

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 _____

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 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

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

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 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 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 _____

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 2021-2022

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

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

Student Name (printed)

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.

Student Signature

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.

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

Date

*****USE BLACK OR BLUE INK AND PRINT NEATLY WITHIN BOXES*****

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 Ethnic Identity: N=Not Hispanic/Latino or H=Hispanic/Latino or A=Asian, W=White, B=Black or African American, J=American Native 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)		MARK "X" if Foster Child	Child's Personal Earned Income	Source of Income (Work?)	Paid How Often? (Circle)	ENTER Benefit Type: CalFresh, CalWORKS, Kin-GAP, FDIPIR	ENTER Benefit Case Number
				Circle One Ethnic Identity	Circle one or more						
①				N OR H	A W B I P	<input type="checkbox"/>	\$		W E T M Y		
②				N OR H	A W B I P	<input type="checkbox"/>	\$		W E T M Y		
③				N OR H	A W B I P	<input type="checkbox"/>	\$		W E T M Y		
④				N OR H	A W B I P	<input type="checkbox"/>	\$		W E T M Y		
⑤				N OR H	A W B I P	<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		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, FDIPIR
				Income Source?	Paid How Often?							
Richard, Larath	<input type="checkbox"/>	\$ 199.98	W	\$ 141.65	Pension	\$ 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:

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.

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

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

Determining Official's Signature & Date _____

Confirming Official's Signature & Date _____

Verification Official's Signature & Date _____

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

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 Child's Information:

Name: _____ Age: _____

Name of School: Tenaya Elementary Grade: _____

Date of Birth: _____ Teacher: _____

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*

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