

Please Print
or Type

SEBASTOPOL UNION SCHOOL DISTRICT

SCHOOL: **PARK SIDE PINE CREST BROOK HAVEN**

TEACHER _____ ROOM _____

ENROLLMENT DATE _____

STUDENT'S LEGAL NAME

CURRENT GRADE

Last First Middle

Sex
 Male
 Female

Mailing Address City Zip

Residence Address City Zip

Social Security Number Home Phone

PARENT/GUARDIAN INFORMATION

Father Work Phone Cell Phone

Mother Work Phone Cell Phone

BIRTHDATE		
Month	Day	Year
BIRTHPLACE		
City	State	Country
BIRTH VERIFICATION		
Evidence	Initials	

ETHNIC GROUP: (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> American Indian or Alaskan Native (100) | <input type="checkbox"/> Vietnamese (204) | <input type="checkbox"/> Filipino (400) |
| <input type="checkbox"/> Chinese (201) | <input type="checkbox"/> Other Asian (299) | <input type="checkbox"/> Hispanic or Latino (500) |
| <input type="checkbox"/> Japanese (202) | <input type="checkbox"/> Hawaiian (301) | <input type="checkbox"/> Black (600) |
| <input type="checkbox"/> Korean (203) | <input type="checkbox"/> Pacific Islander (399) | <input type="checkbox"/> White (700) |

PARENT EDUCATION: (Check one only)

- | | | |
|---|---|---|
| <input type="checkbox"/> Not High School Graduate (1) | <input type="checkbox"/> Some College (3) | <input type="checkbox"/> Graduate School/Post Grad Training (5) |
| <input type="checkbox"/> High School Graduate (2) | <input type="checkbox"/> College Graduate (4) | <input type="checkbox"/> Decline to State (6) |

SPECIAL PROGRAMS: (Check all that apply)

- | | | | | | | | | |
|------------------------------|-------------------------------|----------------------------------|---------------------------------|-------------------------------|----------------------------------|--------------------------------|-------------------------------|----------------------------------|
| <input type="checkbox"/> SDC | <input type="checkbox"/> Past | <input type="checkbox"/> Present | <input type="checkbox"/> Speech | <input type="checkbox"/> Past | <input type="checkbox"/> Present | <input type="checkbox"/> Other | <input type="checkbox"/> Past | <input type="checkbox"/> Present |
| <input type="checkbox"/> RSP | <input type="checkbox"/> Past | <input type="checkbox"/> Present | <input type="checkbox"/> GATE | <input type="checkbox"/> Past | <input type="checkbox"/> Present | | | |

STUDENT IS LIVING WITH: (check)

- | | |
|--|--|
| <input type="checkbox"/> father | <input type="checkbox"/> mother |
| <input type="checkbox"/> stepfather | <input type="checkbox"/> stepmother |
| <input type="checkbox"/> guardian (male) | <input type="checkbox"/> guardian (female) |
| <input type="checkbox"/> foster-father | <input type="checkbox"/> foster-mother |
| <input type="checkbox"/> other | |

STATUS OF PARENT(S)

- | |
|------------------------------------|
| <input type="checkbox"/> married |
| <input type="checkbox"/> separated |
| <input type="checkbox"/> divorced |
| <input type="checkbox"/> deceased |

PREVIOUS SCHOOL INFORMATION

Name of Previous School
Address
City County State
Fax/Phone Number Grade

HEALTH INFORMATION:

- | | | | | | |
|--|--------------------------|---|---|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Bee Sting Allergy | Date of last sting _____ | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Speech |
| | | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vision |
| | | <input type="checkbox"/> Moderate Asthma | <input type="checkbox"/> Hearing | <input type="checkbox"/> Medication | |
| | | <input type="checkbox"/> Severe Asthma | <input type="checkbox"/> Heart Problems | | |
| | | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | | |

Describe reaction _____

I understand that I need to have a completed AUTHORIZATION FOR ADMINISTERING MEDICATION form on file in the office for my child to be given any medication.

What?	When? Why?
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SIBLINGS LIVING IN YOUR HOME:

Name	Birthdate	Name	Birthdate	Name	Birthdate
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LANGUAGE SURVEY:

The California Education Code requires schools to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students. Your cooperation in helping us meet this important requirement is requested.

Please answer the following questions:

1. What language did your son/daughter learn when he/she first began to talk? _____
2. What language does your son/daughter most frequently use at home? _____
3. What language do you most frequently use to speak to your son/daughter at home? _____
4. Name the language most often spoken by the adults at home? _____

First entered US	Month/Day/Year
First entered US school	Month/Day/Year
First entered CA school	Month/Day/Year

Please send home letters/reports in: English Spanish I will need an interpreter for meetings and conferences

IMMUNIZATIONS: School Use Only Requirements Met <input type="checkbox"/> YES <input type="checkbox"/> NO	DISCIPLINE: Any previous expulsions, or ever brought up for expulsion? <input type="checkbox"/> YES <input type="checkbox"/> NO	PARENT/GUARDIAN SIGNATURE	DATE
<input type="checkbox"/> COURT ORDER (Must have copy)	Explain: _____		