Two Rock Union
School District
5001 Springhill Rd.
Petaluma, CA 94952
707-762-6617
707-762-1923 Fax

To: ______________________________
Name of school coming from

____
Street Address

____
City, State, Zip Code

Re: RELEASE OF RECORDS FOR:

____
Students Name

____
Present Grade

____
Birth Date

I hereby grant permission to release all records concerning my child. This information may include the cumulative folder, intelligence achievement test scores, health records, Child Study Team records and any other information pertinent in pupil placement, including speech, guidance and any other related services pertinent to pupil instruction.

______________________________ ______________________
Parent/Guardian Signature Date

Please return to: Two Rock Union School
5001 Spring Hill Rd.
Petaluma, CA 94952

TWO ROCK ELEMENTARY SCHOOL
STUDENT REGISTRATION FORM

STUDENT'S NAME

Last First Middle

LEGAL NAME________________________________ Circle One: Male Female

TELEPHONE_______________________ Student S.S#_____ _____ _____

ADDRESS_______________________ CITY_______________________ ZIP__________

MAILING ADDRESS ____

STUDENT IS LIVING WITH (CHECK)	STATUS OF PARENT	ETHNIC GROUP
___father ___mother	___deceased	___White
___stepfather ___stepmother	___married	___Black
___guardian(m) ___guardian(f)	___divorced	___Hispanic
___foster father ___foster mother	___separated	___Amer.Indian/Alaskan
___other ___other	___other	___Asian
		___Filipino
		___Pacific Islander

PARENT CHECKED ABOVE	OCCUPATION	BUSINESS PHONE
Mother		
Father		
Mother Birthplace	Father Birthplace	
U.S. Citizen Yes No	U.S. Citizen Yes No	

Other Children in Family

last	first	middle	birthdate
last	first	middle	birthdate
last	first	middle	birthdate
last	first	middle	birthdate

HOME LANGUAGE SURVEY

1 . Which language did your son/daughter learn when he/she firsts began to talk?__________

2. What language did your son/daughter most frequently use at home?__________

3. What language do you use most frequently to speak to your son/daughter?__________

4. Name the language most often spoken by the adults at home:__________

BIRTHDATE:

Month Day Year

BIRTHPLACE

City State

PREVIOUS SCHOOL

Name

Address

City/State/Zip

SCHOOL USE ONLY

1. Immunization ________

2. Emergency Card______

3. Lunch Application_____

4. Special Programs_____

BIRTH VERIFICATION

Evidence ____________ Initials ________

Has your child been retained?
What Grade?______________

Is child in special classes?

PARENT LEVEL OF EDUCATION (For STAR test- State required):
Please circle one:

1=Not a high school graduate
2=High school graduate
3=Some college
4=College graduate
5=Graduate school/post graduate training

Assigned to grade _______ Teacher_______________________ Parent Signature ______________________________

Date ______________

TWO ROCK UNION SCHOOL DISTRICT

Dear Parent/ Guardian,

It is known that each year thousands of children playing on school grounds are stung by stinging insects (honeybees, yellow jackets, and wasps). Some of these students react to stings with severe allergic symptoms. Over one half of the children who have life threatening reactions to insect stings have never had a reaction before. A few of them die!

These severe reactions occur within a few minutes of the sting. There often isn't time to wait for transportation to a hospital before acting to stop the reaction. The hives, wheezing or vomiting may begin immediately.

Severe food allergies are rare but can also cause a life threatening reaction.

The school district is permitted, but not required, by law to provide specialized physical care services for students who need services during the school day, or who may need special treatment for physical crisis such as a systemic insect sting reaction.

In regard to the possible systemic reaction of a student attending the Two Rock Union School District, we the Two Rock Union School Board authorize emergency treatment consisting of an Epi-Pen containing a one time dose of .3 cc epinephrine, providing school personnel have been adequately trained to give such treatment on at least an annual basis. Written authorization to administer the Epi-Pen will be requested from the parent or guardian.

I/We the undersigned parent(s) or legal guardian(s) having legal custody of the above minor, do hereby authorize school personnel to act as our agents and to administer Epi-Pen in the event it is determined by the school personnel that our child is experiencing an allergic reaction.

____

Signature of Mother/Guardian | Print Name | Date

____

Signature of Father/Guardian | Print Name | Date

Sonoma County Office of Education
STUDENT HEALTH HISTORY

Date: __/__/__ School: ________________________

Student's Name: ____________________________ Sex: M F

Birthdate: ________________ Teacher: ______________________

Parent/Guardian: ____

Address:____

Street Apt. City Zip

Telephone: (Home)_____-__________ (Work)_____-____________

HAS YOUR CHILD HAD ANY OF THE FOLLOWING:

[ ]Chicken pox [ ]Tuberculosis [ ]Diabetes

[ ]Asthma [ ]Allergies [ ]Stinging Insect Allergy

[ ]Heart Problems [ ]Behavior Problems [ ]Convulsion,seizure

[ ]Frequent colds [ ]Recurring ear infections [ ]Eye problems [ ]Movement limitation

[ ]Recent illness, hospitalization, surgery or other physical condition which limits your child's physical activity at school

Please provide additional information for any of the above conditions checked:__________

____

ALL MEDICATION SENT TO SCHOOL MUST BE IN THE PRESCRIPTION CONTAINER WITH A CURRENT DATE

Does your child require medication while at school? [ ] yes [ ]no

If yes, Please complete an "Authorization for Administration of Medication" (obtain form from the school secretary)

Please indicate:

Medication ______________________Dosage__________ Hour(s) given ________

Medication ______________________Dosage __________Hour(s) given ________

Date of last physical exam ____/____/____ Doctor____________________________

Date of last dental exam ____/____/ ____ Dentist ____________________________

Does your child wear glasses? [ ]Yes [ ] No

Does your child have any medical condition which might require care while at school or which might restrict his/her physical activity, such as in contact sports? (Please describe)

____

Information obtained from this health history may be included on a confidential health conditions list, if appropriate. For more information/concerns, please contact the school nurse.

____

PARENT SIGNATURE/DATE

Sonoma County Office of Education
STUDENT HEALTH HISTORY

Date: ______________________ School: ______________________

Student's Name: ______________________ Sex: M F

Birthdate: ______________________ Teacher: ______________________

Parent/Guardian: ______________________

Address: ______________________
Street Apt. City Zip

Telephone: (Home) ( ) ______________ (Work) ( ) ______________

HAS YOUR CHILD HAD ANY OF THE FOLLOWING:

- ❑ Chicken Pox
- ❑ Asthma
- ❑ Heart Problems
- ❑ Frequent Colds
- ❑ Movement Limitation
- ❑ Tuberculosis
- ❑ Allergies
- ❑ Behavior Problems
- ❑ Recurring Ear Infections
- ❑ Diabetes
- ❑ Stinging Inset Allergy
- ❑ Convulsion, Seizure
- ❑ Eye Problems
- ❑ Recent illness, hospitalization, surgery or other physical condition which limits your child's physical activity at school

Please provide additional information for any of the above conditions checked:

____

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Date of last physical exam: / / Doctor ____________
Date of last dental exam: / / Dentist ____________
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Does your child have any medical condition which might require care while at school or which might restrict his/her physical activity, such as in contact sports? (Please describe)

____

Information obtained from this health history may be included on a confidential health conditions list, if appropriate. For more information/concerns, please contact the school nurse.

______________________ ______________________
PARENT SIGNATURE DATE

H 5 White: CUM File Yellow: Health Office