New Student Registration Checklist

Kindergarten

2020-2021

Student Name ____

1. Application completed fully.
______ Student Application
______ Transfer of Student Records Form (If entering 2nd semester)
______ Consent to Treatment Form
______ Image Release Form
______ Riding Permission Form
______ Immunization Records
______ Copy of Birth Certificate
______ Student Medical Record/Physician Examination Form

2. ___ Financial Clearance Completed (Appointment with Finance Office & Financial Contract Completed)
3. ___ Receipt and review of last semester grades/school records (If entering 2nd semester)
4. ___ Testing by classroom teacher
5. ___ Approval of admission by Admissions Committee or School Board

6. VANPOOL—Visalia is our only pick-up/drop off location

Our vanpool service is on a first come, first served basis. We only have 14 spots available.

☐ Please check the box if your above-named student needs to ride the vanpool

ARMONA UNION ACADEMY *14435 Locust St/PO BOX 397 Armona, CA 93202* (559)-582-4468

CONSENT TO TREATMENT
2020-2021

Only designated staff will have access to the completed form. This form will be stored in a locked file. This form must be filled out at the beginning of each school year to cover the activities for the school year. A copy of each student's form must be taken on off-campus activities.

Student's Name ____

Age _________ Date of Birth ____________________ Social Security Number ___________________________
mo. day yr.

Address ____

Parent/Guardian's Name ____

Father/Guardian _____________________ _________________________ ___________________________
Business Number Home Number Cellular Number

Mother/Guardian ____________________ _________________________ ___________________________
Business Home Number Cellular Number

Please describe allergies to substances and medication. ____

If on regular medication, please specify __________________________ Date of last Tetanus shot ______________

Please give the name of your local family physician(s) to be called in case your son or daughter becomes ill or has an accident at school and you cannot be reached.

1. Family Physician _______________________________________ Office Telephone _________________

   Address ____

2. Family Physician _______________________________________ Office Telephone _________________

   Address ____

Hospital preference ____ Telephone ______________________

Please give the names of two relatives or friends who have consented to assume the responsibility of your son/daughter in case of illness or accident until you can be reached. In case of any changes in the named persons, notify the school in writing.

1. Name ____ Telephone ______________________

   Address ____

2. Name ____ Telephone ______________________

   Address ____

If emergency service involving medical action or treatment is required and neither the parent nor the family physician can be reached for consent, the parents hereby consent to the rendering of such emergency medical service for the above named student as shall be necessary in the medical opinion of the doctor rendering service. This authorization is given pursuant to the local state Civil Code.

Signature of Parent or guardian: ____ Date: ________________

IMAGE RELEASE FORM
2020-2021

Dear Parent/Guardian:

During the school year, our school will hold events that the news media, the school and the conference may like to feature. A representative may be on campus to gather photographs and/or video footage highlighting the event and featuring the faces of Armona Union Academy. We value your child's participation, and ask for your permission to include him or her. Please indicate below whether your child has your permission to participate.

You may update this form at any time by contacting our main office at (559) 582-4468.

I hereby consent and authorize Armona Union Academy, or its assigns, to use my name and/or the names of my family members who are minors, as listed below, as well as my likeness, photos, videos and other information (or that of family members who are minors) for the purpose of news releases, advertising, publicity, publication or distribution in any manner whatsoever. I further consent to such use in their present form and to any changes, alterations, or additions thereto. I hereby release Armona Union Academy from all liability in connection with all such uses.

Dated this __________ day of _________________________, 20___.

____
Parent/Guardian's name (please print)

____
Parent/Guardian's signature

Address:_____________________________________

____

Telephone Number:____________________________

All Family Members to Whom the Release Applies:

1.)___________________________________ 3.) ___________________________________

2.)___________________________________ 4.)___________________________________

**** Please return to the school office on or before the first day of school. ****

Riding Permission
2020-2021

Auto riding consent
Student Name ______________________________ Grade: ________________________

☐ Has permission to ride to and from school with the following **student(s):**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

☐ Has permission to ride to and from school with the following **adult(s):**

______________________________ ______________________________

______________________________ ______________________________

☐ The following students have permission to ride to and from school **with** my child:

______________________________ ______________________________

______________________________ ______________________________

The parent or guardian signing this form is granting permission, for the above mentioned child, to ride home with the person [s] mentioned above. If the student mentioned above is granted permission to ride home with another AUA student, that student <u>must</u> also have your child mentioned in their Riding Permission form. Please coordinate with the parent or guardian of the child. If you do not want to grant permission for your child to ride with anyone simply write N/A in the section [s] it applies to.

Student Signature____ Date_________________________

Parent Signature ____ Date _________________________

Student Medical Record

2020-2021

Only designated staff, such as the school nurse or physician will have access to the completed form. This form will be stored in a locked file.

Name ______________________________ Birth Date __________ SSN ____________

Address ____

Street City State Zip code

Name of Father _______________________ Name of Mother _______________________

History (Past illnesses and allergies. Please check those he/she has had).

- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Measles
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Ear Infections
- ☐ Other

Allergies:

- ☐ Asthma
- ☐ Hay Fever
- ☐ Insect Bites
- ☐ Penicillin
- ☐ Other Drugs

Explain briefly factors, such as surgeries, serious accidents or injuries, congenital defects, which may affect the child's school experience: ____

____

____

Indicate physical problem by check: Hearing ( ) Heart ( ) Sight ( ) Speech ( )

Other (specify): ____

IMMUNIZATIONS- An official record of immunizations must accompany this medical record for all students entering school for the first time in the United States regardless of grade level. Records considered official are:

- State Immunization Record
- Health Provider Record (must have signature, stamp, or initials next to each date)
  - Physician's Record
  - County Health Department Record
- Official Immunization Record from another state
- School Immunization Record

LABORATORY RECORD

TB SKIN TESTS	Type*	Given By	Date Read		Impression
	☐ PPD Mantoux ☐ OTHER				☐ Pos ☐ Neg
	☐ PPD Mantoux ☐ Other				☐ Pos ☐ Neg
	☐ PPD Mantoux ☐ Other				☐ Pos ☐ Neg
CHEST X-RAY	Film date: _____/_____/_____ Impression: ( ) normal ( )abnormal Person is free of communicable tuberculosis ( ) yes ( ) no Signature/Agency ________________________________				

PHYSICIAN'S EXAMINATION

Height: __________ Weight: ____________ Blood Pressure: ____________

	Normal	Abnormal	Not Examined
Skin			
Eyes, vision, glasses			
Ears, hearing			
Nose, throat			
Mouth, teeth, speech			
Glands			
Chest lungs			
Cardiovascular, heart			
Abdomen, enlargement			
tenderness			
hernia			
Spine, back			
Scoliosis (grade 7)			
Posture			
Extremities			
Genitourinary			
Nervous System, reflexes			

Explain Abnormalities:
____
____
____
____
____
____
____
____
____
____
____
____

Nutritional Status and general appearance of the child
____
____

Recommendations for additional medical or dental care ____

This student may participate in a normal physical education program, which includes activities such as running, jumping, tumbling. ___Yes ___No

If student must be restricted from participating in activities such as those listed above, please indicate physical activities that may be permitted. ____
____
____

Date __________________ Physician's signature ____

Address ____
____

*To be completed by the family physician and kept on file at the school for all children a) entering school for the first time, b) at grade seven (this should include the scoliosis examination, c) at least once in grades 9-12, and d) at other grades, when required by the Conference Board of Education