

2020 PreKindergarten Registration

Welcome to the Athol-Royalston Regional School District PreKindergarten Registration for 2020! We appreciate your interest in our program and are working to welcome as many to you our program as possible. This step in the registration process demonstrates your interest in our program, it does not guarantee a spot in our program. We will notify families in June of your acceptance into our program. Following that initial enrollment, we will maintain a waitlist throughout the 2020-2021 school year and will call families as we have openings.

All PreK classes are held at ACES.

Students who have one year remaining in PreK: (attending K in Fall 2021- age 5 by 9/1/2021)

5 days a week (Monday - Friday)

Afternoon class (PM) - 12:15pm - 2:45pm

Students who have two years remaining in PreK: (must be age 3 to start)

4 days a week (Monday - Thursday)

Morning class (AM) - 8:45am - 11:15am

COMPLETED REGISTRATIONS INCLUDE:

- Registration Form
- Home Language Survey
- Military Family Form
- ORIGINAL Birth Certificate (with raised seal- school will make copy and give back original)
- Proof of Residence (Utility bill, cable bill, lease agreement, purchase and sale agreement
NO credit card, insurance or cell phone bills will be accepted)
- Immunization Record (must be current within one year)
- Documentation of a physical (Massachusetts School Health Record) including lead test
screening results, vision screening, and hearing screening (current within one year)
- Custody Agreement (if present)
- Release of Records form (If transfer from another district)

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- Pre- 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 _____

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 _____	Gender F <input type="checkbox"/> M <input type="checkbox"/>
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) _____	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 <input type="checkbox"/> N <input type="checkbox"/>	Will you require an interpreter/translator at Parent-Teacher meetings? Y <input type="checkbox"/> N <input type="checkbox"/>		
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

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



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)

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.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

Screening:

	(Pass) (Fail)		(Pass) (Fail)		(Pass) (Fail)
Vision: Right Eye	<input type="checkbox"/> <input type="checkbox"/>	Hearing: Right Ear	<input type="checkbox"/> <input type="checkbox"/>	Postural Screening:	<input type="checkbox"/> <input type="checkbox"/>
Left Eye	<input type="checkbox"/> <input type="checkbox"/>	Left Ear	<input type="checkbox"/> <input type="checkbox"/>	(Scoliosis/Kyphosis/Lordosis)	
Stereopsis	<input type="checkbox"/> <input type="checkbox"/>				

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:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> 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