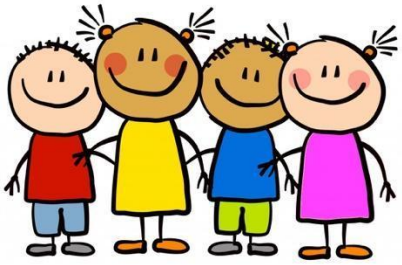
Enrollment Application

Luther Burbank School District
ENGAGE / EDUCATE / EMPOWER

LBSD offers enrollment options to eligible students based on age priority and availability of space. Students living within the school's district boundary will be given priority enrollment. If you reside outside of the LBSD attendance area, you must first complete an interdistrict transfer with your residence school district. In case of any doubts, please feel free to call the district office at (408) 295-2450 or send an email to lbsdsupport@lbsdk8.org. Along with this application, please submit the following:

3 Proofs of Residency (This policy applies only to students who live within the boundaries of the school district)

The following proofs of residency may be submitted:



- Current property tax bill, lease, or lease renewal.
- Current utility bill with name and address
- Home Utility Bills
- Automobile registration or insurance card
- Bank or Financial Institution Records
- Mailing from a government agency (Local, state, or federal)
  The documents must have a date that falls within 30 days from the time when the packet is submitted.

Proof of Student's Date of Birth

- A Birth Certificate, Passport, Baptismal Record, or other Official Document indicating the age and date of birth (DOB)

Updated Immunization Record

- Tuberculosis proof
- Immunization Card

Previous School Records

- Transfer Card, Report Card, Letter from previous school, confirming attendance and grade level, Test Scores, IEP.
- Proof of Custody (If applicable)

LUTHER BURBANK SCHOOL DISTRICT (LBSD)

Transitional Kindergarten (TK) / Kindergarten Enrollment Application

2026-2027 School Year

Transitional Kindergarten (TK): Students must be 4 years old on or before September 1, 2026.

Kindergarten: Students must be 5 years old on or before September 1, 2026.

LBSD allows students that qualify to enroll in TK or Kindergarten based on birthday priority and space availability. Priority for enrollment will be given to children in the school's attendance area. If you don't reside in the school district attendance area, you must complete an interdistrict transfer form first, within your residing school district. If you have any questions, please call the front office. This application must be submitted at 4 Wabash Avenue San José, CA 95128 • Phone (408) 295-1814 • Email: lbsdsupport@lbsdk8.org
Please complete a separate form for each child in your family for whom you are requesting enrollment.

STATEMENT

*For the **2026–2027 school year**, children are eligible for **Transitional Kindergarten (TK)** if they turn **4 years old on or before September 1, 2026**. In limited circumstances, the school district may allow a child who does not meet this age requirement to enroll in TK if it is determined to be in the child's best interest and with parent or guardian agreement.*

PROCEDURE

1. Applications will be placed on a waiting list that will be prioritized by birthday priority and space availability. Priority for children with birthdays on the same day will be determined by lottery.
2. Prior to the first day of school, the district will accept TK students from the waiting list.
3. Priority for enrollment will be given to children in the school's attendance area. After all neighborhood children have been offered enrollment, schools may enroll students outside of the school's attendance area based on space availability, but **transportation is the responsibility of the parent/guardian.**
4. To enroll an age-eligible child in TK or Kindergarten, the parent/guardian must submit the following documents:
    a. Completed enrollment packet.
    b. All required immunization records and TB
    c. Proof of Physical and Dental
    d. 3 proofs of district residency within the district (Postmarked within 30 days of submission)
    e. Present a valid birth certificate/baptismal certificate/passport

Student's Legal Last Name, First, Middle Birthday

Registering for: ☐ Early Transitional Kindergarten ☐ Transitional Kindergarten ☐ Kindergarten **Gender:** ☐ Male ☐ Female

I have read and understood all the information above.

Parent/Guardian Name (Print) Relationship to Child Parent/Guardian Signature Date

District Office Use Only

Date Received:_____ **Child is on**: ☐ Waiting List ☐ Enrolled/Approved By:_____ **Date**:_____

LUTHER BURBANK SCHOOL DISTRICT

NEW STUDENT ENROLLMENT FORM

Student Legal Last Name, First Name, Middle Name _____ DOB _____ Gender _____

Student Resides with: ☐ Both Parents ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____

PRIMARY HOME ADDRESS: location where the student resides each night. P.O. Boxes addressed will not be accepted.

Address _____ Apt # _____ City _____ Zip _____

PARENTS / GUARDIAN INFORMATION

1st Parent: ☐ Mother ☐ Father ☐ Other: _____ **2nd Parent** ☐ Mother ☐ Father ☐ Other: _____

First Name, Last: _____ First Name, Last: _____

Cell Phone: _____ Cell Phone: _____

Other Phone: _____ Other Phone: _____

Email: _____ Email: _____

Secondary Home Address: This is intended ONLY for parents who live in a separate household.

Mailing Address of: ☐ Mother ☐ Father ☐ Other: _____

Address _____ Apt # _____ City _____ Zip _____

PARENTS / GUARDIAN INFORMATION: Please Check the highest Education Level of either parents/guardians:
☐ Not High School Graduate ☐ H.S Graduate ☐ Some College ☐ College Grad ☐ Graduate/post Grad ☐ Decline to State

EMERGENCY INFORMATION

Please enter the name of the contact and their relationship to the students. **DO NOT** enter Parents / Guardians here if you are already in the Parent/ Guardian Section above.

Last Name	First Name	Relationship	Phone #

As the parent or legal guardian of the student (whose name is listed above), I certify that the information provided above is complete and correct according to the best of my knowledge. I understand that intentionally providing false or misleading information that leads to a financial benefit on behalf of the student may lead to ineligibility of any type of aid; lengthen the processing time of enrollment; or subject you to criminal or civil liability as allowed by law. The parent/guardian must notify the school district if any changes are necessary.

Parent / Guardian Name _____ Signature _____ Date _____

OFFICE USE ONLY: ☐ ID ☐ OFD
Check List: ☐ 3 Proof of Address ☐ Birth Cerf. / Baptismal Certificate ☐ Immunizations ☐ Physical ☐ Dental
Class Teacher: _____ Grade: ____ Student District #: _____ Date Enrolled: _____Starting Date: _____

STUDENT LEGAL INFORMATION

Student Legal Last Name, First Name | DOB | Birth City | Birth State | Birth Country

If born outside of the U.S., When did the student enter the US: _____

When did this student first attend school in the US? _____

When did this student first attend a CA public school: _____

Is there an active **COURT ORDER** which, affects this student? ☐ Yes ☐ No (If yes, please provide document)

STUDENTS'S ETHNICITY / RACE

ETHNICITY: Is this student Hispanic or Latino? ☐ Yes, Hispanic, or Latino ☐ No, Not Hispanic or Latino

RACE: ☐ American Indian or Alaskan Native ☐ Asian Indian ☐ Black or African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hawaiian ☐ Hmong ☐ Japanese Korean ☐ Laotian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Tahitian ☐ Vietnamese ☐ White

HOME LANGUAGE SURVEY

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. English proficiency will be assessed if the response to any of the first three questions is in any language other than English. This information is essential 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 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 questions 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 he/she first began to talk? _____
2. Which language does your child most frequently speak at home? _____
3. Which language do you (the parents or guardians) most frequently use when speaking with the child? _____
4. Which language is most often spoken by adults in the home? _____
5. Which language does your child use at preschool or with any childcare provider? _____
6. In what language do you wish to receive school information: _____

SPECIAL EDUCATION

Has this student received special education services? ☐ Yes ☐ No

Is there a 504 Plan? ☐ Yes ☐ No

Is there an IFSP? ☐ Yes ☐ No

Special Education: ☐ Resource (RSP) ☐ Special Day Class ☐ Speech / Language

PREVIOUS SCHOOL INFORMATION (If applicable)

School Name | City | State/ Country | Phone # | Date Left

As the parent or legal guardian of the student (whose name is listed above), I certify that the information provided above is complete and correct according to the best of my knowledge. I understand that intentionally providing false or misleading information that leads to a financial benefit on behalf of the student may lead to ineligibility of any type of aid; lengthen the processing time of enrollment; or subject you to criminal or civil liability as allowed by law. If any changes are necessary, the parent/guardian must notify the school district.

Parent / Guardian Name | Signature | Date

STUDENT HEALTH INFORMATION

_____

Student Last Name First Name DOB

MEDICAL OR HEALTH CONDITIONS? ☐ **NO** ☐ **YES.** *If Yes, please check all that applies to your child.*

☐ ADD/ADHD ☐ Eczema/skin condition ☐ Migraine headaches ☐ Seizures
☐ Asthma ☐ Heart Problems ☐ Frequent Nosebleeds
☐ Diabetes ☐ Joint Pains ☐ Severe Allergy (anaphylaxis)
☐ Other (please explain)_____

MEDICATIONS? ☐ NO ☐ YES. If yes, please list all medication taken by your child

_____

_____

Does the student wear glasses or contact lenses? ☐ YES ☐ NO

Does the student wear hearing aids or have a history of hearing problems? ☐ YES ☐ NO

Does your child have health insurance? ☐ YES ☐ NO

Is your student currently able to participate in the regular education program? ☐ YES ☐ NO

Has your child ever experienced any asthma symptoms during the past year such as coughing, wheezing, shortness of breath, chest tightness, or phlegm?
☐ Not at all ☐ Less than every month ☐ Every week ☐ Every day ☐ Not sure

Has your child had any serious illness, operation, or accident? ☐ YES ☐ NO

If yes, when did this occur? Was she/he admitted to the hospital? ☐ YES ☐ NO

Please share any additional important health information about your child.

_____

_____

_____

As the parent or legal guardian of the student (whose name is listed above), I certify that the information provided above is complete and correct according to the best of my knowledge. I understand that intentionally providing false or misleading information that leads to a financial benefit on behalf of the student may lead to ineligibility of any type of aid; lengthen the processing time of enrollment; or subject you to criminal or civil liability as allowed by law. If any changes are necessary, the parent/guardian must notify the school district.

_____

Parent / Guardian Name Signature Date

Luther Burbank School District

Housing Questionnaire

Student Last Name First Name DOB Gender

The information provided below will help the LEA 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 the appropriate school district and site staff.

Presently, are you and/or your family living in any of the following situations? *(Please check if applicable)*

- ☐ Staying in a shelter (family shelter, domestic violence shelter, youth shelter) or Federal Emergency Management Agency (FEMA) trailer
- ☐ Sharing housing with other(s) due to loss of housing, economic hardship, natural disaster, lack of adequate housing, or similar reason
- ☐ Living in a car, park, campground, abandoned building, or other inadequate accommodations (i.e. lack of water, electricity, or heat)
- ☐ Temporarily living in a motel or hotel due to loss of housing, economic hardship, natural disaster, or similar reason
- ☐ Living in a permanent single-home residence.

I am a student under the age of 18 and living apart from parent(s) or guardian ☐ YES ☐ NO

Your child or children may have the right to:

- Immediate enrollment in the school they last attended (school of origin) or the local school where you are currently staying, even if you do not have all the documents normally required at the time of enrollment.
- Continue to attend their school of origin, if requested by you and it is in the best interest.
- Receive transportation to and from their school of origin, the same special programs, and services, if needed, as provided to all other children, including free meals and Title I.
- Receive the full protections and services provided under all federal and state laws, as it relates to homeless children, youth, and their families.

Please list all children currently living with you.

Full Name	Gender	DOB	Grade	School

If you have any questions about this, please contact our school homeless Liaison at (408) 295-1814

As the parent or legal guardian of the student (whose name is listed above), I certify that the information provided above is complete and correct according to the best of my knowledge. I understand that intentionally providing false or misleading information that leads to a financial benefit on behalf of the student may lead to ineligibility of any type of aid; lengthen the processing time of enrollment; or subject you to criminal or civil liability as allowed by law. If any changes are necessary, the parent/guardian must notify the school district.

Parent / Guardian Name Signature Date

Child's Name: _____ Birthdate: _____ Male/Female School: _____
Last, First month/day/year

Address _____ Phone: _____ Grade: _____
Street City Zip

Santa Clara County Public Health Department
Tuberculosis (TB) Risk Assessment for School Entry

This form must be completed by a U.S. licensed primary care provider and returned to the child's school.

1. Was your child born in, or has your child resided in or traveled to (for more than one week) a country with an elevated TB rate?*	☐ Yes ☐ No
2. Has your child been exposed to anyone with TB disease?	☐ Yes ☐ No
3. Has a family member had a positive TB test or received medications for TB?	☐ Yes ☐ No
4. Was a parent, household member, or visitor who stayed in the child's home for >1 week, born in a country with an elevated TB rate?*	☐ Yes ☐ No
5. Is your child immunosuppressed [e.g. due to HIV infection, organ transplant, treatment with TNF-alpha inhibitor or high-dose systemic steroids (e.g. prednisone ≥ 15 mg/day for ≥ 2 weeks)].	☐ Yes ☐ No

*Most countries other than the U.S., Canada, Australia, New Zealand, or a country in western or northern Europe. This does not include tourist travel for <1 month (i.e. travel that does not involve visiting family or friends, or involve significant contact with the local population).

If YES, to any of the above questions, the child has an increased risk of TB and should have a TB blood test (IGRA, i.e. QuantiFERON or T-SPOT.TB) or a tuberculin skin test (TST) unless there is either 1) a documented prior positive IGRA or TST performed in the U.S. or 2) no new risk factors since last documented negative IGRA (performed at age ≥2 years in the U.S.) or TST (performed at age ≥6 months in the U.S.).

All children with a current or prior positive IGRA/TST result must have a medical evaluation, including a chest x-ray (CXR; posterior-anterior and lateral for children <5 years old is recommended). CXR is not required for children with documented prior treatment for TB disease, documented prior treatment for latent TB infection, or BCG-vaccinated children who have a positive TST and negative IGRA. If there are no symptoms or signs of TB disease and the CXR is normal, the child should be treated for latent TB infection (LTBI) to prevent progression to TB disease.

Enter test results for all children with a positive risk assessment:

Interferon Gamma Release Assay (IGRA) Date:	Result: ☐ Negative ☐ Positive ☐ Indeterminate
Tuberculin Skin Test (TST/Mantoux/PPD) Date placed: Date read:	Induration _____ mm Result: ☐ Negative ☐ Positive
Chest X-Ray Date: _____	Impression: ☐ Normal ☐ Abnormal
LTBI Treatment Start Date: _____ ☐ Rifampin daily - 4 months ☐ Isoniazid/rifapentine - weekly X 12 weeks ☐ Isoniazid daily - 9 months ☐ Other: _____	☐ Prior TB/LTBI treatment (Rx & duration): _____ ☐ Treatment medically contraindicated: _____ ☐ Declined against medical advice

Please check one of the boxes below and sign:

☐ Child has no TB symptoms, no risk factors for TB, and does not require a TB test.
☐ Child has a risk factor, has been evaluated for TB and is free of active TB disease.
☐ Child has no new risk factors since last negative IGRA/TST and no TB symptoms.

_____ _____
Health Care Provider Signature, Title Date

Name/Title of Health Provider:
Facility/Address:
Phone number:

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	/ /
Tuberculin Test (Mantoux/PPD)	/ /
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					
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.

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.

Migrant Education Program

Student's Name _____ School_____

Parent's Name_____ Phone_____ Date_____

1. Have you moved in the past three years to obtain work in agriculture or fishing? ☐ Yes ☐ No

2. Please check the jobs you have done.

~If you answered ***YES*** to either question, please complete the bottom of this form~
Please check the agricultural/fishing jobs you have now or have had in the past:



☐Harvesting fruits/ vegetables



☐Cultivation/ preparation of soil/ irrigating



☐Planting/ pruning trees and vines (orchards)



☐ Greenhouse/nursery/ sod/ mushroom farms



☐Harvesting nuts/ Packing facility



☐Dairy/ Livestock



☐Commercial fishing/ crabbing/ shellfish



☐Meat processing/ seafood processing

Other _____

** Please list the names of all children under 22 years old in your household

First Name	Last Name	Sex	School	Grade	Date of Birth