

# Torrance Unified School District Enrollment Requirements

Dear Parent(s)/Guardian(s):

The following documents are required at time of enrollment. Please be advised that if you do not have all the required documents, your student will not be enrolled.

## 1) Proof of Age

- Birth Certificate or Passport (Original required)

## 2) State Immunization Records (original required)

- Records must be up-to-date with child's name and date of birth.
- Each immunization must have a date and signature and/or stamp of the health care provider.

## 3) Proof of Residency – 2 proofs required (dated within the past 60 days)

A home check may be conducted to verify student residency.

- |  |   |
|--|---|
| <ul style="list-style-type: none"><li>• Electric</li><li>• Gas</li><li>• Water</li><li>• Trash</li><li>• Cable/Satellite</li></ul> | <ul style="list-style-type: none"><li>• Internet</li><li>• Lease/Rental Agreement</li><li>• Mortgage Statement</li><li>• Property Tax Bill</li><li>• Home Telephone (landline only)</li></ul> |
|--|---|

**Disconnect Notices and Cell Phone Bills are not accepted.**

WE DO NOT FAX OR PHONE PREVIOUS SCHOOLS, LANDLORDS, OR UTILITY COMPANIES REQUESTING DOCUMENTS. Parents/guardians are responsible for providing ALL required documentation.

## 4) Parent/Guardian Photo ID (original required)

## 5) Enrollment Form – completed and signed

## 6) Health History Form – completed and signed

## 7) Student Residency Questionnaire/Affidavit – completed and signed

## 8) Enrollment Eligibility – completed and signed

## 9) School Records

- Most recent Report Card or Transcript if the student attended school prior to enrollment at TUSD

~ ~ ~ ~ ~ If Applicable ~ ~ ~ ~ ~

## 10) IEP – please bring this with you to Enrollment

## 11) 504 – please bring this with you to Enrollment

**Any students entering from another country must have all documents translated into English.**

### HOURS OF SERVICE

**Enrollment Processing: Monday – Friday 8:00am – 3:00pm**

- Enrollment processing may close earlier if lines are long.

Questions and Forms: Monday – Friday 8:00am – 4:00pm Saturday/Sunday: CLOSED

2336 Plaza Del Amo ~ Torrance, CA 90509 ~ (310) 972-6280 ~ [www.tusd.org](http://www.tusd.org)

Torrance Unified School District  
**ENROLLMENT FORM**

\_\_\_\_ / \_\_\_\_

OFFICE USE ONLY

**STUDENT ID:**

SCHOOL: \_\_\_\_\_

ENROLLMENT DATE: \_\_\_\_\_

**Welcome to the Torrance Unified School District. It is our desire to help your student in every possible way. We appreciate you giving us the following information completely and honestly, which will enable us to better assist your student.**

PLEASE PRINT:

STUDENT'S **LEGAL** NAME:

\_\_\_\_ Last \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ (OTHER NAME USED) \_\_\_\_\_ SEX (M/F) \_\_\_\_\_ GRADE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_ CITY \_\_\_\_\_ STATE OR COUNTRY \_\_\_\_\_  
MONTH DAY YEAR

RESIDENCE ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_ CITY \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
NO P.O. BOX ADDRESS

PREVIOUS ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE \_\_\_\_\_

<b>PARENT/GUARDIAN - #1</b>		<input type="checkbox"/> FATHER	<input type="checkbox"/> MOTHER	<input type="checkbox"/> STEP-FATHER	<input type="checkbox"/> STEP-MOTHER	<input type="checkbox"/> LEGAL GUARDIAN	<input type="checkbox"/> FOSTER PARENT	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> MR	<input type="checkbox"/> MRS / MS	FIRST NAME _____		LAST NAME _____		<input type="checkbox"/> LIVES WITH STUDENT		
RESIDENCE ADDRESS _____		(If different from Student)				<b>EMAIL ADDRESS</b> _____		
PHONE# _____		HOME (If different from student)		WORK _____		CELL _____		
<b>PARENT/GUARDIAN - #2</b>		<input type="checkbox"/> FATHER	<input type="checkbox"/> MOTHER	<input type="checkbox"/> STEP-FATHER	<input type="checkbox"/> STEP-MOTHER	<input type="checkbox"/> LEGAL GUARDIAN	<input type="checkbox"/> FOSTER PARENT	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> MR	<input type="checkbox"/> MRS / MS	FIRST NAME _____		LAST NAME _____		<input type="checkbox"/> LIVES WITH STUDENT		
RESIDENCE ADDRESS _____		(If different from Student)				<b>EMAIL ADDRESS</b> _____		
PHONE# _____		HOME (If different from student)		WORK _____		CELL _____		

**WHAT IS YOUR CHILD'S ETHNICITY?** (Please check ONE box)

- |  |   |
|--|---|
| <input type="checkbox"/> Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican South or Central American, or other Spanish culture or origin, regardless of race) | <input type="checkbox"/> Not Hispanic or Latino |
|--|---|

**WHAT IS YOUR CHILD'S RACE?** (Please check up to five racial categories)

*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.*

- |  |   |
|--|---|
| <input type="checkbox"/> African American or Black (having origins in the black racial groups of Africa)   | <input type="checkbox"/> Japanese   |
| <input type="checkbox"/> American Indian or Alaskan Native (having origins in any of the original people of North, Central, or South America <i>and</i> maintaining tribal affiliations) | <input type="checkbox"/> Korean   |
| <input type="checkbox"/> Asian Indian  | <input type="checkbox"/> Laotian (including people of Hmong origin)   |
| <input type="checkbox"/> Cambodian   | <input type="checkbox"/> Samoan   |
| <input type="checkbox"/> Chinese (including people of Chinese or Taiwanese origins)  | <input type="checkbox"/> Tahitian   |
| <input type="checkbox"/> Filipino  | <input type="checkbox"/> Vietnamese   |
| <input type="checkbox"/> Guamanian   | <input type="checkbox"/> White, not of Hispanic Origin (European, Middle Eastern, North African origins)  |
| <input type="checkbox"/> Hawaiian Native   | <input type="checkbox"/> Other Asian (having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent if not listed above) |
| <input type="checkbox"/> Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race)                 | <input type="checkbox"/> Other Pacific Islander   |

**PARENT EDUCATION LEVEL** (Per Education Code sections 52052, 60630)

*Please check the level that indicates the educational attainment of the student's most educated parent or guardian with whom the student resides (check one):*

- ☐ Not a high school graduate
- ☐ High school graduate (high school diploma by graduation or testing, or have completed or have received a comparable high school degree in another country)
- ☐ Some college (completion of any courses within a two or four year academic program, including AA degree)
- ☐ College graduate (B.A./B.S. or equivalent degree from foreign university)
- ☐ Post-graduate training/Graduate School (attended graduate school with or without attaining a graduate degree)
- ☐ Declined to state or unknown

DATE

PARENT OR GUARDIAN SIGNATURE

STUDENT'S LEGAL NAME:

Last

FIRST

MIDDLE

SEX (M/F)

GRADE

Please complete the following survey:

**HOME LANGUAGE SURVEY**

The California Education Code requires schools to determine the language(s) spoken at home by each student and assess with the California English Language Development Test (CELDT) if a language other than English is identified. (CA Ed Code 313.60810 and 60812)

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: \_\_\_\_\_

**EMERGENCY IMMIGRANT EDUCATION PROGRAM (EIEP) ELIGIBILITY**

If born outside the U.S., give date first entered ANY U.S. school, K-12: MONTH \_\_\_\_\_ YEAR \_\_\_\_\_, this includes all 50 states, the Commonwealth of Puerto Rico, the District of Columbia, Guam, American Samoa, the Northern Mariana Islands, or the Trust Territory of the Pacific Islands. As part of the criteria for emergency immigrant, the child must not have been attending schools in any one or more states for more than three full academic years. Therefore, if a child was born in China, moved to Guam and was educated there for three years and then entered a Torrance school, he would not qualify for emergency immigrant funds.

PARENT CURRENTLY IN THE MILITARY? ☐ YES ☐ NO

**PLEASE GIVE THE FOLLOWING INFORMATION ABOUT "ALL" ADULTS LIVING IN THE HOME:**

NAME	RELATIONSHIP TO STUDENT	WORK PHONE	WORK EMAIL	NAME OF EMPLOYER	OCCUPATION

Has student ever been enrolled in Torrance schools before? ☐ YES ☐ NO If yes, which Torrance school? \_\_\_\_\_

Date first attended \_\_\_\_\_ Date last attended \_\_\_\_\_

**LIST ALL PREVIOUS K-12 SCHOOLS ATTENDED (MOST RECENT FIRST - USE ANOTHER PAPER IF NEEDED):**

GRADES	SCHOOL	CITY	STATE	PUBLIC SCHOOL?	FROM (Month / Year)	TO (Month / Year)
				YES NO	____ / ____	____ / ____
				YES NO	____ / ____	____ / ____
				YES NO	____ / ____	____ / ____
				YES NO	____ / ____	____ / ____

**OFFICE USE ONLY**

Kinder	TK	_____	Public school:	YES	NO	State:	_____	START Date:	____ / ____
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Has student been enrolled in any of the following special programs?

- Individual Education Plan ☐ YES ☐ NO
- 504 ☐ YES ☐ NO
- Gifted and Talented Education ☐ YES ☐ NO

NAMES OF ALL CHILDREN LIVING IN THE HOME	SEX	RELATIONSHIP	DATE OF BIRTH	SCHOOL ATTENDING

I hereby certify under penalty of perjury that the foregoing is true and correct and I understand the above information may be verified at any time by the Torrance Unified School District.

DATE

PARENT OR GUARDIAN SIGNATURE

**STUDENT RESIDENCY QUESTIONNAIRE/AFFIDAVIT**

This document is intended to address the McKinney-Vento Assistance Act. Your answers will help determine documents necessary to enroll your child quickly.

Student: \_\_\_\_\_ (Male \_\_\_\_ Female \_\_\_\_)

Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_

1. Do you and your student live in a fixed, regular, adequate nighttime residence? **Yes** \_\_\_\_ **No** \_\_\_\_  
(If you circled "Yes", stop here. You must provide a gas or electric bill in your name as proof of residence. If you circled "NO", please continue with this form.)

2. Do you and the student live in:

- ☐ shelter
- ☐ motel/hotel
- ☐ temporarily with another family in a house, mobile home, or apartment
- ☐ in a car or RV
- ☐ at a campsite
- ☐ transitional housing
- ☐ other location \_\_\_\_\_

3. The student lives with:

- ☐ one parent
- ☐ two parents
- ☐ a qualified relative
- ☐ friend(s)
- ☐ an adult that is not the legal guardian
- ☐ alone with no adult(s)

4. I am:

- ☐ the parent/legal guardian of the above-named student
- ☐ a qualified adult relative of the above-named student  
(Relationship: \_\_\_\_\_)

***I declare under penalty of perjury under the laws of this state that the information provided here is true and correct and of my own personal knowledge.***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Your Name: \_\_\_\_\_

Residence: \_\_\_\_\_  
Street City Zip

Mailing Address: \_\_\_\_\_  
Street City Zip

Telephone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

PLEASE PRINT

TORRANCE UNIFIED SCHOOL DISTRICT

HEALTH HISTORY INFORMATION

School Year 2016 - 17

☐ New Enrollee

☐ Returning Student

Student \_\_\_\_\_ Male Female \_\_\_\_\_  
LEGAL LAST NAME LEGAL FIRST NAME DATE OF BIRTH GRADE

Current Address \_\_\_\_\_

Place of Birth (City / State) \_\_\_\_\_ Country \_\_\_\_\_

Last school attended \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Please check the appropriate box and provide an explanation if your child currently has or has had in the past any of the following conditions:

<input type="checkbox"/> Allergy needing an epinephrine auto-injector (Epi-Pen / Auvi-Q / Other Brand)	Trigger(s) _____ Symptoms _____
<input type="checkbox"/> Allergy	Trigger(s) _____
<input type="checkbox"/> Asthma	Trigger(s) _____
<input type="checkbox"/> ADD or <input type="checkbox"/> ADHD	
<input type="checkbox"/> Autism or <input type="checkbox"/> Developmental Delay	Specify _____
<input type="checkbox"/> Cancer / Leukemia	Specify _____
<input type="checkbox"/> Cerebral Palsy	
<input type="checkbox"/> Confidential Health Problem	Specify _____
<input type="checkbox"/> Cystic Fibrosis	
<input type="checkbox"/> Deaf / Hearing Loss or Impairment	Specify _____
<input type="checkbox"/> Diabetes, Type 1 - Insulin Dependent	Diagnosed at age _____ Uses <input type="checkbox"/> Pump <input type="checkbox"/> Syringe <input type="checkbox"/> Insulin Pen
<input type="checkbox"/> Diabetes, Type 2	Diagnosed at age _____ <input type="checkbox"/> Diet Controlled <input type="checkbox"/> Requires Medication
<input type="checkbox"/> Eating Disorder (physician diagnosed)	Specify _____
<input type="checkbox"/> Epilepsy / Seizure	Describe seizure & Aura _____
<input type="checkbox"/> Seizure trigger(s) _____	Date of last seizure _____
<input type="checkbox"/> Gastrointestinal Problems	Specify _____
<input type="checkbox"/> Heart Problem followed by specialist	Specify _____
<input type="checkbox"/> Hemophilia / Bleeding Disorder	Specify _____
<input type="checkbox"/> Kidney or Urinary Disease / Disorder	Specify _____
<input type="checkbox"/> Mental Health Problems	Specify _____
<input type="checkbox"/> Neurological Problems	Specify _____
<input type="checkbox"/> Severe Nose Bleeds	
<input type="checkbox"/> Orthopedic Problems	Specify _____
<input type="checkbox"/> Physical Activity Limitations	Specify _____
<input type="checkbox"/> Respiratory Condition	Specify _____
<input type="checkbox"/> Scoliosis	Please provide written statement from child's doctor
<input type="checkbox"/> Sickle Cell Anemia	
<input type="checkbox"/> Vision (Wears glasses / contacts)	Specify condition _____
<input type="checkbox"/> Visually Impaired / Blind	Specify _____
<input type="checkbox"/> Other (also list any injuries, accidents or operations that impact your student's functioning at school):	_____

Continued on the back

Please list all medication taken at home:

Medication	Dosage	Frequency	Reason for taking medication

Medication to be taken at school:

NOTE: A TUSD Medication form is required for each medication. Family must provide the medication(s).

Medication	Dosage	Frequency	Reason for taking medication

All medication, including over-the-counter medications taken at school requires a physician's order and must be accompanied by a TUSD medication form. Forms are available in the school's health office.

#### Policies Regarding Medication at School

According to the California State Education Code 49432, definite procedures must be followed with regard to taking medications at school. During the regular school day, any pupil who is required to take medication prescribed by a physician must provide:

- 1 A written statement from the physician stating the method, amount and time in which medication is to be taken and relevant side effects.
- 2 A written statement from the parent or guardian of the pupil granting their permission that the physician's orders are carried out, and
- 3 The medication in the original pharmacy container; labeled by a California pharmacist giving the student name, doctor name, drug, dosage, route of administration and schedule.

All medication is to be kept in the health office, unless otherwise arranged with the District Nurse. A parent or guardian can bring a prescribed medication to the school office and give it to their student directly. A District Nurse or Health Assistant is not present at the school site at all times or on all days when the school is in session. Therefore, because non-medically trained District personnel may be providing emergency assistance, parents must assure that physicians provide complete, precise, legible directions and instructions. The District is not responsible for notifying parents before or after prescribed medication is depleted or the expiration occurs. Expired medications will not be administered. The completed medication form(s) expire at the end of the school year and will need to be renewed annually.

#### Disaster / Emergency Information

In the event of a natural or community disaster/emergency, students and staff may be required to remain on campus for several hours or several days. If your student requires medication/treatment, which, if he/she were unable to receive, may result in a life-threatening condition, it would be prudent to have the medication/equipment, medication forms and training in place. If you and your physician determine that it is necessary to have a three-day supply of medication/equipment stored at school, please contact the school Health Office.

Does your child have health insurance? ☐ Medi-Cal / Covered CA ☐ Private Company ☐ Not currently insured

**If there is a new diagnosis/health condition or medication changes, it is important that you contact the Health Assistant or District Nurse to update the health information in your student's health record.**

I have read and completed the Health History Information form. I understand that health information is confidential and is shared with staff on a need only basis. I will notify the health office at my school site of any changes in my child's health condition or change of medication. I give permission to have my child screened (vision, color vision, hearing, blood pressure, scoliosis, acanthosis nigricans, dental and height and/or weight) as necessary throughout the school year.

\_\_\_\_\_  
Signature of Parent / Legal Guardian

(      )  
\_\_\_\_\_  
Home Telephone Number

(      )  
\_\_\_\_\_  
Work Telephone Number

\_\_\_\_\_  
Date

**OFFICE: SEND THIS ORIGINAL DIRECTLY TO HEALTH CLERK.**



# Torrance Unified School District

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P. O. BOX 2954  
TORRANCE, CALIFORNIA 90509-2954

TELEPHONE (310) 972-6500  
[www.tusd.org](http://www.tusd.org)

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## ENROLLMENT ELIGIBILITY INFORMATION

The State of California requires us to ask newly enrolling students to the Torrance Unified School District the following information regarding enrollment eligibility.

I certify that \_\_\_\_\_, who is enrolling in grade \_\_\_\_\_

✓ Check one:

- ☐ was not expelled from his/her previous district.  
☐ has a pending expulsion hearing with his/her previous district.

Date of Hearing: \_\_\_\_\_

- ☐ was expelled from his/her previous district.

Date of Expulsion: \_\_\_\_\_

Readmission Date: \_\_\_\_\_

(Expulsion means removal from all schools of the district by Board of Education action.)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Current Street Address Apt. #

\_\_\_\_\_  
City/State Zip Code