



Dunham Elementary School's Enrollment Application

FAQS:

What is Dunham's School Priority List?

#1 children with parent's living in the district. #2 children with siblings currently attending Dunham. #4 Employee children #3 Children actively attending a Dunham district daycare/preschool. #5 Lottery waiting list

How will I know if my child got in?

Applications will be randomized by a random drawing aka lottery, then given a waiting list number. Enrollment is not guarantee with a waiting list number. Enrollment begins late spring, and continues throughout summer depending on availability. All applications will remain on the waiting list unless requested to be taken off by the parent.

What time does school start?

School starts at 8:00 a.m. - The classroom doors open at 7:50 a.m. There is supervision in the Daycare Room from 7:30 to 7:50, should you need to drop your child off a little early. There is no cost for morning care.

What time does school end?

- ✓ 1st – 6th Grade dismisses at 2:30 p.m. on Monday, Tuesday, Thursday, and Friday.
1:30 pm. on Wednesdays
- ✓ Kindergarten dismisses at 11:45 a.m. After Thanksgiving break Kindergartners will stay at school until 1:30 p.m.

Our Mission: In partnership with our families, Dunham Elementary School is committed to providing an educational experience that will ready students for successful living in the 21st Century.



DUNHAM SCHOOL DISTRICT

Dunham Charter School (TK-6th Grade) & Dunham School (6th Grade)

4111 Roblar Road, Petaluma, CA 94952

Phone: (707)795-5050

Fax: (707) 795-5166

DunhamSD.org

Application/Registration for the _____ School Year.

Child's LEGAL Name (as listed on Birth Certificate):

Last Name First Name Middle Name
Grade Entering: _____ Male Female Date of Birth: ____/____/____

Home Address

City State Zip

Mailing Address (IF DIFFERENT) City State Zip

Mother's/Guardian's Name Mother's Maiden Name

() _____ () _____ () _____
Home Phone Cell Phone Work Phone

Email Address: Occupation

Father's/2nd Guardian's Name

() _____ () _____ () _____
Home Phone Cell Phone Work Phone

Email Address: Occupation

Your Child's last school: _____

City/State: _____ Phone Number: _____

Student's Birthplace: City/State _____ Country: _____

If your child was not born in the United States, when did he/she enter the U.S. (month/year)? ____/____

When did your child first enroll in a U.S. school (month/year)? ____/____ California school (month/year)? ____/____

APPLICATION RECEIVED:

OFFICE USE

- Lives in District
- In-District Employment
- In-District Childcare
- Sibling

Proof of Residency:

- Utility/Telephone Bill
- Rent/Lease Agreement
- Affidavit of Residency
- Tax Documents
- Proof In-District Employment
- Proof In-District Childcare

- _____ CSIS Number
- _____ Emergency Form
- _____ Immunizations
- _____ Proof of Residency
- _____ Birth Certificate
- _____ Cum. Requested

PARENT/GUARDIANSHIP INFORMATION: Who does this child live with? (Please check all that apply)

Father Mother Both Step-Mother Step-Father Guardian Foster/Group Home Other: _____

Is the above checked person (s) the student's LEGAL guardian? Yes No If No, please complete a "Caregiver Affidavit".

Is there any LEGAL or GUARDIANSHIP information about your child we should be aware of? Yes No

If yes, please check one: Joint Custody Sole Custody Guardian Please attach copies of LEGAL DOCUMENTS.

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: Name: _____ House # _____ cell # _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

ETHNICITY: Mark ethnicity with which the student most closely identifies: (only one) (Confidential Information needed for Federal/State Reports)

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

WHAT IS YOUR CHILD'S RACE: Select one or more boxes to indicate what you consider your child's race to be. (Confidential Information needed for Federal/State Reports)

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

HIGHEST EDUCATION LEVEL OF EITHER PARENT: (Information needed for State Testing)

Not a high school graduate Some college (incl. AA degree) Graduate school/post graduate training
 High school graduate College graduate

HOME LANGUAGE SURVEY

Which language did your son/daughter learn when he/she first began to talk? _____

What language does your son/daughter most frequently use at home? _____

What language do you use most frequently to speak to your son/daughter? _____

Name the language most often spoken by the adults at home: _____

WHAT SPECIAL SERVICES HAS YOUR CHILD RECEIVED? (Please check all boxes that apply)

Special Education: Resource (RSP) Special Day Class (SDC) Speech/Language 504 Accommodation Plan
Other: Gifted (GATE) Remedial Math Remedial Reading Counseling
 English Language Development Medical Health Plan

Has the student been expelled or is the student in the process of being expelled from any school? Yes No

If yes: Name of school: _____ Location: _____ Date: _____

RESIDENCE – where is your child/family currently living? (Federally mandated by NCLB: Please check all that apply)

In a single family permanent residence (house, apartment, condo, mobile home) In a motel/hotel
 Doubled-up (sharing housing with other families/individuals due to economic hardship, loss, or other reasons) Unsheltered (car/campsite)
 Other _____

OTHER CHILDREN IN THE FAMILY:

First and Last Name	Relationship	Lives at Home	Birth date	Grade
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____

OTHER ADULTS IN THE HOME:

Name	Relationship	Name	Relationship
_____	_____	_____	_____

HEALTH PROBLEMS (Check all that apply)

Diagnosed ADD or ADHD <input type="checkbox"/>	Epilepsy..... <input type="checkbox"/>
Asthma <input type="checkbox"/>	Eye Injury <input type="checkbox"/>
Bladder Problems..... <input type="checkbox"/>	Hypoglycemia <input type="checkbox"/>
Bleeding Disorder..... <input type="checkbox"/>	Frequent Nosebleeds..... <input type="checkbox"/>
Color Vision Deficiency..... <input type="checkbox"/>	Scoliosis..... <input type="checkbox"/>
Diabetes <input type="checkbox"/>	Seizure Disorder..... <input type="checkbox"/>
Eczema/Skin Trouble..... <input type="checkbox"/>	Chicken Pox..... <input type="checkbox"/>
History of Ear Problem <input type="checkbox"/>	Describe _____
Heart Problem..... <input type="checkbox"/>	Describe _____
Head Injury..... <input type="checkbox"/>	Describe _____
History of Fractures..... <input type="checkbox"/>	Describe _____
History of Hospitalization..... <input type="checkbox"/>	Describe _____
History of Surgery <input type="checkbox"/>	Describe _____
Known Hearing Loss <input type="checkbox"/>	Right <input type="checkbox"/> Left <input type="checkbox"/>
Known Vision Loss..... <input type="checkbox"/>	Right <input type="checkbox"/> Left <input type="checkbox"/>
Physical Limitations..... <input type="checkbox"/>	Describe _____
Wears Contact Lens <input type="checkbox"/>	
Wears Glasses <input type="checkbox"/>	For close work <input type="checkbox"/> For distance only <input type="checkbox"/> At all times <input type="checkbox"/>

Other or further details of above _____

ALLERGIES (Check all that apply) none:

Animals <input type="checkbox"/>	Drugs <input type="checkbox"/>	List specific item(s) student is allergic to: _____ _____
Insects <input type="checkbox"/>	Food <input type="checkbox"/>	
Bee Stings <input type="checkbox"/>	Plants <input type="checkbox"/>	
		Describe allergic reaction and/or treatment: _____ _____

Other Explain: _____

CURRENT MEDICATION(S) No Yes Epi-Pen *If medication is needed at school a medication consent form must also be completed.*

I have reviewed this two page document and to the best of my knowledge, the information contained herein is true and complete. By signing below, I declare under penalty of perjury that I am the parent or legal guardian of the above-named student and grant the above authorizations.

Signature of Parent/Guardian _____

Date: _____