

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

As a legal custodian of _____, a minor, I hereby authorize the principal or his/her designee, into whose care the aforementioned minor pupil has been entrusted, to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

This authorization shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand that the Junction School District, its employees, and its Board assume no liability of any nature in relation to the transportation or treatment of the said minor. I further understand that all costs of paramedic transportation, hospitalization, and any examination, X-Ray, or treatment provided in relation to this authorization shall be my responsibility.

***PLEASE NOTE:** Junction School District cannot give medication to your child without a Medication Release from signed by a doctor or parent. **Please contact the school office.**

SPECIAL INFORMATION: If your child has any of the following health problems, please check or state below:

- | | | | | |
|--|------------------------------------|---------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> HEMOPHILIA | <input type="checkbox"/> ALLERGY | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> HEAT |
| <input type="checkbox"/> CHRONIC DIZZINESS | <input type="checkbox"/> EMOTIONAL | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> NOSE BLEEDS | <input type="checkbox"/> SENSITIVITY TO CERTAIN DRUGS |
| <input type="checkbox"/> OTHER: _____ | | | | |

PERMISSION FOR EMERGENCY CARE- Information as of (date) _____. If I cannot be reached at home or business, contact any of the following individuals:

1. Name: _____ Relationship to child: _____ Phone: (____) _____
2. Name: _____ Relationship to child: _____ Phone: (____) _____
3. Name: _____ Relationship to child: _____ Phone: (____) _____

In the event of any emergency, you have my permission to attempt to obtain treatment from: Dr. _____ Phone: (____) _____ or any physician selected by the school who will provide emergency treatment.

It is understood that the named physician may refuse to provide emergency treatment without additional authorization from the parent or guardian.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

According to appropriate grade level schedules, all children will receive vision, hearing, and dental screening. You have the right to refuse these services for your child. Unless you notify the office in writing, your child will be screened at no expense to you. My 7th grade daughter/8th grade son may participate in the free scoliosis screening. Yes _____ No _____

I (we) the parent /guardian are active in the Armed Forces (Army, Navy, Air Force, Marine Corps, Coast Guard, or active duty or full-time Nation Guard). Yes _____ No _____

FOR SCHOOL USE ONLY- PLEASE DO NOT ENTER INFORMATION BELOW

DISTRICT MOBILITY: _____ SCHOOL MOBILITY: _____ SPED SERVICES: _____ GATE: _____ NSLP: _____

DATE OF ENROLLMENT: ____/____/____ GRADE: _____ LAST SCHOOL ATTENDED: _____

CUM REQUESTED: ____/____/____ CUM RECEIVED: ____/____/____ CONF. FILE: Y N

Enrollment Packet Checklist

- Proof of Address
- Copy of Birth Certificate
- Proof of Completed Immunizations
- Completed Physical Form
- Completed Enrollment Packet

Please call us the school at
530 547 3276
with any questions about these
required documents!

Junction Elementary School District

Clay Ross, Superintendent

Junction School
9087 Deschutes Rd.
Palo Cedro, CA 96073
Phone: (530) 547-3276
Fax: (530) 547-4080
www.junctionesd.net



Christopher Nelson, Principal

Board Members:
Hope Bjerke
Ken Parisot
Clint Snyder
Kelly Lindblom
Kristen Knott

HOME LANGUAGE SURVEY

Directions to Parents and Guardians:

The *California Education Code* contains legal requirements which direct schools to determine the language(s) spoken in the home of each student. 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 this legal requirement. 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.

1. Which language did your child learn when he/she first began to talk? _____
2. What language does your child most frequently speak at home? _____
3. What language do *you* (the guardian) most frequently use when speaking with your child?

4. Which language is most often spoken by adults in the home? _____

Signature of Parent/Guardian

Date

Name of Student

Grade

Age

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Clint Snyder
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Kristen Knott

Student's Name: _____ Date: _____

Dear Parent/Guardian,

So we may better serve your child, please answer the following questions:

	<u>YES</u>	<u>NO</u>
1. My child was previously enrolled in a special program. If known, what is the name of the program? _____	_____	_____
2. My child was seeing a Speech Therapist	_____	_____
3. My child was in an Instrumental Music Program	_____	_____
4. My child needs to wear eyeglasses in school	_____	_____
5. My child can be released to either parent If no, are custody papers on file in child's records?	_____	_____
6. My child has behavior problems in school	_____	_____
7. My child was in a GATE or MGM Program	_____	_____
8. My child has a hearing problem	_____	_____
9. My child has special needs If yes, please indicate: _____	_____	_____
10. Is English the primary language spoken in the home? If the answer is no please explain: _____	_____	_____

Parent/Guardian's Signature: _____

Comments: _____

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TRANSPORTATION INFORMATION

Child's Name: _____ Grade: _____

First Name or Nickname Child answers to: _____

Parent/Guardian Name: _____

Home Address: _____

Street

City

State

Zip

Primary Phone Number: _____ Secondary Phone Number: _____

Address your child will be going to after school:

Street

City

State

Zip

Please draw a map showing the nearest crossroads:

Signature of Parent/Guardian

Date

NOTE: It is Junction's policy to return any child under 3rd grade to school when someone is not able to meet the child at the bus stop. This is for your child's safety.

Junction Elementary School District

This document is intended to address the McKinney-Vento Assistance Act. Your truthful and accurate answers help the district identify services that the student may be eligible to receive.

Student: _____ (Male___ Female___)

Birthdate: ___/___/___ Grade: _____

1. Do you and your student lived in a fixed, regular, adequate nighttime residence? **Yes**___ **No**___(If you circled "Yes," stop here. You may need to provide a utility 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 is 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 [p;''City Zip

Mailing Address: _____
Street City Zip

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

For School Use Only

Date Received: ___/___/___

- ____ Student not covered by McKinney Vento Act
- ____ Student covered by McKinney-Vento Act
- ____ Follow-up required

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To: _____

From: _____

Fax: _____

Pages: _____

Phone: _____

Date: _____

REQUEST FOR RECORDS

The following students have enrolled in our school. Please send the cumulative and confidential records, including psychological, health, speech, and all Special Education Materials.

Last Name	First	M.I.	Birthdate
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Last Name	First	M.I.	Birthdate
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Send to:

Junction Elementary School District
9087 Deschutes Rd.
Palo Cedro, CA 96073

Please Fax the following documentation:

- X – Birth Certificate
- X – Immunization Records
- X – IEP or 504 Plan