Trillium Charter School 1464 Spear Ave. Arcata, CA 95521

Male ❑
Female ❑
Nonbinary ❑

Paperwork much be received by first Friday in March to be included in the 1st enrollment round.
All students must follow CA immunization regulations & provide documentation.

Please answer with as much detail as possible. Personal information will not be shared with non-staff members, but allows us to meet your child's specific needs and/or link your family with school and community support or services that may be available. Thank you.

Student's LEGAL Name: _____ Preferred name: _____

Date of Birth: _____ Place of Birth : _____ * Please include one of the following to document birthdate: birth certificate, adoption record, foreign certificate, medical or religious certificate, etc.
City/State/Country

If not born in the US, when did your child enter US? ___/___
Mo Yr

Adult Guardian #1: _____ Home #: _____ Cell #: _____

Relationship to student: _____ Address: _____

Email: _____ % of time residing with student: _____

Adult Guardian #2: _____ Home #: _____ Cell #: _____

Relationship to student: _____ Address: _____

Email: _____ % of time residing with student: _____

Please list other adults or family members that live in your household or share in the care of your child. Please include relationship to student:

_____

RESIDENCE/ FAMILY: What best describes where you currently live? Please check the most appropriate box:

❑ Single family permanent residence (house, apartment, condo, mobile home)
❑ Doubled-up (sharing housing with other families/individuals)
❑ In a shelter or other transitional housing
❑ Hotel/Motel
❑ Unsheltered (car, tent, camping)
❑ Farm

Does your student live in more than one household? ❑ Yes ❑ No
If yes, please tell us when, where, and how often your student changes households.

_____

_____

* If there are court documents for legal or physical custody arrangements please provide a copy.

Is your student: ☐ In foster care ☐ In a temporary custody arrangement ☐ Adopted ☐ Homeless

If you checked yes, please provide information and/or paperwork as needed. _____

_____

ETHNICTY: Mark the ethnicity with which the student most closely identifies. Please check one:
❑ Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South/Central American, or other Spanish culture or origin, regardless of race)
❑ Not Hispanic or Latino

What is your child's race (Please check up to 5 racial categories) The above section is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking boxes to indicate what you consider your race to be.

❑ Laotian (205)
❑ Chinese (201)
❑ Japanese (202)
❑ Korean (203)
❑ Vietnamese (204)
❑ Asian Indian (205)
❑ Tahitian (304)
❑ Cambodian (207)
❑ Hmong (208))
❑ Other Asian (299)
❑ Hawaiian (301)
❑ Guamanian (302)
❑ Other Pacific Islander
❑ African American or Black (600)
❑ White (700) (Person having origins in any of the original peoples of Europe, North African or Middle Eastern)
❑ American Indian or Alaskan Native (100) (Person having origins in any of the original people of North and South America, including Central America)

HOME LANGUAGE SURVEY:

What language did your child first learn to speak? _____

What language does your child most often use at home? _____

What language is most often used by the adults in your home? _____

HEALTH: Does your child have any known physical or mental health concerns? ☐ Yes ☐ No
If yes, please explain. Include how this may affect your child at school.

_____

_____

Does your child wear glasses? Yes ☐ No ☐ **Worn for:** Distance only Reading only At all times

Does your child have any hearing loss? ☐ Yes ☐ No **Does your child require the use of any assistive devices?** ☐ Yes ☐ No

Please list any known allergies or sensitivities (food, medication, environmental stimuli, other.)

_____

Does your child take any prescription medications? ☐ Yes ☐ No **If yes, please list below:**
Name of Medication(s) Dosage Time Taken Purpose

_____

_____

If medication is to be administered at school, a current form must be on file signed by both you *and* your child's doctor.

All medication must be properly stored and *may not* be kept in student cubbies.

EMERGENCY MEDICAL AUTHORIZATION

I am the parent/guardian of the above named student. In case I am unable to be reached during an emergency, I hereby authorize a representative of the school, pursuant to the provision of Family Code Section 6910, to act as an agent to consent to the giving of any and all medical, dental, hospital or surgical care to the above named student. Initial: _____

Last School Attended: _____ **Last Day Attended:** _____
Name of School City/State

Reason for transfer: _____

How did you hear about Trillium? _____

What Special Services has your child received? (Please check all that apply)
☐ Resource (RSP) ☐ Special Day Class (SDC) ☐ Speech/Language ☐ 504 Accommodation Plan
☐ Gifted (GATE) ☐ Remedial Math ☐ Remedial Reading ☐ Counseling ☐ English Language Development

Has the student been expelled or is the student in the process of being expelled from any school? ☐ **Yes** ☐ **No**
If yes: Name of School: _____ Address: _____ Date: _____

MEDIA PERMISSION: I give permission for my child to be observed, interviewed, photographed, and/or filmed during school-related activities when a representative of the media has been permitted by the staff to be on campus. **Initial** _____
***This does not apply to ParentSquare (PS). All students may have photos shared on this limited access site.**

TECHNOLOGY USE: I understand that, under adult supervision, my child may have access to the Internet at school as part of the educational program. Such use is a privilege and will be extended for acceptable use, including approved websites, emails, and school activities only. Unacceptable uses may result in revocation of computer usage and/or appropriate disciplinary action for acts deemed to be cyber-bullying, malicious in nature, or a willful invasion of another's privacy. Initial: _____

EDUCATION LEVEL: Check the response that describes the highest education level of either adult/guardian.
☐ Did not complete high school ☐ Some College (includes AA degree) ☐ Graduate school/post graduate training
☐ High School Graduate ☐ College Graduate

I have reviewed this 2 page document and to the best of my knowledge, the information contained herein is true and complete. The undersigned declares that they are the legal guardian/s of the above named student(s) and have the authority to grant the above authorizations.

Date: _____ **Signature:** _____

Date: _____ **Signature:** _____

Trillium Community Charter School

• 1464 Spear Ave. _ Arcata, CA 95521 _ (707) 822-4721 • FAX 822- 7054 •

Acknowledgement of Diverse Topics

As outlined in the Trillium Charter, our curriculum will include activities and information designed to educate our students about social, environmental, or political issues in a local and global context. Although Trillium's staff ***will not*** attempt to influence students to adopt any specific agenda or philosophy, we intend to offer them truthful, age-appropriate information allowing them to make educated decisions as they become active members of society.

Some of this information is sensitive and may elicit an emotional response from students that will require follow-up conversations at home. We will alert parents to the need for awareness when potentially difficult topics are discussed throughout the school year.

Topics may include, but are not limited to:

World History, Local History, Native American Studies, Slavery, Environmental Education, Conflict Resolution, Health and Nutrition, Body Image, Acceptance and Tolerance of others, Death and Life-Cycles, American Government, Current Events, or Social Activism.

Each of these topics can include subtopics that will be covered in detail.

>>

I have read and understand the above information.

______________________________ ______________

Parent/Guardian Signature date

______________________________ ______________

Parent/Guardian Signature date

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:	Child's race/ethnicity: ▫ White ▫ Black/African American ▫ Hispanic/Latino ▫ Asian ▫ Native American ▫ Multi-racial ▫ Other_____ ▫ Native Hawaiian/Pacific Islander ▫ 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 fillings present) ▫ Yes ▫ No	Visible Decay Present: ▫ Yes ▫ No	Treatment Urgency: ▫ No obvious problem found ▫ Early dental care recommended (caries without pain or infection; or child would benefit from 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.

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School or Agency	2. Site Name	3. Site Phone Number
4. Name of Child or Participant		5. Age or Date of Birth
6. Name of Parent or Guardian		7. Phone Number

8. Description of Child or Participant's Physical or Mental Impairment Affected:

9. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:

10. Indicate Food Texture for Above Child or Participant:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

11. Foods to be Omitted and Appropriate Substitutions:

Foods To Be Omitted	Suggested Substitutions

12. Adaptive Equipment to be Used:

13. Signature of State Licensed Healthcare Professional*	14. Printed Name	15. Phone Number	16. Date

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or a nurse practitioner.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

State of California—Health and Human Services Agency

Department of Health Care Services
Child Health and Disability Prevention (CHDP) Program

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.

CHDP website: www.dhcs.ca.gov/services/chdp

Trillium Charter School

• 1464 Spear Ave. Arcata, CA 95521 • (707) 822-4721 • FAX 822- 7054 •

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

(I) (We), the undersigned parent(s) of _____, a minor, do hereby authorize Trillium Charter School as agent for the undersigned to consent to any X-ray, examination, anesthetic, medical surgical diagnosis or treatment, and hospital care that is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of Trillium Charter School to give specific consent to any and all such diagnosis, treatment, or hospital care that aforementioned physician in the exercise of his/her judgment may deem advisable.

(I) (We) hereby authorize any hospital that has provided treatment to the above-named minor pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to Trillium Charter School upon the completion of treatment. This authorization is given pursuant to section 1283 of the Health and Safety Code of California.

These authorizations shall remain in effect unless revoked in writing delivered to Trillium Charter School, or change of enrollment status of aforementioned student.

_____ _____

Parent/Guardian Signature Date

Child's DOB: _____ Doctor: _____ Dentist: _____

Allergies: _____

Chronic Illnesses: _____

Medications: _____ Date last Tetanus: _____

Insurance Policy Name: _____ Number: _____

Insured's Name _____

Trillium Charter School
Field Trip/Excursion Waiver and Medical Authorization-Minor

_____ has my permission to participate in the activities listed below. I fully understand the following:

1) Participation in these activities is voluntary.
2) I may revoke this permission at any time by notifying the school in writing.
3) Revocation is not effective until receipt is acknowledged by the school.

As stated in California Education Code Section 35330:
"All persons making the field trip or excursion shall be deemed to have waived all claims against the school, school district, and the State of California for injury, accident, illness, or death occurring during or by reason of the field trip or excursion."

The field trip/excursion may include but not be limited to:

1. Museums
2. Tide pools/Maritime lab
3. Concerts/Plays
4. Libraries
5. Lumber mills
6. Public/Private businesses
7. Environmental trips
8. Other similar trips

Consent to Treat

In the event of illness or injury, I do hereby consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care that are considered necessary in the best judgment of the attending physicians or dentist and performed by or under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

A special note to parents /guardians in accordance with Ed. Code Section 49423:

1)_____ Check here if there are *NO* special problems that the staff should be aware of and *NO* medications are required on the trip.
2) All medications must be registered on this form with a physician's written instructions on dispensing. List medications:_____
3) All prescriptions, excepting those which must be kept on the student's person for emergency use, must be kept and distributed by the staff.

If your son or daughter has a special medical problem, please attach a description of that problem and any necessary precautions to this form. Thank you.

I fully understand that participants are to abide by all rules and regulations governing conduct during field trips/excursions. Any violation of those rules and regulations may result in the school contacting the parents and arranging transportation for that child at his/her and/or parents' expense.

_____ _____
Signature of Parent of Guardian Date

_____ _____
Daytime Phone Number Emergency Contact – Name and Phone Number

_____ _____
Parent's/Guardian's Health Insurance/MEDI-CAL Policy Number

TRILLIUM
COMMUNITY CHARTER SCHOOL

PARENT SOCIAL MEDIA & ADVERTISING PERMISSION SLIP

Dear Parents & Guardians,

Our school has staff-run social media accounts and a school website. Teachers & staff also work to collaboratively create promotional materials for the school. These accounts and marketing tools are being newly re-launched in an effort to build local awareness about our little school. These are spaces where we may share student photos of daily activities, classroom/school functions and samples of students amazing work. Some of these photos also may be used in the future (after your child has graduated from Trillium) for school promotional materials such as brochures or enrollment flyers. Please fill out this form below indicating if you approve or disapprove of your child or children's images being featured on our website, social media pages or promotional materials and return it to a classroom teacher or the school office.

Thank you!

PARENT SOCIAL MEDIA & ADVERTISING PERMISSION SLIP

[ ] Yes, I give my permission for my child's images to be featured on the school website, social media and promotional materials.

[ ] No, I do not give my permission.

[ ] I give conditional permission for the following usage of my child's image (circle your choices)

Facebook. Instagram. School Website Promotional Materials

Student Name:_____

Parent Name Printed:_____

Parent Signature:_____ (date)_____

Please return this slip to a classroom teacher or the school office. Thank you!

Trillium Charter School

• 1464 Spear Ave. Arcata, CA 95521 • (707) 822-4721 • FAX 822- 7054 •

To: _____

_____

_____

The following students have enrolled in Trillium Charter School beginning: _____

Name	Date of Birth	Grade

In accordance with the Family Educational Rights and Privacy Act of 1974 and California State Law, I hereby authorize the release to Trillium Charter School of all records, including grades and health records as well as psychological, social, education or developmental information (including confidential information relevant to the Special Education Individual Education Plan) regarding the above pupil(s).

Authorized Signature: _____

Date: _____