ENROLLMENT PACKET

INGLEWOOD UNIFIED SCHOOL DISTRICT

401 S. INGLEWOOD AVENUE, INGLEWOOD, CALIFORNIA 90301 * TELEPHONE (310) 419-2700 *

Enrollment Checklist

Student Name: _____ **Grade:** _____

REQUIRED DOCUMENTS:

1. Proof of Residency (Provide any two (2) current documents listed below in the parent's name)

- ☐ Property tax payment receipt
- ☐ Rental property contract, lease or payment receipts
- ☐ Current utility service contract, statement or payment receipt(s)
- ☐ Pay stubs
- ☐ Voter registration
- ☐ Correspondence from a government agency

If you reside with someone else **(Refer to Child Welfare & Attendance Office):**

☐ Parent/legal guardian must complete Verification of Shared Residence Form and provide required documentation specified on the form to CWA.

Other **(Refer to Child Welfare & Attendance Office):**

- ☐ For guardianships, caregiver affidavits and foster placements
- ☐ Experiencing homelessness or transitional living situation (McKinney-Vento) **(must be renewed annually)**
- ☐ Permit (if applicable)

2. Parent/Guardian Photo I.D.

☐ Parent, guardian, caregiver or foster parent to provide government-issued ID card, driver's license or passport.

3. Proof of Age of Child (only one (1) required)

- ☐ Birth Certificate
- ☐ Baptismal Certificate
- ☐ Affidavit of Birth

4. Proof of Current Grade Level / School of Attendance

- ☐ Transfer from previous school
- ☐ Last report card from previous school
- ☐ Current IEP (If student is receiving Special Education Services**, (not speech only)** parent must contact our Special Education Office at (310-419-2775)
- ☐ Transcripts for 10th -12th grade (9th grade if applicable)
- ☐ CELDT Results (if applicable)

5. Health and Immunization Records

- ☐ Health History Forms (pg. 6-7)
- ☐ Vision To Learn Consent Form (pg. 17)
- ☐ Oral Health Assessment (Dental Screening) (pg. 12) **for new enrolling Kindergartners or 1st graders** this must be completed and submitted to the school on or before May 31st during the first year of enrollment.
- ☐ Physical Exam **for Kindergartners and 1st graders** (pg. 18) (must have a doctor's signature or stamp)**(PM 171A)**
- ☐ Complete Immunization Record(s) **(Blue card CDPH 286)**

6. Enrollment and District Policy Forms

- ☐ All forms completed (pg. 1-18)
- ☐ Emergency Card (pg. 5)
- ☐ TK Agreement (pg. 11) **(if applicable)**

FOR OFFICE USE ONLY
(initial each section if complete)

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

INGLEWOOD UNIFIED SCHOOL DISTRICT

401 S. INGLEWOOD AVENUE, INGLEWOOD, CALIFORNIA 90301 * TELEPHONE (310) 419-2700 *

ENROLLMENT FORM

FOR SCHOOL USE ONLY

Grade _____ Teacher_____

McKinney-Vento (Homeless) _____ Special Education _____

Inter-District (Incoming) Permit # _____

STUDENT INFORMATION

Has your child ever attended the Inglewood Unified School District? Yes _____ No _____ If yes, When? _____

Last Name	First Name	Middle Initial
Birthdate	Birth Place	

Home Address (**NO P.O. BOX ADDRESS**)	Age	Gender ❑ Female ❑ Male
City State Zip Code	County	Grade

PARENT # 1 CONTACT INFORMATION and EDUCATION LEVEL **Mother ❑ Father ❑ Guardian ❑**

Parent / Guardian Name _____ Parent's Email Address _____@_____

Parent's Home Phone _____ Parent's Mobile Phone _____ Parent's Work Phone _____

Parent Employer: Number/Street _____ City _____ State _____ Zip Code _____

❑ Some high school ❑ College graduate ❑ Graduate school/ Post grad
❑ High School graduate ❑ Some college ❑ None of the above

PARENT # 2 CONTACT INFORMATION and EDUCATION LEVEL **Mother ❑ Father ❑ Guardian ❑**

Parent / Guardian Name _____ Parent's Email Address _____@_____

Parent's Home Phone _____ Parent's Mobile Phone _____ Parent's Work Phone _____

Parent Employer: Number/Street _____ City _____ State _____ Zip Code _____

❑ Some high school ❑ College graduate ❑ Graduate school/ Post grad
❑ High School graduate ❑ Some college ❑ None of the above

MILITARY CONNECTED FAMILY: In effort to provide resources and support to military connected students and their families please respond to the following.	Immediate family member in the military (Active Duty, Guard, Reserve, or Veteran): ☐ YES ☐ NO Relationship to student:: _____	Currently Deployed: ☐ YES ☐ NO Military Branch : _____ Status: _____

Child is living with:

❑ Both parents	❑ Mother only	❑ Father only	❑ Guardian	❑ Other

PLACE ORIGINAL IN CUM FOLDER

Student Last Name:_____ First Name:_____ Permanent ID#_____ School Name:_____

INGLEWOOD UNIFIED SCHOOL DISTRICT

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WHAT IS YOUR CHILD'S ETHNICITY? (Please check one):

❑ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)	❑ Not Hispanic or Latino

WHAT IS YOUR CHILD'S RACE? (Check at least one box, you may mark up to five boxes):

No matter what ethnicity you selected above, mark at least one box below to indicate what you consider your race to be		
❑ American Indian or Alaskan Native (100) (Persons having origins in any of the original people of North, Central or South America)	❑ Laotian (206)	❑ White (700) (Persons having origins in any of the original peoples of Europe, North America or the Middle East)
❑ Chinese (201)	❑ Cambodian (207)	❑ Samoan (303)
❑ Japanese (202)	❑ Hmong (208)	❑ Tahitian (304)
❑ Korean (203)	❑ Other Asian (299)	❑ Other Pacific Islander (399)
❑ Vietnamese (204)	❑ Hawaiian (302)	❑ Filipino/Filipino American (400)
❑ Asian Indian (205)	❑ Guamanian (302)	❑ African American or Black (600)

HOME LANGUAGE SURVEY

The California Education Code requires schools to determine the language(s) spoken at home by each student. Your cooperation in answering the questions below will help us meet this important requirement. When a language other than English is identified in question 1, 2, or 3 below, districts are required to assess the student with the California English Language Development Test (CELDT). (CA Ed Code 313, 60810 and 60812)

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

If a language other than English is identified in question 1, 2, or 3, you will be contacted to schedule a CELDT assessment. Parents may not opt out of the CELDT for their student. The CELDT score will help schools provide meaningful instruction for students.

In which language do you wish to receive written communication from the school? ❑ English ❑ Spanish ❑ Both

SPECIAL EDUCATION

Does your child have an IEP? ❑ Yes ❑ No If yes, check all that apply, below.

❑ Special Day Class (SDC) ❑ Adapted Physical Education ❑ Speech / Language Program

❑ Resource Specialist Program (RSP) ❑ Designated Instructional Services (DIS)

❑ Other: Please Specify_____

OTHER SPECIAL PROGRAMS (Please check all that apply)

❑ Title I Program ❑ SARB ❑ 504 Plan ❑ McKinney Vento ❑ Foster Youth ❑ Probation

❑ English Language Development (ELD) Program ❑ Gifted and Talented Education (GATE) ❑ Continuation

❑ Other: Please Specify_____

SCHOOL HISTORY

_____

School Last Attended Address City State Zip Code

_____ _____ _____

Phone # Grade Date Left

Date student first enrolled in a United States school (kindergarten or above)._____

Has the student previously been enrolled in a California school? ❑ Yes ❑ No

If yes, provide name of school: _____ City_____

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SCHOOL HISTORY (cont.)

Date student first enrolled in a California School _____

Has the student ever been enrolled in Inglewood Unified Schools before? ❑ Yes ❑ No

If yes, name of school(s): _____ Grade: _____

school(s): _____ Grade: _____

school(s): _____ Grade: _____

Has the student ever been retained? ❑ Yes ❑ No If yes, which grade(s) _____

If the student is in 10th through 12th grade and has taken the California High School Exit Exam (CAHSEE), please enclose a copy of the latest results.

I certify that my son/daughter:

___ is not under an expulsion order or recommended for expulsion from another school district.

___ is currently under expulsion or has been recommended for expulsion from _____ School District

HEALTH HISTORY

Does your son/daughter have a family physician? ❑ Yes ❑ No

If yes, which physician? _____

Name Address Phone#

Does your family have health insurance? ❑ Yes ❑ No

Does your student wear corrective lenses? ❑ Yes ❑ No

List any health problems your student has, if any:_____

_____

_____

Does your child have prescribed medications that need to be taken regularly? ❑ Yes ❑ No If yes, please explain

_____

_____

Will your student need to take these medications at school? ❑ Yes ❑ No If yes, please explain and complete a medication form from the school health office:

_____

I am aware that falsification of information will invalidate future consideration for attendance in the Inglewood Unified School District.

_____ _____

Parent /Guardian Signature Date

INGLEWOOD UNIFIED SCHOOL DISTRICT

401 S. INGLEWOOD AVENUE, INGLEWOOD, CALIFORNIA 90301 * TELEPHONE (310) 419-2700 *

EMERGENCY CONTACT INFORMATION 20___ to 20___

Student Last Name _____ First Name _____ Middle In. _____ Gender ___ M ___ F Birthdate _____ Grade _____

Street Address _____ City _____ Zip _____ Home Phone _____

Parent/Guardian Information: **Preferred Language of Communication_____**

Name _____ Relationship _____ Address (if different than above) _____ Home Phone _____ Email _____

Place of Employment _____ Work Address _____ Work Phone _____ Cell Phone _____

Name _____ Relationship _____ Address (if different than above) _____ Home Phone _____ Email _____

Place of Employment _____ Work Address _____ Work Phone _____ Cell Phone _____

Student Lives with: (circle one**)** **Both Parents** **Mother only** **Father only** **Guardian** **Other:_____**

Sibling: _____ Grade: _____ Age: _____ __ M __ F School of Attendance: _____

Sibling: _____ Grade: _____ Age: _____ __ M __ F School of Attendance: _____

Sibling: _____ Grade: _____ Age: _____ __ M __ F School of Attendance: _____

ADDITIONAL EMERGENCY CONTACTS

In the event of emergency and parents cannot be contacted, you may contact OR release my child to:

Name	Relationship	Address	Home Phone	Work Phone
Name	Relationship	Address	Home Phone	Work Phone
Name	Relationship	Address	Home Phone	Work Phone
Name	Relationship	Address	Home Phone	Work Phone

GENERAL HEALTH INFORMATION

Please list any <u>medical</u> condition that may result in a classroom emergency: _____

Please list any allergies your child has, if any: _____

Is your child currently taking medication? ❑ Yes ❑ No If yes, list medication & dosage: _____

Physician's Name and phone number: _____

With my signature below, I affirm that that above information provide in the form above is accurate and correct.

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

INGLEWOOD UNIFIED SCHOOL DISTRICT

401 S. INGLEWOOD AVENUE, INGLEWOOD, CALIFORNIA 90301 * TELEPHONE (310) 419-2700 *

STUDENT HEALTH UPDATE

NAME: _____ BIRTHDATE: _____ _____ M ____ F

SCHOOL YEAR: _____ ROOM: _____ GRADE: _____

SEVERE ALLERGIES Complete only if your student has **SEVERE** allergies

❑ My child has a severe allergic reaction to the following: _____

❑ Will emergency medication be required at school? ❑ Yes ❑ No If yes, contact the school office for appropriate forms

❑ Allergy medication(s) taken at home: _____

❑ Allergy medication(s) taken at school: _____

❑ Comments/Special Instructions: _____

Please submit medical Action Plan from physician if available

Complete only if your child has asthma

ASTHMA ❑ Yes ❑ No Specify: _____

Current status of your child's asthma (Please check one) ___ Mild ___Moderate ___Severe

Does your child use an "as needed" inhaler? ❑ Yes ❑ No

Does your child require any asthma medication at school? ❑ Yes ❑ No If yes, contact the school office for appropriate forms)

Asthma medication(s) taken: _____

Please identify the things that trigger an asthma episode for your child: _____

_____

Physician treating asthma: _____ Phone: _____

Please submit medical Action Plan from physician if available

DOES YOUR CHILD HAVE?

ALLERGIES	❑ Yes	❑ No	Specify: _____
BEE STING	❑ Yes	❑ No	Specify: _____
DIABETES	❑ Yes	❑ No	Specify: _____
EAR INFECTION	❑ Yes	❑ No	Specify: _____
SEIZURES	❑ Yes	❑ No	Specify: _____
HEART CONDITION	❑ Yes	❑ No	Specify: _____
CANCER	❑ Yes	❑ No	Specify: _____
NOSE BLEEDS	❑ Yes	❑ No	Specify: _____
ORTHOPEDIC PROBLEMS	❑ Yes	❑ No	Specify: _____
OTHER	❑ Yes	❑ No	Specify: _____

HAS YOUR CHILD HAD?

Chicken Pox	❑ Yes	❑ No	Specify: _____
Serious Illness	❑ Yes	❑ No	Specify: _____
Surgery	❑ Yes	❑ No	Specify: _____

DOES YOUR CHILD?

Have trouble seeing up close?	❑ Yes	❑ No	Specify: _____
Have trouble seeing far away?	❑ Yes	❑ No	Specify: _____
Have trouble hearing?	❑ Yes	❑ No	Specify: _____
Have any other medical or physical restriction?	❑ Yes	❑ No	Specify: _____

DOES YOUR CHILD?

Take daily medication?	❑ Yes	❑ No	Specify: _____
Take emergency medication?	❑ Yes	❑ No	Specify: _____

MEDICATION POLICY

State law and district policy require doctor and parent permission for any medication to be taken at school. You can obtain the necessary forms in the health office. All medications MUST be in a prescription container with the student's name, name of the medicine, dosage and prescribing doctor's name on the bottle. No "over the counter" medications such as cough drops, cough medicine, pain medication (i.e. Tylenol) etc., may be taken by students without a doctor's prescription. All medications are kept in the health office and given with adult supervision. Under certain circumstances, students may be able to carry emergency medications with them.

Any physical restrictions must be confirmed by a written physician's note stating the type and duration of the restriction (i.e. casts crutches, wheelchairs, ace bandages, stiches, sunglasses, open-toed shoes, etc.)

Please bring a copy of your student's immunization records that we may keep to update our records.

Parent/Guardian Signature: _____ Date: _____

INGLEWOOD UNIFIED SCHOOL DISTRICT

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STUDENT RESIDENCY QUESTIONNAIRE/AFFIDAVIT

OFFICE USE ONLY
IF THEY SELECT "NO" IN QUESTION NUMBER (1) PLEASE REFER TO CWA

This document is intended to assist students and families who may be experiencing homelessness or currently living in transitional settings as outlined in the Federal McKinney-Vento Assistance Act. Your response to these questions will help the school district identify the appropriate support services. **(must be renewed annually).**

Student: _____ (Male ___ Female___)

Birthdate: _____ Grade: _____

1. Do you and your student live in a fixed, regular, adequate nighttime residence? ***Yes___ No___***
(If you circled "Yes", stop here. You must provide a gas or electric bill in your name as proof of residence. If you circled "NO", please continue with this form.)

2. Do you and the student live in:

- ☐ shelter
- ☐ motel /hotel
- ☐ temporarily with another family in a house, mobile home, or apartment
- ☐ in a car or RV
- ☐ at a campsite
- ☐ transitional housing
- ☐other location _____

3. The student lives with:

- ☐ one parent
- ☐ two parents
- ☐ a qualified relative
- ☐ friend(s)
- ☐ an adult that in not the legal guardian
- ☐ alone with no adult(s)

4. I am:

- □ the parent/legal guardian of the above-named student
- □ a qualified adult relative of the above-named student
  (Relationship: _____)

I declare under penalty of perjury under the laws of this state that the information provided here is true and correct and of my own personal knowledge.

Signature: _____ Date: _____

Print Your Name: _____

Residence: _____
Street City Zip

Mailing Address: _____
Street City Zip

Telephone: (_____)_____ Cell Phone: (____)_____

INGLEWOOD UNIFIED SCHOOL DISTRICT

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AUTHORIZATION FOR PHOTOGRAPHING, VIDEOTAPE RECORDING

I hereby consent to the videotaping, photographing, or other electronic recording of:

_____
Name of Student

I further authorize the use of such reproductions for educational purposes, including, but not limited to, use for teacher training and in-service and/or posting on the District website or other publications related to school activities. I understand that no monetary compensation now, or in the future, will be paid to Student or his/her parents or guardian for the District's use of such reproductions for educational or school-related purposes.

As a condition of my child's participation, I agree to waive all claims against Inglewood Unified School District and to indemnify and hold the Inglewood School District, the Superintendent, its Board, officers, agents, and employees, harmless from any and all liability or claims, demands, losses, causes of action, suits or judgments of any kind whatsoever that I, my heirs, executors, administrators or assignees may have against the District or any other person or entity may have against the district because of any personal injury, bodily injury, or property damage or loss that may arise out of or in any way be connected with the above described activity. This waiver shall not apply to any occurrences that may arise solely out of the negligence of the District, its employees or agents.

Parent's Name: _____Signature_____Date:_____

AUTHORIZATION FOR STUDENT USE OF DISTRICT TECHNOLOGY

As a student in the Inglewood Unified School District, I understand that before being allowed to use a District computer or access the internet provided by the District, I agree to follow the rules and guidelines for acceptable use, as described in District's Technology Plan. These rules and guidelines include using the internet appropriately, respecting the work of other students and people, taking care of computer hardware, software and equipment and reporting anything that may go wrong on a district computer to a teacher or administrator. Failure to abide by any of the above rules and guidelines may result in a student having his/her technology privileges revoked or limited.

Student's Name: _____Signature: _____ Date: _____

Parent's Name: _____Signature:_____ Date:_____

INGLEWOOD UNIFIED SCHOOL DISTRICT

401 S. INGLEWOOD AVENUE, INGLEWOOD, CALIFORNIA 90301 * TELEPHONE (310) 419-2700 *

PARENT NOTIFICATION OF POSSIBLE CHANGE OF CLASSROOM OR SCHOOL ASSIGNMENT

Thank you for entrusting the Inglewood Unified School District to serve the educational needs of your child. We welcome you to our district.

At this time, your child has been placed in his/her Home School. To maximize space in our schools and account for students not returning for this new school year, some grade levels and classes may be filled beyond capacity limits temporarily. One week after the first day of school, the district will assess numbers in all schools. Classrooms that remain over capacity at that time may require restructuring, in order to lower class sizes and equalize numbers throughout the district.

As a result, some students may need to change to another classroom or possibly to another school site within the district. Students will be chosen equitably, based on date of last enrolled.

The Inglewood Unified School District reserves the right to change the assignment of a student in order to maintain reasonable class sizes throughout the District, as described above. Your signature below indicates that you have been advised of above-mentioned policy and understand its implications.

Parent Signature: _____ Date: _____

Student Name: _____ Grade: _____

School Assignment: _____

INGLEWOOD UNIFIED SCHOOL DISTRICT

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Agreement for Student to Participate in Transitional Kindergarten

California law provides that any child whose fifth birthday **falls between September 2 and December 2**, may participate in a two-year kindergarten program. The first year is called "Transitional Kindergarten." For the second year of this two-year program, the child will be enrolled in traditional kindergarten. This program will be a bridge between preschool and kindergarten and will give children an opportunity to learn important academic and social skills in a hands-on way that supports their development.

This is important because California's kindergarten standards and curriculum have changed over the years, and many of the skills children were once taught in first grade are now expected to be mastered in kindergarten. Transitional Kindergarten is a wonderful new option that will allow families to give their children the gift of time to develop at their own pace and continue building the social, emotional and academic skills that will help them succeed in elementary school.

Filling out the bottom portion signifies that you are interested in enrolling your child in Transitional Kindergarten and that you understand it is part of a two-year kindergarten program, and that your child will be enrolled in traditional Kindergarten their second year.

_____

Please Print

Student's Name: _____

Date of Birth: _____

Parent/Guardian's Name: _____

School of Attendance: _____

Address: _____

Parent Email Address:

_____

Home Phone: _____ Cell Phone: _____

Signature of Parent/Guardian: _____ Date: _____

Please note: The Transitional Kindergarten program is contingent on the current California State Law remaining in effect.

For Office Use Only: Date Received _____

INGLEWOOD UNIFIED SCHOOL DISTRICT

401 S. INGLEWOOD AVENUE, INGLEWOOD, CALIFORNIA 90301 * TELÉFONO (310) 419-2700 *

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: □ Male □Female
Parent/Guardian Name:	**C**hild's race/ethnicity: □White □Black/African American □Hispanic/Latino □Asian □Native American □Multi-racial □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 filling present) □Yes □No	Visible Decay Present: □Yes □No	Treatment Urgency: □No obvious problem found □Early dental care recommended (caries without or infection; or child would benefit sealants or further evaluation) □Urgent care needed(pain, infection, swelling or soft tissue lesions

_____ _____ _____

Licensed Dental Professional Signature **CA License Number** **Date**

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.

IUSD Bullying/Harassment Policy

It is a priority for The Inglewood Unified School District (IUSD) to ensure the physical, mental and emotional well-being and safety of all students enrolled in the IUSD. To that end, IUSD takes seriously any acts of bullying or harassment that jeopardizes the physical, mental and emotional well-being and safety of students. The IUSD will investigate any acts of bullying or harassment as defined by Ed Code 48900(r) which prohibits bullying or harassment on a California Public School. The appropriate disciplinary measures will be taken if evidence of bullying or harassment exist. The IUSD adheres to Ed Code 48900(r) which defines bullying as:

(r) Engaged in an act of bullying. For purposes of this subdivision, the following terms have the following meanings:

(1) "Bullying" means any severe or pervasive physical or verbal act or conduct, including communications made in writing or by means of an electronic act, and including one or more acts committed by a pupil or group of pupils as defined in Section 48900.2, 48900.3, or 48900.4, directed toward one or more pupils that has or can be reasonably predicted to have the effect of one or more of the following:

(A) Placing a reasonable pupil or pupils in fear of harm to that pupil's or those pupil's person or property.
(B) Causing a reasonable pupil to experience a substantially detrimental effect on his or her physical or mental health.
(C) Causing a reasonable pupil to experience substantial interference with his or her academic performance
(D) Causing a reasonable pupil to experience substantial interference with his or her ability to participate in or benefit from the services, activities, or privileges provided by a school.

(2)(A) "Electronic act" means the creation or transmission originated on or off the school site, by means of an electronic device, including, but not limited to, a telephone, wireless telephone, or other wireless communication device, computer, or pager, of a communication including, but not limited to, any of the following:

(i) A message, text, sound, video, or image.
(ii) A post on social network Internet Web site, including, but not limited to:

(I) Posting to or creating a burn page. "Burn page" means an Internet Web site created for the purpose of having one or more of the effects listed paragraph (1).
(II) Creating a credible impersonation of another actual pupil for the purpose of having one or more of the effects listed in paragraph (1). "Credible impersonation" means to knowingly and without consent impersonate a pupil for the purpose of bullying the pupil and such that another pupil would reasonably believe, or has reasonably believed, that the pupil was or is the pupil who was impersonated.

My signature below acknowledges that I have read and understand the IUSD Bullying / Harassment Policy regarding Ed Code 48900(r).

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature Date

IUSD Classroom Suspension Policy

California Education Code 48900 outlines the behaviors that may lead to an in-school or out-of-school suspension. Per California Education Code 48910, a classroom teacher has the right to issue a classroom suspension for up to two days for any behaviors under California Education Code 48900. The classroom teacher must consult with the principal prior to issuing a classroom suspension and communicate the reason for the classroom suspension to the parent. A parent-teacher conference must be held when the student returns to the classroom to discuss classroom behavior expectations and any supports needed for the student to be successful.

California Education Code 48910 states the following:

(a) A teacher may suspend any pupil from class, for any of the acts enumerated in Section 48900, for the day of the suspension and the day following. The teacher shall immediately report the suspension to the principal of the school and send the pupil to the principal or the designee of the principal for appropriate action. If that action requires the continued presence of the pupil at the school site, the pupil shall be under appropriate supervision, as defined in the policies and related school regulations adopted by the governing board of the school district. As soon as possible, the teacher shall ask the parent or guardian of the pupil to attend a parent-teacher conference regarding the suspension. If practicable, a school counselor or a school psychologist may attend the conference. A school administrator shall attend the conference if the teacher or the parent or guardian so requests. The pupil shall not be returned to the class from which he or she was suspended, during the period of the suspension, without the concurrence of the teacher of the class and the principal.

(b) A pupil suspended from a class shall not be placed in another regular class during the period of suspension. However, if the pupil is assigned to more than one class per day this subdivision shall apply only to other regular classes scheduled at the same time as the class from which the pupil was suspended.

(c) A teacher may also refer a pupil, for any of the acts enumerated in Section 48900, to the principal or the designee of the principal for consideration of a suspension from the school.

My signature below acknowledges that I have read and understand the IUSD classroom suspension policy.

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature Date

INGLEWOOD UNIFIED SCHOOL DISTRICT

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Classroom Visitation Policy

IUSD encourages and values the involvement and contribution of parents in their children's education. Parents are encouraged to visit their child's classroom to see their children's learning environment and gain a deeper understanding of what their children are learning. Per California Education Code 4909.10, parents may submit a request to the school principal to observe their child's classroom for a period of 20 minutes. The following procedures must be followed to request a 20-minute parent classroom observation:

1. Submit written classroom observation request stating the date, class and teacher requesting to be observed.
2. The Principal or Assistant Principal will provide parent an oral or written response confirming the date, class and teacher approved to be observed.
3. The Principal or Assistant Principal will accompany the parent on the observation. During the observation, the parent is not allowed to interfere with their child's classroom by speaking with the teacher, their child or other students.
4. Following the observation, the Principal or Assistant Principal will debrief the observation with the parent.
5. Schedule a time to meet with the teacher to discuss the observation if necessary.

My signature below acknowledges that I have read and understand the IUSD classroom visitation policy.

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature Date

Vision To Learn
Focus on the Future

MOBILE VISION SERVICES CONSENT AND RELEASE FORM

Health Net® COMMUNITY SOLUTIONS L.A. Care HEALTH PLAN

Dear Parent/Guardian,

Vision To Learn is a nonprofit organization that offers eye exams and glasses to kids at no cost on behalf of L.A. Care Health Plan and Health Net. Vision To Learn will be bringing its mobile vision care clinic to your child's school to provide eye exams and glasses to children who need them. If you would like to give your child permission to participate in this program, please complete and sign this form. Return the completed form to the school nurse. **There is no cost for your child to participate in the program.**

However, if your child is a member of L.A. Care or Health Net, then the services offered to your child will be covered by Medi-Cal.

PLEASE PRINT OR TYPE:

REQUIRED:

Child's First Name: | Child's Last Name:

Child's Date of Birth: Month / Date / Year | Child's Gender (please check one): ☐MALE ☐FEMALE

Parent/ Guardian First Name: | Parent/ Guardian Last Name:

CONTACT INFORMATION:

Street Address: Unit/ Apt:	City:	State:	Zip:
Phone Number:	Emergency Phone Number:	Email:	

SCHOOL INFORMATION:

Name of School:	Name of Teacher:
Grade:	Classroom:

INSURANCE INFORMATION:

OPTIONAL:

☐Child Has Medi-Cal

Provider (circle one): L.A. CARE HEALTHNET	I.D. Number:

☐Child Has Private Insurance

Provider:	I.D. Number:

☐Child Is Uninsured

By signing this form, I agree to allow my child to receive vision care services through Vision To Learn's mobile vision clinic. I acknowledge that I have the right to refuse any services provided by Vision To Learn but that I am choosing voluntarily for my child to receive vision services. I understand that my child is allowed one eye exam, one pair of frames and the dispensing of one pair of glasses every 24 months as a member of L.A. Care or Health Net. I understand that receiving vision services through Vision To Learn's mobile vision clinic will not disqualify me from accessing non-mobile services for vision care. I also authorize the release of any medical or related information required for L.A. Care, Health Net or the Provider to submit a claim and receive payment from Medi-Cal, where applicable, for vision services provided to my child. I agree that I am waiving any and all claims against the school where my child is a student that may arise from my child's participation in the program. My signature shows that I have read and understood this voluntary Consent and Release and I agree to its provisions.

Parent/ Guardian Signature: _____ Date: _____

11611 San Vicente Blvd. Suite 500, Los Angeles, CA 90049 (800) 485-9196 Fax: (213) 402-5261 VisionToLearn.org

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.