



# Sol Aureus College Preparatory

A Tuition-Free Charter School Serving K-8 Grades

## Kindergarten Application

<b>Return completed application to:</b> Sol Aureus College Preparatory (S.A.C. Prep) 6620 Gloria Drive Sacramento, CA 95831 School Phone: (916) 421-0600 School Fax: (916) 421-0601 <a href="http://www.sacprep.org">www.sacprep.org</a>	<b>Include a copy of:</b> <i>(Incomplete applications will not be processed.)</i> <ul style="list-style-type: none"><li>• <b>Birth Certificate</b></li><li>• <b>Immunization Records</b></li><li>• <b>Report of Health Examination</b></li><li>• <b>Oral Assessment Report</b></li><li>• <b>Home Language Survey</b></li></ul>
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### STUDENT INFORMATION

First Name:	Middle:	Last Name:
Date of Birth (MM/DD/YY):	Gender:	Home Phone:
Street Address:	City, State:	Zip Code:

### RACE/ETHNICITY

Is your student Hispanic/Latino?  YES  NO

<input type="checkbox"/> American Indian or Alaska Native (100)	<input type="checkbox"/> Chinese (201)
<input type="checkbox"/> Japanese (202)	<input type="checkbox"/> Korean (203)
<input type="checkbox"/> Vietnamese (204)	<input type="checkbox"/> Asian Indian (205)
<input type="checkbox"/> Laotian (206)	<input type="checkbox"/> Cambodian (207)
<input type="checkbox"/> Hmong (208)	<input type="checkbox"/> Other Asian (299)
<input type="checkbox"/> Hawaiian (301)	<input type="checkbox"/> Guamanian (302)
<input type="checkbox"/> Samoan (303)	<input type="checkbox"/> Tahitian (304)
<input type="checkbox"/> Other Pacific Islander (399)	<input type="checkbox"/> Filipino (400)
<input type="checkbox"/> Hispanic/Latino (500)	<input type="checkbox"/> Black or African American (600)
<input type="checkbox"/> White (700)	<input type="checkbox"/> Declined to State/Unknown (999)



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### FATHER/GUARDIAN #1 INFORMATION

First Name:	Middle:	Last Name:
Street Address:	City, State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:
Email Address – Please print clearly:		
Parents Highest Level of Education received:		
<input type="checkbox"/> High School Graduate	<input type="checkbox"/> Graduate Degree/Higher	
<input type="checkbox"/> Some College/Associate Degree	<input type="checkbox"/> Not a High School Graduate	
<input type="checkbox"/> College Graduate	<input type="checkbox"/> Decline to State	

### MOTHER/GUARDIAN #2 INFORMATION

First Name:	Middle:	Last Name:
Street Address:	City, State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:
Email Address – Please print clearly:		
Parents Highest Level of Education received:		
<input type="checkbox"/> High School Graduate	<input type="checkbox"/> Graduate Degree/Higher	
<input type="checkbox"/> Some College/Associate Degree	<input type="checkbox"/> Not a High School Graduate	
<input type="checkbox"/> College Graduate	<input type="checkbox"/> Decline to State	



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### EMERGENCY CONTACT INFORMATION

1.	First Name:	Last Name:	Relationship:	Phone Number:
2.	First Name:	Last Name:	Relationship:	Phone Number:
3.	First Name:	Last Name:	Relationship:	Phone Number:

### GENERAL EMERGENCY AUTHORIZATION

In an emergency, when I cannot be reached, I authorize the school authorities to take my student, at my expense, to my family doctor, licensed physician, nearest hospital or emergency first aid station for treatment. This consent is effective until revoked in writing.

(Please initial)

Yes, I do give permission. \_\_\_\_\_

No, I do not give permission. \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### NOTICE OF NON-DISCRIMINATION POLICY

Sol Aureus admits students of any race, color, national and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. Sol Aureus does not discriminate on the basis of race, color, national and ethnic origin in administration of its education policies, admission policies, and athletic or other school-administered programs.



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**REQUEST FOR STUDENT CUM FILE**

Current School Name: \_\_\_\_\_ Phone: \_\_\_\_\_

By adding my signature below, I am asking that you accept this application to Sol Aureus College Preparatory and authorizing my student's previous school to forward all confidential records of my student to Sol Aureus College Preparatory (S.A.C. Prep).

\_\_\_\_\_  
Parent/Guardian Name (Print Clearly)

\_\_\_\_\_  
Date

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

### Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31 of his/her first year in public school. A California licensed dental professional operating within his scope of practice must perform the check-up and fill out Section 2 of this form. If your child had a dental check-up in the 12 months before he/she started school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

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

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:	Child's race/ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other _____ <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown		

#### Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

**IMPORTANT NOTE:** Consider each box separately. Mark each box.

Assessment Date:	Caries Experience (Visible decay and/or fillings present) <input type="checkbox"/> Yes <input type="checkbox"/> No	Visible Decay Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Urgency: <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) <input type="checkbox"/> Urgent care needed (pain, infection, swelling or soft tissue lesions)
<div style="display: flex; justify-content: space-between; margin-top: 10px;"> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span><i>Licensed Dental Professional Signature</i></span> <span><i>CA License Number</i></span> <span><i>Date</i></span> </div>			

#### Section 3: Waiver of Oral Health Assessment Requirement

To be filled out by parent or guardian asking to be excused from this requirement

Please excuse my child from the dental check-up because: (Check the box that best describes the reason)

- I am unable to find a dental office that will take my child's dental insurance plan.  
 My child's dental insurance plan is:  
 Medi-Cal/Denti-Cal     Healthy Families     Healthy Kids     Other \_\_\_\_\_     None
  - I cannot afford a dental check-up for my child.
  - I do not want my child to receive a dental check-up.
- Optional: other reasons my child could not get a dental check-up: \_\_\_\_\_

If asking to be excused from this requirement: ► \_\_\_\_\_  
*Signature of parent or guardian*
*Date*

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school.

**Return this form to the school no later than May 31** 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	Middle	BIRTH DATE—Month/Day/Year
ADDRESS—Number, Street	City	SCHOOL
	ZIP code	

### 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/d (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

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.

#### 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)*

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, pídale 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	Segundo Nombre	FECHA DE NACIMIENTO—Mes/Día/Año
DOMICILIO—Número y Calle	Zona Postal	Escuela
	Ciudad	

## 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)	/ /
Evaluación 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
<b>POLIO</b> (OPV o IPV)					
<b>DTaP/DTp/DT/d</b> (difteria, tétano y [acelular] pertusis [los ferina]) O (tétano y difteria solamente)					
<b>MMR</b> (sarampión, paperas, rubéola)					
<b>HIB MENINGITIS</b> (Hemófilo, Tipo B) (Requerida para centros de cuidado para niños y centros preescolares solamente)					
<b>HEPATITIS B</b>					
<b>VARICELLA</b> (Viruelas locas)					
OTRA (e.g. prueba TB, de ser indicado)					
OTRA					

## PARTE III INFORMACIÓN ADICIONAL DEL EXAMINADOR DE SALUD (opcional)

### 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)

## PERMISO PARA DIVULGAR (DISTRIBUIR) EL INFORME DE SALUD

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 \_\_\_\_\_

\*de ser indicado

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 Jóvenes (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](http://www.dhcs.ca.gov/services/chdp)

# HOME LANGUAGE SURVEY

Name of Student: \_\_\_\_\_ Name of School: \_\_\_\_\_

Grade: \_\_\_\_\_

## Directions to Parents/ Guardians:

The California Education Code contains legal requirements which direct schools to determine the language(s) spoken in the home of each student. 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 this legal requirement. 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.

1. Which language did your child learn when he/she first began to talk? \_\_\_\_\_
2. Which language does your child most frequently speak at home? \_\_\_\_\_
3. Which language do you (the parents or guardians) most frequently use when speaking with your child? \_\_\_\_\_
4. Which language is most often spoken by adults in the home? (parents, guardians, grandparents, or any other adults) \_\_\_\_\_

If your child was not born in the United States, please answer the following questions.

1. Where was your child born? \_\_\_\_\_
2. What was his/her entry date to the first school in the United States? \_\_\_\_\_

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

\_\_\_\_\_  
Date