case number, skip STEP 3, and continue to STEP 4.	**Select Program Type:** **CalFresh** **CalWORKs** **FDPIR**	**Enter Case Number:**

STEP 3 – REPORT INCOME FOR ALL HOUSEHOLD MEMBERS (Skip this step if you answered 'YES' in STEP 2)

A. STUDENT INCOME: Sometimes students in the household earn income. Enter the **TOTAL GROSS** income (before deductions) in whole dollars earned by all students listed in STEP 1. **Enter the appropriate pay period in the "How Often" box: W = Weekly, 2W = Biweekly, 2M = Twice a Month, M = Monthly, Y = Yearly**

Total Student Income	**How Often**
$	

B. ALL OTHER HOUSEHOLD MEMBERS (including yourself): List **ALL** household members not listed in STEP 1, **even if they do not receive income**. For each household member, report the **TOTAL GROSS** income (before deductions) in whole dollars for each source. If the household member does not receive income from any sources, write "0". If you enter "0" or leave any fields blank, you are certifying (promising) that there is no income to report.

Enter the appropriate pay period in the "How Often" box: W = Weekly, 2W = Biweekly, 2M = Twice a Month, M = Monthly, Y = Yearly

Print the name of **ALL OTHER** Household Members (First and Last)	Earnings from Work	**How Often**	Public Assistance/SSI/ Child Support/Alimony	**How Often**	Pensions/Retirement/All Other Income	**How Often**
	$		$		$	
	$		$		$	
	$		$		$	
	$		$		$	

C. Total Household Members (Children and Adults)

D. Enter the last four digits of Social Security number (SSN) from the Primary Wage Earner or Other Adult Household Member

Check the box if NO SSN

STEP 4 – CONTACT INFORMATION & ADULT SIGNATURE

Certification: I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable state and federal laws.

OPTIONAL – CHILDREN'S ETHNIC AND RACIAL IDENTITIES

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced-price meals.

Ethnicity (check one):

Hispanic or Latino Not Hispanic or Latino

Race (check one or more):

American Indian or Alaskan Native Asian Black or African American

Native Hawaiian or other Pacific Islander White

DO NOT COMPLETE. SCHOOL USE ONLY

How Often? ☐ Weekly ☐ Bi-Weekly ☐ Twice a Month ☐ Monthly ☐ Yearly

Annual Income Conversion: Weekly x52, Biweekly x26, Twice a Month x24, Monthly x12

Total Household Income $

Total Household Size

Eligibility Status: ☐ Free ☐ Reduced-price ☐ Paid (Denied) ☐ Categorical

Verified as: ☐ Homeless ☐ Migrant ☐ Runaway ☐ Error Prone