



Rialto Unified School District Enrollment Checklist (TK-Transitional Kinder)

- 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
- Physical Exam (**required for ELO only** – Extended Learning Opportunity Extended day for TK students)
- 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

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**

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

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/DTaP/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



Grade	Number of Doses Required of Each Immunization ^{1,2,3}				
K-12 Admission	4 Polio⁴	5 DTaP⁵	3 Hep B⁶	2 MMR⁷	2 Varicella
(7th-12th)⁸	K-12 doses	+ 1 Tdap			
7th Grade Advancement^{9,10}		1 Tdap⁸			2 Varicella¹⁰

- Requirements for K-12 admission also apply to transfer pupils.
- Combination vaccines (e.g., MMRV) meet the requirements for individual component vaccines. Doses of DTP count towards the DTaP requirement.
- Any vaccine administered four or fewer days prior to the minimum required age is valid.
- Three doses of polio vaccine meet the requirement if one dose was given on or after the 4th birthday.
- 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.
- For 7th grade admission, refer to Health and Safety Code section 120335, subdivision (c).
- 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.
- For 7th-12th graders, at least one dose of pertussis-containing vaccine is required on or after the 7th birthday.
- For children in ungraded schools, pupils 12 years and older are subject to the 7th grade advancement requirements.
- 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/3RRENK>

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 Eligibility Determination

The county will process your application for eligibility.

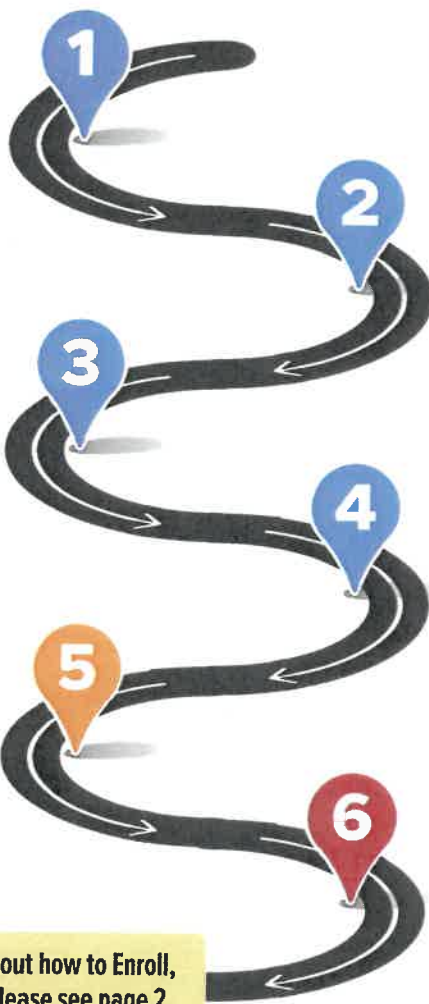


3 Get Care

Medi-Cal covers ALL medically necessary care.



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



4 Apply for Medi-Cal

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

5 Select a Health Care Plan

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

6 Renew Your Medi-Cal

Most people must renew their Medi-Cal every year.



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/3T1G88e>



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
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606 E. Mill St., San Bernardino
(800) 722-4777

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

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

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16888 Baseline Ave., Fontana
(855) 422-8029

INLAND FAMILY COMMUNITY HEALTH CENTER
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(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



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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



DENTAL CARE

DENTI-CAL
(800) 322-6384

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

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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

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