Oasis Charter Public School

Enrollment Form SY 2024-2025

CHILD'S INFORMATION:

Child's Full Name _____
Last First Middle

Child's Nickname_____Birth date _____ Birth Place_____ Gender **M F**

Grade Child will enter in SY 2024-2025 _____ District of Residence_____

Last School Attended_____ Preferred Correspondence Language: English/ Spanish/ Other

Student Lives With: ___ Both Parents ___Father ___Mother ___ Joint Custody ___Guardian ___Foster

FAMILY INFORMATION:

	Mother/Step Mother/Guardian	*Father/Step Father/Guardian*
Full Name	_____	_____
Physical Address	_____	_____
Mailing Address	_____	_____
City	_____	_____
State & Zip	_____	_____
Phone	(hm) _____ (wk) _____	(hm) _____ (wk) _____

Ethnicity: Is this student/staff member Hispanic or Latino? *(Select only one)*
_ No, not Hispanic or Latino
_ Yes, Hispanic or Latino

The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be. MUST ANSWER BOTH QUESTIONS.

Race: What Is the race of this student? (*Select one or more*)
__ American Indian or Alaska Native
Asian:
__Chinese __Japanese __Korean __Vietnamese __Asian Indian __Laotian __Cambodian __Filipino __Hmong __Other Asian
Native Hawaiian or Other Pacific Islander:
__Hawaiian __Guamanian __Samoan __Tahitian __Other Pacific Islander
__Black or African American
__White

Parent Education Level: Check the response that describes the highest education level of parent/guardian(s):

Parent/Guardian 1:_____(Name)
___Not a high school graduate ___Some College (includes AA degree) ___Graduate school/postgraduate training
___High school graduate ___College graduate

Parent/Guardian 2:_____(Name)
___Not a high school graduate ___Some College (includes AA degree) ___Graduate school/postgraduate training
___High school graduate ___College graduate

Has your child ever been evaluated for special education or received special education services? ___Y ___N
If yes, please answer the following:

1. **Which class or service did your child attend? (Circle all that apply).**
   SPEECH, LH/SDC, ED/SDC, CH/SDC, ADAPTIVE P.E., OTHER.
2. **Has your child ever attended a special education class? __ y __ n If so, when: month___ year___**
3. **Was this in a public or private school (please circle one)? Name of School_____**

Parent/Guardian Signature_____ Date _____

OCPS will not discriminate on the basis of race, color, sex, national and ethnic origin, age, religion, or disability in the administration of its educational, admission and athletic policies and other school-administered programs.

Office Use ONLY:	**Proof of Birth** Type: _____ Verified by: _____	**Proof of Immunization**: Type: _____ Verified by: _____	**Assigned Grade:**	**Enroll Date:**	**Notes:**

Oasis Charter Public School
EMERGENCY FORM SY 2024-25

Teacher _____Grade_____

Name_____ M__ F__
Last First Middle

Address _____Apt. No._____ City/State _____ Zip_____

Birthdate _____/_____/_____ **Birthplace**_____ **Language Spoken at Home**_____

Mother/Guardian/ Caregiver Name:	**Father/Guardian/ Caregiver Name:**
Employer:	**Employer:**
Home Phone: **Work Phone:**	**Home Phone:** **Work Phone:**
Cell Phone:	**Cell Phone:**
E-mail	**E-mail**

Child Living With_____ **Relationship**_____

Emergency Contacts In case my child becomes ill or injured at school and parent contact cannot be made, you may contact or release my child to the following: The following people are also allowed to pick my child up after school.

	Name	Relationship	Home Phone	Other/Cell Phone
1.				
2.				
3.				

Health Care Provider _____ **Phone** _____

Name of Medical Insurance_____ **Policy Number**_____

___*No Medical Condition* Or

___My child receives regular care for the following medical condition(s):

Allergies/Allergic to: _____ **Date of last reaction:** _____

Requires Epinephrine (circle one): Yes No

__Asthma __Diabetes *is insulin required? (Circle one): Yes No ___Seizures

☐ **Does your child have any other major health issue (s) Please list:** _____

☐ **Is your child taking medication (s)? Please list medication (s) and times taken:**

_____ _____ _____

Other children in the family:

Name	Year of Birth	Relationship	Grade	M/F

In an emergency, when we cannot be contacted, the school authorities or parent volunteers have our permission to use their best judgment in the interest of our child's health and welfare. The school assumes no financial responsibility or legal liability. If emergency service involving medical action or treatment is required and neither parent nor the family physician can be reached for consent, the parent hereby consents to the rendering of such emergency medical service for the above named students as shall be necessary in the opinion of the adult performing supervision.

I certify that my child is a resident of California. Yes____ No____

Signature of Parent/ Guardian:_____ **Date**_____

Oasis Charter Public School
HOME LANGUAGE SURVEY

DATE: _____ **SCHOOL:**

Oasis Charter Public

The California Education Code requires schools to determine the language(s) spoken at home by each student and the dates they first enrolled in schools in the United States. This information is essential 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 and return this form to the office. Thank you for your help.

NAME OF STUDENT:

Last _____ First _____ Middle _____

BIRTHDATE OF STUDENT: **Age:** **Grade:**

MONTH: _____ DAY: _____ YEAR: _____

FIRST ENROLLED IN A CALIFORNIA PUBLIC SCHOOL: DATE FIRST ENROLLED IN ANY SCHOOL IN THE UNITED STATES:

MONTH: _____ DAY: _____ YEAR: _____

MONTH: _____ DAY: _____ YEAR: _____

1. Which language did your son or daughter learn when he or she first began to talk?

_____

2. What language does your son or daughter most frequently use at home?

_____

3. In what language do you most frequently speak to your son or daughter?

_____

4. What language is spoken most often by the adults at home?

_____

Signature of Parent or Guardian: _____

Print Name: _____

FOR OFFICE USE ONLY

Language Proficiency Designation:

English Only _____ FEP _____ ELL _____

Income Survey SY 2024–2025

Encuesta de Ingresos

We need the following information in order to qualify for certain funds through the California Department of Education. We appreciate you taking the time to complete this form.

Name of Oasis Student:

_____

How many adults are there in the household? _____

How many children are there in the household? _____

For School use only, **total monthly income**: _____

Please circle all services that you are receiving: CalFRESH CalWORKS Kin-GAP FDPIR

This information is confidential and will only be used to determine eligibility for state funds through the California Department of Education for the school year 24-25. This information will not be divulged for any other reason.

_____

Necesitamos la siguiente información para solicitar fondos del Departamento de Educación del Estado de California. Les agradecemos mucho su tiempo en completar esta forma.

Nombre del estudiante:

_____

¿Cuántos adultos hay en la casa? _____

¿Cuántos niños hay en la casa? _____

Para uso de la escuela, **todo el ingreso del hogar**: _____

Por favor de marcar todos los programas que recibe: CalFRESH CalWORKS Kin-GAP FDPIR

Esta información en esta forma es confidencial y solo será usada para determinar la elegibilidad para fondos del estado por el Departamento de Educación del Estado de California, Esta información no será divulgada por ningún otro motivo.

X_____ _____

Signature of parent/guardian filling out **Date/Fecha**

Firma de adulto/miembro del hogar quien llena está forma

****

For OFFICE Use Only:

Teacher: _____

Free: _____Reduced: _____N/A: ____

Grade: _____

Free with FS/CALworks/Kin-Gap/FDPIR: _____

Field Trip Permission

SY 2024-2025

My child, _____ has my permission to participate in the following school authorized field trips:

Lunchtime playground activities and Enrichment Club activities.	**Yes____**	**No____**
School field trips within walking distance of school.	**Yes____**	**No____**
School field trips involving car pooling with parent volunteers as drivers.	**Yes____**	**No____**

(Parents will be notified with additional Form)

I hold Monterey County Office of Education, the UCEN Board of Directors, and Oasis Charter Public School, its Faculty, Agents and Employees harmless from any and all liability or claims which may arise out of or in connection with my child's participation in any school authorized field trip.

In an emergency when I cannot be contacted, the school authorities have my permission to use their best judgment in the interest of my child's health and welfare. The school assumes no financial responsibility. If emergency services involving medical action or treatment is required and neither parent nor the family physician can be reached for consent, I consent to the rendering of such emergency medical service for the above named student as shall be necessary in the opinion of the medical staff rendering service.

Oasis Charter Public School

PERMISSION SLIP FOR PHOTOGRAPHING YOUR CHILD

SY 2024-2025

From time to time we take pictures during activities. We would like your permission to use these pictures on our website, advertisement, or in our tri-fold. We will never reference your child by name or provide any specific information regarding your child. We also will never sell these pictures; we will use them exclusively for Oasis purposes.

Please take a moment to let us know your preferences regarding our use of photos of your children:

_____ YES, I grant you permission to use photos of my child.

-Or-

_____ NO, Please do use any photos of my child.

Parent/Guardian's Name (PLEASE PRINT): _____

Parent/Guardian's Signature: _____

Date: _____

Office use ONLY:
Teacher: _____
Grade: _____

Family Participation AGREEMENT for 2024-2025

By enrolling my child at Oasis Charter Public School, in agreement with the school's charter, I commit to support the school and my child's education by:

- Attending BOTH All Family Meetings. _____ Initial
- Attending the parent-teacher conferences. _____ Initial
- Participating in school wide events. _____ Initial
- Having my child to school on time and making every effort to ensure my child attends school every day. _____ Initial
- Supporting the Oasis Charter Public School by modeling appropriate behavior at school. _____ Initial

_____

Signature Parent(s)

_____

Printed Name(s)

Family Participation Options

Classroom Support Position

- Coordinate with your child's teacher to help with needs in the classroom.

Individual Support Position (Do you have a talent/skill you would like to share with Oasis?)

_____

School-wide Leadership Position

- Leadership position on the OCC

School-wide Support Position

- Participate on a school wide committee, help with recess duty, or maintenance needs.

- School-wide events to participate in for the 2024-2025 school year include:

School Camping
Book Fairs
Gala
Harvest Feast (Nov)
School Dances
Boxland (May)
6th grade promotion (Jun)

I have read and understand the family participation contract.

Child's Name: _____ Teacher: _____

Child's Name: _____ Teacher: _____

Child's Name: _____ Teacher: _____

Guardian Signature: _____

Date: _____

Oasis Charter Public School
A small school for kids with BIG ideas.

Homeless Children and Youth Services Program

Student Housing Questionnaire

The information provided below will help determine what services you and/or your child may be eligible to receive. 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 INFORMATION

Student Name: _____Birthdate: _____
Grade: _____
Parent(s)/Guardian(s) Name: _____
Address: _____City:_____
State: _____ Zip: _____ Contact Number: _____

PLEASE CHECK THE BOX BELOW WHICH BEST DESCIBES YOUR CURRENT LIVING ARRANGEMENT

☐ Rent or own a home, mobile home, apartment, or condominium.

☐ Sharing housing with other(s) due to loss of housing, economic hardship, natural disaster, lack of adequate housing

☐ Temporarily living in a motel or hotel due to loss of housing, economic hardship, natural disaster, or similar reason

☐ Staying in a shelter (family shelter, domestic violence shelter, youth shelter) or transitional housing

☐ Moving from place to place/couch surfing

☐ Living in car, RV, park, campsite, encampment, or on the street

☐ Living in a residence with inadequate facilities (no water, no heat, or no electricity), shed, or unconverted garage.

PLEASE LIST ANY ADDITIONAL CHILDREN LIVING WITH YOU – They qualify for services, too!

Name: _____ Birthdate: _____ Age: _____
Name: _____ Birthdate: _____ Age: _____
Name: _____ Birthdate: _____ Age: _____

YOUR CHILD OR CHILDREN MAY HAVE THE RIGHT TO:

*Immediate enrollment in the school they last attended or the local school where you are currently staying, even if you do not have all the documents needed to enroll. *Continue to attend their school of origin. *Receive transportation to and from their school of origin. *Receive special programs and services. *Free school meals. *Receive the full protections and services provided under all federal and state laws, as it relates to homeless children and youth.

As the parent/guardian of the above-named child, I declare under penalty of perjury under the laws of the State of California that the information provided here is true and correct.
Signature: _____ Date: _____

FOR DISTRICT PERSONNEL ONLY

For data collection purposes and student information system coding.
☐ Student not covered by McKinney-Vento Act. ☐ Student covered by McKinney-Vento Act

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MEDICATION AUTHORIZATION FORM

School Medication Permission Form (CEC 49423) This form must be completed fully in order for schools to administer the required medication. A new Medication Permission form must be completed each school year for each medication, and whenever there is a change in the pupil's authorized health care provider, or a change in the medication dosage, method by which the medication is required to be taken, or date(s) or time(s) the medication is required to be taken.

****

Health Care Provider (HCP) Authorization:

Student Name:_____Birthdate:_____Grade:_____
Medication Name: _____ Strength:_____
[ ] Tablet/Capsule [ ] Liquid [ ] Injection [ ] Topical
Required Dose: _____Time(s) to be given at school: _____ [ ] AM [ ] PM
If PRN, frequency: _____ If PRN, for what symptoms:_____
Reason for giving medication:
_____
Relevant side effects: _____
How soon can dose be repeated? _____
Medication shall be administered from: _____to_____[ ] Remainder of school year
Additional Instructions:_____
Prescriber's Name/Title:_____
Telephone: _____ Fax:_____
Address:_____

Dr./Prescriber's Signature: _____Date:_____

****

Parent/Guardian Consent: I give consent for school personnel to administer the above medication to my child per the instructions of the above Health Care Provider (HCP). I give my consent for exchange of information and communication directly between the HCP listed above or dispensing pharmacist and an Administrative Assistant, regarding the HCP's written statement or any other questions about the medication or medication administration. I understand that I may refuse consent for this permission at any time by notifying the school principal in writing. I understand and agree to the following responsibilities regarding medication administration: ● Prescription medication must be in a container labeled by the pharmacist or healthcare provider. ● Non-prescription medication must be in the original container with the label intact ● An adult must bring the medication to the school and pick up any outdated or unused medication. ● Pill splitting must be done by parent/guardian prior to providing medication to school officials. ● Parents/Guardians provide all materials or necessary equipment (e.g. measuring spoon, pill crusher) for medication administration. ● Parents will notify the school nurse or administrator and provide new consent to any changes to the above authorization. ● Any modifications or changes to the above authorizations may only be made after written notification is received from t**he HCP.**

Emergency Contact Info. (Name/Phone #):_____

Parent/Guardian Signature_____**Date**_____