



SJVA: PYP Candidate school

480 North San Jacinto Avenue San Jacinto, California 92583 Phone: 951-654-6113 Fax: 951-654-5083

APPLICATION FOR ADMISSION 2018-2019 SCHOOL YEAR

TK/KINDERGARTEN

Dear Parent/Guardians:

San Jacinto Valley Academy is a charter school of choice. In order to attend you must complete an application and provide the required documents (See below). Enrollment space is limited.

Students must turn five years old by September 1st to be enrolled in Kindergarten.

Students must turn five years old between September 2nd and December 2nd to be enrolled in Transitional Kindergarten.

Student Name: _____ 2018-2019 Grade _____

- _____ Completed Application
_____ Health Examination Form
_____ Oral Health Assessment Form
_____ Copy of Current Report Card (if applicable)
_____ Disciplinary Record (if applicable)
_____ Copy of Birth Certificate (From any Country)
_____ Immunization Record
_____ Copy of Current IEP or 504 Plan (if applicable)
_____ Expulsion Affidavit/Special Needs Form

Notes: _____

Note: Incomplete applications will not be accepted.

Note: We try to accommodate AM/PM request, however we cannot guarantee that you will receive your preferred time. Please see attached form.

FOR OFFICE USE ONLY:
Date: _____ Initials: _____ Time: _____ AM/PM Sibling of current SJVA student YES/NO
Note: Failure to disclose these documents prior to acceptance at SJVA may result in immediate dismissal.

PLEASE SUBMIT THIS APPLICATION AT OUR LOCATION ON ESPLANADE ACROSS VALLEY-WIDE



San Jacinto Valley Academy

➤ PLEASE PRINT – STUDENT’S LEGAL NAME				ENTERING GRADE _____ 2018-2019				
Legal Last Name		Legal First Name		Legal Middle Name		Other Legal Name (if applicable)		
<input type="checkbox"/> Male		<input type="checkbox"/> Female		Birth date:				
		Month	Day	Year				
				()		()		
Parent/Guardian First Name		Last Name		Home Phone		Work Phone		
				()		()		
Parent/Guardian First Name		Last Name		Home Phone		Work Phone		
Residence Address				Apt#	City		State	Zip
Mailing (IF DIFFERENT)				Apt #	City		State	Zip
E-mail Address								

WHAT IS YOUR CHILD’S ETHNICITY? (Please check one): <input type="checkbox"/> Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race) <input type="checkbox"/> Not Hispanic or Latino
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WHAT IS YOUR CHILD’S RACE? (Please check up to five racial categories) <i>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.</i>		
<input type="checkbox"/> American Indian or Alaskan Native (100) <small>(Persons having origins in any of the original people of North, Central or South America)</small> <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/Filipino American (400) <input type="checkbox"/> African American or Black (600) <input type="checkbox"/> White (700) <small>(Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East)</small>

PARENT EDUCATION – Check the response that describes the education level of the most educated parent . <input type="checkbox"/> Graduate Degree or Higher (10) <input type="checkbox"/> College Graduate (11) <input type="checkbox"/> Some College or Associate’s Degree (12) <input type="checkbox"/> High School Graduate (13) <input type="checkbox"/> Not a High School Graduate (14)

Date your Child first attended school in the U.S.		
Month	Day	Year

BIRTHPLACE: City: _____ State: _____ Country: _____
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LIST ANY OTHER CHILDREN LIVING AT HOME

Full Name	Birth Date	Grade	Sex	Current SJVA Student?
Full Name	Birth Date	Grade	Sex	Current SJVA Student?
Full Name	Birth Date	Grade	Sex	Current SJVA Student?
Full Name	Birth Date	Grade	Sex	Current SJVA Student?

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

Residence – where is your child/family currently living? – 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 or loss) (11) Unsheltered (car/campsite) (12) hardship
 In a shelter or transitional housing program (10) Other (15) (please specify) _____

- 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: _____

Parent/Guardian and Student Questionnaire

To help us provide the best educational experience for your child we ask that you complete this questionnaire with your child prior to the student-parent/guardian-teacher conference. Having this background knowledge on your child will enable us to plan and adjust our instructional program to fit the needs of your child. Please use extra sheets of paper if you need more space than is provided on this form.

STUDENT NAME: _____ GRADE: _____

1. What kind of reading does your child enjoy at home? For example, nature or sports magazines, his/her own books, books from school, library, etc.

2. Please list any books and/or authors your child has read and would like to read again:

3. What writing do you see your child do at home? Example: letter writing, diary, etc.

4. What are your child's special interests at home?

5. What are your child's favorite subjects in school? Please explain.

6. What are your child's least favorite subjects in school? Please explain.

7. What is your child looking forward to in coming to a charter school?

8. What is your child most concerned about in coming to a charter school?

9. As a parent what is it that you hope the charter school will accomplish for your child?

10. Are there any other questions and concerns you have about the charter school and /or other information we should know about your child?

11. Is there any other significant information we should know about your child that would help us in his/her education?

12. How did you hear about San Jacinto Valley Academy?



San Jacinto Valley Academy

480 N. San Jacinto Ave, San Jacinto CA 92583

(951) 654-6113

This form does not guarantee placement in either session.

Student Name _____ Date of Birth __/__/__

Kindergarten preference for:

AM class

PM class

Reason: _____

The school site will mail you a placement letter in August before school starts.

Parent signature _____ Date _____



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Este formulario no garantiza la colocacion en ninguna de las sesiones.

Nombre del Estudiante _____ Fecha de Nacimiento __/__/__

Preferencia de Kinder para:

Kinder de la manana

Kinder de la tarde

Razon: _____

La escuela le enviara una carta en Agosto, antes de que empiecen las clases, con informacion acerca de la colocacion.

Firma de padre/tutor _____ Fecha _____

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;"> <div style="width: 35%; border-top: 1px solid black; border-bottom: 1px solid black;"></div> <div style="width: 30%; border-top: 1px solid black; border-bottom: 1px solid black;"></div> <div style="width: 30%; border-top: 1px solid black; border-bottom: 1px solid black;"></div> </div>			
<i>Licensed Dental Professional Signature</i>		<i>CA License Number</i>	<i>Date</i>

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	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, pídale al examinador de salud que llene este informe y entregue a la escuela—este informe será 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)	/ /
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	Cuarto	Quinto
POLIO (OPV o IPV)					
DTaP/DTP/DT/Td (difteria, tétano y [acelular] 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)

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

y 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

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