SAN DIEGO UNIFIED SCHOOL DISTRICT
2018-19 PreK-Grade 12 ENROLLMENT FORM

Complete Sections I-III and sign page 2. Section IV must be completed by office staff. Please print legibly using black or blue ink.
For full directions, please refer to *Directions for Completing the PreK-12 Enrollment Form* available at https://www.sandiegounified.org/enrollment-forms.

OFFICE ONLY **1.** Student District ID:	***OFFICE ONLY*** **2.** Student State ID (SSID):

I. STUDENT INFORMATION

3. Last name (LEGAL NAME ONLY) | First | Middle | Suffix (Jr, II, III)

4. Preferred/Actual Name: | **5.** Former legal name(s) (optional): | **6.** Birthdate: / / | **7.** Gender ❑ Female ❑ Male

8. Is student Hispanic or Latino? ❑ Yes ❑ No

9. Race: (check all boxes that apply)
❑ American Indian or Alaskan Native
❑ Black or African American
❑ Filipino
❑ White
Asian/ Indochinese
❑ Asian Indian ❑ Cambodian ❑ Chinese
❑ Hmong ❑ Japanese ❑ Korean
❑ Laotian ❑ Vietnamese ❑ Other Asian
Pacific Islander
❑ Guamanian ❑ Hawaiian
❑ Samoan ❑ Tahitian
❑ Other Pacific Islander

10. Release of Information: Directory-type information may be shared with individuals and organizations authorized to receive this type of information unless it is prohibited by the parent/guardian. See the district's Facts for Parents for the individuals and organizations, and the student information that may be released. If you do not want the information shared, you must select "Opt Out." ❑Opt Out

11. Student email address (optional):

12. Household address: | City, State: | ZIP Code:

13. Home phone: ( )

14. Mailing address (if different from household): | City, State: | ZIP Code:

15. City, State, Country of birth:

16. First enrolled in a CA school (TK-12): Date: / /

17. First enrolled in a US school (TK-12): Date: / /

18. Current Caregiver (check one): ❑ Parent/legal guardian ❑ Other adult (not legal guardian, requires Caregiver Affidavit)

19a. Foster Living Situation:
Check one if applicable:
❑ Family Home (FFH) ❑ Group Home (FGH) (FFA)
❑ Formal Kinship Care (including NREFM)

19b. Homeless Living Situation (temporary residence due to financial hardship):
Check all that apply:
❑ Living with someone/Doubling up ❑ Unaccompanied Youth
❑ Hotel/motel ❑ Sheltered ❑ Unsheltered ❑ Runaway Youth

20. Other Living Situation: ❑ International Exchange ❑ Residential facility ❑ Hospital (not state hospital) ❑ _____

21. Complete and include siblings who are currently in PreK–Grade 12 in San Diego Unified (only if applicable).

Sibling 1 Full name:	Grade:	School name:
Sibling 2 Full name:	Grade:	School name:
Sibling 3 Full name:	Grade:	School name:

II. CONTACT INFORMATION
Provide at least three contacts—if additional space is needed use "Notes" in Section IV on back of form.

	22. Parent/Guardian/Contact	**23. Parent/Guardian/Contact**	**24. Emergency Contacts (other than parents)**
Full name			Full name:
Relationship to student			
Lives with student?	❑ Yes ❑ No If no, provide address here: _____ _____	❑ Yes ❑ No If no, provide address here: _____ _____	Relationship to student: Home phone ( ) Work phone ( )
Home phone	( )	( )	Cell Phone ( )
Work phone	( )	( )	❑ Interpreter required ❑ OK to release student
Cell phone	( )	( )	
Email address			Full name:
Employer			
Military (check all that apply)	❑ Active Duty ❑ DOD Employee ❑ Reserves National Guard ❑ Full Time ❑ Part Time	❑ Active Duty ❑ DOD Employee ❑ Reserves National Guard ❑ Full Time ❑ Part Time	Relationship to student:
Primary language			
Education level (select one)	❑ Not a High School Graduate ❑ High School Graduate ❑ Some College/AA Degree ❑ College Graduate ❑ Graduate School/Post-Graduate ❑ Decline to state	❑ Not a High School Graduate ❑ High School Graduate ❑ Some College/AA Degree ❑ College Graduate ❑ Graduate School/Post-Graduate ❑ Decline to state	Home phone ( ) Work phone ( ) Cell phone ( )
Additional information	Report card & Progress report provided ❑ Interpreter required ❑ Access to student info online	❑ Report card ❑ Progress report ❑ Interpreter required ❑ Access to student info online	❑ Interpreter required ❑ OK to release student

SIGNATURE REQUIRED ON REVERSE

OFFICE ONLY Student Name: _____ Grade: _____ Teacher: _____ Room #: _____

III. QUESTIONS FOR PARENT/GUARDIAN

The following questions provide important information for the school staff. Parents must answer the following questions. Check "Yes" or "No" for each question where appropriate. Questions 29, 31 & 32 require that you check "Opt Out" or leave blank if you agree to your student's participation.

25a. Has your student ever received **Special Education** services? ❑ Yes ❑ No

25b. Does your student have a **504 Plan**? ❑ Yes ❑ No

26. Has one of the parents/guardians engaged in migrant work (moved and worked seasonally in jobs related to agriculture, lumber or fishery) in the past three years? ❑ Yes ❑ No

27. Name, city, and state/country of last school attended:

_____

_____

_____

Last grade level completed: _____

28

29. (For students in Grades 7, 9, & 11) The district would like your student to participate in the California Healthy Kids Survey (CHKS). The survey is anonymous and confidential. If you do not want your student to participate, you must select "Opt Out." ❑ Opt Out

30. (High school students only) Has your student ever played interscholastic athletics? ❑ Yes ❑ No

31. (High school students only) The district is required to submit a Cal Grant high school GPA to the California Student Aid Commission (CSAC) for all graduating seniors unless the parent opts out of the submission process. The GPA will be submitted electronically unless you select "Opt Out," or submit an Opt Out form. ❑ Opt Out

32. (High school students only) Federal law requires release of student information to military recruiters. If you do **NOT** want this information released for your student, you must select "Opt Out." http://www2.ed.gov/policy/gen/guid/fpco/hottopics/ht-10-09-02a.html ❑ Opt Out

33. (High school students only) Parents may authorize their student's school to release educational information including, but not limited to:

a. Transcripts, Letters of Recommendation, Financial Aid Forms, School Reports, and Class Ranking Status ❑ Yes ❑ No

b. Disciplinary Records ❑ Yes ❑ No

By checking "Yes" I give permission to State/Federal Financial Aid Programs/Scholarship Programs/Private Schools/University/College personnel and their authorized agents to access my student's educational records.

The information provided in Sections I-III is true to the best of my knowledge.

✘ _____ _____

Parent/Guardian/Contact signature (required) ***Date***

IV. DISTRICT ADMINISTRATIVE INFORMATION – FOR OFFICE USE ONLY

34. Address verification document:_____

35. Date address verified: / /

36. Neighborhood school: _____

37. Birth verification documents:

❑ Birth certificate ❑ Affidavit ❑ Church records ❑ Passport

❑ School records ❑ Unverified

38. District of residence: _____

❑ Interdistrict Attendance Permit ❑ InterSELPA agreement

39. Boundary exception for non-resident student_____

ENTRY INFORMATION

40. Previously enrolled in San Diego Unified? ❑ Yes* ❑ No

*If Yes: Last year enrolled_____ School_____Grade_____

41. Entry date: _____ / _____ / _____

42. Entry reason (check one):

❑ Enter from within San Diego Unified ❑ Enter from Out of District ❑ Initial Enrollment-Preschool ❑ Enter from Out of State

❑ Initial Enrollment TK-12 ❑ Preschool Enroll-Not Initial ❑ Enter from Charter School within San Diego Unified

43. For students new to San Diego Unified entering from **within** California:

Student State ID (SSID) (if known): _____

Previous CA district: _____

Previous CA school name: _____

44. For students new to San Diego Unified entering from **outside** of California:

Previous school name: _____

City, State/Country: _____

EXIT INFORMATION

45. Exit date: _____ / _____ / _____

47a. Immunization status:

❑ Complete ❑ Incomplete ❑ Exempt

47b. (**K only**) Dental Exam? ❑ Yes ❑ No

46. Exit reason (check one):

❑ PK-6 transferred within San Diego Unified ❑ PK-6 transferred out of San Diego Unified

❑ 7-12 transferred within San Diego Unified ❑ 7-12 transferred out of San Diego Unified

❑ No Show-Enrollment Dropped ❑ Other: _____

NOTES/ADDITIONAL INFORMATION/LEGAL BINDINGS

SAN DIEGO UNIFIED SCHOOL DISTRICT
HOME LANGUAGE ASSESSMENT SURVEY

Date
Fecha
Petsa
Taariikh

School
Escuela
Paaralan
Dugsi

Please answer the following questions.
Favor de contestar las siguientes preguntas.
Pakisuyong sagutin ang mga sumusunod na tanong.
Fadlan waxaad ka jawaabtaa su'aalahan soo socda.

1. *Name of student*

	Last	*First*	*Middle*	*Grade*	*Birth Date*
Nombre del alumno	Apellido	Primero	Segundo	Grado	Fecha de Nacimiento
Pangalan ng mag-aaral	Apelyido	Una	Apelyido ng Ina	Baytang	Kapanganakan
Magaca ardeyga	Magaca Awoowga	Magacaaga	Magaca Aabbaha	Heerka Fasalka	Taariikhda Dhalashada

2. *Which language did your son or daughter learn when he or she first began to talk?*
Cuando su hijo o hija empezó a hablar - ¿cuál idioma aprendió primero?
Aling wika ang natutuhan ng iyong anak simula ng siya ay matutong magsalita?
Luuqadee ayaa ugu horreysay oo uu ilmahaagu barto, kuna hadlo?

3. *What language does your son or daughter most frequently use with adults in the home?*
¿Cuál idioma usa principalmente su hijo o hija cuando conversa con adultos de su casa?
Anong wika ang pinaka-malimit na sinasalita ng iyong anak sa mga nakatatandang kasama sa tahanan?
Luuqadee ayuu ilmahaagu inta badan kula hadlaa dadka waa weyn ee uu guriga la joogo?

4. *Which language is used most frequently by the adults in your home?*
¿Cuál idioma usan los adultos de su casa con más frecuencia cuando conversan entre ellos mismos?
Aling wika ang pinaka-malimit gamitin ng mga nakatatanda sa inyong tahanan?
Luuqadee ayey dadka waa weyn ee guriga jooga inta badan ku hadlaan?

5. *What language do you use most frequently to speak to your son or daughter?*
¿Cuál idioma usa Ud. con más frecuencia cuando habla con su hijo o hija?
Anong wika ang pinaka-malimit mong sinasalita sa iyong anak?
Luuqadee ayaad ilmahaaga inta badan kula hadashaa?

Signature of parent or guardian
Firma del padre de familia o tutor
Lagda ng magulang o tagapangalaga
Saxiixa waalidka ama qofka ilmaha masuulka ka ah

This information will be used by district and U.S. Office for Civil Rights to develop school programs.
Esta información se usará por el distrito escolar y La Oficina de Derechos Civiles para desarrollar programas escolares.
Ang kabatirang ito ay gagamitin ng Distrito at ng Tanggapan ng Pamamahala ng Karapatan ng Mga Mamamayan sa pagbabalangkas ng mga gawaing pampaaralan.
Warbixintan waxay waxbarashadda degmadu iyo Xafiiska Xuquuqda Madaniga ee Maraykanku u isticmaali doonaan inay barnaamijyada dugsiyada sameeyaan.
(2-06)

CERTIFICATION OF PARENT APPLICATION

Child's Name _____ School Site _____

State regulations require a formal application and certification for child development services. You will receive written notice of your eligibility no later than 30 days from the date of your signature on this form. Eligibility is determined on the basis of need for child development services and either CalWORKs status or adjusted gross monthly income in relation to family size. Documentation to establish eligibility must be completed by an agency representative in consultation with the family.

DECLARATIONS

1. I declare under penalty of perjury that the information provided is true and correct to the best of my knowledge.
2. I understand that the information about my eligibility may be reviewed by representatives of the State of California, the Federal Government, independent auditors, or others as necessary for the administration of the program.
3. I understand that if the agency denies this application for services, I have the right to appeal.
4. I understand that I must review my eligibility at least once per year or sooner. I further understand that if I do not renew my eligibility, I will no longer be eligible for subsidized child care services for my child.
5. I understand that I will receive a notice of approval or denial of my application within thirty (30) days from the date I sign this form.
6. I understand that this certification is not complete until all documentation is submitted and has been reviewed, signed, and dated.
7. I certify that the information provided on Head Start/State Preschool/Child Development Center application is correct to the best of my knowledge. I also certify I was not encouraged, advised or influenced to do any of the following: Misrepresent, alter documentation, or not be truthful about my income; household size or living arrangements; and any other situation that would impact my eligibility or preclude my participation in the program.

Applicant Signature	Print Name of Applicant	Date
Staff Signature	Print Name of Staff	Date

MV:ma 4.18.18

HEALTH SCREENING ASSESSMENT CONSENT AND ACKNOWLEDGEMENT FORM

Child's Name: _____ Date: _____

Your child may be eligible to receive hearing, vision, blood pressure, measurements and developmental screenings and assessment through San Diego Unified School District and/or collaborative partners. There is no cost for these services and you will be notified of the results. These screenings and assessments will be done by trained staff at your child's school. If there is a need for further evaluation, you will need to sign an additional permission slip. Your participation may be required.

#	**Please indicate whether you would like your child to receive the following screenings/assessments by initialing the boxes.**	INITIALS
1	I want my child to have a vision screening. Vision screenings will be conducted by SDUSD and/or collaborative partners. If your child needs glasses, the glasses will be provided to your child free of charge.	
2	I want my child to have a hearing screening. Hearing screenings will be provided by SDUSD and/or collaborative partners. This screening will tell you if your child has a hearing problem. A hearing problem can affect your child's ability to learn and be successful in school.	
3	I grant staff permission to perform the following health screenings on my child: Blood pressure, height and weight. These screenings will prompt follow-up treatment for abnormal findings. Follow-up treatment is given as part of the school program.	
4	Developmental assessments and screenings as well as a mental health screening will be conducted by SDUSD and/or collaborative partners. These screenings/assessments will evaluate your child's development in speech and communication, fine motor skills, gross motor skills, social and emotional skills and problem solving skills. The findings may help school personnel provide additional support for your child. *I understand that developmental and mental health screenings and assessments will be conducted as required and grant permission for staff to provide social, emotional and behavioral consultation services for my child as needed.*	
5	I want my child to participate in the fluoride program (daily brushing with fluoride toothpaste). Regular tooth brushing helps to prevent cavities and gum disease. Good dental health contributes to positive attitudes and success in school.	
6	I understand that I must provide up-to-date immunizations or have other required documentation on file prior to my child attending the program.	
7	I am aware that my child is required to have a complete physical examination annually. A completed physical exam includes; vision screening, hearing screening, measurements, anemia testing, lead testing, TB risk assessment and blood pressure results. The physical exam is due within 30 days of the child's attendance in the program.	
8	I am aware that my child is required to have a complete dental examination annually. I will be responsible to ensure that all treatment and follow-up is completed. The dental exam is due within 90 days of the child's attendance in the program.	

I have read and understand the above information.

Parent's name_____ **Parent's Signature**_____

MV:DD:ma rev. 11/6/16

Attachment A

Immunization records are online!

San Diego Unified School District uses the California Immunization Registry (CAIR) to store immunization records for many of their students. By using this system, the school can make sure that your children's immunization records can be easily located by a school nurse or health care provider when you change schools, doctors, or during a disease outbreak, or natural disaster. Once the record is in CAIR, then you will be able to access it in the future through an online registration process at http://www.sandiegoimmunizationregistry.org/mraccess/login.jsp

San Diego Unified School District staff enter immunization records into the centralized, secure, and confidential database. Please return this completed form and a copy of the individual's immunization record to your school.

For more information, visit the SDIR Website at:
www.sdiz.org/CAIR-SDIR/index.html or call the SDIR Help Desk at (619) 692-5656 .

Please complete the information below. **Fill out additional form(s) if submitting more than one individual's immunization record.**

Please print clearly and include your phone number in case we need to call you!

PARENT/GUARDIAN	**STUDENT**
Name:	Last name:
Street Address:	First name:
City:	Date of Birth:
Zip Code:	Gender: ☐ Male ☐ Female
☐ Email:	**Fields below will help locate the immunization record in the future:**
Home Telephone:	
Relationship to student: ☐ Parent ☐ Guardian ☐ Other [specify]	☐ Mother's maiden name: ☐ Medical record # (optional) Office use only ☐ ENTERED in SDIR DATE: ___/___/___ STAFF INITIALS_____
Signature of Parent/Guardian: _____	

Immunization records are **only shared** with public health, participating health care providers, schools, childcare and other authorized programs that require the review of immunization records for enrollment. Check here only if you do not want the record to be shared. ☐ Initials:_____

EARLY CHILDHOOD EDUCATION PROGRAMS
Child's Health History

Student's Name: (Last) (First) (Middle) ☐ M ☐ F

Parents/Guardian Names: (Last) (First) (Last) (First)

Telephone: Student's Date of Birth:

TO BE COMPLETED BY PARENT/GUARDIAN

Allergy:	☐ Y	☐ N	Diabetes:	☐ Y	☐ N	Ear problem/Hearing Defect:	☐ Y	☐ N
Allergic to:			Seizure Disorder:	☐ Y	☐ N	Frequent ear infections:	☐ Y	☐ N
Reaction:			Heart problems:	☐ Y	☐ N	Eye problem:	☐ Y	☐ N
Chicken Pox	☐ Y	☐ N	Chronic disease:	☐ Y	☐ N	Glasses:	☐ Y	☐ N
Rheumatic Fever	☐ Y	☐ N	Special Meals:	☐ Y	☐ N	Milk Intolerance	☐ Y	☐ N
Hay Fever	☐ Y	☐ N	Asthma:	☐ Y	☐ N	Three-Day Measles (Rubella)	☐ Y	☐ N
Mumps	☐ Y	☐ N	Poliomyelitis	☐ Y	☐ N	Ten-Day Measles (Rubeola)	☐ Y	☐ N
Whooping Cough	☐ Y	☐ N						
Medications:	☐ Y	☐ N	List:					

Previous Operations/Hospitalizations: ☐ Y ☐ N Reason:

(I), (WE), the undersigned parent/guardian of _____, do hereby authorize employees of the San Diego Unified School District to obtain **emergency medical treatment** as prescribed and deemed necessary. This authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California and is given in advance of any specific diagnosis, treatment or hospital care being required.

Parent/Guardian Signature _____ Date _____

Historial de la Salud del Niño

Nombre del alumno: (Apellido) (Nombre) (Segundo) ☐ M ☐ F

Nombres de los padres/tutor: (Apellido) (Nombre) (Apellido) (Nombre)

Teléfono: Fecha de nacimiento del alumno:

DEBE SER COMPLETADA POR EL PADRE/TUTOR

Alergia:	☐ S	☐ N	Diabetes:	☐ S	☐ N	Problemas del oído/ Defecto auditivo:	☐ S	☐ N
Alérgico a:			Trastorno convulsivo:	☐ S	☐ N	Infecciones frecuentes del oído:	☐ S	☐ N
Reacción:			Problemas del corazón:	☐ S	☐ N	Problemas de los ojos:	☐ S	☐ N
Varicela	☐ S	☐ N	Enfermedad crónica:	☐ S	☐ N	Lentes:	☐ S	☐ N
Fibre Reumática	☐ S	☐ N	Comida Especial:	☐ S	☐ N	Intolerancia a la leche:	☐ S	☐ N
Fibre de Heno	☐ S	☐ N	Asma:	☐ S	☐ N	Sarampión de diez días (Rubéola)	☐ S	☐ N
Paperas	☐ S	☐ N	Poliomielitis	☐ S	☐ N	Sarampión de tres días (Rubéola)	☐ S	☐ N
Tos Ferina	☐ S	☐ N						
Medicamentos:	☐ S	☐ N	Lista:					

Operaciones/Hospitalizaciones Previas: ☐ S ☐ N Razón:

(Yo), (Nosotros), el padre/tutor infrascrito de _____, autorizo por medio de la presente que los empleados del Distrito Escolar Unificado de San Diego obtengan **tratamiento médico de emergencia** como sea recetado y considerado necesario. Se otorga esta autorización según lo acordado en la provisión de la Sección 25.8 del Código Civil de California, y se da antes de que se requiera diagnosis, tratamiento u hospital específico.

Firma del padre/tutor _____ Fecha _____

PHYSICAL EXAMINATION FORM

Child's Name: _____ Date of Birth: ____ / ____ /____ FID#: _____

Site: _____ Phone: _____ Fax: _____

PHYSICIAN: Please complete the following sections

Office Stamp:	**Exam Date:**
	Physician:
	Phone:
Physician Signature:	

	Screening Requirement	**Normal**	**Abnormal**
Physical Examination	General Appearance		
	Eyes, ears, nose, mouth		
	Arms/Legs		
	Skin		
	Muscle/Bones		
	Heart		
	Lungs		
	Stomach/GI		
	Neurological/Cognitive		
	Urinary/Genitalia		
	Glands/Lymphatic/Thyroid		
	Speech/Communication		
Dental Assessment			
Nutritional Assessment			
Developmental Screening			
Behavioral Assessment			
Tobacco Assessment			
Anticipatory Guidance Given?		**Yes**	**No**

Tuberculin Test/Exposure Risk Assessment

☐ Risk factors not present, TB test not required
☐ Risk factors present, TB test performed
Date given: _____ Date read: _____
Results _____ mm ☐ Negative ☐ Positive
Chest X-Ray *(if positive)*
Date: _____ ☐ Normal ☐ Abnormal

Immunizations Received during Exam:

☐ None, child is up-to-date
☐ DTap ☐ MMR ☐ Polio ☐ Varicella
☐ Hepatitis B ☐ Hib (after 1 year old)

Head Start Staff Only :

Date Received ____ / ____ /____ **Staff Initials:** _____

Required Tests/Evaluations

Blood Pressure ☐ Normal ☐ Abnormal
Systolic/Diastolic _____

Growth Assessment
☐ Normal Weight ☐ Underweight ☐ Overweight
Height: _____ Weight: _____ BMI % _____
Treatment Plan for Under/Overweight:

Hearing Screening	**Vision Screening**
Audiometric	Visual Acuity Test
Results:	**Results:**
☐ Pass	☐ Pass
☐ Fail	☐ Fail
☐ Uncooperative;	☐ Uncooperative

Hemoglobin/Hematocrit
(Test or Risk Assessment required each year)
Date: _____ **Test Results:** _____ mg/dL or %
Anemia? ☐ Yes ☐ No
Treatment Plan for Anemia:

Risk Assessment
(if yes to #1 or no to #2, must do Hgb/Hct test is required)
1. Do you ever struggle to put food on the table?
☐ Yes ☐ No
2. Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?
☐ Yes ☐ No

Blood Lead Test *(At least one at 24 months or older)*
Date: _____ **Results:** _____
Treatment Plan for High Lead Levels:

Is child under treatment for any of the following?	
Asthma	☐ Yes ☐ No
Severe Allergy: _____	☐ Yes ☐ No
Other: _____	☐ Yes ☐ No
Are emergency medications needed at school?	☐ Yes ☐ No

Restrictions/Recommendations for School:

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
PUBLIC HEALTH SERVICES
3851 ROSECRANS STREET, MAIL STOP P-578
SAN DIEGO, CA 92110-3134
(619) 531-5800 • FAX (619) 542-4185

WILMA J. WOOTEN, M.D.
PUBLIC HEALTH OFFICER

September 1, 2015

Dear Medical Provider:

LEAD TESTING AND SCREENING IN CHILDREN

The Childhood Lead Poisoning Prevention Program (CLPPP) of the County of San Diego Health and Human Services Agency strongly encourages physicians to provide lead screening testing to children presenting, who are attempting to enroll in Head Start. Head Start programs are required to ensure that all enrolled children between the ages of 12 months and 72 months of age receive a lead toxicity screening.

The requirements for a child enrolled in Head Start are:

- For a child enrolled before the age of 12 months, the program must obtain documentation that blood lead tests were conducted for the child at the ages of 12 *and* 24 months;
- If there is no documentation that a blood lead test was performed at 12 months, for a child enrolled between 12 and 24 months of age, a blood lead test must be performed as soon as possible. A second blood lead test will be required at 24 months of age;
- The program is required to obtain documentation that a blood lead test was performed at 24 months of age, or soon thereafter, for a child enrolled at age 24 months or older.

San Diego County ranks third in 2012 among California counties for having the highest number of lead poisoned children. Children living in San Diego County are particularly vulnerable because of the abundance of older housing stock and the proximity to the border where cultural traditions that may be associated with lead toxicity frequently accompany immigrant families into San Diego. Lead is a neurotoxin that is harmful to developing young children even at low levels and can cause irreversible damage to a developing brain and other body systems.

Please contact the Childhood Lead Poisoning Prevention Program at (619) 692-8487 for further information about testing, case management services, education and outreach, or to request educational materials.

Live Well!

WILMA J. WOOTEN, M.D., M.P.H.
Public Health Officer
Director, Public Health Services

WJW:

Dental Health Form

Patient Information (To be completed by Head Start staff)

Child's name | **Date of Birth** | **FID#**

Site Name | **Phone** | **Fax**

Current Oral Health Status (To be completed by Dental Professional)

Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit (To be completed by Dental Professional)

Date of Exam and/or Treatment _____ / _____ / _____

Diagnostic/Preventive Services

Examination: ☐ Yes ☐ No
X-rays: ☐ Yes ☐ No
Oral Hygiene Instr: ☐ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride varnish: ☐ Yes ☐ No
Dental sealants: ☐ Yes ☐ No

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ☐ No
Crowns: ☐ Yes ☐ No
Extractions: ☐ Yes ☐ No
Emergency Care: ☐ Yes ☐ No
Other: _____
(Please specify)

Future Dental Treatment Needed (To be completed by Dental Professional)

All treatment completed: ☐ Yes ☐ No

Next recall date: _____/_____(month/year)

More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed: _____ Next appointment: Date: _____ Time: _____

Please Describe Dental Treatment/Follow-Up Procedures Needed Below:

Oral Health Provider's Contact Information and Signature/Official Stamped Signature

Provider name ***(please print)*** | **Phone number** | **Fax number**

Provider Signature/Official Stamped Signature

Early Head Start/Head Start Staff Only
Date Received:
___ / ___ / ___