Rialto Unified School District
Enrollment Checklist
(TK - Kindergarten)

- ❑ Immunization Record
- ❑ *TB Test – must include results
- ❑ Proof of Date of Birth (birth certificate, certified birth record, baptismal certificate, passport, or affidavit)
- ❑ Current address verification in parent/guardian name (Utility bill, official mail, rental/lease agreement or payment receipts, property tax receipt, pay stubs, voter registration, or affidavit **no more than 30 days old**)
- ❑ Identification of the enrolling parent/guardian
- ❑ Dental Exam
- ❑ Physical Exam (recommended to meet 1st grade requirement, **required** for **ELO)
- ❑ **Current/Signed** IEP if the student is receiving special education services

Applies to all students (TK – 12th Grade) who seek admission to a California school for the first time or have been away from the U.S. for more than 12 months

****ELO – Extended Learning Opportunity. Extended day for TK students***

Enrollment Center

260 South Willow Avenue, Rialto, CA 92376

Phone: 909-873-4300 Fax: 909-873-4301

email: enrollmentcenter@rialtousd.org

RIALTO UNIFIED SCHOOL DISTRICT ENROLLMENT FORM

STUDENT INFORMATION (please use blue or black ink)

Legal Last Name	Legal First Name	Legal Middle Name

Grade	Retained? If yes, what grade?	Also Known As (other names used)

Address	Apt./Space	☐ Rialto ☐ San Bernardino ☐ Colton ☐ Fontana ☐ Other: _____	Zip Code

Mailing address, if different	Apt./Space	☐ Rialto ☐ San Bernardino ☐ Colton ☐ Fontana ☐ Other: _____	Zip Code

Primary Phone Number	Date of Birth	Sex ☐ Male ☐ Female	Preferred Language of Correspondence

ETHNICITY (Please select one)
Is your child Hispanic or Latino?
☐ Yes, Hispanic or Latino
☐ No, Not Hispanic or Latino

RACE (Please select all that apply)
☐ American Indian or Alaska Native (Origins in North, Central or South America)
☐ African American or Black ☐ Cambodian ☐ Chinese ☐ Filipino/Filipino American ☐ Guamanian
☐ Hawaiian ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Other Asian
☐ Other Pacific Islander ☐ Samoan ☐ Tahitian ☐ Vietnamese
☐ White (Origins in Europe, North Africa, or the Middle East)

FAMILY INFORMATION (If there is a custody/restraining order for your child, please provide copy)

Name of Person Enrolling Student	**Relationship to student** ☐ Mother ☐ Father ☐ Caregiver ☐ Foster Parent ☐ Legal Guardian	Home Phone / Work Phone

Name of Legal Mother	☐ Lives with ☐ Not in the home	Home Phone / Work Phone

Name of Legal Father	☐ Lives with ☐ Not in the home	Home Phone / Work Phone

CHILDREN LIVING IN THE HOME

Name	Date of Birth	School
Name	Date of Birth	School
Name	Date of Birth	School
Name	Date of Birth	School

PREVIOUS SCHOOL INFORMATION (List last school first)

Name of School	City	State	Grade	School Year
Name of School	City	State	Grade	School Year

Has the student attended a Rialto USD school? ☐ Yes ☐ No (ex: Preschool)
If yes, name school: Grade: School Year:

PARENT EDUCATION LEVEL

The California State Department of Education requests information regarding the highest level of education completed by the enrolling parent/guardian. Please check for both parents.

Mother/Guardian 1
☐ Not a high school graduate ☐ High school graduate ☐ Some College
☐ College graduate ☐ College degree from a 4 year university with additional coursework in graduate school

Father/Guardian 2
☐ Not a high school graduate ☐ High school graduate ☐ Some College
☐ College graduate ☐ College degree from a 4 year university with additional coursework in graduate school

PRIOR SPECIAL EDUCATION PROGRAMS

Please provide the following information for student placement in a special service or program:

☐ My child has **NOT** participated in a special program
☐ My child has had a special education evaluation

My child has participated in the following services:
☐ Specialized Academic Instruction (ex. RSP/SDC)
☐ Speech Therapy
☐ Occupational Therapy
☐ Adaptive Physical Education
☐ Physical Therapy
☐ Other: _____

OFFICE USE ONLY

Notes:

_____

Grade: _____

Date: _____

Student #:

_____

School of Residence:

_____

School Assigned:

_____

Start Date:

_____

Teacher/Counselor:

_____

Classroom/AM or PM:

_____

Birth Verification: _____

P.O.B: _____

Enter Code: _____

Reason:
☐ Overflow
☐ Inter/Intra
☐ Other: _____

Address Verification:
☐ Utility/Rent Receipt
☐ Affidavit of Residence
☐ Other: _____
☐ McKinney Vento
☐ Foster
4-digit zip: _____

Enrolled by:

_____

My signature certifies that all information provided is accurate. I understand that changes in address, telephone numbers, and/or emergency information must be reported to the school within <u>24 hours</u> for the safety of my student.

Parent/Guardian Signature: _____ Date: _____

Home Language Survey

Student Name: _____

Date of Birth: _____ Grade: _____

Directions to Parents and Guardians:

The California *Education Code* contains legal requirements which direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with these requirements. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered. If an error is made completing this home language survey, you may request correction before your student's English proficiency is assessed.

1. Which language did your child learn when they first began to talk? _____
2. Which language does your child most frequently speak at home? _____
3. Which language do you (the parents and guardians) most frequently use when speaking with your child? _____
4. Which language is most often spoken by adults in the home? (parents, guardians, grandparents, or any other adults) _____

Please sign and date this form in the spaces provided below, then return this form to your child's teacher. Thank you for your cooperation.

Signature of Parent or Guardian: _____ Date: _____

OFFICE USE ONLY

School: _____ Reviewed by: _____
Enrollment Staff

☐ Sent to Multilingual Programs on: _____

☐ Received by MLP/LAC on: _____

Rialto Unified School District
Child Welfare and Attendance
McKinney-Vento Questionnaire

STUDENT'S NAME	DATE OF BIRTH	PREVIOUS SCHOOL

PLEASE LIST ALL CHILDREN CURRENTLY LIVING WITH YOU

NAME	DATE OF BIRTH	SCHOOL

THE ANSWERS TO THE FOLLOWING QUESTIONS WILL HELP DETERMINE IF YOUR STUDENT MAY BE ELIGIBLE TO RECEIVE ADDITIONAL SUPPORT SERVICES UNDER THE MCKINNEY-VENTO ACT. PLEASE CHECK ALL THAT APPLY.

Student is living in **SHARED HOUSING** due to **economic hardship and/or a crisis driven situation** ☐ **YES** ☐ **NO**
(i.e. domestic violence, abuse, rotating homes, living in one room, garage, etc.)

Student is living in **INADEQUATE HOUSING** not originally designated for sleeping ☐ **YES** ☐ **NO**
(i.e. cars, parks, campers, trailer parks, abandoned buildings, etc.)

Student is **TEMPORARILY** living in **HOTELS/MOTELS** ☐ **YES** ☐ **NO**

Student is **TEMPORARILY** living in **EMERGENCY OR TRANSITIONAL SHELTERS** ☐ **YES** ☐ **NO**

Student is living in **SUBSTANDARD HOUSING** ☐ **YES** ☐ **NO**
(i.e. damaged or destroyed property, basic utilities are unavailable on the premises, lacks basic functional parts, etc.)

Student is living with someone **OTHER than his/her parent(s) or legal guardian** ☐ **YES** ☐ **NO**

Student is considered a **MIGRANT STUDENT** ☐ **YES** ☐ **NO**
(i.e. parent/guardian works in agricultural/fishing industries, requiring them to move according to various seasons)

STOP **IF YOU ANSWERED 'NO' TO ALL THE QUESTIONS ABOVE, STOP HERE.** STOP

IF YOU MARKED 'YES' TO ANY OF THE ABOVE QUESTIONS, PLEASE COMPLETE THE REMAINDER OF THIS FORM.

☐ Student has an active **IEP, 504 plan, or SST**. Please specify:

☐ Attendance concerns *(refusing and/or afraid to go to school)*

☐ Student is in need of or interested in **counseling services, tutoring services, afterschool programs, and/or mentorship programs**. Please specify: _____

☐ Behavior concerns. Please specify: _____

☐ Medical concerns. Please specify: _____

BY SIGNING BELOW, THE PARENT/GUARDIAN CERTIFIES THAT THE INFORMATION PROVIDED IS CORRECT AND ACCURATE

PRINT NAME	SIGNATURE	DATE

PLEASE TURN DOCUMENT TO VIEW FURTHER INFORMATION REGARDING THE MCKINNEY-VENTO ACT

Rialto Unified School District
Child Welfare and Attendance
McKinney-Vento Questionnaire

Under the McKinney-Vento act, your child(ren) may be entitled to:

- **immediate school enrollment and full participation in all school activities for eligible children, even when records normally required for enrollment are not available**
- **remain in their school of origin (the school the student attended when permanently housed or the school in which the student was last enrolled), when in the child's or youth's best interest to do so**
- **transportation to and from the school of origin at the request of the parent or guardian**
- **provision of services comparable to services offered to other students in the school, including Title I services or similar state or local programs, educational programs for children with disabilities, and educational programs for English learners; career and technical education; programs for gifted and talented students; and school nutrition programs**

If you have any questions regarding these rights, please contact your school site's homeless youth representative.

Krystal Rojas • Brenda Salas
McKinney-Vento and Foster Youth Liaisons

Per State Law (AB 16) "A child will not be removed from the child's family solely because the child's family is experiencing homelessness per Section 48851 to the Education Code.

OFFICE USE ONLY

DATE OF ENROLLMENT	STUDENT ID NUMBER	SCHOOL OF ENROLLMENT	GRADE

Student Name: _____

Rialto Unified School District

Custody Issues

Parent Disputes over Custody in School Setting

Parents may try to use the school as a forum for disputing custody matters. If needed, the school district may consider including the following form in their annual notification to parent and legal guardians.

Custody disputes must be handled by the courts. The school has no legal jurisdiction to refuse a biological parent access to their child. The only exception is when a signed restraining order or proper divorce papers, specifically stating visitation limitations, are on file in the school office. Any student release situation which leaves the student's welfare in question will be handled at the discretion of the site administrator or designee. Should any such situation become a disruption to the school, law enforcement will be contacted and an officer requested to intervene. Unless Educational Rights have been revoked, both parents have access to student records.

Parents are asked to make every attempt not to involve school sites in custody matters.

The school will make every attempt to reach the custodial parent when a parent or any other person not listed on the emergency card attempts to pick up a child.

I have read and understand the above statement.

_____

Parent/Guardian Signature 1 Date

_____

Parent/Guardian Signature 2 Date

Office use only:

Date Received: _____ Home School: _____

Notification placed on Synergy: _____ Document(s) uploaded to Synergy: _____

RIALTO UNIFIED SCHOOL DISTRICT
HEALTH SERVICES
815 S. Willow Ave., Rialto, CA 92376 • Tel (909) 820-8150 • Fax (909) 820-8151

STUDENT HEALTH HISTORY

Student Name: _____ **Date of Birth:** _____ **Grade:** _____

☐ **My child does NOT have any known health conditions**

☐ **My child has the following health conditions:**
(check all that apply **and** if medication or treatment is required at school)

	Medication / Treatment required at school
☐ Allergies	☐ Yes ☐ No
☐ ADHD / ADD	☐ Yes ☐ No
☐ Asthma	☐ Yes ☐ No
☐ Autism	☐ Yes ☐ No
☐ Birth Defects / Genetic Disorders	☐ Yes ☐ No
☐ Blood / Bleeding Disorders	☐ Yes ☐ No
☐ Hearing Loss	☐ Yes ☐ No
☐ Kidney Disorder / Bladder Problems	☐ Yes ☐ No
☐ Psychological Problems	☐ Yes ☐ No
☐ Serious accidents or hospitalizations	☐ Yes ☐ No
☐ Vision Impairment	☐ Yes ☐ No
☐ **Cancer / Leukemia**	☐ Yes ☐ No
☐ **Cerebral Palsy**	☐ Yes ☐ No
☐ **Colostomy Bag**	☐ Yes ☐ No
☐ **Diabetes:** ☐ **Type 1** ☐ **Type 2 – Insulin Dependent:** ☐ Yes ☐ No **If applicable:** ☐ Dexcom ☐ Insulin Pump ☐ Metformin ☐ Humalog Insulin Pen	☐ Yes ☐ No
☐ **Epilepsy / Seizures –** Requires Diastat	☐ Yes ☐ No
☐ **Gastrostomy Tube (G-Tube) –** Requires G-Tube feeding	☐ Yes ☐ No
☐ **Heart Problems / Heart Surgery**	☐ Yes ☐ No
☐ **Tracheostomy** ☐ Requires Suctioning ☐ Ventilator Dependent ☐ Oxygen Dependent	☐ Yes ☐ No
☐ **Other:** _____	☐ Yes ☐ No

Special Treatments and/or Medications: _____

_____

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

OFFICE USE ONLY

Emailed Health Services: _____ Verified by Health Services: _____ School: _____

Provided parent with the following documents:
☐ Authorization for Medical Release ☐ Medication Form

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31 of his/her first year in public school. A California licensed dental professional operating within his scope of practice must perform the check-up and fill out Section 2 of this form. If your child had a dental check-up in the 12 months before he/she started school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Sex: ☐ Male ☐ Female
Parent/Guardian Name:	Child's race/ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Multi-racial ☐ Other_____ ☐ Native Hawaiian/Pacific Islander ☐ Unknown		

Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box.

Assessment Date:	Caries Experience (Visible decay and/or fillings present) ☐ Yes ☐ No	Visible Decay Present: ☐ Yes ☐ No	Treatment Urgency: ☐ No obvious problem found ☐ Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) ☐ Urgent care needed (pain, infection, swelling or soft tissue lesions)

_____ _____ _____

Licensed Dental Professional Signature ***CA License Number*** ***Date***

Section 3: Waiver of Oral Health Assessment Requirement

To be filled out by parent or guardian asking to be excused from this requirement

Please excuse my child from the dental check-up because: (Check the box that best describes the reason)

☐ I am unable to find a dental office that will take my child's dental insurance plan.
My child's dental insurance plan is:

☐ Medi-Cal/Denti-Cal ☐ Healthy Families ☐ Healthy Kids ☐ Other _____ ☐ None

☐ I cannot afford a dental check-up for my child.

☐ I do not want my child to receive a dental check-up.

Optional: other reasons my child could not get a dental check-up: _____

If asking to be excused from this requirement: ▶ _____

Signature of parent or guardian ***Date***

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school.

Return this form to the school *no later than* May 31 of your child's first school year.
Original to be kept in child's school record.

State of California—Health and Human Services Agency

Department of Health Care Services
Child Health and Disability Prevention (CHDP) Program

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTH DATE—Month/Day/Year

ADDRESS—Number, Street	City	ZIP code	SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	/ /
Physical Examination	/ /
Dental Assessment	/ /
Nutritional Assessment	/ /
Developmental Assessment	/ /
Vision Screening	/ /
Audiometric (hearing) Screening	/ /
TB Risk Assessment and Test, if indicated	/ /
Blood Test (for anemia)	/ /
Urine Test	/ /
Blood Lead Test	/ /
Other	/ /

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER (e.g., TB Test, if Indicated)					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER *(optional)* and RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

☐ Examination shows no condition of concern to school program activities.

☐ Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: *(please explain)*

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

☐ Please check this box if you ***do not*** want the health examiner to fill out Part III.

Signature of parent or guardian — Date

Name, address, and telephone number of health examiner

Signature of health examiner — Date

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.

PM 171 A (09/07) (Bilingual)

CHDP website: www.dhcs.ca.gov/services/chdp

Enroll. Get Care. Renew.

Health Coverage All Year Long: 2022 Public Health Emergency Edition

all in HEALTH CARE FOR ALL FAMILIES

Health Coverage Options

Medi-Cal:

- Children—regardless of immigration status—foster youth, pregnant women and legally present individuals—including those with DACA status—may be eligible for no- or low-cost Medi-Cal.
- Medi-Cal covers immunizations, checkups, specialists, vision and dental services, and more for children and foster youth up to age 26 at no or low cost.
- Medi-Cal enrollment is available year round.
- During COVID-19, Medi-Cal plans began offering more services using telehealth. Ask your provider about accessing care over video or telephone.

Covered California:

- Covered California is where legal residents of California can compare quality health plans and choose the one that works best for them.
- Based on income and family size, many Californians may qualify for financial assistance.
- Enroll during Open Enrollment or any time you experience a life-changing event, like losing your job or having a baby. You have 60 days from the event to complete enrollment.

Immigrant Families: *Visit the public charge guide.* Receiving government health insurance and using health services will not affect your immigration status. Information is only used to determine eligibility. Click the English or Spanish versions for more details.

Enroll.

Three ways to enroll in Medi-Cal and Covered California:

- 1(800) 300-1506
- www.coveredca.com
- Find in-person help: www.coveredca.com/support/membership/contact-medi-cal/

Get Care.

- Find a primary care doctor in your network.
- Schedule an annual checkup for you and your family.
- Make sure to take your child to the dentist.
- Pay your monthly premium if your plan requires it.

Renew.

Medi-Cal must be renewed every year. While this has temporarily paused during the COVID-19 pandemic, it is important to ensure that Medi-Cal has your current address so that when it's time to renew your coverage, they can contact you. If you receive a renewal notice, be sure to act: you can renew by mail, online or over the phone. For help, contact your local Medi-Cal office. Click here to find your county office.

Health plans through Covered California must be renewed every year. Renewal information will be mailed at the end of the year, or you can contact Covered California directly at: 1(800) 300-1506.

Financial Help. You and your family may qualify for financial help:

SEE NOTE BELOW FOR INCOMES IN THIS RANGE	Federal Premium Tax Credit*								Tax credit continues beyond 400%	
	American Indian / Alaska Native (AI/AN) Zero Cost Sharing								AI/AN Limited Cost Sharing	
% FPL	100%	138%	150%	200%	213%	250%	266%	300%	322%	400%
Household Size	If 2022 household income is at or less than									
1	$12,880	$17,775	$19,320	$25,760	$27,435	$32,200	$34,261	$38,640	$41,474	$41,474
2	$17,420	$24,040	$26,130	$34,840	$37,105	$43,550	$46,338	$52,260	$56,093	$56,093
3	$21,960	$30,305	$32,940	$43,920	$46,775	$54,900	$58,414	$65,880	$70,712	$70,712
4	$26,500	$36,570	$39,750	$53,000	$56,445	$66,250	$70,490	$79,500	$85,330	$85,330
5	$31,040	$42,836	$46,560	$62,080	$66,116	$77,600	$82,567	$93,120	$99,949	$99,949
6	$35,580	$49,101	$53,370	$71,160	$75,786	$88,950	$94,643	$106,740	$114,568	$114,568
	Medi-Cal for Adults		Medi-Cal for Pregnant Women				Medi-Cal Access for Pregnant Women			
	Medi-Cal for Kids (0–18 Yrs.)							CCHIP		

Note: Consumers after 138% FPL may qualify for a Covered California health plan with financial help including: federal premium tax credit, Zero Cost Sharing and Limited Cost Sharing AI/AN plans.

Source: www coveredca.com/pdfs/FPL-chart.pdf

For more information go to: www.allinforhealth.org

The Children's Partnership | csba | California School-Based Health Alliance | CCHI | health happens aquí | Covered California

California Immunization Requirements for

K–12th Grade (including transitional kindergarten)

Grade	Number of Doses Required of Each Immunization[1,2,3]				
K-12 Admission	4 Polio[4]	5 DTaP[5]	3 Hep B[6]	2 MMR[7]	2 Varicella
(7th-12th)[8]	K-12 doses	+ 1 Tdap			
7th Grade Advancement[9,10]		1 Tdap[8]			2 Varicella[10]

1. Requirements for K-12 admission also apply to transfer pupils.
2. Combination vaccines (e.g., MMRV) meet the requirements for individual component vaccines. Doses of DTP count towards the DTaP requirement.
3. Any vaccine administered four or fewer days prior to the minimum required age is valid.
4. Three doses of polio vaccine meet the requirement if one dose was given on or after the 4th birthday.
5. Four doses of DTaP meet the requirement if at least one dose was given on or after the 4th birthday. Three doses meet the requirement if at least one dose of Tdap, DTaP, or DTP vaccine was given on or after the 7th birthday (also meets the 7th-12th grade Tdap requirement. See fn. 8.) One or two doses of Td vaccine given on or after the 7th birthday count towards the K-12 requirement.
6. For 7th grade admission, refer to Health and Safety Code section 120335, subdivision (c).
7. Two doses of measles, two doses of mumps, and one dose of rubella vaccine meet the requirement, separately or combined. Only doses administered on or after the 1st birthday meet the requirement.
8. For 7th-12th graders, at least one dose of pertussis-containing vaccine is required on or after the 7th birthday.
9. For children in ungraded schools, pupils 12 years and older are subject to the 7th grade advancement requirements.
10. The varicella requirement for seventh grade advancement expires after June 30, 2025.

DTaP/Tdap = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine
Hep B = hepatitis B vaccine
MMR = measles, mumps, and rubella vaccine
Varicella = chickenpox vaccine

Instructions:

California schools are required to check immunization records for all new student admissions at TK / Kindergarten through 12th grade and all students advancing to 7th grade before entry. See shotsforschool.org for more information.

Unconditionally Admit a pupil whose parent or guardian has provided documentation of any of the following for each immunization required for the pupil's age or grade as defined in the table above:

- Receipt of immunization.
- A permanent medical exemption.*

Conditionally Admit any pupil who lacks documentation for unconditional admission if the pupil has:

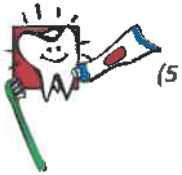
- Commenced receiving doses of all the vaccines required for the pupil's grade (table above) and is not currently due for any doses at the time of admission (as determined by intervals listed in the Conditional Admission Schedule, column entitled "Exclude If Not Given By"), or
- A temporary medical exemption from some or all required immunizations.*

RIALTO UNIFIED SCHOOL DISTRICT • HEALTH SERVICES • 815 S. WILLOW AVENUE, RIALTO, CA 92376 • TEL: (909) 820-8150

Possible Referrals: If you have a personal health care provider, please feel free to use them. *We do not endorse any specific health care provider.*
Posibles recomendaciones: Si usted tiene su propio dentista u optometrista por favor usarlos. *Nosotros no endosamos ningún médico específico.*

DENTAL CARE

DENTAL REFERRAL SERVICE
(800) 511-8663 *or* (800) 322-6384



FIRST 5 DENTAL
(5 years old and younger)
(800) 722-4597

DENTI-CAL
(800) 322-6384

LOMA LINDA SCHOOL OF DENTISTRY
(Pediatric Dental Clinic)
Loma Linda (909) 558-4689

INLAND FAMILY COMMUNITY HEALTH CENTER
(For Dental Office)
665 North 'D' Street
San Bernardino (909) 708-8168

GOLDEN WEST DENTISTRY
9922 Sierra Ave.
Fontana (909) 822-4800

BR DENTAL
(Next to Clinica Medica Familiar)
Dr. Kwon, DDS
436 S. Riverside Ave.
Rialto (909) 874-5200

DR. DAVID A. NEWSHAM, DDS
1735 N. Riverside Ave.
Rialto (909) 820-9081

MEDICAL CARE

SAC HEALTH SYSTEM
815 S. Willow Ave.
Rialto (909) 820-8160
To schedule an appointment
(909) 382-7100

COUNTY OF SAN BERNARDINO DEPT. OF PUBLIC HEALTH
351 N Mt. View Ave.
San Bernardino (800) 722-4777

ONTARIO DEPT. OF PUBLIC HEALTH
(909) 458-9447

BLOOMINGTON COMMUNITY HEALTH CENTER
18601 Valley Blvd.
Bloomington (909) 546-7520

MOMMY AND ME
790 E. Foothill Blvd.
Rialto (909) 421-0493

GOLDEN SHORE MEDICAL
790 E. Foothill Blvd.
Rialto (909) 546-7135

190 E. Highland Ave.
San Bernardino (909) 882-4788

INLAND FAMILY COMMUNITY HEALTH CENTER
(For Medical Office)
665 North 'D' Street
San Bernardino (909) 708-8158

ARROWHEAD REGIONAL MEDICAL CENTER - MEDICAL MOBILE CLINIC
For clinic location and/or appointment
(909) 520-1207

VISION EXAMS

FREESTONE OPTOMETRIC CENTER
Dr. Gary M. Freestone, OD
1850 N. Riverside Ave., Suite 220
Rialto (909) 875-1144

RIALTO OPTOMETRIC CENTER
Dr. Bernard Rubin, OD
1850 N. Riverside Ave., Suite 210
Rialto (909) 421-3030

COLTON OPTOMETRIC CENTER
Dr. Thomas B. Law, OD
190 W. H St., Suite 105
Colton (909) 825-9044

COUNSELING SERVICES

MESA COUNSELING SERVICES
850 E. Foothill Blvd.
Rialto (909) 421-9358

BILINGUAL FAMILY COUNSELING SERVICES
317 West 'F' Street
Ontario (909) 986-7111

LOMA LINDA UNIVERSITY MARITAL & FAMILY THERAPY CLINIC
164 W. Hospitality Ln., Suite 15
San Bernardino (909) 722-4777

SOUTH COAST COMMUNITY SERVICES
San Bernardino County
(877) 527-7227

COVERED CALIFORNIA
(800) 300-1506
www.coveredca.com

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(800) 720-4347
www.iehp.or

MEDI-CAL
(877) 410-8829
www.C4Yourself.com

SAN BERNARDINO COUNTY TRANSITIONAL ASSISTANCE DEPARTMENT
1175 W. Foothill Blvd.
Rialto (877) 410-8829

Updated: 03/2022