WINCHENDON PUBLIC SCHOOLS

PRE-K REGISTRATION FORM

2020-2021

Childs' Name _____ Boy _____ Girl _____
First Middle Last

Address _____

Date of Birth _____ Place of Birth _____
Month Date Year

Primary Telephone _____ Email Address _____

Child's Legal Guardian(s) _____ Relationship _____

Parent/Guardian #1 _____ Occupation _____

Address _____ Telephone _____

Place of Employment _____ Work Phone _____

Parent/Guardian #2 _____ Occupation _____

Address _____ Telephone _____

Place of Employment _____ Work Phone _____

Other Children of the Household:

Name	Relationship	Date of Birth	School

Please send completed form to:

Winchendon Pre-K Program
175 Grove Street, Suite D-2
Winchendon , MA. 01475

If you have any questions please call the Winchendon Pre-K Office at 978-297-3436.

Winchendon Public Schools
STUDENT EMERGENCY AND HEALTH RECORD
School Year 2020-2021

Name:________________________Teacher__________Grade Birthdate__________

Home address: phone# _ _ _ _ _

Email address:_ _

Mother/Guardian______________________________Home Phone______________

Home Address______________________________Cell Phone______________

Employed at ______________________________Business Phone______________

Father/Guardian______________________________Home Phone______________

Home Address______________________________Cell Phone______________

Employed at______________________________Business Phone______________

- Are there any legal restrictions for the release of your child or his/her records to the non-custodial parent?
  _YES _NO. If yes, please specify and provide legal documents:______________________

List three people to whom we may release your child to assume temporary care of him/her if the school is unable to contact you.

1. Name:..__________Relationship______________
   Address:____
   Home#: ______________ Work #: Cell #._·______________

2. Name:______________________________ Relationship ______________
   Address:.____
   Home#: Work #· Cell #._·______________

3. Name: _ Relationship______________
   Address·____
   Home#: ______________ Work #· Cell #·.______________

Physician Name:______________________________Telephon-e_#______________

Does your child have health insurance?_Y _N Name:______________________Policy #___ _

Dentist Name:______________________________Telephone# ______________

Does your child have dental insurance?___ Name:______________________Policy# ________

Does your child see a dentist every 6 months?__________Fluoride treatment Sealants,__ _

By signing below:

- I am authorizing the school to release my child to any of the people listed above,
- I release all parties from all liability and responsibility while acting in the best interest of the above named child.

Signature of Parent/Guardian:____________________________________Date:__________

••*PLEASE NOTIFY THE SCHOOL OF ANY CHANGES AS SOON AS POSSIBLE*"'.. ***

Please complete both sides and return to school

HEALTH HISTORY; LIFE THREATENING ALLERGIES; MEDICATIONS

Please indicate if your child has a physician verified allergy to any of the following. If yes, please provide official documentation by your child's physician and an Emergency Care Plan to the Nurse's Office at the beginning of the school year. Written prescriptions are required for all EpiPens, Inhalers, Benadryl and prescription medications.

ALLERGIES.:.

Bee Stings_ Peanuts_ Nuts_ Medications_____Other_____

EpiPen Required? Yes No Benadryl required? Yes_ No ..
Has an EpiPen ever been used? Yes No.
Does your child carry their Epipen? Yes__ No.._

ILLNESS/CHRONICCONDITIONS (Indicate if your child has experienced any of the following and explain)

Asthma	Anxiety	Attention-Deficit	Concussion
Depression	Diabetes	Fainting	Heart Condition
Hearing Deficit	Hospitalization	Lactose Intolerant	Migraines
Injuries	Scoliosis	Seizures	Other_____

Please explain condition:_____

Vision: Eye Glasses/Contacts: Yes_ No Dateoflasteyeexam:_____

Sports: *Do* you know of any reason your child should not participate in sports? Please explain:_____
(A physical exam is required for students entering grade 9, as well as annually for school sports)

MEDICATIONS (Please list prescribed and over the counter medications your child takes. Include herbal treatments.)

Name of Medication & Dose	Reason	Home	School

Statement: "*I hereby authorize the school to arrange transportation via ambulance to the hospital in case of accident or serious illness. I understand that all attempts will be made to reach me. I give permission to the School Nurse to share information relevant to my child's health with appropriate school personnel when needed to meet my child's health and safetJ! needs. I give permission to exchange information with my child's primary care physician and specialists for the purpose of referral, diagnosis and treatment, as well as obtaining current immunization and physical exam status.*•

Parent/Guardian Signature:_____Date:_____

MEDICATION PERMISSION

Yes **No** I give permission to the School Nurse to administer Acetaminophen as directed by mouth.
Yes **No** I give permission to the School Nurse to administer Ibuprofen as directed by mouth.
Yes **No** I give permission to the School Nurse to administer Tums (or generic equivalent) 1-2 tabs.

Parent/Guardian Signature:_____Date:_____

Our School Physician, Dr. john Harrington, has agreed to grant his permission far the administration af Acetaminophen, Ibuprofen and Tums in the school at the discretion of the School Nurse, with written parental permission. Please complete above.

Winchendon Public Schools
District Student Enrollment Form
2020-2021

Student Information:

SASID:_____ LASID:_____ Male_____ Female_____
Last Name:_____Current Grade: _____ Retained: _____no _____yes _____ grade retained
First Name:_____ Home Phone:_____
Middle Name:_____ Date of Birth: _____City of Birth:_____
Country of Origin_____

Home Address: _____
City/Town: _____
State & Zip: _____

Race: (check all that apply) ___American Indian or Alaska Native _____Asian ___Black or African American
___Native Hawaiian or Other Pacific Islander ___White

Ethnicity: ___Hispanic or Latino _____Not Hispanic or Latino

Low Income Status: ___Eligible for free lunch (01)
___Eligible for reduced lunch (02)

First Native Language: _____Primary Language Spoken at home_____
Child speaks and understands English fluently: ___yes ___no Secondary Language Spoken at home_____
Child's parent/guardian speaks, reads and understands English fluently: _____yes _____no

Parent/Guardian Information:

Parent/Guardian: _____
Address: (if different from above): _____
Home Phone: _____Work Phone_____ Cell Phone_____
E-Mail Address: _____
Emergency Contact: (name, relationship and phone number) _____

Special Education Information:

Foster Placement: _____yes _____no
Name of Social Worker & agency: _____Phone:_____
Receiving any Special Educational Services: _____yes _____No
If so, please specify: _____

Miscellaneous:

School Choice: _____yes _____no
Previous School Attended: _____
Address: _____
City, State, Zip: _____

Additional Information Needed:

Date of Enrollment: _____
First Day of Attendance _____
Homeroom Teacher: _____

Original form is to be maintained in the school office file. Copies should be sent to the following:

_____Central Office _____School Nurse _____Special Education Office

Over

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)

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):
Date of PPD: ____; Results: ____mm.
Referred for evaluation to: _____ ☐ Low risk (no PPD 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 11/23/04*

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / / **Sex:** □female □male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		**Other:**		
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)* **Date:** / /

Signature: _____

Facility name: _____