

____ New
____ Returning

Teacher _____
Grade _____
Date Enrolled _____



Re/Enrollment Checklist 1st-6th

Student Name: _____

DOB: _____

Necessary at time of Enrollment

- _____ Enrollment Form
- _____ Emergency Form
- _____ Home Language Survey
- _____ Income Eligibility Survey
- _____ Photographing Permission Slip
- _____ Family Participation Contract
- _____ Student Housing Questionnaire
- _____ Medical Authorization Form

Parent/ Guardian must provide the following: (If new to the school)

- _____ Immunization record
- _____ Birth Certificate

_____ Staff Initial



Oasis Charter Public School
Re/Enrollment Form SY 2025-2026

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 2025-2026 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:

- Which class or service did your child attend? (Circle all that apply). SPEECH, LH/SDC, ED/SDC, CH/SDC, ADAPTIVE P.E., OTHER.
Has your child ever attended a special education class? y n If so, when: month year
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.

Table with 5 columns: Office Use ONLY, Proof of Birth, Proof of Immunization, Assigned Grade, Enroll Date, Notes.



Oasis Charter Public School
EMERGENCY FORM SY 2025-26

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 2025-2026

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 25-26. 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

Firma de adulto/miembro del hogar quien llena esta forma

Date/Fecha

For OFFICE Use Only:

Teacher: _____

Free: _____ Reduced: _____ N/A: _____

Grade: _____

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



Oasis Charter Public School

PERMISSION SLIP FOR PHOTOGRAPHING YOUR CHILD

SY 2025-2026

During the current school year, your child's image/photograph or work may be included in a classroom or school projects that could be used in one of the following ways:

- Used as a demonstration project/activity in education workshops/classes/conferences
- Used as a sample project/activity for use in education workshops and student classrooms
- Posted on the district, the school, or teacher webpages on the Internet
- Appear on media made during a student presentation, in video broadcasts, or in a project demonstrating computer multimedia in general

While your child's first name may accompany the photo, video, or work, no last name or address will be included with your child's picture/video when publishing on the Web. There is no monetary compensation for the use of the work, but it will help many teachers get more use out of their devices, show other students a good example of what can be, and prepare students for career and college readiness. Your permission grants us approval to publicize without prior notification and remains in effect unless and until you revoke this permission in writing.

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: _____

<p>Office use ONLY:</p> <p>Teacher: _____</p> <p>Grade: _____</p>
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Family Participation AGREEMENT for 2025-2026

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)



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 DESCRIBES YOUR CURRENT LIVING ARRANGEMENT

- | | |
|--|--|
| <input type="checkbox"/> Rent or own a home, mobile home, apartment, or condominium. | <input type="checkbox"/> Staying in a shelter (family shelter, domestic violence shelter, youth shelter) or transitional housing |
| <input type="checkbox"/> Sharing housing with other(s) due to loss of housing, economic hardship, natural disaster, lack of adequate housing | <input type="checkbox"/> Moving from place to place/couch surfing |
| <input type="checkbox"/> Temporarily living in a motel or hotel due to loss of housing, economic hardship, natural disaster, or similar reason | <input type="checkbox"/> Living in car, RV, park, campsite, encampment, or on the street |
| | <input type="checkbox"/> 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



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 **the HCP**.

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

Parent/Guardian Signature _____ **Date** _____