



# McSwain Elementary School

922 Scott Road \* Merced, CA 95341

(209)354-2700 \* Fax (209)723-2630

*Growing Leaders, One Child at a Time*

Sara Sanders, Principal

Hector Perez, Assistant Principal

Catarina Lourenco, Assistant Principal /Program Coordinator

Dear McSwain families

Welcome to our TK/K roundup! I am Mrs. Sanders, and I am excited to be the Principal for the upcoming school year. For our incoming families, we are excited to get to know you and welcome you to the McSwain Family!

McSwain School is built on a solid academic foundation that is second to none. Our staff goes above and beyond to design lessons and experiences for our students that will prepare them for the academic challenges they will face in high school and beyond. The successes exhibited by our students are a direct result of the educational and emotional support they receive at school and at home. We are grateful for our partnerships with our families, and we thank you in advance for fostering these partnerships this school year.

As you embark on our roundup, I want to review how parents can connect to our McSwain community. At McSwain School, there are many ways you can be involved. Please stay tuned and look for notes that will be sent home by the McSwain Education Foundation and the McSwain Community Parent Club. Through fundraising efforts, these two organizations contribute significantly to the overall well-being of our school. In addition, please be on the lookout for correspondence from your student's teacher(s) and the administration regarding additional opportunities to support your child in and outside the classroom.

Please take some time to fill out this registration packet and download parent square.

As we gear up for the 25-26 school year, we will continue to message and reach out to you regarding the start of school. Additional events may be added to our online school calendar on our website: [www.mcswain.k12.ca.us](http://www.mcswain.k12.ca.us). Please check our website regularly.

Thank you for trusting McSwain School with what is most precious to you – your child(ren).

Best regards,

Mrs. Sanders



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## Welcome to McSwain School

Please complete the attached registration packet. We will also need the following documentation from you.

Please provide:

- Birth certificate
- Photo ID of parent/guardian
- Immunization Records
- Health Questionnaire
- Proof of dental exam
- Any court orders the school should be aware of
- Proof of residency please provide the following

\*Own your home please provide one of the following

1. Deed
2. Property Tax
3. Mortgage Statement

\* Rent your home please provide the following

A copy of your rental agreement/lease

**&**

**Three** bills that are mailed to your home monthly (One of the bills MUST be a utility bill)

**Once we have enrolled your student you will now have access to our parent portals. Please check your email for log in information.**

<p style="text-align: center;"><b>Aeries</b></p> <p>Please set this up to view child's classes, medical history, view &amp; sign our student handbook.</p> 	<p style="text-align: center;"><b>Parent Square App</b></p> <p>Please download our Parent Square app to start receiving messages this summer</p> 	<p style="text-align: center;"><b>Lunch Application</b></p> <p>Apply for Free or reduced meals after August 1st.</p> 
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# Mc Swain Elementary School

## Student Registration

GRADE

### STUDENT INFORMATION

▶ Has your student ever attended McSwain Elementary School before?  Yes  No

#### STUDENT'S LEGAL NAME

Legal First Name	Legal Middle Name	Legal Last Name	Other Legal Name/Alias/Goes by
------------------	-------------------	-----------------	--------------------------------

Male    Female  
 Non-Binary

Birth date:

Month	Day	Year	
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BIRTHPLACE: City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

U.S. Citizen:  Yes  No

### STUDENT RESIDENCY

Residence & Mailing Address:  Own  Rent  Shared Residency

Residence Address	Apt#	City	State	Zip
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Mailing Address(IF DIFFERENT)	Apt #	City	State	Zip
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**Residence** – where is your child/family currently living? (federally mandated by NCLB) – **Please check appropriate box:**

- |   |  |
|---|--|
| <input type="checkbox"/> In a single family permanent residence (house, apartment, condo, mobile home)                      | <input type="checkbox"/> In a motel/hotel (09)             |
| <input type="checkbox"/> Doubled-up (sharing housing with other families/individuals due to economic hardship or loss) (11) | <input type="checkbox"/> Unsheltered (car/campsite) (12)   |
| <input type="checkbox"/> In a shelter or transitional housing program (10)  | <input type="checkbox"/> Other (15) (please specify) _____ |

#### CHILD'S ETHNICITY?(Please check one):

other Spanish culture or origin, regardless of race)

- Hispanic or Latino (A person of Cuban, Mexican, Puerto, South or Central American or other Spanish culture or origin, regardless of race)  
 Not Hispanic or Latino

#### WHAT IS YOUR CHILD'S RACE?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> American Indian or Alaskan Native(100)<br><small>(Persons having origins in any of the original people of North, Central or South America )</small> | <input type="checkbox"/> Laotian (206)     | <input type="checkbox"/> Tahitian (304)   |
| <input type="checkbox"/> Chinese (201)   | <input type="checkbox"/> Cambodian (207)   | <input type="checkbox"/> Other Pacific Islander (399)   |
| <input type="checkbox"/> Japanese (202)  | <input type="checkbox"/> Hmong (208)       | <input type="checkbox"/> Filipino/Filipino American (400)   |
| <input type="checkbox"/> Korean (203)  | <input type="checkbox"/> Other Asian (299) | <input type="checkbox"/> African American or Black (600)  |
| <input type="checkbox"/> Vietnamese (204)  | <input type="checkbox"/> Hawaiian (301)    | <input type="checkbox"/> White (700) <small>(Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East)</small> |
| <input type="checkbox"/> Asian Indian (205)  | <input type="checkbox"/> Guamanian (302)   |   |
|  | <input type="checkbox"/> Samoan (303)      |   |

Date child first attended school in the US:

Date child first attended school in CA:

MOST RECENT SCHOOL ATTENDED:			
School	Address/City/State/Zip	Grade(s)	Date(s)

Are there psychological or confidential reports available from your child's former school?  Yes  No  
 Has your child been suspended?  Yes  No Has your child ever been expelled?  Yes  No  
 What special services has your child received? **(please check all boxes that apply)**  
**Special Education:**  Resource (RSP)  Special Day Class (SDC)  Speech/Language  504  IEP  
**Other:**  Gifted (GATE)  Remedial Math  Remedial Reading  Counseling  English Language Development  Adv. Math 7<sup>th</sup> & up  
 Help to Improve Attendance/ Behavior  Other (Specify) \_\_\_\_\_

**Parent/Guardianship Information (with whom the student lives) – check all that apply**

Father  Mother  Both  Step-Father  Step-Mother  Guardian  Foster/Group Home  Other \_\_\_\_\_  
 Is the above (checked) person (s) the student's LEGAL guardian?  Yes  No If No, please provide documentation/ "Caregiver Affidavit"  
 If there is a legal custody agreement regarding this student, please check one:  Joint Custody  Sole Custody  Guardian

**PLEASE COMPLETE INFORMATION BELOW FOR PARENT(S)/GUARDIAN WITH WHOM THE STUDENT LIVES:**

1. **Full Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Portal Access:**  Yes  No  
**Email:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Cell Phone # (\_\_\_\_\_)** \_\_\_\_\_ **Daytime Phone # (\_\_\_\_\_)** \_\_\_\_\_  
**Education Level:**  Graduate Degree or Higher  College Graduate  Some College or Associate's Degree  High School Graduate  
 Not a High School Graduate

2. **Full Name:** \_\_\_\_\_ **Relationship :** \_\_\_\_\_ **Portal Access:**  Yes  No  
**Email:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Cell Phone # (\_\_\_\_\_)** \_\_\_\_\_ **Daytime Phone # (\_\_\_\_\_)** \_\_\_\_\_  
**Education Level:**  Graduate Degree or Higher  College Graduate  Some College or Associate's Degree  High School Graduate  
 Not a High School Graduate

**DUPLICATE MAILING** – If divorced/separated & joint custody allows duplicate mailing/information to be given to other parent,  
 Please include their name, address, and phone number:

**Full Name:** \_\_\_\_\_ **Phone #: (\_\_\_\_\_)** \_\_\_\_\_  
**Mailing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**Other Contacts**

3. **Full Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Portal Access:**  Yes  No  
**Email:** \_\_\_\_\_  
**Can pick up student?**  Yes  No **Cell Phone # (\_\_\_\_\_)** \_\_\_\_\_ **Daytime Phone # (\_\_\_\_\_)** \_\_\_\_\_

4. **Full Name:** \_\_\_\_\_ **Relationship :** \_\_\_\_\_ **Portal Access:**  Yes  No  
**Email:** \_\_\_\_\_  
**Can pick up student?**  Yes  No **Cell Phone # (\_\_\_\_\_)** \_\_\_\_\_ **Daytime Phone # (\_\_\_\_\_)** \_\_\_\_\_

STUDENT TRANSPORTATION	
▶ Does your student need bus transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I will need transportation in: <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Both AM/PM	
Address of bus pickup/drop off: _____	

**STUDENT MEDICAL INFORMATION**

**Proof of immunizations:**     Yes     No

**Family Physician Name/Phone number:**

**List any known health problems:**

**List any medications child takes on a regular basis:**

**Does your child need to take any at school?**     Yes     No

**If Yes, did you fill out a PPS form?**     Yes     No

**List any allergies child has:**

**HOME LANGUAGE SURVEY**

The California Education Code requires that schools determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students. Your cooperation in helping us meet this important requirement is requested. Please answer the following questions below.

Which Language did your child learn when they first began to talk?

Which language does your child most frequently use at home?

Which language do you use most frequently to speak to your child?

Name the language most often spoken by the adults at home.

In which country was your child born?

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Office Use Only:     Guardian Verification     BC Verification     Proof of Residence     Proof of Immunization

Initials Aeries Input:

McSwain Union Elementary School District

**Student Health Information Sheet/ Información de Salud del Estudiante**

Birthdate (Fecha de Nacimiento) \_\_\_\_\_ Grade of Student (Grado del Estudiante) \_\_\_\_\_

Name (Nombre) \_\_\_\_\_  
 Last (Apellido) First (Primer) Middle (Segundo)

Address (Dirección) \_\_\_\_\_  
 Street (Calle) P.O. Box

City (Ciudad) State (Estado) Zip Code (Código Postal)

Father's Name (Nombre del Padre) Mother's Name (Nombre de la Madre)

Birth Defects? _____ ¿Defectos de Nacimiento? _____	Yes/No Si/No	Heart Problems? ¿Problemas Cardiacos?	Yes/No Si/No
Developmental Delay? _____ ¿Retrasos de Desarrollo? _____	Yes/No Si/No	Heart Murmur/High BP? ¿Soplo Cardíaco? Presión Arterial Alta?	Yes/No Si/No
Blood Disorder? _____ ¿Trastornos de la Sangre? _____	Yes/No Si/No	Dizziness/ Chest Pain with exercise? ¿Mareos o dolor de pecho al hacer ejercicio?	Yes/No Si/No
Diagnosis of Asthma? ¿Diagnóstico de Asma?	Yes/No Si/No	Hearing Problems? ¿Problemas de Audición?	Yes/No Si/No
Uses Inhaler? ¿Usa Inhalador?	Yes/No Si/No	Hearing Aids? ¿Aparato del oído?	Yes/No Si/No
Medication Allergies? _____ ¿Alergia a algún medicamento? _____	Yes/No Si/No	Vision Problems? ¿Problemas de visión?	Yes/No Si/No
Food Allergies? _____ ¿Alergia a alguna comida? _____	Yes/No Si/No	Glasses/Contacts? ¿Lentes/Contactos?	Yes/No Si/No
Seasonal Allergies? ¿Alergias de temporada?	Yes/No Si/No	TB Skin Test Positive? ¿Prueba positiva de la piel para el Tuberculosis?	Yes/No Si/No
Diabetes? ¿Diabetes?	Yes/No Si/No	Loss of one of paired organs? ¿Pérdida de uno de los órganos emparejados	Yes/No Si/No
Seizures? ¿Convulsiones?	Yes/No Si/No	Serious Illness? ¿Enfermedades Serias?	Yes/No Si/No
Bone/Joint Problems? ¿Problemas de huesos/articulaciones?	Yes/No Si/No	Any other health condition? _____ ¿Algún otra condición de salud? _____	Yes/No Si/No
Scoliosis? ¿Escoliosis?	Yes/No Si/No	Any Medications taken at home? _____ ¿Toma Medicamentos en casa? _____	Yes/No Si/No
Migraines or Headaches? ¿Migrañas o Dolores de Cabeza?	Yes/No Si/No	Any Medications taken at school? _____ ¿Toma Medicamentos en la Escuela? _____	Yes/No Si/No

**By initialing below/ Poniendo sus iniciales a continuación:**

\_\_\_\_\_ 1. I acknowledge that if the emergency care of my child involves medication, I will have a Medication at school authorization form filled out by a physician and turned in to the school office on or before the first day of school.

Reconozco que, si la atención de emergencia de mi hijo/a involucra medicamentos, tendré un formulario de autorización de Medicamentos en la escuela completado por un médico y entregado en la oficina de la escuela el primer día de clases o antes.

\_\_\_\_\_ 2. I authorize the school district, and its employees and agents, to take the action they believe is appropriate in an emergency.

Autorizo al distrito escolar y a sus empleados y agentes a tomar las medidas que consideren apropiadas en caso de emergencia.

\_\_\_\_\_ 3. I agree to indemnify and hold harmless the School District, and its employees and agents, against any claims, except a claim based on willful and wanton conduct, arising out of the emergency care of my child.

Acepto indemnizar y eximir de responsabilidad al Distrito Escolar, a sus empleados y agentes, contra cualquier reclamo, excepto un reclamo basado en una conducta deliberada y lasciva, que surja de la atención de emergencia de mi hijo.

\_\_\_\_\_ 4. I authorize this health information to be shared with appropriate school staff.

Autorizo que esta información de salud se comparta con el personal escolar apropiado.

\_\_\_\_\_  
Parent(s) / Guardian(s) Printed Name/ Nombre impreso de Padres/Tutor

\_\_\_\_\_  
Parent(s) / Guardian(s) Signature Name/ Firma de Padres/Tutor

\_\_\_\_\_  
Date/ Fecha

### Oral Health Assessment Form

California law (*Education Code* Section 49452.8) says every child must have a dental check-up (assessment) by May 31<sup>st</sup> of his/her first year in public school. A California licensed dental professional must do the check-up and fill out Section 2 of this form. If your child had a dental check-up in the last 12 months, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out the separate Waiver of Oral Health Assessment Requirement Form.

This assessment will let you know if there are any dental problems that need attention by a dentist. This assessment will also be used to evaluate our oral health programs. Children need good oral health to speak with confidence, express themselves, be healthy and, ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of California’s children.

#### Section 1: Child’s Information (Filled out by parent or guardian)

Child’s First Name:	Last Name:	Middle Initial:	Child’s Birth Date: MM – DD – YYYY
Address:			Apt.:
City:		ZIP Code: 	
School Name:	Teacher:	Grade:	Year child starts kindergarten:   Y   Y   Y   Y
Parent/Guardian First Name:	Parent/Guardian Last Name:		Child’s Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Child’s Race/Ethnicity:	<input type="checkbox"/> White <span style="margin-left: 150px;"><input type="checkbox"/> Native American</span> <input type="checkbox"/> Black/African American <span style="margin-left: 100px;"><input type="checkbox"/> Multi-racial</span> <input type="checkbox"/> Hispanic/Latino <span style="margin-left: 100px;"><input type="checkbox"/> Native Hawaiian/Pacific Islander</span> <input type="checkbox"/> Asian <span style="margin-left: 150px;"><input type="checkbox"/> Unknown</span> <input type="checkbox"/> Other (please specify)		

*Continued on Next Page*



**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:  MM – DD – YYYY	Untreated Decay (Visible Decay Present)  <input type="checkbox"/> Yes <input type="checkbox"/> No	*Caries Experience (Visible decay and/or fillings present)  <input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Urgency: <input type="checkbox"/> <b>No obvious problem found</b> <input type="checkbox"/> <b>Early dental care recommended</b> (caries without pain or infection; or child would benefit from sealants or further evaluation) <input type="checkbox"/> <b>Urgent care needed</b> (pain, infection, swelling or soft tissue lesions)		
_____ <b>Licensed Dental Professional Signature</b>		_____ <b>CA License Number</b>
		_____ <b>Date</b>

\*Check “Yes” for Caries experience if there is presence of untreated decay or fillings  
 Check “No” for Caries experience if there is no untreated decay and no fillings

**Section 3: Follow-up to Urgent Care (Filled out by entity responsible for follow up)**

Parent notified that child has urgent dental care need on:	MM – DD – YYYY
A follow-up appointment for this child has been scheduled for:	MM – DD – YYYY
Did child receive needed treatment? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> (If no, entity responsible for follow-up will be encouraged to check back in with parent) <input type="checkbox"/> <b>I don't know</b>	

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.

**Return this form to the school *no later than* May 31st of your child's first school year.**

***Original to be kept in child's school record.***