2020-2021 School Year - Establishing Proof of Residency

In accordance with California Education Code, proof of residency must be established prior to enrollment in school. To establish residency, parents/guardians need to produce at least two documents from the list below including the name of parent/guardian, and current Riverside address. Documents shall be dated within the previous thirty (30) days of their presentation to school site staff.

Acceptable Documents Used to Establish Residency:

- Escrow Papers, with closing date not more than 30 days from the current date. (Note: Schools may ask for the final closing docs after the 30-day date to assure residence).
- Lease/rental agreement with receipt from property owner;
- Mortgage statement
- Utility service contracts, statements, or payment receipts, (Gas, Electric, Water providers).
- Employer’s verification of address (i.e. pay stub);
- Proof of Insurance – car or home;
- Electronic payment receipt of monthly payments or security deposit or cancelled checks;
- Statements from medical providers, (Example Kaiser Permanente)
- Mail from old address with forwarding address label with new address – online confirmation;
- Mail from state or federal government agencies: (i.e., Medi-Cal, food stamps, court ordered child support payments, DMV registration, jury summons, housing authority document, County DPSS, Medical, Cal Works, Child support statements, voter registration, taxes
- Court documents regarding foster care, guardianship, custody orders.

Documents NOT Acceptable:

- Cable, Trash, Telephone/Cellphone, bills
- Credit card statements
- Junk Mailers, (Advertisements)
- Driver’s License
- Restraining Orders
- Bank Statements

Revised 2/2020
Checklist for K-6 Registration:

(Children are eligible for Kindergarten enrollment if they have their fifth birthday on or before September 1st, 2020)
(Children must turn 5 between September 2nd – December 2nd, 2020 to be eligible for Transitional Kindergarten if space is available)

☐ **Proof of student’s birth** (provide ONE from the list below):
  - Birth Certificate (County Record), or
  - Hospital Record, or
  - Baptismal Record

☐ **Current Immunization Record**
(Must have ALL of the immunizations, listed below documented on the doctor’s record):
  - Polio, 4 doses required (3 accepted if last dose given after 4th birthday)
  - DTP, 5 doses required (4 accepted if last dose given after 4th birthday)
  - MMR, 2 doses
  - Hep B, 3 doses
  - Varicella, 2 doses

☐ **TWO Proof of Residence**
  For acceptable documents please see the back of this form...

☐ **Verification of Physical Examination Screening**
  (ONLY for Kindergarten or First Grade, dated within 6 months prior to starting school)

☐ **Copy of IEP** (Special Education students only)

☐ **Completed RUSD Registration Packet**

☐ **Parent/Guardian Photo ID**
STUDENT NAME: ___________________________ DATE OF BIRTH: ___________________________

STUDENT HOUSING QUESTIONNAIRE

The purpose of this questionnaire is to identify students living in homeless situations. Completing the information below will ensure that a homeless student is provided with the educational rights, protections, and services under the federal McKinney-Vento Homeless Education Assistance Act.

☐ Does not apply; student is not homeless (if this box is checked, please proceed to sign and date at bottom)

If your family is experiencing homelessness, please select one of the following statements:

☐ Living in a shelter, including transitional housing shelters (i.e. Path of Life Family Shelter);
  Please provide name of shelter: ___________________________________________________________
  Shelter Address: _________________________________________________________________

☐ Living on the streets, abandoned buildings, in cars, trailers, campgrounds, public places, or housing not fit for habitation;
  Please provide information regarding area in which student is living:

☐ Living in a hotel/motel for lack of other suitable housing; Please list name and address of hotel/motel (including room #):

☐ TEMPORARILY Doubled-up; living with family or friends due to lack of adequate housing or economic hardship.
  Please provide address of where student is living:

Please answer the following if you checked one of the four boxes above:

  Date student moved into this address: ___________________________
  How long do you expect to be at this address? ___________________________
  Are you seeking permanent housing? ___________________________
  Is a parent living in the home with the student? ___________________________
  If not, with whom is the student living? ___________________________  Relationship: ___________________________

Please provide the following information for pre-school and school-age siblings (brothers and/or sisters) of the student:

<table>
<thead>
<tr>
<th>NAME</th>
<th>GRADE</th>
<th>DATE OF BIRTH</th>
<th>SCHOOL</th>
<th>DISTRICT</th>
</tr>
</thead>
<tbody>
<tr>
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I declare under penalty of perjury of the laws of California that the information I have provided is true and correct.

Parent/Legal Guardian/Caregiver/Unaccompanied Student ___________________________ Print Name ___________________________ Date ___________________________

For Office Use Only:

If student qualifies for the homeless program scan and email this form to Jaemy Zavala in Pupil Services: jzavala@riversideunified.org

Name of school site personnel receiving this form: ___________________________________________

Riverside Unified School District prohibits discrimination, harassment, intimidation, or bullying in all district programs, activities, and employment on the basis of actual or perceived ancestry, age, color, disability, gender, gender identity, gender expression, nationality, race or ethnicity, religion, sex, sexual orientation, parental or marital status, pregnancy, or association with a person or a group with one or more of these actual or perceived characteristics. If you have any complaints or questions regarding this policy you may contact: Director of Pupil Services or the District Resolution Officer: 5700 Arlington Avenue, Riverside, CA 92504, (951) 398-7135 or (951) 352-1200.

Revised 2/20/2020
Please read and answer each question carefully to assist the school in planning the most appropriate educational program for your child:

1. Which language did your child learn when he or she first began to speak?

2. Which language does your child use most frequently at home?

3. Which language do you use most frequently to speak to your child?

4. Name the language spoken most often by the adults at home?

5. Would you like to have school correspondence sent home to you translated in English or another language?

   - English
   - Other Language

Signature of Parent/Guardian

Home or work phone

Other languages spoken by your child

Student's Address

Student Name: __________________________

Student ID: __________________________

Name of Previous School Attended

City

State

Zip Code

Grade

Programs and Services

Home Language Survey

Department of Research, Assessment, and Evaluation

RUSD Riverdale Unified School District
Student Name ____________________________  □ Male □ Female  Birthdate __________ Age ______ Grade ______

□ My child does not have any health issues at this time.

If your child has health issues please answer the following questions:

Does your child take medication on a routine basis?  □ Yes □ No  □ During school hours?  □ Yes □ No  If yes,
Name of medication ____________________________  Name of medication ____________________________
Name of medication ____________________________  Name of medication ____________________________

If your child must take prescriptions or over the counter medications during the school day, complete the
Medication Administration parent/physician authorization form and return to the school office. (One form for
each medication).

Check □ the box and explain if your child has a history of or now has the following conditions or concerns.

□ Asthma □ Mild □ Moderate □ Severe
  □ Inhaler at home □ Inhaler at school office
□ Seizures □ As an infant only □ Currently takes medication

□ Physical Limitations
  □ Special Equipment needed at home
  □ Special Equipment needed at school

□ Other Conditions

□ Diabetes □ Type I □ Type II
  • Has your child been hospitalized for diabetes?  □ Yes □ No
    □ If yes, give date and explain hospital course:
  • Can your child monitor his/her blood glucose level independently? □ Yes □ No
  • Can your child tell if he/she is having symptoms of high or low blood glucose levels?  □ Yes □ No
    □ If yes, what are his/her symptoms?
  • Has Glucagon ever been given to your child? □ Yes □ No  □ Last given:

Is your child currently under a doctor’s care for any of the above? □ Yes □ No
□ If yes: Doctor’s name ____________________________  Phone _______  Fax _______

Address ____________________________  ____________________________  ____________________________

□ I hereby give permission to share information pertaining to the health of my child with school staff who need to know.

Parent/Guardian Signature ____________________________  Date __________

For Office Use Only:
□ Doctor’s orders completed including parent and physician signatures.
□ Diabetic Supplies
□ Snacks
□ Signed Diabetic Treatment Plan for School indicating parent review
□ Original to Curr □ Fax to District Nurse 951-274-4200 (Internal #83100) □ Health Assistant □ Teacher

Health History Form 2/26/2020
# 2020-2021 Riverside Unified School District

## Student Emergency Card

**Student ID #**

**Gender:** M / F  
**Grade:**  
**Age:**  
**Birthdate:**

**Name**  
Last / Apellido  
First / Nombre

**Address**  
Domicilio

**Zip Code**  
Código Postal

**Home Phone**  
Teléfono

**Father/Guardian Name**  
Padre/Tutor

**Work Phone**  
Num. del Trabajo

**Lives with student**  
Vive con el estudiante  
Yes  
No

**Mother/Guardian Name**  
Padre/Tutor

**Work Phone**  
Num. del Trabajo

**Lives with student**  
Vive con el estudiante  
Yes  
No

---

**List medical conditions that may require special attention**  
Apunte cualquier condición médica crónica la cual pueda requerir atención especial

**Name of prescribed medication**  
Nombre del medicamento recetado

**Physician’s Name**  
Nombre del doctor

**Phone**  
Teléfono

**Is there a court order restraining any person from this student?**  
¿Tiene una orden judicial de los tribunales para restringir a una persona que se acerque al estudiante?

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**Other than Parent/Guardian, please list at least two local contacts with phone numbers.**  
To assure the safety and well-being of my child, only the following persons are authorized to sign for his/her release from school with prior written notice from the parent/guardian. If your student must be picked up as determined by the school site administration, every attempt will be made to contact the parent/guardian prior to releasing the child to the following individuals. Parents are responsible for updating parent contact information. **Students may only be released to adults 18 years of age or older.**  
Además del Padre/Tutor, por favor anote 2 contactos locales con números de teléfono. Para asegurar el bienestar de mi estudiante, solamente las personas siguientes están autorizadas para firmar la salida de mi estudiante de la escuela con una **notas de previo aviso por escrito del Padre/Tutor.** Si su estudiante tiene que ser recogido por una decisión de la administración de la escuela, se va hacer todo lo posible de contactar a los contactos locales. Los padres tienen la responsabilidad de actualizar la información de los contactos. Alumnos solamente pueden ser entregados a adultos, mayores de 18 años de edad.

| Name / Nombre | Relationship to student / Parentesco con el estudiante | Home/Work/Cell | Teléfono de casa/trabajo/cel
<table>
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</thead>
<tbody>
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</tr>
</tbody>
</table>

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**In case of an emergency and I cannot be reached, I authorize the physician/hospital to administer medical care as deemed medically necessary.**  
En caso de una emergencia si no se puede comunicar conmigo, yo doy autorización al doctor/hospital para que le den cuidados médicos.

**Parent/Guardian Signature**  
Firma de Padre/ Tutor

**Date**  
Fecha

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Rev. 2/2010 J
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

<table>
<thead>
<tr>
<th>CHILD'S NAME—Last</th>
<th>First</th>
<th>Middle</th>
<th>BIRTH DATE—Month/Day/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS—Number, Street</td>
<td>City</td>
<td>ZIP code</td>
<td>SCHOOL</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>REQUIRED TESTS/EVALUATIONS</th>
<th>DATE (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health History</td>
<td>/ / /</td>
</tr>
<tr>
<td>Physical Examination</td>
<td>/ / /</td>
</tr>
<tr>
<td>Dental Assessment</td>
<td>/ / /</td>
</tr>
<tr>
<td>Nutritional Assessment</td>
<td>/ / /</td>
</tr>
<tr>
<td>Developmental Assessment</td>
<td>/ / /</td>
</tr>
<tr>
<td>Vision Screening</td>
<td>/ / /</td>
</tr>
<tr>
<td>Audiometric (hearing) Screening</td>
<td>/ / /</td>
</tr>
<tr>
<td>TB Risk Assessment and Test, if indicated</td>
<td>/ / /</td>
</tr>
<tr>
<td>Blood Test (for anemia)</td>
<td>/ / /</td>
</tr>
<tr>
<td>Urine Test</td>
<td>/ / /</td>
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<tr>
<td>Blood Lead Test</td>
<td>/ / /</td>
</tr>
<tr>
<td>Other</td>
<td>/ / /</td>
</tr>
</tbody>
</table>

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).

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DATE EACH DOSE WAS GIVEN</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>First</td>
</tr>
<tr>
<td>POLIO (OPV or IPV)</td>
<td>/ / /</td>
</tr>
<tr>
<td>D TaP/DTP/DT/Td (diphtheria, tetanus, and [acellular]</td>
<td>/ / /</td>
</tr>
<tr>
<td>pertussis) OR (tetanus and diphtheria only)</td>
<td></td>
</tr>
<tr>
<td>MMR (measles, mumps, and rubella)</td>
<td>/ / /</td>
</tr>
<tr>
<td>HIB MENINGITIS (Haemophilus Influenzae B)</td>
<td>/ / /</td>
</tr>
<tr>
<td>(Required for child care/preschool only)</td>
<td></td>
</tr>
<tr>
<td>HEPATITIS B</td>
<td>/ / /</td>
</tr>
<tr>
<td>VARICELLA (Chickenpox)</td>
<td>/ / /</td>
</tr>
<tr>
<td>OTHER (e.g., TB Test, if indicated)</td>
<td>/ / /</td>
</tr>
<tr>
<td>OTHER</td>
<td>/ / /</td>
</tr>
</tbody>
</table>

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 ________________