Rialto Unified School District
Enrollment Checklist
(2nd – 5th Grade)

- ❑ Immunization Record
- ❑ *Tuberculosis (TB) Risk Assessment or TB Test with results

  Applies to all students (TK – 12th Grade) who seek admission to a California school for the first time or have been away from the U.S. for more than 12 months
- ❑ Proof of Date of Birth (birth certificate, certified birth record, baptismal certificate, passport, or affidavit)
- ❑ Current address verification in parent/guardian name (Utility bill, official mail, rental/lease agreement or payment receipts, property tax receipt, pay stubs, voter registration, or affidavit **no more than 30 days old**)
- ❑ Identification of the enrolling parent/guardian
- ❑ **Current/Signed** IEP if the student is receiving special education services

Enrollment Center

260 S Willow Ave, Rialto, CA 92376

Tel: 909-873-4300 | Fax: 909-873-4301

enrollmentcenter@rialtousd.org

RIALTO UNIFIED SCHOOL DISTRICT ENROLLMENT FORM

STUDENT INFORMATION (please use blue or black ink)

Legal Last Name	Legal First Name	Legal Middle Name

Grade	Retained? If yes, what grade?	Also Known As (other names used)

Address	Apt./Space	☐ Rialto ☐ San Bernardino ☐ Colton ☐ Fontana ☐ Other: ____	Zip Code
Mailing address, if different	Apt./Space	☐ Rialto ☐ San Bernardino ☐ Colton ☐ Fontana ☐ Other: ____	Zip Code

Primary Phone Number	Date of Birth	Sex ☐ Male ☐ Female	Preferred Language of Correspondence

ETHNICITY (Please select one)
Is your child Hispanic or Latino?
☐ Yes, Hispanic or Latino
☐ No, Not Hispanic or Latino

RACE (Please select all that apply)
☐ American Indian or Alaska Native (Origins in North, Central or South America)
Name of enrolled or principal tribe(s): ____
☐ African American or Black ☐ Cambodian ☐ Chinese ☐ Filipino/Filipino American ☐ Guamanian
☐ Hawaiian ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Other Asian
☐ Other Pacific Islander ☐ Samoan ☐ Tahitian ☐ Vietnamese
☐ White (Origins in Europe, North Africa, or the Middle East)

FAMILY INFORMATION (If there is a custody/restraining order for your child, please provide copy)

Name of Person Enrolling Student	Relationship to student ☐ Mother ☐ Father ☐ Caregiver ☐ Foster Parent ☐ Legal Guardian	Home Phone / Work Phone
Name of Legal Mother	☐ Lives with ☐ Not in the home	Home Phone / Work Phone
Name of Legal Father	☐ Lives with ☐ Not in the home	Home Phone / Work Phone

CHILDREN LIVING IN THE HOME

Name	Date of Birth	School
Name	Date of Birth	School
Name	Date of Birth	School
Name	Date of Birth	School
Name	Date of Birth	School

PREVIOUS SCHOOL INFORMATION (List last school first)

Name of School	City	State	Grade	School Year
Name of School	City	State	Grade	School Year
Has the student attended a Rialto USD school? ☐ Yes ☐ No (ex: Preschool)	If yes, name school:		Grade	School Year

PARENT EDUCATION LEVEL

The California State Department of Education requests information regarding the highest level of education completed by the enrolling parent/guardian. Please check for both parents.

Mother/Guardian 1
☐ Not a high school graduate ☐ High school graduate ☐ Some College
☐ College graduate ☐ College degree from a 4 year university with additional coursework in graduate school

Father/Guardian 2
☐ Not a high school graduate ☐ High school graduate ☐ Some College
☐ College graduate ☐ College degree from a 4 year university with additional coursework in graduate school

PRIOR SPECIAL EDUCATION PROGRAMS

Please provide the following information for student placement in a special service or program:

☐ My child has **NOT** participated in a special program
☐ My child has had a special education evaluation

My child has participated in the following services:
☐ Specialized Academic Instruction (ex. RSP/SDC)
☐ Speech Therapy
☐ Occupational Therapy
☐ Adaptive Physical Education
☐ Physical Therapy
☐ Other: ____

OFFICE USE ONLY

Notes:
____
Grade: ____
Date: ____
Student #:
____
School of Residence:
____
School Assigned:
____
Start Date:
____
Teacher/Counselor:
____
Classroom: AM or PM
____
Birth Verification: ____
P.O.B: ____
Enter Code: ____
Reason:
☐ Overflow
☐ Inter/Intra
☐ Other: ____
Address Verification:
☐ Utility/Rent Receipt
☐ Affidavit of Residence
☐ Other: ____
☐ McKinney Vento
☐ Foster
4-digit zip: ____
Enrolled by:
____

My signature certifies that all information provided is accurate. I understand that changes in address, telephone numbers, and/or emergency information must be reported to the school within <u>24 hours</u> for the safety of my student.

Parent/Guardian Signature: ____________________ Date: ________

Home Language Survey

Student Name: ______________________________

Date of Birth: ______________ Grade: ______

Directions to Parents and Guardians:

The California *Education Code* contains legal requirements which direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with these requirements. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered. If an error is made completing this home language survey, you may request correction before your student's English proficiency is assessed.

1. Which language did your child learn when they first began to talk? ______________
2. Which language does your child most frequently speak at home? ______________
3. Which language do you (the parents and guardians) most frequently use when speaking with your child? ______________
4. Which language is most often spoken by adults in the home? (parents, guardians, grandparents, or any other adults) ______________

Please sign and date this form in the spaces provided below, then return this form to your child's teacher. Thank you for your cooperation.

Signature of Parent or Guardian: ______________________________ Date: __________

OFFICE USE ONLY

School: ______________________ Reviewed by: ______________________
Enrollment Staff

☐ Sent to Multilingual Programs on: ______________

☐ Received by MLP/LAC on: ______________

Housing Questionnaire

The information provided below will help your child's school to determine whether you and/or your child may be eligible for specialized services and supports. This could include additional educational services through Title I, Part A and/or the federal McKinney-Vento Assistance Act. The information provided on this form will be kept confidential and only shared with appropriate school district and site staff.

Student Name	**Date of Birth**
School Assigned	**Grade**

Which of the following describes you and/or your family's current living situation? *Please check all that apply.*

- ☐ **Sharing housing** with other(s) due to loss of housing, economic hardship, natural disaster, lack of adequate housing, or similar reason
- ☐ Staying in a **shelter** (family shelter, domestic violence shelter, youth shelter) or Federal Emergency Management Agency (FEMA) trailer
- ☐ Living in a car, park, campground, abandoned building, or other inadequate accommodations (i.e. lack of water, electricity, or heat)
- ☐ Temporarily living in a **motel or hotel** due to loss of housing, economic hardship, natural disaster, or similar reason
- ☐ I am a student under the age of 18 and **living apart from parent(s) or guardian**
- ☐ **None of the above**. My student and I live in permanent, adequate housing

The undersigned parent/guardian certifies that the information provided above is correct and accurate.

Parent/Guardian Name (Print) **Parent/Guardian Signature** **Date**

Street Address **City** **State** **Zip Code** **Phone Number**

Your child or children may have the right to:

- Immediate enrollment in the school they last attended (school of origin) or the local school where you are currently staying, even if you do not have all the documents normally required at the time of enrollment.
- Continue to attend their school of origin, if requested by you and it is in the best interest.
- Receive transportation to and from their school of origin, the same special programs and services, if needed, as provided to all other children, including free meals and Title I.
- Receive the full protections and services provided under all federal and state laws, as it relates to homeless children, youth, and their families.

Please list all children currently living with you.

Name	**Birthdate**	**Grade** (if applicable)	**School** (if applicable)

If you have any questions about these rights, please contact your school site's homeless youth representative. If you have trouble contacting them, you may contact the Rialto USD McKinney-Vento & Foster Youth Liaisons at 909-873-4336.

Student Name: ____________________

Rialto Unified School District

Custody Issues

Parent Disputes over Custody in School Setting

Parents may try to use the school as a forum for disputing custody matters. If needed, the school district may consider including the following form in their annual notification to parent and legal guardians.

Custody disputes must be handled by the courts. The school has no legal jurisdiction to refuse a biological parent access to their child. The only exception is when a signed restraining order or proper divorce papers, specifically stating visitation limitations, are on file in the school office. Any student release situation which leaves the student's welfare in question will be handled at the discretion of the site administrator or designee. Should any such situation become a disruption to the school, law enforcement will be contacted and an officer requested to intervene. Unless Educational Rights have been revoked, both parents have access to student records.

Parents are asked to make every attempt not to involve school sites in custody matters.

The school will make every attempt to reach the custodial parent when a parent or any other person not listed on the emergency card attempts to pick up a child.

I have read and understand the above statement.

____

Parent/Guardian Signature 1 Date

____

Parent/Guardian Signature 2 Date

Office use only:

Date Received: ____________ Home School: ____________

Notification placed on Synergy: ______ Document(s) uploaded to Synergy: _____

RIALTO UNIFIED SCHOOL DISTRICT
HEALTH SERVICES
815 S. Willow Ave., Rialto, CA 92376 • Tel (909) 820-8150 • Fax (909) 820-8151

STUDENT HEALTH HISTORY

Student Name: ______________________________ **Date of Birth:** __________ **Grade:** _____

☐ **My child does NOT have any known health conditions**

☐ **My child has the following health conditions:**
(check all that apply **and** if medication or treatment is required at school)

	Medication / Treatment REQUIRED at school
☐ Non-food Allergy Type of allergy: __________ Type of Medication: __________	☐ Yes ☐ No
☐ Food Allergy Type of allergy: __________ Type of Medication: __________	☐ Yes ☐ No
☐ ADHD / ADD	☐ Yes ☐ No
☐ Asthma	☐ Yes ☐ No
☐ Autism	☐ Yes ☐ No
☐ Birth Defects / Genetic Disorders	☐ Yes ☐ No
☐ Blood / Bleeding Disorders	☐ Yes ☐ No
☐ Hearing Loss	☐ Yes ☐ No
☐ Kidney Disorder / Bladder Problems	☐ Yes ☐ No
☐ Psychological Problems	☐ Yes ☐ No
☐ Serious accidents or hospitalizations	☐ Yes ☐ No
☐ Vision Impairment	☐ Yes ☐ No
☐ **Cancer / Leukemia**	☐ Yes ☐ No
☐ **Cerebral Palsy**	☐ Yes ☐ No
☐ **Colostomy Bag**	☐ Yes ☐ No
☐ **Diabetes:** ☐ **Type 1** ☐ **Type 2** – **Insulin Dependent:** ☐ Yes ☐ No **If applicable:** ☐ Dexcom ☐ Insulin Pump ☐ Metformin ☐ Humalog Insulin Pen	☐ Yes ☐ No
☐ **Epilepsy / Seizures** – ☐ Requires Diastat	☐ Yes ☐ No
☐ **Gastrostomy Tube (G-Tube)** – ☐ Requires G-Tube feeding	☐ Yes ☐ No
☐ **Heart Problems / Heart Surgery**	☐ Yes ☐ No
☐ **Tracheostomy** ☐ Requires Suctioning ☒ Ventilator Dependent ☐ Oxygen Dependent	☐ Yes ☐ No
☐ **Other:** ______________________________	☐ Yes ☐ No

Special Treatments and/or Medications: ______________________________

____

Parent/Guardian Signature: ______________________________ **Date:** __________

OFFICE USE ONLY

Emailed Health Services: _______ Verified by Health Services: _______ School: ______________

Provided parent with the following documents: ☐ Authorization for Medical Release ☐ Medication Form

California Immunization Requirements for

K–12th Grade (including transitional kindergarten)

Grade	Number of Doses Required of Each Immunization[1,2,3]				
K-12 Admission	4 Polio[4]	5 DTaP[5]	3 Hep B[6]	2 MMR[7]	2 Varicella
(7th-12th)[8]	K-12 doses	+ 1 Tdap			
7th Grade Advancement[9,10]		1 Tdap[8]			2 Varicella[10]

1. Requirements for K-12 admission also apply to transfer pupils.
2. Combination vaccines (e.g., MMRV) meet the requirements for individual component vaccines. Doses of DTP count towards the DTaP requirement.
3. Any vaccine administered four or fewer days prior to the minimum required age is valid.
4. Three doses of polio vaccine meet the requirement if one dose was given on or after the 4th birthday.
5. Four doses of DTaP meet the requirement if at least one dose was given on or after the 4th birthday. Three doses meet the requirement if at least one dose of Tdap, DTaP, or DTP vaccine was given on or after the 7th birthday (also meets the 7th-12th grade Tdap requirement. See fn. 8.) One or two doses of Td vaccine given on or after the 7th birthday count towards the K-12 requirement.
6. For 7th grade admission, refer to Health and Safety Code section 120335, subdivision (c).
7. Two doses of measles, two doses of mumps, and one dose of rubella vaccine meet the requirement, separately or combined. Only doses administered on or after the 1st birthday meet the requirement.
8. For 7th-12th graders, at least one dose of pertussis-containing vaccine is required on or after the 7th birthday.
9. For children in ungraded schools, pupils 12 years and older are subject to the 7th grade advancement requirements.
10. The varicella requirement for seventh grade advancement expires after June 30, 2025.

DTaP/Tdap = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine
Hep B = hepatitis B vaccine
MMR = measles, mumps, and rubella vaccine
Varicella = chickenpox vaccine

Instructions:

California schools are required to check immunization records for all new student admissions at TK / Kindergarten through 12th grade and all students advancing to 7th grade before entry. See shotsforschool.org for more information.

Unconditionally Admit a pupil whose parent or guardian has provided documentation of any of the following for each immunization required for the pupil's age or grade as defined in the table above:

- Receipt of immunization.
- A permanent medical exemption.*

Conditionally Admit any pupil who lacks documentation for unconditional admission if the pupil has:

- Commenced receiving doses of all the vaccines required for the pupil's grade (table above) and is not currently due for any doses at the time of admission (as determined by intervals listed in the Conditional Admission Schedule, column entitled "Exclude If Not Given By"), or
- A temporary medical exemption from some or all required immunizations.*

Enroll. Get Care. Renew.

FREE MEDI-CAL OR LOW-COST COVERED CALIFORNIA EXISTS FOR MOST LOW-INCOME CALIFORNIA FAMILIES.

- **Medi-Cal** is a **public health insurance** available to low-income Californians. Starting January 1, 2024, all income-eligible Californians qualify for full scope Medi-Cal benefits REGARDLESS OF AGE OR IMMIGRATION STATUS. **Full scope Medi-Cal** covers more than just care when you have an emergency. It provides medical, dental, mental health, and vision (eye) care. Applying for Medi-Cal via the Covered California website is the fastest way to get covered.
- **Covered California** is a **free service** for individuals and families to get free or low-cost health insurance OR to get help paying for **private** health insurance. More information on page 2.

APPLY for Medi-Cal or Covered California:

By phone: ***1(800) 300-1506***

www.CoveredCA.com (Covered CA and Medi-Cal)
www.BenefitsCal.com (Medi-Cal)

In-person: ***https://bit.ly/3Tk3cXV***

Apply by mail: Medi-Cal printable applications here: ***http://bit.ly/3RRENIK***

Need Help?

Find Help in Your Community and More!
Scan this QR code.
www.allinforhealth.org

The 6 Step Roadmap to Medi-Cal

1 Check Your Eligibility

Medi-Cal eligibility is based primarily on your income and state residency.

2 Apply for Medi-Cal

Medi-Cal enrollment is open and available all year. Read more about enrollment above!

3 Eligibility Determination

The county will process your application for eligibility.

4 Select a Health Care Plan

Most Medi-Cal enrollees must enroll in a health care plan.

5 Get Care

Medi-Cal covers ALL medically necessary care.

6 Renew Your Medi-Cal

Most people must renew their Medi-Cal every year.

For more detailed information about how to Enroll, Get Care, and Renew Medi-Cal, please see page 2.

This flyer was created with the support of the Whole Child Equity Partnership.

The 6 Steps to Medi-Cal

STEP 1

Check Your Eligibility

Children, pregnant and 12 months postpartum individuals have higher income eligibility levels than other adults. Your child(ren) may still qualify for Medi-Cal even if adult family members do not qualify.

If your income is above the Medi-Cal eligibility level, you may qualify for Covered California. If so, Medi-Cal will forward your information to Covered California, which will send you information about your automatic enrollment and what you need to do to activate it. ***See the income limit chart.***

STEP 2

Enroll.

Apply for Medi-Cal in person, online, by mail, by phone, or find help in your community. Go to page 1 for more information or enroll at: ***www.CoveredCA.com***

STEP 3

Eligibility Determination

After you apply:

- You will receive a ***Notification of Likely Eligibility*** by mail. **NEW!**—many Medi-Cal eligible applicants can now receive real time enrollment. This means that once the application is received, **you will have full coverage while the county processes the application.** For the fastest "real-time" enrollment, apply for Medi-Cal through ***www.CoveredCA.com*** (applications submitted by mail start accelerated enrollment when the county receives the application).
- You will receive a ***Final Notice of Action*** notifying you whether you can receive Medi-Cal. If you are denied Medi-Cal, you have the right to appeal. Ask for a ***State Fair Hearing*** by calling ***800-952-5253***, or by requesting it in writing.
- It can take up to 45 days to receive your Medi-Cal card in the mail after you apply, if you are eligible.

STEP 4

Select a Health Care Plan

You must choose a health plan within 30 days of receiving your health plan options in the mail. If you do not choose a plan within 30 days, Medi-Cal will choose a plan for you. The health plans available to you **depend on what county you live in.**

- Go to the Medi-Cal ***Managed Care Health Plan Directory*** to find your options.
- Visit the ***Health Care Options*** website for more information.

STEP 5

Get Care.

Find a primary care doctor. Ask your health plan for help locating an available doctor near you. Your health plan is required to help you make appointments, get interpretation services, ***get free transportation to appointments,*** and use telehealth.

Medi-Cal covers ALL COSTS for screenings, mental health, vision, dental services, and all other medically necessary care.

Find a dental home. Medi-Cal offers dental benefits to both children and adults. Visit ***SmileCalifornia.org*** to find a Medi-Cal dentist.

Kids and Teens. Medi-Cal for Kids & Teens provides free services to keep your child healthy from birth to age 21. For more information, visit: ***https://bit.ly/3T1Ga8e***

2024 Financial Help

You or your family may qualify for free Medi-Cal or *premium assistance* under Covered California.

For information on calculating income and household size, visit:

www.allinforhealth.org/financial-help

STEP 6

Renew.

It's important to ensure that Medi-Cal has your current address and updated phone number so that when it's time to renew your coverage, they can contact you. If you receive a renewal notice, be sure to act!

Follow these steps:

- Set up a ***BenefitsCal.com*** account to get renewal updates.
- Submit changes to your contact information so Medi-Cal can contact you about renewals.
- Fill out and submit renewal forms when they are received (online, phone, mail, or in person).

Often when family income increases, your child(ren) may still qualify for Medi-Cal even if adult family members no longer qualify. Fill out and submit Medi-Cal renewal information to keep your child(ren)'s free Medi-Cal coverage even if you may be enrolled in employer coverage or Covered California.

Children in foster care and former foster youth are not required to renew their coverage. Postpartum individuals also do not need to renew their coverage within 12 months postpartum.

Covered California

If you are ineligible for Medi-Cal:

- Covered California offers a selection of health plans. They help in comparing and choosing a health plan that works best for each person. To learn more, visit: ***www.CoveredCA.com***
- Many Californians may qualify for financial assistance via a Premium Tax Credit or reductions in what enrollees pay for their health care (known as cost-sharing reductions).
- Open enrollment is the time of year when everyone can apply for a plan through Covered California. Enroll during Open Enrollment or any time you experience a life-changing event, like losing your job or having a baby. You have 60 days from the event to complete enrollment.

www.allinforhealth.org

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RIALTO UNIFIED SCHOOL DISTRICT • HEALTH SERVICES • 815 S. WILLOW AVENUE, RIALTO, CA 92376 • TEL: (909) 820-8150

Possible Referrals: If you have a personal health care provider, please feel free to use them. ***We do not endorse any specific health care provider.***

Posibles referencias: Si tiene un proveedor de atención médica personal, no dude en utilizarlo. ***No respaldamos a ningún proveedor de atención médica específico.***

For additional information, please scan the QR codes provided. • Para obtener información adicional, escanee los códigos QR proporcionados.

DENTAL CARE

DENTI-CAL
(800) 322-6384

LOMA LINDA SCHOOL OF DENTISTRY
(Pediatric Dental Clinic)
Loma Linda (909) 558-4689

SAN BERNARDINO HEALTH CENTER
(For Dental Services)
606 E. Mill St., San Bernardino
(800) 722-4777

ONTARIO HEALTH CENTER
(For Dental Services)
150 E. Holt Blvd., Ontario
(909) 458-9447

INLAND FAMILY COMMUNITY HEALTH CENTER
(For Dental Services)
665 North 'D' St., San Bernardino
(909) 708-8168

GOLDEN WEST DENTISTRY
9922 Sierra Ave., Fontana
(909) 822-4800

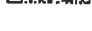
B R DENTAL
(Next to Clinica Medica Familiar)
436 S. Riverside Ave., Rialto
(909) 874-5200

DR. DAVID A. NEWSHAM, DDS
1735 N. Riverside Ave., Rialto
(909) 820-9081

MEDICAL CARE

SAC HEALTH SYSTEM
815 S. Willow Ave., Rialto
To schedule an appointment
(909) 382-7100

SAN BERNARDINO HEALTH CENTER
(For Medical Services)
606 E. Mill St., San Bernardino
(800) 722-4777



ONTARIO HEALTH CENTER
(For Medical Services)
150 E. Holt Blvd., Ontario
(909) 458-9447

BLOOMINGTON COMMUNITY HEALTH CENTER
18601 Valley Blvd., Bloomington
(909) 546-7520

MOMMY AND ME MEDICAL GROUP
790 E. Foothill Blvd., Rialto
(909) 421-0493

ARROWHEAD FAMILY HEALTH CENTER
16888 Baseline Ave., Fontana
(855) 422-8029

INLAND FAMILY COMMUNITY HEALTH CENTER
(For Medical Services)
665 North 'D' St., San Bernardino
(909) 708-8158

MEDICAL CARE...*continued*

LASALLE MEDICAL ASSOCIATES
790 E. Foothill Blvd., Rialto
(909) 546-7135

UNICARE COMMUNITY HEALTH CENTER
17500 Foothill Blvd. #A-2, Fontana
(909) 428-0170

VISION EXAMS

NORTHPOINTE OPTOMETRIC CENTER
1850 N. Riverside Ave., Ste. 220
Rialto (909) 875-1144

RIALTO OPTOMETRIC CENTER
1850 N. Riverside Ave., Ste. 210
Rialto (909) 421-3030

COLTON OPTOMETRIC CENTER
190 W. H St., Ste. 105
Colton (909) 825-9044

COUNSELING SERVICES

MESA COUNSELING SERVICES
850 E. Foothill Blvd.
Rialto (909) 421-9358

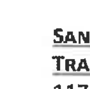
SOUTH COAST COMMUNITY SERVICES
1461 E. Cooley Dr., Ste. 100, Colton
(877) 527-7227

COVERED CALIFORNIA
(800) 300-1506
www.coveredca.com

IEHP
(800) 720-4347
www.iehp.org

MEDI-CAL
(800) 410-8829
keepmedicalcoverage.org

BENEFITSCAL
(877) 410-8829
www.benefitscal.com



SAN BERNARDINO COUNTY - TRANSITIONAL ASSISTANCE DEPARTMENT
1175 W. Foothill Blvd., Rialto (877) 410-8829

Updated: 01/2024