Norwich Public Schools

K-8 REGISTRATION PACKET
for 2018-19 School Year

COMPLETE & RETURN

RETURN TO:

526 East Main Street
Norwich, CT 06360

REGISTRAR:

Jolea Cannon
jcannon@norwichpublicschools.org
(860) 823-4201 ext. 2104

2018-19 **School** _____ **SASID#**_____ **State**_____ **PS**_____ Entry Date_____ **Class** _____

NORWICH PUBLIC SCHOOLS REGISTRATION FORM

Please print legibly. All items must be completed

Student's Legal Name: _____
Last First Full Middle

Student's Address: _____ **Norwich, 06360** **Taftville, 06380** **Yantic, 06389**

Date of Birth _____ **Birth City and State:** _____ **Male** ☐ **Female** ☐ **Non-Binary** ☐

ETHNICITY: **Hispanic or Latino: Y N** **LANGUAGE SPOKEN AT HOME** _____ Grade____

RACE: Check ALL that apply:
☐ American Indian or Alaskan ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander

STUDENT LIVES WITH: ☐Parents ☐Mother ☐Father ☐Guardian ☐Foster ☐Other _____

Parent /Legal Guardian 1: _____ **Relationship**_____

Address: _____ **Norwich, 06360** **Taftville, 06380** **Yantic, 06389**

Mailing Address: _____ **E-mail** _____
(if different)

Home Phone _____ **Cell Phone** _____ Military? ☐ Y ☐N

Employer _____ **Work Phone** _____

Parent /Legal Guardian 2: _____ **Relationship**_____

Address: _____ **Norwich, 06360** **Taftville, 06380** **Yantic, 06389**

Mailing Address: _____ **E-mail** _____
(if different)

Home Phone _____ **Cell Phone** _____ Military? ☐ Y ☐N

Employer _____ **Work Phone** _____

****Phone number we should use first for attendance calls or school text messages**** _____
Message and data rates may apply

Emergency Contact Information: **(In case of illness or emergency and you are unable to be reached)**

Name_____Relationship_____ Telephone _____

Name_____Relationship_____ Telephone _____

Has this pupil ever attended school in the Norwich School System? ☐ Y ☐N (If *Yes*, answer below)

Name of School _____Grade _____Year_____

School Last Attended (For Kindergarten Students include Preschool if applicable)

_____
Name of School City/State Phone # Grade

Other Children in Family:

*Name*_____ *School* _____*Grade*_____ *Relationship*_____
Name_____ School _____Grade_____ Relationship_____
Name_____ School _____Grade_____ Relationship_____

Day Care Provider ☐ **A.M.** ☐ **P.M.**
Name_____**Address**_____**Phone**_____

I give my permission to have my child taken to the nearest hospital in case of an emergency.

_____
Signature of Parent/Guardian Date

Student's Legal Name *Last* _____ *First* _____ *Full Middle*_____

SUPPORT SERVICES Please check all that apply:

☐ IEP ☐ 504 ☐ Hearing Impairment ☐ Visual Impairment
☐ Emotional Disturbance ☐ Orthopedic Impairment ☐ Specific Learning Disability
☐ Other Health Impairment ☐ Speech or Language Impairment ☐ Other _____

Student's Physician:_____ **Phone:**_____
Student's Dentist:_____ **Phone:**_____

Does your child have health insurance? Yes No

PLEASE CIRCLE AREAS OF CONCERN. WRITE IN IF NOT LISTED.

1. General Health (e.g., fatigue, low energy level, poor sleeping habits, frequent illness, poor posture)
   _____
2. Behavior/personal relationships (e.g., very active, runs away, needs to be center of attention, loner, easily upset, shy has difficulty making friends).
   _____
3. Specific physical condition/illness past or present (e.g., cerebral palsy, epilepsy, back abnormality, sickle cell anemia, asthma, diabetes, heart problems)
   _____
4. Does this child have a health problem which may require EMERGENCY ACTION while at school (e.g., respiratory or epileptic, heart problem)? ☐ YES ☐ NO If *yes*, please explain:
   _____
   _____
5. Allergy (e.g., insect stings, foods, drugs, pollen)? Please list: _____
   _____
6. MEDICINE AT HOME: Please list any prescribed medicine your child may be taking before or after school (not vitamins).
   Medication: _____ Doctor: _____
   NOTE: Medicine may not be taken at school unless a **STATE AUTHORIZED FORM** is filled in by your doctor.
7. May the pupil participate in normal school activities? ☐ YES ☐ NO
   If *No*, PLEASE LIST EXCEPTIONS:
   _____
8. Vision, hearing, speech:
   _____
9. If female: Menstrual (e.g., pain, irregularity, late or early onset)
   _____
10. **If you would like to discuss your child's health with school or school health personnel, please check below**
    ☐ Nurse ☐ Teacher ☐ Principal ☐ Counselor

I give permission for the release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____
Signature of Parent / Guardian *Date*

State of Connecticut Department of Education

Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	❑ Black, not of Hispanic origin
Primary Care Provider	❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N Does your child have dental insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* If applicable

Part I — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
Lead:	
***HCT/HGB:**	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____

Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap						
IPV/OPV	*	*	*			
MMR						
Measles	*	*				
Mumps	*					
Rubella	*					
HIB	*				Students under age 5	
Hep A						
Hep B	*	*	*			
Varicella	*					
PCV					Pneumococcal conjugate vaccine	
Meningococcal						
HPV						
Flu						
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption

Religious _____ Medical: Permanent _____ Temporary _____ Date _____

Recertify Date _____ Recertify Date _____ Recertify Date _____

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN
DTaP: At least 4 doses. The last dose must be given on or after 4th birthday
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hib: Children less than 5 yrs of age need 1 dose at 12 months or older Children 5 and older do not need proof of Hib vaccination
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 1-6
DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday
Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 7-12
Td/Tdap: At least 3 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after first birthday or verification of disease:
VARICELLA VACCINE: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart
VERIFICATION OF DISEASE: Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

NORWICH PUBLIC SCHOOLS
VERIFICATION OF RESIDENCY

In order to verify residency within the Norwich Public Schools, a driver's license and one current document from the following list must be provided. If a parent does not have a driver's license, two of the following documents must be provided. Said documents must show parent/guardian name and address, and must be dated within 60 days prior to your child's first day of school. Past due bills are not acceptable for verification. Post Office box numbers are not acceptable as residence addresses:

Current Address/City/State_____

_____ **Driver's License (make copy) and one of the following: ____ Passport ___Photo ID**

_____ Escrow papers, mortgage book or statement

_____ Lease Agreement/Rental Contract and current rent receipt or notarized letter from landlord.

_____ Affidavit

_____ Utility Bill _____ Cable Bill ____ Affidavit _____Other _____

I, _____(print name of parent/guardian)

_____(Student's name) declare under penalty of perjury that the above named student resides at the address shown on the documents indicated above and attached. **I will notify the school within two weeks if residency changes** and agree to provide a new residency proof and updated signed statement at that time. If I move outside of the school district, written approval from the Superintendent of Schools must be granted in order for the student's continued attendance.

WARNING: Falsification of any information or document required for residency verification or the use of the address of another person without actually residing there may result in revocation of student enrollment.

Parent/Guardian Signature:_____Date:_____

FOR SCHOOL USE ONLY:
The attached documents show the name and address of the person enrolling the above named student. If not the parent, court papers for guardianship is required, or residency affidavit.

Signature of School Official:_____ Date:_____
02/23/2016

A.1.a English Language Learner's Survey and School History – English

Norwich Public Schools
ENGLISH LANGUAGE LEARNER'S SURVEY

Child's Full Name		Date of Birth	
School		Grade	

Dear Parents/Guardians: In compliance with Public Act 77-588, please complete this questionnaire on behalf of your child.

What is the primary language used in the home, regardless of the language spoken by the student?	
What is the language most often spoken by the student?	
What is the language the student first acquired?	

CHILD'S SCHOOL HISTORY

Has the student ever been in **bilingual classes** (Classes taught in a language other than English)?					Yes		No	
If ***yes***, where?	School							
	Town, State							
When?	Dates		Grades					

Has the student ever been enrolled in **ESL** (English as a Second Language) classes (special classes or extra help learning English) in another school district in the United States?					Yes		No	
If ***yes***, where?	School							
	Town, State							
When?	Dates		Grades					

CHILD'S RESIDENCE

Is your child entering the United States from another country?	Yes ☐ No ☐
If ***yes***, from which country?	
On what date did your child first enter the United States?	
On what date did your child first attend school in the United States?	When? Where?

PARENTS' PREFERRED LANGUAGE FOR OFFICIAL NOTIFICATIONS

In which language would you prefer to receive official notifications from Norwich Public Schools? (Please choose one.)							
English		Spanish		Haitian Creole		Chinese	

SIGNATURE

Name of person completing this form			
Relationship to child		Date	