Kindergarten Registration 2020

Welcome to the Kindergarten registration process! We are excited to welcome your child to Kindergarten this fall. In order to register for Kindergarten, you will need to complete the forms below and bring the required paperwork to the ACES or RCS main office. These forms can be printed from our website or picked up at the ACES or RCS main office. Once registered, you will sign your child up for a Kindergarten Screening date and time.

COMPLETE REGISTRATIONS INCLUDE

- ❑ Registration Form
- ❑ Home Language Survey
- ❑ Military Family Form
- ❑ Early Childhood Experiences Survey
- ❑ ORIGINAL Birth Certificate (with raised seal- school will make a copy)
- ❑ Proof of Residence (utility bill, cable bill, lease agreement, purchase and sale agreement NO credit card bills, NO cell phone bills)
- ❑ Immunization Record (current within one year)
- ❑ Documentation of a physical (Massachusetts School Health Record) including lead screening test results, vision screening, and hearing screening (current within one year)
- ❑ Custody Agreement (if present)

WE WILL NOT BE ACCEPTING ANY REGISTRATION PACKETS THAT ARE NOT COMPLETE. Updated physical/immunization records can be added to the file at any time, however the current physical/immunization record must be on record for registration.

If you have any questions, please feel free to call the ACES Main Office at 978-249-2406.

Athol Royalston Regional School District- Kindergarten Registration Form

Student Name _____
Last First Full Middle

Male ☐ Female ☐ Date of Birth: Month_____ Day_____ Year _____

Place of Birth _____ Country of Origin _____

Address _____
Street Town Zip Code

Phone_____ Cell Phone _____ E Mail _____

Any custody/legal paperwork (restraining orders, custody agreements, etc.) the school should be aware of? No ☐ Yes ☐
Please submit copies of legal documents to school. Any DCF involvement?_____

DCF Worker _____ Phone _____

With whom does the student live? (Circle all that apply) _____
Both Parents, Mom, Dad, Step Mother, Step Father, Legal Guardian, Grandparent, Foster Parent, Other

Parent/Guardian #1 Name _____

Address_____Phone_____

Employer_____ Phone _____

Cell Phone _____ Email_____

Parent/Guardian #2 Name _____

Address_____Phone_____

Employer_____ Phone _____

Cell Phone _____ Email_____

Will your child receive medication during the school day? Yes ☐ No ☐
If so, please see the school nurse to fill out proper forms.

Does your child wear glasses? Yes ☐ No ☐

List Health Problems and/or Allergies_____

Does your child's allergy or health condition constitute an emergency that warrants immediate attention? Yes ☐ No ☐

Doctor's name _____

Dentist's name _____

Please check any services your child receives:

IEP ☐ 504 ☐ Speech ☐ DCF ☐ English Lang. Learner Service ☐

Has your child attended Pre-school? Yes ☐ No ☐

If yes, for how long? 6 mos ☐ 1 year ☐ 2 years ☐ More than 2 years ☐

Name of the pre-school _____

List names of brothers and/or sisters _____

_____

_____

IS there anything else that we should know?

_____

_____

_____

Parent/Guardian Signature_____ Date_____

WELCOME TO ARRSD!

Home Language Survey

Massachusetts Department of Elementary and Secondary Education regulations require that *all* schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. If a language other than English is spoken in the home, the District is required to do further assessment of your child. Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

Student Information

First Name _____ Middle Name _____ Last Name _____ F ☐ M ☐ Gender

Country of Birth _____ Date of Birth (mm/dd/yyyy) ___/___/___ Date first enrolled in ANY U.S. school (mm/dd/yyyy) ___/___/___

School Information

Start Date in New School (mm/dd/yyyy) ___/___/20___ Name of Former School and Town _____ Current Grade _____

Questions for Parents/Guardians

What is the native language(s) of each parent/guardian? (circle one) _____ (mother / father / guardian) _____ (mother / father / guardian)	**Which language(s) are spoken with your child?** (include relatives -*grandparents, uncles, aunts,etc.* - and caregivers) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always
What language did your child first understand and speak?	**Which language do you use most with your child?**
Which other languages does your child know? (circle all that apply) _____ speak / read / write _____ speak / read / write	**Which languages does your child use? (circle one)** _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always
Will you require written information from school in your native language? Y ☐ N ☐	**Will you require an interpreter/translator at Parent-Teacher meetings?** Y ☐ N ☐
Parent/Guardian Signature: X	___/___/20___ **Today's Date:** (mm/dd/yyyy)

Please answer both question 1 and 2.

1) **Is this student Hispanic or Latino (choose only one answer)**

- ☐ **Not, not Hispanic or Latino**
- ☐ **Yes, Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish ethnicity, regardless of race)**

2) **What is the student's race?**

- ☐ **American Indian or Alaskan Native (A person having origins in any of the original peoples of North or South America –including Central America- and who maintain a tribal affiliation of community attachment)**
- ☐ **Asian (A person having origins in any of the original peoples of the far east , southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippines, Thailand, and Vietnam)**
- ☐ **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)**
- ☐ **White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa)**

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

ATHOL-ROYALSTON REGIONAL SCHOOL DISTRICT

1062 Pleasant Street ◦ P.O. Box 968
Athol, MA 01331
Tel: 978-249-2400 ◦ Fax: 978-249-2402
Website: www.arrsd.org

The Athol-Royalston Regional School District is committed to providing challenging educational experiences that inspire students to acquire the knowledge and skills to become responsible citizens in the global community.

Student Information

Birth Date _____

Last Name _____

First Name _____

Middle Name _____

In May 2012, as part of the VALOR Act, Massachusetts joined other states as part of the Interstate Compact on Educational Opportunity for Military Children. Please visit www.mic3.net for more information.

What Children Are Eligible for Assistance Under the Compact?
Children of:

- Active duty members of the uniformed services, National Guard and Reserve on active duty orders
- Members or veterans who are medically discharged or retired for (1) year
- Members who die on active duty

What Children Are Not Eligible for Assistance Under the Compact?
Children of:

- Inactive members of the National Guard and Reserves
- Members now retired not covered above
- Veterans not covered above
- Dept. of Defense personnel, federal agency civilians and contract employees not defined as active duty

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Please answer the following question:
Is this student eligible for assistance as a member of a military family as defined by the Interstate Compact on Educational Opportunity for Military Children?

Yes

No

Early Childhood Education Experience Survey

Please check next to the option that best describes your child's preschool experience in the school year prior to entering Kindergarten. Select one option only, and indicate hours where applicable. Thank you!

Name of child:_____ Date of Birth:_____

☐ My child did not have any formal early childhood program experience

☐ My child did not have formal early childhood program experience but participated in Coordinated Family and Community Engagement (CFCE) services.

☐ My child did not have formal early childhood program experience but participated in Parent Child Home Program (PCHP) services.

☐ My child did not have formal early childhood program experience but participated in **BOTH** Coordinated Family and Community Engagement (CFCE) **AND** Parent Child Home Program (PCHP) services.

☐ My child attended a Licensed Family Child Care Provider **(indicate hours below)**

___ for less than 20 hours per week

___ for 20+ hours per week

☐ My child attended a Center Based Program **(indicate hours below)**

___ for less than 20 hours per week

___ for 20+ hours per week

☐ My child attended **BOTH** a Licensed Family Child Care Provider **AND** a Center Based Program **(indicate hours below)**

___ for less than 20 hours per week

___ for 20+ hours per week

Definitions:

Coordinated Family and Community Engagement (CFCE) Services: locally based programs serving families with children birth through school age (e.g. parent/child playgroups, parent-child activities).

Parent Child Home Program (PCHP): home visiting model program funded through the Department of Early Education and Care.

Licensed Family Childcare: refers to EEC licensed child care in a group setting in a home. It may include care in the home of a family member, if the provider is both a relative and an EEC licensed child care provider providing care to children from multiple families.

Center-Based Care: refers to care for children in a group setting, including public and private preschools, Head Start, day care centers, and integrated public preschools.

MEDICAL POLICIES

MEDICATION POLICY

Ideally, all medication should be given at home. If the physician feels it is necessary for the student to receive medication during school hours, school must receive the following for each medication (both for prescription and over the counter medication!)

- A written, signed, dated medication form from the parents
- A written, signed, dated order from the physician (for each medication - for both prescription and over the counter medications)
- Prescription medication must be brought to the health office by a parent/guardian. Medication must be labeled with the pharmacy label and in the original container. The medication name, child's name, and the directions must be clearly labeled.
- All over the counter medication must be brought to the health office by a parent/guardian. Medication must be in original packaging.
- NO MEDICATION IS TO BE TRANSPORTED TO SCHOOL OR HOME WITH A CHILD.

IMMUNIZATION LAW:

Under the laws of the Massachusetts Department of Public Health, the minimum acceptable immunizations for school enrollment are:

- DTaP (Diphtheria, Tetanus, and Pertussis) - 5 doses
- Polio - 4 doses
- Measles, Mumps, Rubella (German Measles) - 2 doses
- Hepatitis B Vaccine - 3 doses
- Varicella - 2 doses

REQUIRED DOCUMENTATION:

- Immunization Record (current within a year)
- Documentation of a physical (Massachusetts School Health Record) including lead screening test results, vision screening, and hearing screening (current within one year)

Athol-Royalston Regional School District 2020/2021

Annual Health Survey - For School Nurse Use Only

Student name: _____ Teacher _____ Grade _____

LIFE THREATENING ALLERGIES: Please indicate if your child has an allergy to any of the following. If yes, please provide official documentation by your child's physician. Written prescriptions from your child's doctor are required for ANY medication that is given during the school year.

Bee Stings _____ Peanuts _____ Nuts _____ Food _____ Latex _____ Other _____

Describe your child's reaction: _____

Describe how the reaction was last treated: _____

OTHER ALLERGIES: Please list

Medications: _____

Environmental: _____

Describe reactions: _____

Date of last Physical Exam: _____ **Date of last Dental Exam:** _____

Primary Care Physician Name: _____ Phone # _____

Physician Specialist Name: _____ Phone # _____

Medical Insurance: _____ Policy # _____

Dentist Name: _____ Phone # _____

Dental Insurance: _____ Policy # _____

ILLNESS/CHRONIC CONDITIONS: Indicate if your child has experienced any of the following below.

Asthma _____	Anxiety _____	Attention Deficit _____
Concussion _____	Depression _____	Diabetes _____
Fainting _____	Heart Condition _____	Seizures _____
Injuries over summer _____	Migraines _____	Mobility concerns _____
Hospitalizations _____	Scoliosis _____	Toileting concerns _____
Surgeries _____	IEP _____	Dietary concerns _____
504 _____	Physical limitations _____	Other _____

Please explain: _____

VISION: Glasses : Yes ___ No ___ Full-time Yes ___ No ___ Contact lenses: Yes ___ No ___

Preferential seating: Front___ Rear___

HEARING: Frequent earaches: Yes ___ No ___ Ear tubes: Yes ___ No ___ Hearing aids: Yes ___ No ____

Preferential seating: Front___ Rear___

SPORTS: Do you know any reason your child should not participate in sports/PE? Yes ___ No ___

Please explain: _____

**A physical exam is required annually for middle and high school level sports.*

MEDICATIONS: Please list prescribed and over the counter medications your child takes. Please provide name and dose of medication. * *A reminder that this information is kept confidential.*

1. _____ 2. _____

3. _____ 4. _____

Medication orders from a physician are required before **any medication can be administered at school.*

SIBLINGS: Name, age and School attending

1. _____ 2. _____

3. _____ 4. _____

Please complete the following items with asterisks.

I, *_____, Parent/guardian of *_____,

(Parent/guardian name) (Student name)

Do give permission for health information to be shared with necessary school staff.

Do give permission for communication and Fax use between my child's physician and the School Nurse to exchange necessary information.

Do grant the right to obtain emergency medical treatment for my child.

Do give permission for ambulance transport to the nearest hospital. Payment for any and all medical treatment is the financial responsibility of the parent/guardian.

*Parent/Guardian Signature: _____ Date: _____

This information is valid for one year from the date of your signature.

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth: _____

Medical History _____

_____

Pertinent Family History

Current Health Issues

Y N

☐ ☐ Allergies: Please list: Medications _____ Food _____ Other _____

History of Anaphylaxis to _____ Epi -Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: _____

☐ ☐ Other (*Please specify*) _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:** _____

Hgt: _____(____%) Wgt: _____(____%) BMI: _____(____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General _____ ☐ Lungs _____ ☐ Extremities _____

☐ Skin _____ ☐ Heart _____ ☐ Neurologic _____

☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____

☐ Dental/Oral _____ ☐ Genitalia _____

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other _____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):

TB Test Type: ☐ TST ☐ IGRA Date: _____ Result: ☐ Positive ☐ Negative ☐ Indeterminate/Borderline

Referred for evaluation to: _____ Date: _____ ☐ Low risk (no TB test done)

This student has the following problems that may impact his/her educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit

☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations: _____

☐ Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** _____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.**

_____ _____

Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____ _____

Group Practice Telephone

_____

Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 08/15/13*