Continuing Student Grades 1 – 12
Enrollment Packet

Welcome to Big Pine U.S.D. 
2021 - 2022

The enclosed Registration Packet includes items that need to be read carefully by parents. The forms listed and attached are critical to have on file for your student.

The prompt return of the packet to the school office is encouraged. Your student will only be able to participate in all school activities, including use of the library and sports, when all the forms are completed and returned.

THESE FORMS MUST BE TURNED INTO THE SCHOOL OFFICE BY AUGUST 14TH!
Dear Parent or Guardian:

We are pleased to inform you that Big Pine Unified School District participates in the National School Lunch and School Breakfast Programs called the Community Eligibility Provision (CEP).

Schools that participate in the CEP are able to provide healthy breakfasts and lunches each day at no charge for all students enrolled in that CEP school during the school year.

If we can be of any further assistance, please contact us at 760-938-2222.

Sincerely,

Ed Dardenne-Ankringa
Superintendent/Principal

in accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD-3027), found online at http://www.ascr.usda.gov/complaint_filing_cust.html and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) Fax: 202-690-7442

(3) E-mail: program.intake@usda.gov

This institution is an equal opportunity provider.
<table>
<thead>
<tr>
<th>Form/Permission</th>
<th>Status</th>
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<tr>
<td>Emergency Form</td>
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<td>Registration Card</td>
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<td>Health Registration</td>
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<td>Consent to Treat</td>
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<td>Field Trip Form</td>
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<td>Parent Permission for Student Photo</td>
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<td>Medication at School Form/ If Applicable</td>
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<td>Caregiver Form/ If Applicable</td>
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<td>Copy of Immunizations</td>
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<td>(7th Graders updated records)</td>
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<td>Parental Acknowledgement and Permission Page</td>
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<td>(In The Annual Notice to Parents/Guardians)</td>
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<tr>
<td>Confidential Education Benefit Form</td>
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<tr>
<td>Chromebook Use Agreement (3rd-12th)</td>
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<tr>
<td>(In The Student &amp; Parent Technology Handbook)</td>
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**Big Pine Unified School District Emergency Information 2021-2022**

**Alternate Contact Information**

<table>
<thead>
<tr>
<th>Student</th>
<th>Grade</th>
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**PARENT(S)/GUARDIAN(S)**
- Mother (or Guardian):  
- Father (or Guardian): 
- Mailing Address:  
- Street Address:  
- Home Phone:  
- Cell Phone:  

**PLACE OF BUSINESS/WORK:**
- Mother: Name of business:  
  Phone:  
  Address:  
- Father: Name of business:  
  Phone:  
  Address:  

**PERSONS TO CONTACT IF UNABLE TO CONTACT PARENTS:**
1. ___________________________ Relationship:  
   Phone:  
2. ___________________________ Relationship:  
   Phone:  
3. ___________________________ Relationship:  
   Phone:  

**RELEASE FOR EMERGENCY MEDICAL TREATMENT:**
In the event of an injury, medical treatment may only be provided if this authorization is signed and contact with parent(s)/guardian(s) is not possible.

I/we hereby authorize the Big Pine Unified School District to provide medical treatment by a licensed physician in the event of a medical emergency for our child(ren):

**All Children Covered Under this Release Must be Listed on the Back of this Sheet!**

Parent/Guardian:  
Date:  
## Student Information

<table>
<thead>
<tr>
<th>Name</th>
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**Thank you**
Big Pine Unified School District Annual Registration Card 2021 - 2022

Name: (Last Name) __________________ (First Name) __________________ (Middle Name) __________________

Male ___ Female ___ Nonbinary ___ Birth Date: ___________ Birth City & State __________________ Current Grade ___________

Name: (Last Name) __________________ (First Name) __________________ (Middle Name) __________________

Male ___ Female ___ Nonbinary ___ Birth Date: ___________ Birth City & State __________________ Current Grade ___________

Name: (Last Name) __________________ (First Name) __________________ (Middle Name) __________________

Male ___ Female ___ Nonbinary ___ Birth Date: ___________ Birth City & State __________________ Current Grade ___________

Name: (Last Name) __________________ (First Name) __________________ (Middle Name) __________________

Male ___ Female ___ Nonbinary ___ Birth Date: ___________ Birth City & State __________________ Current Grade ___________

(additional children see back side)

Mailing Address: __________________ City/Town __________________

Physical Address: __________________ Located on Federal Land? Y or N

Student Resides with: ___ Both Parents ___ Mother ___ Father ___ Step-Parent ___ Guardian ___ Homeless ___

<table>
<thead>
<tr>
<th>Name</th>
<th>Home #</th>
<th>Work #, Ext</th>
<th>Cell #</th>
<th>E-mail Address</th>
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<tbody>
<tr>
<td>Father:</td>
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<td>Mother:</td>
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<tr>
<td>Step-Parent:</td>
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<tr>
<td>Guardian:</td>
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Emergency Contact (other than parent): Parent will ALWAYS be called first. If parent contact cannot be made, the following
ADULTS will be contacted in matters involving this student (medical emergency, discipline matters, illness, etc.)

<table>
<thead>
<tr>
<th>Name/Relationship</th>
<th>Home #</th>
<th>Work #, Ext</th>
<th>Cell #</th>
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</table>

Father: ____________________________

Mother: ____________________________

Not a High School Graduate
High School Graduate/G.E.D.
Some College/Vocational School
4 year College Graduate (B.A)
Graduate School/Post Graduate Training (M.A., Ph.D.)

I, ________________________________, authorize for the disclosure of health information as required by HIPAA Privacy rules to occur regarding my child with health care providers and the school office.

Initial: Yes ____ No ____
Name: ___________________________ (Last Name) ___________________________ (First Name) ___________________________ (Middle Name) ___________________________

____ Male ____ Female ____ Nonbinary  Birth Date: ____________  
Birth City & State ___________________________  Current Grade ___________________________

Name: ___________________________ (Last Name) ___________________________ (First Name) ___________________________ (Middle Name) ___________________________

____ Male ____ Female ____ Nonbinary  Birth Date: ____________  
Birth City & State ___________________________  Current Grade ___________________________

Name: ___________________________ (Last Name) ___________________________ (First Name) ___________________________ (Middle Name) ___________________________

____ Male ____ Female ____ Nonbinary  Birth Date: ____________  
Birth City & State ___________________________  Current Grade ___________________________
**HEALTH REGISTRATION**

<table>
<thead>
<tr>
<th>NAME:</th>
<th>M F</th>
<th>BIRTHDATE:</th>
<th>GRADE:</th>
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<tr>
<td>NAME:</td>
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</tr>
</tbody>
</table>

**PARENT(S) NAME(S):**  

**PHONE:**

**Medical Insurance:**  
- Group  
- Medi-Cal  
- None  

**Family Physician:**  

**Phone:**

**IMMUNIZATIONS:** California State Law (Health & Safety Code Div.4, Chap. 7, 8,10) requires that students entering school in California must have proof of immunizations.

**VISION:**  
- Has Glasses Yes/No  
- Began wearing glasses (month/year)  
- Last vision exam (month/year)  
- Name of M.D. or O.D.

**HEARING:**  
- Any problems Yes/No  
- Parent Concerns:
  - Frequent Ear Infections  
  - Preferential Seating  
  - Hard Wax  
  - Hearing Aid

- Last seen by Dr.  

**SCHOOL HISTORY:**  
- Speech Therapy: Preschool, Grade ___ to Grade ___. Still needs help: Yes  
- Psychological Evaluation for: Learning Problems  
- Behavioral Problems  
- There no longer seems to be a problem  
- We would like further help for our child.

- Parental concerns:
  - Took Special Education Class from Grade ___ to Grade ___
  - Still has Special Education needs

**MEDICAL HISTORY:**

<table>
<thead>
<tr>
<th>Last Complete Physical (month/year):</th>
<th>Doctor Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies:</td>
<td>Medications</td>
</tr>
<tr>
<td>Foods</td>
<td>Bees</td>
</tr>
<tr>
<td>Asthma:</td>
<td>Mild</td>
</tr>
<tr>
<td>Moderate</td>
<td>Severe</td>
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</tbody>
</table>

**Needs:**  
- Asthma medication at School Y/N  
- Diabetic: Date diagnosed (month/year)  
- Orthopedic Problems: Describe:

- Epilepsy?  
  - Petit mal  
  - Grand mal  
  - Other

- Medication(s):

- Heart Problems. Describe

- Urinary:  
  - Incontinence

- Respiratory Problems? Describe

- TB Contact:  
  - Whooping Cough

Continued – Please Complete Following Page
MEDICATION POLICY:
If your child is taking medication and it must be taken during school hours, contact the school secretary and your physician for an authorization form. No student is permitted to take medication at school unless the authorization form is signed by the physician and the parent and returned to school. No medications can be self-administered by students without signed permission forms on file in the school office.

EMERGENCY CARE POLICY:
I understand that in the event that I, or my emergency contacts, cannot be reached and my dependent is in need of emergency medical treatment, he/she would be transported to the Northern Inyo Hospital emergency room via ambulance. As the parent, agency representative, or legal guardian, I hereby give consent for all emergency dental, or medical care prescribed by a duly licensed physician (M.D.), or dentist (D.D.S.) for my dependent. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependent. My signature also indicates acknowledgement of receipt of information pertaining to parent's rights and specialized instructional programs.

I, __________________, authorize for the disclosure of health information as required by HIPAA Privacy rules to occur regarding my child with health care providers and the school office.

Initial: Yes ___ No ___

Form completed by: __________________________ Date: __________________

Signed: __________________________ Date: ________________

Relationship to Student: __________________________
Authorization to Consent to Treatment of Minor

(I) (We), the undersigned, parent/guardian(s) of child(ren) listed above, a minor(s), do hereby grant, any hospital, emergency center, doctor, nurse/and/or paramedic, authorization to give treatment to my child(ren), when accompanied by or escorted to the treating facility by a teacher, coach, teacher’s aide, principal, or any member of Big Pine Unified School District. As agent(s) for the undersigned, (I) (WE) authorize consent of any x-ray examinations, anesthetic, medical or surgical diagnosis or treatment and hospital care which 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 Medicine Practice Act on the medical staff of any licensed 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 specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

Further, should the attending physician determine after examination that life-saving surgery or other life-saving procedures may be necessary; permission is hereby extended to the above parties to grant same. Additionally, (I) (WE) agree to hold harmless such personnel and the Big Pine Unified School District Board of Education by my/our action of granting said permission.

(I) (WE) hereby authorize any hospital which 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 (My) (Our) above-named agent(s) upon the completion of treatment. His authorization is given pursuant to Section 1283 of the Health and Safety Code of California.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective until the above-named minor is un-enrolled from Big Pine Unified Schools or the current school year of 2021 – 2022 has been completed.

Name and Phone # of Current Physician: ________________________________________

Birth Dates: _____________ Date of Last Tetanus Shots: ______________

Insurance Carrier/Number: ________________________________________________

Allergies: ____________________ Medications: ____________________________

Other Medical Information: ______________________________________________

_________________________ __________________________
Signature of Father/Mother/Legal Guardian & Date Cell Phone

_________________________ __________________________
Signature of Father/Mother/Legal Guardian & Date Cell Phone

In case of emergency and inability to notify parents/guardians, BPUSD will attempt to notify:

1. Name: ______________________  2. Name: ______________________

Phone: _______________________ Phone: ______________
BIG PINE UNIFIED SCHOOL DISTRICT
FIELD TRIP PERMISSION FORM 2021 – 2022

Student Names: ____________________________  Grade Level: ________________

Dear Parent/Guardian:

From time to time throughout the school year, your child will have the opportunity to participate in educational and athletic field trips and excursions. Typical trips have included musical performances, guest speakers, nature visits, academic competitions, and athletic events. Students are transported by school bus, school van, or private vehicles approved by the school district. Students often walk for nearby visits.

In order to eliminate the necessity of completing a separate authorization form for each of these trips, we ask that you initial the appropriate choice (A, B, or C) for your child.

This will authorize the school to include your child in ANY OR ALL of the activities planned during the year.

A. _____ I hereby authorize ____________________________, grades _____, to participate in any or all expedition or case study fieldwork trips, outdoor adventures, or athletic events in which the student is qualified to attend, which may be planned by his/her teacher or the school during the current school year.

If you prefer, Line B can be used for ONE SPECIFIC EVENT ONLY.

B. _____ I hereby authorize ____________________________, grade ___, to participate in Name Activity ____________________________________.

If you have any objections to your student’s participation in school related trips - Line C.

C. _____ I do NOT wish ____________________________, grade ___, to participate in school sponsored activities, which require the students to leave the school

RELEASE FOR EMERGENCY MEDICAL TREATMENT

When a student suffers a serious injury or illness while at school or at an off-campus school trip or function, first aid will be rendered in accordance with local school policies and an immediate and continuing effort will be made to contact the parents of that student. If contact with the parent/guardian is not possible, medical treatment may not be provided unless this authorization is signed.

I hereby authorize the Big Pine Unified School District to provide medical treatment by a licensed physician in the event of a medical emergency for ______________________________________

__________________________________ Date ______________________

Parent/Guardian Signature

Home Phone: __________________________ Work Phone: ____________________

Family Physician: ____________________ Phone: _________________________

Medical Insurance: __________________ Policy No.: ______________________

List any physical disabilities (i.e.: diabetes, epilepsy, severe allergy, etc.) ______________________________________________________

List any medication your student has had an allergic reaction to: ______________________________________________________
Parent Permission 2021 – 2022

Student Photo/Picture/Information

For Public Relations purposes and with student safety in mind, your student’s photo/information may be used to help promote a program, awards, assemblies, sporting programs, campus life, etc., via local media (radio, television, newspaper) and on our district website.

Please fill out the slip below, detach and return slip to school with your student.

Thank you!

Student Name & Grade

Student Name & Grade

Student Name & Grade

Student Name & Grade

Student Name & Grade

Student Name & Grade

Parent/Guardian Signature: __________________________ Date: __________

____ Yes, BPUSD has permission to use my child’s picture as noted above.

____ No, I prefer personal contact if my child’s photo is to be used in any manner.
AUTHORIZATION FOR MEDICATION TAKEN DURING SCHOOL HOURS
Valid for school year 2021 - 2022

Part 1: To be completed by Parent or Legal Guardian

Note: All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child’s name, name of the medication, dosage, method of administration, and name of Physician.

I request that designated personnel assist my child in taking this prescribed medication. I understand that my child may not have, nor take medication at school unless all requirements are met. I hereby give consent for contact/communication with my child’s physician regarding the medication(s) prescribed for my child, (see reverse).

Child’s Names __________________________ M/F ___ SS# __________________

Grade Levels _____ Teachers ___________________

I have read and understand the “Notice of Provisions”, printed below. I will immediately notify the school if there are any changes in medication(s) that my child is taking during school hours.

Date ______ Parent/Guardian Signature __________________________

Home Phone ______ Work Phone ______ Emergency # ______

*Notice of Provisions” California Ed. Code Sections 49423, 49480, and California Administrative Code Title 5, 18170*

California Education Code, Section 49423 – Administration of prescribed medication for pupil:
Notwithstanding the provisions of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated personnel if the school district receives:
1. A written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken, AND
2. A written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in matters set forth in the physician’s statement.

California Education Code, Section 49480 – Continuing medication regimen for non-episodic condition; required notice to school employees:
1. An assigned staff member shall administer medications prescribed by a physician for a child provided written parental consent has been given.
2. Record of medication dosages to the child and date and time medication is administered shall be maintained by the facility.
3. Centrally stored medicines shall be kept in a safe and locked place that is not accessible to persons other than employees responsible for health supervision. Each container shall carry the name of the medication, the name of the person for whom prescribed, the name of the prescribing physician and the physician’s instructions. All centrally stored medications shall be labeled and maintained in compliance with State and Federal laws. Each person’s medication shall be stored in its originally received container.

No medications shall be transferred between containers. The agency shall be responsible for assuring that a record of centrally stored prescription medications for each person in care includes: the name of the person for whom prescribed, the drug name, strength and quantity, the date filled, the prescription number and name of issuing pharmacy.
4. All medications shall be centrally stored in an area, which is totally inaccessible to children.

*Procedures under the Individualized Education Program (IEP), Individualized Health Program (IHP) or 504 Plan should not be addressed on this form. Please request form for Specialized Physical Health Care Services pursuant to California Education Code Section 49423.5.

Reverse Side MUST be completed by Physician to Validate
Part 2: To be completed by Physician

Name of Children: ____________________________________________

*Diagnosis for which medication has been prescribed: ____________________________________________

Name of medication(s) and dosage:

1. ____________________________________________

2. ____________________________________________

3. ____________________________________________

Time/Hour of day to be given ______________________ Frequency or “as needed” ______________________

If “as needed”, describe indications and sequence orders: ____________________________________________

Method of Administration:
Oral: Liquid ___ Tablet ___ Inhaler ___ Drops: Eye ___ R/L Ear ___ R/L Nostril ___ R/L

Topical ___ Application Area _____________ Other: ____________________________________________

Precautions, Reactions, or Side Effects: ____________________________________________

If Severe Allergic Reaction Occurs:
___Choking ___ Hives ___ Skin Rash ___ Swelling (any kind) ___ Loss of Voice ___ Difficulty Breathing

___ Loss of Consciousness ___ Other ____________________________________________

Use: (circle one) Epi-pen Jr. or Epi-pen OR Transport to Nearest Hospital Emergency Room

Storage and Handling:
___ Routine handling, medications in locked storage administered by authorized personnel

___ 72 hour Disaster Supply Only ___ Refrigeration

If Medically Necessary: ___ Child to carry, school personnel to administer

___ Child trained to carry and self-administer/medicate

Additional Special Instructions/Interventions

____________________________________________________

____________________________________________________

Name of Physician: ___________________________ Address: ___________________________

Office Phone: ___________________________ Office Fax: ___________________________

Signature of Physician: ___________________________ Date: ___________________________

*School Staff: Notify school nurse and necessary personnel if allergy or asthma is indicated.
Big Pine Unified School District
Caregiver’s Affidavit

Use of this affidavit is authorized by Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code.

Instructions: Completion of items 1-4 and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. Completion of items 5-8 is additionally required to authorize any other medical care. Print clearly.

The minor named below lives in my home and I am 18 years of age or older.

1. Name of minor: ____________________________________________________________

2. Minor’s birth date: _______________________________________________________

3. My name (adult giving authorization): ______________________________________

4. My home address: ________________________________________________________

5. ( ) I am a grandparent, aunt, uncle, or other qualified relative of the minor (see back of this form for a definition of “qualified relative”).

6. Check one or both (for example, if one parent was advised and the other cannot be located):

   ( ) I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care, and have received no objection.

   ( ) I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time, to notify them of my intended authorization.

7. My date of birth: _________________________________________________________

8. My California’s driver’s license or identification card number: ________________

Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: __________________________ Signed: ________________________________

NOTICES:

1. This declaration does not affect the rights of the minor’s parents or legal guardian regarding the care, custody, and control of the minor, and does not mean that the caregiver has legal custody of the minor.

2. A person who relies on this affidavit has no obligation to make any further inquiry or investigation.

3. This affidavit is not valid for more than one year after the date on which it is executed.

Please see reverse side for additional information.
Big Pine Unified School District
500 South Main Street / P. O. Box 908
Big Pine, CA 93513-0908
School Office: (760) 938-2222 - FAX (760) 938-2310

Parent Acknowledgement and Permission Page
2021 – 2022
New Student Enrollment

I hereby acknowledge receipt of the following forms, as well as give my permission for my student to participate in the stated activities as applicable.
(Please initial)

Student Handbook
Annual Notice
Publication of my student’s photo for newspaper and/or Big Pine Schools website

YES ____ Allow Big Pine to provide a list to the Branches of Military with my child’s name and information on it. (Juniors and Seniors only)

NO ____ DO NOT submit my child’s information to the Branches of the Military when requested.

Name of Student/Grade ________________________________
Name of Student/Grade ________________________________
Name of Student/Grade ________________________________
Name of Student/Grade ________________________________
Name of Student/Grade ________________________________
Name of Student/Grade ________________________________
Name of Student/Grade ________________________________

Parent/Guardian Signature ________________________________
Date ____________________
Dear Parent or Guardian:

Big Pine Unified School District has been participating in the National School Lunch and School Breakfast Programs called the Community Eligibility Provision (CEP).

Schools that participate in the CEP are able to provide healthy breakfasts and lunches each day at no charge for ALL students enrolled in that CEP school during the school year.

This year we are required to reapply for the CEP Lunch Program. It is necessary to collect income data for every family. The application has been included in the enrollment packet. Please take a few moments to complete the application and turn it in ASAP. This will help us to qualify our school to continue the CEP Lunch Program.

If we can be of any further assistance, please contact us at 760-938-2222.

Sincerely,

Ed Dardenne-Ankringa
Superintendent/Principal
School Year 2021-2022 Big Pine Unified School District Application for Free and Reduced-Price Meals

Please read the instructions on how to apply. Print clearly with a pen. You may also apply online at www.bigneschools.org. This institution is an equal opportunity provider.

California Education Code Section 49557(a): Applications for free and reduced-price meals may be submitted at any time during a school year. Children participating in the federal National School Lunch Program will not be overtly identified by the use of special tokens, special tickets, special serving lines, separate entrances, separate dining areas, or by any other means.

**STEP 1 – STUDENT INFORMATION**

Children in Foster Care and children who meet the definition of Homeless, Migrant, or Runaway are eligible for free meals.

<table>
<thead>
<tr>
<th>Print the name of EACH STUDENT (First, Middle Initial, Last)</th>
<th>Enter school name and grade level</th>
<th>Enter student's birthdate</th>
<th>Check the applicable box if the student is foster, homeless, migrant, or runaway.</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXAMPLE: Joseph P Adams</td>
<td>Lincoln Elementary 1st</td>
<td>12-15-2010</td>
<td>Foster ☐ Homeless ☐ Migrant ☐ Runaway ☐</td>
</tr>
</tbody>
</table>

**STEP 2 – ASSISTANCE PROGRAMS: CalFresh, CalWORKS, or FDPIR**

Do ANY household members (child or adult) currently participate in CalFresh, CalWORKS or FDPIR? If NO, skip STEP 2 and continue to STEP 3.

If YES, check the applicable program box, enter one case number, skip STEP 3, and continue to STEP 4.

<table>
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<tr>
<th>Select Program Type:</th>
<th>Enter Case Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CalFresh ☐ CalWORKS ☐ FDPIR ☐</td>
<td></td>
</tr>
</tbody>
</table>

**STEP 3 – REPORT INCOME FOR ALL HOUSEHOLD MEMBERS (Skip this step if you answered 'YES' in STEP 2)**

A. STUDENT INCOME: Enter the TOTAL GROSS income (before deductions) in whole dollars earned by all students listed in STEP 1. Enter the appropriate pay period in the "How Often" box: W = Weekly, 2W = Biweekly, 2M = Twice a Month, M = Monthly, Y = Yearly

<table>
<thead>
<tr>
<th>Print the name of ALL OTHER Household Members (First and Last)</th>
<th>Earnings from Work</th>
<th>How Often</th>
<th>Public Assistance/SSI/Child Support/Alimony</th>
<th>How Often</th>
<th>How Often</th>
<th>Pensions/Retirement/All Other Income</th>
<th>How Often</th>
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</table>

B. ALL OTHER HOUSEHOLD MEMBERS (including yourself): List ALL household members not listed in STEP 1, even if they do not receive income. For each household member, report the TOTAL GROSS income (before deductions) in whole dollars for each source. If the household member does not receive income from any sources, write "0". If you enter "0" or leave any fields blank, you are certifying (promising) that there is no income to report.

**STEP 4 – CONTACT INFORMATION & ADULT SIGNATURE**

Certification: I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable state and federal laws.

Signature of adult completing this application:

Print Name:

Date:

Mailing Address:

City: State: Zip:

E-mail:

**DO NOT COMPLETE. SCHOOL USE ONLY**

How Often? ☐ Weekly ☐ Bi-Weekly ☐ Twice a Month ☐ Monthly ☐ Yearly

Total Household Income $ ______

Total Household Size: ______

Eligibility Status: ☐ Free ☐ Reduced-price ☐ Paid (Denied) ☐ Categorical

Verified as: ☐ Homeless ☐ Migrant ☐ Runaway ☐ Error Prone

Determining Official's Signature: Date:

Confirming Official's Signature: Date:

Verifying Official's Signature: Date:

**OPTIONAL – CHILDREN’S ETHNIC AND RACIAL IDENTITIES**

We are required to ask for information about your children’s race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children’s eligibility for free or reduced-price meals.

Ethnicity (check one):

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more):

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White