TK - Kindergarten Enrollment Forms 2025-2026

Parents/Guardians:

In order to enroll your student, the following documents are required and must be provided with the attached enrollment application:

Original or certified copy of the child's **birth certificate**

Complete and up to date s**hot records**

Proof of residence within the Gold Oak Union School District (examples: utility bill/rental or sales agreement).

For incoming kindergarten or transitional kindergarten, the following items are required prior to the first day of school:

CHDP (Wellness Check) Form attached-to be completed by your child's doctor

Oral Health Assessment Form attached-to be completed by your child's dentist

GOLD OAK UNION SCHOOL DISTRICT

STUDENT ENROLLMENT FORM

❒ GOLD OAK SCHOOL (*Do not remove this form from folder)* ❒ PLEASANT VALLEY SCHOOL

Please Print

Student's Name _____
Last First Middle

Student's **Legal** Name (If different from name listed above)_____

_____ _____ _____ _____
Grade Entering Sex (M/F/Nonbinary) Birth Date (MM/DD/YR) Birth Place (City and State)

_____ _____ _____ _____ _____ ❒ YES ❒ NO
Physical Address City Zip Code Home Phone Unlisted?

☐ Current address is a temporary living arrangement. ☐ Temporary living arrangement is due to loss of housing or economic hardship.

_____ _____ _____
Mailing Address (if different from above) City Zip Code

IF STUDENT RESIDES WITH SOMEONE OTHER THAN A PARENT OR LEGAL GUARDIAN - A CAREGIVER AFFIDAVIT MUST BE COMPLETED.

Parent/Legal Guardian _____ Living with child? ❒ YES ❒ NO

Email_____

Parent Highest Education Level:

☐Not high school graduate ☐High school graduate ☐Some academic college ☐College graduate ☐Graduate school/post graduate training

_____ _____ _____ _____ _____ _____
Address (If different from student) City Zip Code Employer Work Phone Cell Phone

Active Duty Military ☐ Army/Navy/Air Force/Marines/Coast Guard

Parent/Legal Guardian _____ Living with child? ❒ YES ❒ NO

Email_____

Parent Highest Education Level:

☐Not high school graduate ☐High school graduate ☐Some academic college ☐College graduate ☐Graduate school/post graduate training

_____ _____ _____ _____ _____ _____
Address (If different from student) City Zip Code Employer Work Phone Cell Phone

Active Duty Military ____Army/Navy/Air Force/Marines/Coast Guard

OTHER CHILDREN IN THE FAMILY

Name	Date of Birth	School Attending	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LANGUAGE SURVEY STATE OF CALIFORNIA, DEPT. OF EDUCATION, FORM HLS REV DEC 2016

The California Education Code, Section 52164.1(a) contains legal requirements which direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with these requirements. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered. If an error is made completing this home language survey, you may request correction before your student's English proficiency is assessed.

Which language did your child first learn to speak? _____
Which language does your child use most frequently at home? _____
Which language do you most frequently use to speak to your child? _____
Which language is most often spoken by the adults in the home? _____

PLEASE ANSWER QUESTIONS 1 AND 2

1. **Is student's ethnicity Hispanic or Latino?** ***(choose only one)*** ☐ No, Not Hispanic or Latino ☐ Yes, Hispanic or Latino
2. **What is the student's race** ***(choose one or more)***

100 - American Indian or Alaska Native
600 - African American/Black
700 - White
201 – Chinese 202 – Japanese
203 - Korean 204 - Vietnamese
205 - Asian Indian 206 - Laotian
207 – Cambodian 208 - Hmong
299 - Other Asian 301 - Hawaiian
302 – Guamanian 303 - Samoan
304 - Tahitian
399 - Other Pacific Islander
400 - Filipino

SPECIAL PROGRAM INFORMATION		
Has your child ever been enrolled in a Title I program?	Yes ❒	No ❒
Has your child ever been enrolled in a Special Education Program?	Yes ❒	No ❒
If yes, does your child have a current Individualized Education Plan (IEP)?	Yes ❒	No ❒
Has your child ever been enrolled in a G.A.T.E. Program (Grade 3-8)?	Yes ❒	No ❒
Does your child qualify for Adaptive Physical Education?	Yes ❒	No ❒
Does your child currently have a 504 plan?	Yes ❒	No ❒

HEALTH INFORMATION - LIST ANY MEDICAL PROBLEMS, IMPAIRMENTS, NEEDS OR SERVICES WHICH THE SCHOOL SHOULD BE AWARE.

Sight: _____

Hearing: _____

Speech: _____ Other: _____

COUNSELING SERVICES:_____

DOES YOUR CHILD HAVE A PHYSICAL DISABILITY? Yes ❒ No ❒

PLEASE SPECIFY _____

DOES YOUR CHILD HAVE ANY HEALTH PROBLEMS? Yes ❒ No ❒

PLEASE SPECIFY _____

DOES YOUR CHILD TAKE MEDICATION DAILY? Yes ❒ No ❒

If yes, what type _____ Dosage _____ Time of day _____

HAS YOUR CHILD EVER BEEN EXPELLED FROM SCHOOL? Yes ❒ No ❒

If yes, a brief explanation _____

_____

Expulsion Date: _____ Readmission Date: _____

OPTIONAL: IS THERE ANY ADDITIONAL INFORMATION THAT YOU FEEL THE SCHOOL SHOULD BE AWARE OF REGARDING YOUR CHILD?

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**

ALL INFORMATION IS NEEDED FOR SCHOOL RECORDS AND IS REGARDED AS CONFIDENTIAL.

Last school attended_____

ADDRESS _____ PHONE_____

TO BE COMPLETED BY SCHOOL PERSONNEL:

DATE REGISTERED _____ **DATE ENTERED** _____ **STUDENT #** _____

GRADE LEVEL _____ **HOMEROOM/TEACHER PLACEMENT** _____

DATE CUM REQUESTED _____

GOLD OAK SCHOOL
Health Inventory Form

Student's Name_____ Male ☐ Female ☐

Birthdate_____ Grade_____ Telephone _____

Home Address _____

Health History (Please check those which your child has had):

☐ Chicken Pox	☐ Diabetes	☐ Frequent Ear Infections
☐ Strep Throat (Repeated)	☐ Heart Disease	☐ Hearing Loss
☐ Scarlet Fever	☐ Convulsions	☐ Fainting Spells
☐ Wears Glasses	☐ Hepatitis	☐ Asthma
☐ Cerebral Palsy	☐ Speech Problems	☐ Bed Wetting
☐ Allergies: to What?_____		

Please explain below any other serious illness, unusual birth or developmental history, operations, hospitalization or injury, give age when occurred and any permanent after effects:

Physician _____ Telephone Number _____

Dentist _____ Telephone Number _____

Family Members (Living at Home)	Relationship To Child	Special Health Issues

Parent/Guardian Signature_____ Date _____

.Gold Oak Union School District

Request for Student Records

3171 Pleasant Valley Road
Placerville, CA 95667
(530) 626-3160

Please send the cumulative records (including health records, intelligence and achievement test records, and ***confidential files***—physiological testing, assessment and placement) for the following children who have enrolled in our school:

Student Name	**Date of Birth**	**Enrolled in Grade**
_____	_____	_____
_____	_____	_____
_____	_____	_____

AUTHORIZATION FOR RELEASE OF INFORMATION

In accordance with Public Law 93-380, I hereby authorize the release of psychological, medical and academic information regarding my child(ren) listed above.

_____ _____
Signature of parent or guardian *Dated*

Please send all records to:

☐ **Gold Oak School**
Attention Registrar
3171 Pleasant Valley Road
Placerville, CA 95667

☐ **Pleasant Valley School**
Attention Registrar
4120 Pleasant Valley Road
Placerville, CA 95667

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) says every child must have a dental check-up (assessment) by May 31st of his/her first year in public school. A California licensed dental professional must do the check-up and fill out Section 2 of this form. If your child had a dental check-up in the last 12 months, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out the separate Waiver of Oral Health Assessment Requirement Form.

This assessment will let you know if there are any dental problems that need attention by a dentist. This assessment will also be used to evaluate our oral health programs. Children need good oral health to speak with confidence, express themselves, be healthy and, ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of California's children.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's Birth Date: MM – DD – YYYY
Address:			Apt.:
City:			ZIP Code:
School Name:	Teacher:	Grade:	Year child starts kindergarten: Y Y Y Y
Parent/Guardian First Name:	Parent/Guardian Last Name:		Child's Gender: ☐ Male ☐ Female

Child's Race/Ethnicity:		
	☐ White	☐ Native American
	☐ Black/African American	☐ Multi-racial
	☐ Hispanic/Latino	☐ Native Hawaiian/Pacific Islander
	☐ Asian	☐ Unknown
	☐ Other (please specify)	

Continued on Next Page

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: MM – DD – YYYY	Untreated Decay (Visible Decay Present) ☐Yes ☐No	*Caries Experience (Visible decay and/or fillings present) ☐Yes ☐No

Treatment Urgency:

◯ **No obvious problem found**

◯ **Early dental care recommended** (caries without pain or infection; or child would benefit from sealants or further evaluation)

◯ **Urgent care needed** (pain, infection, swelling or soft tissue lesions)

_____	_____	MM – DD – YYYY _____
Licensed Dental Professional Signature	***CA License Number***	***Date***

*Check "Yes" for Caries experience if there is presence of untreated decay or fillings
Check "No" for Caries experience if there is no untreated decay and no fillings

Section 3: Follow-up to Urgent Care (Filled out by entity responsible for follow up)

Parent notified that child has urgent dental care need on:	MM – DD – YYYY
A follow-up appointment for this child has been scheduled for:	MM – DD – YYYY

Did child receive needed treatment?

◯ **Yes**

◯ **No** (If no, entity responsible for follow-up will be encouraged to check back in with parent)

◯ **I don't know**

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.

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTH DATE—Month/Day/Year

ADDRESS—Number, Street	City	ZIP code	SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	_____/_____/_____
Physical Examination	_____/_____/_____
Dental Assessment	_____/_____/_____
Nutritional Assessment	_____/_____/_____
Developmental Assessment	_____/_____/_____
Vision Screening	_____/_____/_____
Audiometric (hearing) Screening	_____/_____/_____
TB Risk Assessment and Test, if indicated	_____/_____/_____
Blood Test (for anemia)	_____/_____/_____
Urine Test	_____/_____/_____
Blood Lead Test	_____/_____/_____
Other	_____/_____/_____

IMMUNIZATION RECORD

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

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

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

RESULTS AND RECOMMENDATIONS

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

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

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

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

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

Signature of parent or guardian — Date

Name, address, and telephone number of health examiner

Signature of health examiner — Date

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

INFORME DEL EXAMEN DE SALUD PARA EL INGRESO A LA ESCUELA

Para proteger la salud de los niños, la ley de California exige que antes de ingresar a la escuela todos los niños tengan un examen médico de salud. Por favor, pidale al examinador de salud que llene este informe y entregelo a la escuela—este informe sera archivado por la escuela en forma confidencial.

PARTE I PARA SER LLENADO POR EL PADRE/LA MADRE O EL GUARDIÁN

NOMBRE DEL NIÑO/NIÑA—Apellido	Primer Nombre	Segundo Nombre	FECHA DE NACIMIENTO—Mes/Día/Año

DOMICILIO—Número y Calle	Ciudad	Zona Postal	Escuela

PARTE II PARA SER LLENADO POR EL EXAMINADOR DE SALUD

EXAMEN DE SALUD

AVISO: Todas las pruebas y evaluaciones excepto el análisis de sangre para el plomo deben ser hechas después de la edad de 4 años y 3 meses.

PRUEBAS Y EVALUACIONES REQUERIDAS	FECHA(mm/dd/aa)
Historia de Salud	_____/_____/_____
Examen Físico	_____/_____/_____
Evaluación de Dientes	_____/_____/_____
Evaluación de Nutrición	_____/_____/_____
Evaluación del Desarrollo	_____/_____/_____
Pruebas Visuales	_____/_____/_____
Pruebas con Audiómetro (auditivas)	_____/_____/_____
Evaluacion de Riesgo y prueba Tuberculosis*	_____/_____/_____
Análisis de Sangre (para anemia)	_____/_____/_____
Análisis de Orina	_____/_____/_____
Análisis de Sangre para el plomo	_____/_____/_____
Otra	_____/_____/_____

REGISTRO DE INMUNIZACIONES

Aviso al Examinador: Por favor dé a la familia, una vez completado, o a la fecha, el Registro de Inmunización de California en papel amarillo.
Aviso a la Escuela: Por favor apunte las fechas de inmunización sobre el Registro de Inmunización de la escuela de California en papel azul.

VACUNA	FECHA EN QUE CADA DOSIS FUE DADA				
	Primero	Segundo	Tercero	Quarto	Quinto
POLIO (OPV o IPV)					
DTaP/DTP/DT/Td (difteria, tétano y [acellular] pertusis [tos ferina]) O (tétano y difteria solamente)					
MMR (sarampión, paperas, rubéola)					
HIB MENINGITIS (Hemófilo, Tipo B) (Requerida para centros de cuidado para niños y centros preescolares solamente)					
HEPATITIS B					
VARICELLA (Viruelas locas)					
OTRA (e.g. prueba TB, de ser indicado)					
OTRA					

PARTE III INFORMACIÓN ADICIONAL DEL EXAMINADOR DE SALUD *(optional)* y PERMISO PARA DIVULGAR (DISTRIBUIR) EL INFORME DE SALUD

RESULTADOS Y RECOMENDACIONES

Llene esta parte si el padre/la madre o el guardián ha firmado el consentimiento para divulgar (distribuir) la información de salud de su niño/niña.

☐ El examen reveló que no hay condiciones que conciernen las actividades de los programas escolares.

☐ Las condiciones encontradas en el examen o después de una evaluación posterior que son de importancia para la actividad escolar o física son: (por favor explique)

***de ser indicado**

Yo le doy permiso al examinador de salud para que comparta con la escuela la información adicional de este examen como es explicado en la Parte III.

☐ Por favor marque esta caja si Ud. no desea que el examinador llene la Parte III.

Firma del padre/madre o guardián — Fecha

Firma del examinador de salud — Fecha

Si su niño o niña no puede obtener el examen de salud llame al Programa de Salud para la Prevención de Incapacidades de Niños y Jovenes (Child Health and Disability Prevention Program) en su departamento de salud local. Si Ud. no desea que su niño(a) tenga un examen de salud, puede firmar la orden (PM 171 B), formulario que se consigue en la escuela de su niño(a).

CHDP website: www.dhcs.ca.gov/services/chdp

State of California—Health and Human Services Agency
Primary Care and Family Health Division

Department of Health Services
Children's Medical Services Branch
Child Health and Disability Prevention (CHDP) Program

WAIVER OF HEALTH EXAMINATION FOR SCHOOL ENTRY

CHILD'S NAME—Last	First	Middle	BIRTH DATE—Month/Day/Year

ADDRESS—Number/Street	City	ZIP Code	SCHOOL	Teacher

PARENT OR GUARDIAN:

Please fill out this form if you want to excuse your child from the health examination required by California law for school entry. ***SIGN AND RETURN THIS FORM TO THE SCHOOL*** where it will be maintained as confidential information.

NOTE: SIGNING THIS WAIVER ***DOES NOT*** EXCUSE YOUR CHILD FROM RECEIVING THE IMMUNIZATIONS REQUIRED BY CALIFORNIA LAW FOR CHILDREN IN SCHOOL. ALSO, SIGNING THIS WAIVER WILL NOT DENY YOUR CHILD THE VISION AND HEARING TESTS DONE BY THE SCHOOL.

I have been informed about the health examination recommended by health professionals and required by state law. I have been informed about where my child can receive a health examination and about the income levels for receiving it at no cost to me.

Please check one of the following:

❒ I choose not to have my child receive a health examination as a part of the school entry requirement.

❒ I would like my child to receive a health examination, but I am unable to obtain it.

Reason (see Health and Safety Code, Section 124085):

_____

Signature of parent or guardian Date

INQUIRE AT THE SCHOOL OFFICE OR YOUR LOCAL HEALTH DEPARTMENT IF YOU WANT MORE INFORMATION.

State of California—Health and Human Services Agency
Primary Care and Family Health Division

Department of Health Services
Children's Medical Services Branch
Child Health and Disability Prevention (CHDP) Program

RENUNCIA VOLUNTARIA PARA RECIBIR UN EXAMEN DE SALUD PARA INGRESAR A LA ESCUELA

NOMBRE DEL NIÑO/DE LA NIÑA—Apellido	Primer Nombre	Segundo Nombre	FECHA DE NACIMIENTO—Mes/Día/Año

DIRECCION—Número/Calle	Ciudad	Zona Postal	ESCUELA	Maestro(a)

PADRE/MADRE O GUARDIAN:

Si desea que su niño(a) no reciba el examen de salud requerido por la ley de California antes de ingresar a la escuela, por favor llene este formulario. ***FIRMELO Y DEVUELVALO A LA ESCUELA*** donde será guardado en forma confidencial.

AVISO: EL FIRMAR ESTA RENUNCIA VOLUNTARIA *NO* DISPENSA PARA QUE EL NIÑO/LA NIÑA RECIBA LAS INMUNIZACIONES REQUERIDAS POR LA LEY DE CALIFORNIA PARA LOS NIÑOS EN LA ESCUELA. TAMBIEN, EL FIRMAR ESTE FORMULARIO NO LE NEGARA A SU NIÑO(A) EL DERECHO A RECIBIR LOS EXAMENES DE LA VISTA Y EL OIDO PARA LA ESCUELA.

Se me ha informado acerca del examen de salud recomendado por los respectivos profesionales y requerido por la ley del estado. Se me ha informado también acerca de los lugares donde mi niño(a) puede recibir un examen de salud y sobre los diferentes niveles de ingresos para recibirlos sin costo alguno.

Por favor marque uno de los siguientes casilleros:

❒ Escojo que mi niño(a) no reciba el examen de salud que es uno de los requisitos para ingresar a la escuela.

❒ Me gustaría que mi niño(a) reciba un examen de salud, pero estoy incapacitado(a) para obtenerlo.

Razon (vea Health and Safety Code, Sección 124085):

_____

Firma del padre/madre o guardián — Fecha

SI DESEA MAS INFORMACION CONSIGALA EN LA ESCUELA O EN SU DEPARTAMENTO LOCAL DE SALUD

CALIFORNIA IMMUNIZATION REQUIREMENTS FOR

K – 12TH GRADE (including transitional kindergarten)

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

1. Requirements for K-12 admission also apply to transfer pupils.
2. Combination vaccines (e.g., MMRV) meet the requirements for individual component vaccines. Doses of DTP count towards the DTaP requirement.
3. Any vaccine administered four or fewer days prior to the minimum required age is valid.
4. Three doses of polio vaccine meet the requirement if one dose was given on or after the 4th birthday.
5. 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.)
6. For 7th grade admission, refer to Health and Safety Code section 120335, subdivision (c).
7. 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.
8. For 7th-12th graders, at least one dose of pertussis-containing vaccine is required on or after the 7th birthday.
9. For children in ungraded schools, pupils 12 years and older are subject to the 7th grade advancement requirements.
10. 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 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 in accordance with 17 CCR section 6051.
- A personal beliefs exemption (filed in CA prior to 2016) in accordance with Health and Safety Code section 120335; 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 (17 CCR section 6050).

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
Polio #2	4 weeks after 1st dose	8 weeks after 1st dose
Polio #3[1]	4 weeks after 2nd dose	12 months after 2nd dose
Polio #4[1]	6 months after 3rd dose	12 months after 3rd dose
DTaP #2	4 weeks after 1st dose	8 weeks after 1st dose
DTaP #3[2]	4 weeks after 2nd dose	8 weeks after 2nd dose
DTaP #4	6 months after 3rd dose	12 months after 3rd dose
DTaP #5	6 months after 4th dose	12 months after 4th dose
Hep B #2	4 weeks after 1st dose	8 weeks after 1st dose
Hep B #3	8 weeks after 2nd dose and at least 4 months after 1st dose	12 months after 2nd dose
MMR #2	4 weeks after 1st dose	4 months after 1st dose
Varicella #2	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.

Questions?

See the California Immunization Handbook at ShotsForSchool.org

GOLD OAK UNION SCHOOL DISTRICT
3171 Pleasant Valley Road
Placerville, CA 95667
(530) 626-3160
Fax (530) 644-9622

Medication in School

1. ADMINISTRATIVE STATEMENT

Medication may be dispensed to students by designated school personnel whenever a physician finds it necessary to prescribe medication to be taken during the regular school day.

2. MEDICATION PROCEDURE

The form below or similar authorization must be completed by the parent or guardian **AND** physician for any medication that is to be taken during the regular school day. All medication administered at school, even if sold over the counter, must be prescribed by a physician.

The parent/guardian must provide all medication, including over-the-counter medication, in the original container. For prescription medication, the pharmacist can provide a second labeled bottle so that one bottle can be brought to school and one bottle can be left at home.

3. PARENT REQUEST

I request that designated school personnel assist my child by giving him/her the medication as set forth in the physician's instructions below and give consent for the designated school personnel and physician signing below to exchange medication information. If the medication is an asthma inhaler or an Epi pen, I consent to my child self-administering the medication if designated to do so by the physician below. I release the district and school personnel from civil liability in the event my child has an adverse reaction to the asthma inhaler or Epi Pen. I may terminate consent for administration of medicine at any time.

Student's Name: _____ Birth Date: _____ Grade: _____

Parent's Signature: _____ Date: _____

4. PHYSICIAN'S INSTRUCTIONS

MEDICATION	DOSE	METHOD OF ADMINISTRATION	HOW OFTEN (e.g., EVERY 4 HRS)	DURATION (e.g., SCHOOL YEAR)
#1				
#2				

Indication for Medication: #1 _____ #2 _____
Special Instructions/Precautions: #1 _____ #2 _____
This student is able to carry and self-administer his/her asthma inhaler ___Yes ___No
This student is able to carry and self-administer his/her Epi Pen ___Yes ___No

Physician Signature: _____ Date: _____

Physician Name (PRINT): _____ Phone: _____

BASIC LEGAL PROVISION: 49423. Notwithstanding the provision of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken, and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.