

MAYFAIR MIDDLE/HIGH SCHOOL
REGISTRATION CHECK-OFF SHEET
2015-2016 SCHOOL YEAR

Dear Parent/Guardian:

Welcome to a new school year!

We are excited you are enrolling your student at Mayfair Middle/High School. Below you will find a check-off sheet, itemizing the new student registration forms you can print and complete in advance of registration (except for the student emergency card), as well as the specific student records and residency verification documents required to complete the enrollment process. All paperwork must be submitted to the registrar.

- 1. Complete **both** sides of **both** copies of the blue and white emergency cards.
- 2. Complete the New Student Enrollment Record form.
- 3. Complete the Special Education Information form.
- 4. Complete the Notice of Enrollment and Request for Records form.
- 5. Complete the Home Language Survey.
- 6. Complete the Ethnic Option Form (both Race & Ethnicity).
- 7. Complete the STAR Parent Information Form.
- 8. Complete the Secondary Health Inventory.

THE FOLLOWING MUST BE INCLUDED WITH YOUR CHILD'S REGISTRATION MATERIALS:

- 9. Submit an unofficial **copy of transcript** and check out papers from previous school. This is needed to insure proper placement of your child. All 7th grade students must submit their 6th grade report card.
All 11th and 12th grade students should provide CAHSEE test results.(usually found on transcript)
- 10. Parent/Guardian's driver's license - A current valid California Driver's License, or ID, with current address. **DMV changes must be official printouts, BROWN CARDS ARE NOT ACCEPTED.**
- 11. Proof of Residency - **TWO** of the following types of proof of residence are required to enroll:
 - Current Utility Bills: Water, Gas, Electric-**NO DISCONNECT NOTICES without payment receipts. NO TELEPHONE, CELL PHONE, CABLE BILLS ACCEPTED.**
 - Escrow papers.
 - Mortgage Statement with current address in lieu of one utility bill.
 - Lease Agreement will be accepted **ONLY IF** utilities are included in the rent.
 - Current Property Tax Bill in lieu of one utility bill.
- 12. Student's Immunization Record.
T-Dap shot is a must, your student will NOT be enrolled without it.
- 13. Student's Original Birth Certificate.

Please return your registration packet to the Registrar's Office. The registrar will then schedule you for an appointment with your student's counselor. 7th & 8th grade students will be scheduled for an orientation.

Mayfair Middle/High School New Student Enrollment Record

Please Print

Student Information

Last Name: _____ First: _____ Middle: _____

Grade: _____ Age: _____ Male/Female: _____ Social Security Number: _____

Address: _____ City: _____ Zip Code: _____

Phone Number: () _____ Date of Birth: _____ Place of Birth: _____

School Last Attended: _____ City: _____ State: _____

Parent/Guardian Information

Mother: _____

Work Phone: () _____ Email address: _____

Occupation: _____ Cell Phone: () _____

Father: _____

Work Phone: () _____ Email address: _____

Occupation: _____ Cell Phone: () _____

Student living with: Both Parents: _____ Mother: _____ Father: _____ Guardian: _____

Other, please explain: _____

Additional Student Information

Has the student ever attended a school in Bellflower Unified School District? Yes: _____ No: _____

If yes, Name of School: _____ Grade: _____

Name of School: _____ Grade: _____

Do you have any siblings who attend Bellflower Unified School District? Yes: _____ No: _____

If yes, list name(s) of all siblings and the name of the schools they are attending:

Has the student ever been enrolled in a Gifted and Talented Education (GATE) Program? Yes: _____ No: _____

Has the student ever been enrolled in a bilingual education program? Yes: _____ No: _____

Has the student ever been expelled from another school district? Yes: _____ No: _____

If yes, please explain: _____

Is the student currently or has ever been on probation? Yes: _____ No: _____

If yes, please explain: _____

Parent/Guardian Signature

Date

BELLFLOWER UNIFIED SCHOOL DISTRICT
Mayfair Middle/High School

Student's Name: _____ **Grade:** _____

Is your child enrolled in **Special Education**? YES: _____ NO: _____

_____ If YES, please select which program, check below:

- _____ Adaptive Physical Education
- _____ Visually Impaired Program
- _____ Speech/Language Program
- _____ Resource Specialist Program (RSP)
- _____ Special Day Class (SDC)
- _____ My child currently has a 504 Plan

Do you have a **copy of your child's IEP**? YES: _____ NO: _____

Most **recent school district** where student was enrolled in Special Education:

Parent Signature

Date

BELLFLOWER UNIFIED SCHOOL DISTRICT
MAYFAIR MIDDLE SCHOOL
MAYFAIR HIGH SCHOOL
6000 N. Woodruff Ave · Lakewood, Ca 90713
Phone (562) 925-9981 · Fax (562) 461-2239

PLEASE FAX ASAP:
___ Official Transcript
___ Withdrawal Grades
___ Immunization

NOTICE OF ENROLLMENT & REQUEST FOR STUDENT RECORDS

Please **mail** the following student records:

- | | |
|--|--|
| <input checked="" type="checkbox"/> Cumulative Record
<input checked="" type="checkbox"/> Official Transcript/Report Cards
<input checked="" type="checkbox"/> Health Record
<input checked="" type="checkbox"/> Immunization Record
<input checked="" type="checkbox"/> Guidance Record
<input checked="" type="checkbox"/> Psychological Record
<input checked="" type="checkbox"/> Explanation of your grading system | <input checked="" type="checkbox"/> Test Results-California High School Exit Exam
(10 th , 11 th , 12 th Gr. Students)
<input checked="" type="checkbox"/> Test Results-California Physical Fitness Test
<input checked="" type="checkbox"/> Test Results-State Proficiency Exams
<input checked="" type="checkbox"/> Individual Education Plan (IEP)
<input checked="" type="checkbox"/> Enrollment History
<input checked="" type="checkbox"/> Student CSIS/State ID number _____ |
|--|--|

In compliance with the state and federal laws, please send ALL school records, including but not limited to, **Cumulative, Health, Guidance** and **Psychological** records of the above-named student. The parents or guardian have been informed of this request and notified of their rights under current law. If the above-named pupil left your school with a debt remaining for lost or damaged books or items and you have withheld grades, diplomas, transcripts from the parent/student, we will reciprocally withhold these records on your request, pursuant to EC 48904 et set., until this debt is settled.

Please send the above mentioned records to:

Bellflower Unified School District
Mayfair Middle/High School.
6000 N. Woodruff Avenue
Lakewood, California 90713

I _____ request the above mentioned records be sent to the Bellflower Unified
Parent/Guardian Name School District, Mayfair Middle/High School, for my son/daughter:

_____ <i>Student's Last Name</i>	_____ <i>First Name</i>	_____ <i>M.I.</i>	_____ <i>Date of Birth</i>	_____ <i>Current Grade</i>
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_____ <i>Date</i>	_____ <i>Parent/Guardian Signature</i>
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Prior School Attended: Public Private Charter

_____ <i>School District Name</i>	_____ <i>School Address</i>	_____ <i>School Phone Number</i>
_____ <i>School Name</i>	_____ <i>City State Zip</i>	_____ <i>School fax number</i>

If at prior school for less than one full semester/year, please list any other schools attended for grades 7 – 12.
 Public Private Charter

_____ <i>School District Name</i>	_____ <i>School Address</i>	_____ <i>School Phone Number</i>
_____ <i>School Name</i>	_____ <i>City State Zip</i>	_____ <i>School fax number</i>

**BELLFLOWER UNIFIED SCHOOL DISTRICT
ENGLISH**

Date _____ School _____
Counselor _____

HOME LANGUAGE SURVEY

The California Education Code requires schools to 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 and return this form to the school. Thank you for your help.

Name of Student: _____
Last First Middle Grade Age

1. Which language did your son/daughter learn when he/she first began to talk? _____
2. What language does your son/daughter most frequently use at home? _____
3. What language do you use most frequently to speak to your son/daughter? _____
4. Name the language most often spoken **by the adults** at home: _____

*State of California
Department of Education
OPER - LS 77 - 6/78*

Signature of Parent or Guardian

Birthplace of your child: _____
City State County
When did your child first enroll in the United States? _____ In California? _____
(This information is needed for statistical purposes only)

ESPAÑOL

Fecha _____ Escuela _____
Consejero/a _____

ENCUESTA SOBRE EL IDIOMA QUE SE HABLA EN CASA

El Código de Educación de California requiere que las escuelas especifiquen el/los idioma/s que se habla/n en el hogar de cada estudiante. Esta información es esencial para que las escuelas puedan proveer la mejor instrucción posible a todos los estudiantes.

Solicitamos su colaboración para ayudarnos a cumplir con este importante requerimiento. Por favor responda las siguientes preguntas y entregue este formulario en la escuela. Gracias por su ayuda.

Nombre del Alumno: _____
Apellido Primer Nombre Segundo Grado Edad

1. ¿Cuál es el idioma en el que su hijo/a aprendió a hablar? _____
2. ¿Cuál es el idioma que su hijo/a habla más frecuentemente en casa? _____
3. ¿En qué idioma les habla usted a sus hijos con más frecuencia? _____
4. ¿Cuál es el idioma que **los adultos** hablan con mayor frecuencia en casa? _____

*Estado de California
Departamento de Educación
OPER - LS 77 - 6/78*

Firma del Padre o Tutor Legal

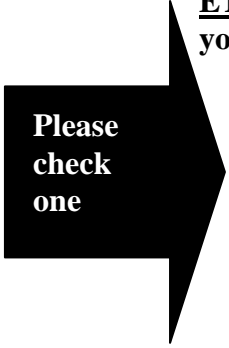
Lugar de nacimiento de su hijo/a: _____
Ciudad Estado Condado
¿En qué fecha matriculó a su hijo/a por primera vez en una escuela de los Estados Unidos? _____
¿En California? _____
(Esta información se necesita solamente para propósitos de estadísticas)

**BELLFLOWER UNIFIED SCHOOL DISTRICT
ETHNIC OPTION FORM**

Each year we are required to report to the State and Federal government the number of students and staff in terms of their race and ethnic backgrounds.

Student Name: _____	Grade Level _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
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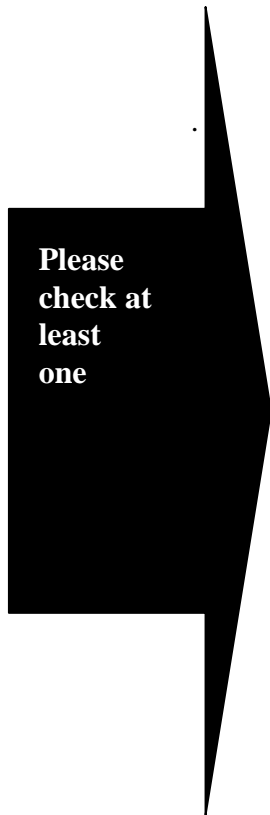
ETHNICITY – from the following list, please check one ethnic background your family feels is the most dominant.



- HISPANIC OR LATINO

- NOT HISPANIC OR LATINO

RACE – select one or more races from the following five groups



- AMERICAN INDIAN OR ALASKA NATIVE - A person having origins in any of the original people of North and South America (including Central America).

- ASIAN/ASIAN AMERICAN - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. **Please specify:**
 - Chinese Japanese Korean
 - Laotian Vietnamese Asian Indian
 - Cambodian Filipino Other Asian

- BLACK OR AFRICAN AMERICAN - A person having origins in any of the black racial groups of Africa

- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands (excludes the Philippine Islands) **Please specify:**
 - Hawaiian Guamanian Samoan
 - Tahitian Other Pacific Islander

- WHITE - A person having origins in any of the original peoples of Europe, North Africa, or the Middle East, e.g., England, Portugal, Egypt, and Iran

Bellflower High/Middle School, BUSD

California Assessment of Student Performance and Progress (CAASPP)
PARENT INFORMATION FORM
(Please Print)

Student Name _____

Please check the response that best describes the highest education level of *either* parent.

_____ Not a high school graduate

_____ High School Graduate

_____ Professional Training or Trade School (Training after high school, i.e. cosmetology school, real estate school, and other classroom work where vocational training, rather than a degree, is a student's main goal)

_____ Some College (any amount of *after* high school course work, working toward an Associate of Arts [A.A.] or Bachelor's [B.A. or B.S.] degree ... includes completion of a junior college program...usually a two year program)

_____ College Graduate (completion of B.A. or B.S. degree from a four year university or college...some trimester programs complete this degree in three years)

_____ Graduate/Post Graduate Training (completion or working toward a Master's or Doctoral degree)

_____ Decline to State or Unknown

THIS INFORMATION TO BE USED FOR CAASPP TESTING ONLY

For the information of parents...

The State of California requires that schools gather this information. Financial penalties are assessed against schools and districts that do not complete this information item for each student taking the test. Please respond accurately to this survey. We have provided some extra description this year to assist you. You may, of course, check the line in which you *decline to state*.

Please check if **NO** new Medical information _____

____ Adult Transition Center
____ Bellflower High School
____ Mayfair High School
____ Somerset High School

To be completed by parent

BELLFLOWER UNIFIED SCHOOL DISTRICT
SECONDARY HEALTH INVENTORY

Name _____ Birthdate _____ M ___ F ___ Parent/Guardian Name _____

Last First Initial (Please Print)

ADDRESS _____ Phone _____ Last School Attended _____ Location _____

Grade _____ Harbor Regional Client? Yes No Case Manager's Name: _____

Usual Source of Medical Care _____ Medi-Cal recipient? Yes No CCS? Yes No Therapist's name _____

OTHER HEALTH INFORMATION: <i>Please answer each question:</i>	STUDENT MEDICAL HISTORY, COMPLAINTS, ILLNESS: <i>Check:</i>			
Allergies: Does your child have an allergic reaction to:	No	Yes	No	Yes
Foods _____ Latex _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications _____ Bee Stings _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explain: Local swelling: _____ Severe Systemic reaction _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does he/she have/require an Epi-pen? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List All Current Medications/Dosage: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication to be Taken at School (medical authorization required): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition (Type & Explain): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure (List seizure type): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last seizure: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization/Serious injury/Surgeries (Date & Explain): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma -Triggered by: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severity: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility (List any devices needed such as wheelchair, walker, etc) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Special Health Services (List any needed and have doctor fill out form): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any physical restrictions? (To be excused from regular PE, a doctor's statement indicating the specific limitation, must be submitted): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision: Wears glasses? Yes No Last Exam _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing: Loss? Yes No Wears aides? Yes No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- No Yes Diabetes
- Seizure*
- Heart Condition*
- Asthma*
- Allergies*
- Sickle Cell disease
- Cancer
- Migraines
- Speech/Language Problem
- Downs Syndrome
- Spina Bifida
- Cerebral Palsy
- Muscular Dystrophy
- Other Neuromuscular Condition
- ADD/ADHD
- Autism
- Oppositional Defiant Disorder
- Bipolar Disorder
- Tourette Syndrome
- Other Behavioral/Psych disorder

- No Yes Lupus
- Other Autoimmune disease
- Cystic Fibrosis
- Other Genetic Disease
- Von Willebrand Disease
- Other Bleeding Disorder
- Addison Disease
- Syncope/Fainting
- Arthritis
- High Blood Pressure
- Urinary Problem
- Chronic Intestinal Problem
- Chronic Kidney Disease
- Tuberculosis
- Skin Problem
- Orthopedic Problem
- Eye Problem
- Frequent Ear Infections
- Severe Menstrual Cramp
- Other _____

*see other column
If any boxes are checked, please explain: _____

Special Diet: Yes No (If needed have doctor fill out diet form)

I understand and agree that the above information may be shared with appropriate school staff.

Date _____ Parent/Guardian's Signature _____