# R.D. Seymour Elementary School

Marsie Luckenbach, Principal

Welcome to East Granby Public Schools
www.eastgranby.k12.ct.us

Registration Information for Grades 3-5

Welcome to R.D. Seymour School! All the forms in our registration packet can be completed in your web browser, saved, and printed for submission. All completed registration forms may be emailed to registration@eastgranby.k12.ct.us. We recommend typing in the fillable forms to ensure the accuracy of the information submitted. Please increase the point size of the type so it is readable for inputting to our database. We look forward to meeting you and your child(ren) in the very near future.
If you have any questions regarding registration, please feel free to email us or leave a message at 860-653-7214. Please complete the following fillable forms included in this registration packet:

- Seymour Registration Form
- Public School Information System Form
- Release of Information
- Dominant Language Form
- Emergency Form
- Bus Transportation Form
- State of Connecticut Health Assessment Record

In order to complete the registration process, you will need to appear in person with the following documentation:

Original Birth Certificate
- We will take a copy for our records.

Proof of Residency:
- If you own your home, we will verify through the Town Assessor's Office
- Copy of a Utility Bill
- Copy of the Sales Agreement if purchasing home and scheduled closing date.
  (If requesting to start school prior to closing date, written request must be submitted and approved by our Superintendent, Melissa Bavaro – mbavaro@eastgranby.k12.ct.us )
- If you are renting, a copy of your current lease agreement with lessee and lessor signatures.
- If residing with family and do not have a lease, a Proof of Residency, Policy 5118, APR#1 must be completed and Notarized.

We look forward to having you become a member

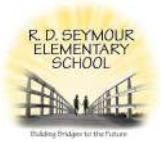
of our Seymour Community!

*mluckenbach@eastgranby.k12.ct.us*

185 Hartford Ave. • East Granby, CT 06026 •860-653-7214 • Fax 860-413-9081

# EAST GRANBY PUBLIC SCHOOLS

☐ Uses an Inhaler
☐ Needs EpiPen for: _____
☐ Daily Meds: _____
*Please note we must have all medication present on the day of Orientation.*




❒ Birth Certificate Received
❒ Proof of Residency

East Granby, Connecticut

## GRADES 3-5 REGISTRATION FORM

**Student/Parent Information:**

☐ Male
☐ Female

_____ _____ _____ _____
Student's Name | Grade | Birth Date | Birth Place

Address: _____ ❒ Own ❒ Rent **Phone #**:_____
*If you are not currently occupying this East Granby residence, give current residence. Written permission must be obtained from the Superintendent of Schools if your current residence is not East Granby.

_____

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

Email Address: _____

*Full Name of Siblings in Family*:

Name: _____ Year of Birth: _____ Grade: _____
Name: _____ Year of Birth: _____ Grade: _____
Name: _____ Year of Birth: _____ Grade: _____

Mother's Name or Guardian: _____ Home Phone:_____
Home Address: _____ Cell Phone: _____
Employer: _____ Work Phone: _____

Father's Name or Guardian: _____ Home Phone:_____
Home Address: _____ Cell Phone: _____
Employer: _____ Work Phone: _____

Guardian: _____ Home Phone:_____
Home Address: _____ Cell Phone: _____
Employer: _____ Work Phone: _____

**Student Education Information:**

Has your child ever been referred for Special Education Services? ❒ Yes ❒ No
Has your child ever received Special Education Services? (ie. Speech, Birth to 3, etc.) ❒ Yes ❒ No
Town where services were received: _____ Provider: _____

***Please Check:***

❒ If there is any information about your child's health or personality which you think the teacher should know, please explain on the back of this form or arrange to have a conference with the teacher.

Signature of Parent (Guardian)_____ Date:_____ **Rev. 3/2022**

# East Granby Public Schools
# Student Information Request Form

| Student's Last Name | Student's First Name | Student's Middle Name |
|---|---|---|
| | | |
| **Street Address** | **City, State, Zip** | **Home Phone** |
| | | |

| Gender *(M, F, Non-binary)* | Birthdate *(MM-DD-YYYY)* | Name of Last School Attended | City and State of Last School Attended |
|---|---|---|---|
| | | | |

| Place of Birth: *Please list City, State and Country* | Year of Immigration *(complete if child was not born in USA)* | Number of School Years Completed in USA *(complete if child was not born in USA)* |
|---|---|---|
| | | |

| Date of Enrollment | Anticipated Year of Graduation | Grade |
|---|---|---|
| | | |

| *(Parent 1)* **Name** | *(Parent 1)* **Street Address** | *(Parent 1)* **City, State, Zip** |
|---|---|---|
| | | |
| *(Parent 1)* **Occupation** | *(Parent 1)* **Employer** | *(Parent 1)* **Home Phone** |
| | | |
| *(Parent 1)* **Work Phone** | *(Parent 1)* **Cell Phone** | *(Parent 1)* **Email** |
| | | |
| *(Parent 2)* **Name** | *(Parent 2)* **Street Address** | *(Parent 2)* **City, State, Zip** |
| | | |
| *(Parent 2)* **Occupation** | *(Parent 2)* **Employer** | *(Parent 2)* **Home Phone** |
| | | |
| *(Parent 2)* **Work Phone** | *(Parent 2)* **Cell Phone** | *(Parent 2)* **Email** |
| | | |

| **Military Family** – the child's parent or guardian is a member of the Armed Forces on active duty or serves on full-time National Guard duty. | **Military Family?** - *YOU MUST CHOOSE ONE* | **Immigrant?** - *YOU MUST CHOOSE ONE* |
|---|---|---|
| | ☐ **YES** ☐ **NO** | ☐ **YES** ☐ **NO** |

**Race/Ethnicity**: **IS YOUR CHILD HISPANIC OR LATINO? –*YOU MUST CHOOSE ONE***

☐ **YES** ☐ **NO**

**Race/Ethnicity**: (*Check all that apply)*-- **YOU MUST CHOOSE AT LEAST ONE**

☐ **American Indian or Alaska Native** ☐ **Asian**
☐ **Black or African American** ☐ **Native Hawaiian or Other Pacific Islander** ☐ **White**

| What is the dominant language at home? *(If other than English)* | Eligible for free/reduced price for milk and lunches? *(Yes or No) Please call 653-6486 for details.* |
|---|---|
| | |
| **Transfer Students Only-School Name (Transferring From)** | **School Address and Phone (Transferring From)** |
| | |

Revised—March 2022

# EAST GRANBY PUBLIC SCHOOLS

East Granby, Connecticut

## RELEASE OF INFORMATION

Name of Student: _____ Date of Birth: _____

Phone # where parent can be reached after moving:_____

❒ I give permission for the East Granby Public Schools to receive the records indicated below from:

Name of school the student attends:

_____

Name of School Address/Zip Code Phone #

❒ I give permission for the East Granby Public Schools to release the records indicated below to:

_____

Name of School Address Zip Code

These records are for the purpose of <u>educational planning and programming.</u>

**IMPORTANT:** Please check items you wish to be received or released:

❒ Health Record
❒ Grades
❒ Achievement Scores
❒ Behavorial Check Lists
❒ Anecdotal Information
❒ Verbal Communication
❒ Psychological Record
❒ Social Work Record
❒ Speech/Language Evaluation Report
❒ I.Q. Scores
❒ Special Education Evaluation Report
❒ Other: _____
❒ PPT Records (Notice of Meeting, Notice of Evaluation, Case Summaries, Referral, etc.)

**NOTE:** This confidential information is being sent on the condition that no other party should have access to it without written consent of parent/guardian, or the student, if he/she is 18 years of age or a graduate.

I understand that I may review the materials checked on this release form before they are transmitted. I understand that one week from the date of this release, the above materials will be forwarded as requested.

_____ _____

Parent/Guardian Signature Date

**Please return this form and all records/correspondence to:**

R.D. Seymour School
185 Hartford Ave.
East Granby, CT 06026
Fax (860) 413-9081
Attn: School Secretary

Rev. 3/2022

# EAST GRANBY PUBLIC SCHOOLS

## DOMINANT LANGUAGE

Parent Questionnaire for Preliminary Assessment of Dominant Language
(Step 1)

Date:_____

Dear Parent / Guardian:

Connecticut State Law requires that each school district conduct a preliminary assessment of the dominant language of each student in its public schools. This assessment is made in order to ascertain the need to provide a required bilingual education program for students who are limited English proficient.

Please complete the following form and return it to the office.

Thank you for your cooperation.

---

Student's Name: _____

Grade: _____

Where was your child born? _____

What language did your child first learn to speak?
_____

What is the primary language spoken by you or other persons in your home?
_____

What is the primary language spoken by your child when he/she is at home?
_____

_____ _____
Parent's Signature Date

Rev. 2/27/02

**Grade** _____
**Teacher** _____
**Bus No.** _____

# EMERGENCY INFORMATION FORM

*(Please Print)*

**For Office Use**

☐ Allergies _____
☐ EMCP
☐ Known Services

**Student Name:** _____ **Birthdate:** _____
Last Middle First

**Address:** _____
Street Town

_____
State Zip Parent Email Address

**Mother's Name:** _____ **Home:** _____
**(Parent 1)** Last First **Cell:** _____

_____ **Work :** _____
Address

**Employer:** _____

**Father's Name:** _____ **Home:** _____
**(Parent 2)** Last First **Cell:** _____

_____ **Work:** _____
Address

**Employer:** _____

**List three neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.**

**Name:** _____ **Address:** _____ **Phone:** _____
**Cell:** _____

**Name:** _____ **Address:** _____ **Phone:** _____
**Cell:** _____

**Name:** _____ **Address:** _____ **Phone:** _____
**Cell:** _____

**In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.**

_____
Signature of Parent/Guardian Date

**Remarks:** _____

**Allergies:** _____

**Other Conditions:** _____

---

**Local Physician's Name:** _____ **Address:** _____

**Office Number:** _____ **Other Number:** _____

**Hospital Preference:** _____ **Does your child have health insurance?** ☐ **Yes** ☐ **No**

Print

# Transportation Request Form

***IMPORTANT:*** *To plan for next year's transportation, we are asking for parents/guardians to complete a transportation form for* ***each*** *student.* ***Please complete in full and return to your child's school office.*** ***If we do not receive a completed form, your child will be assigned the bus route for your home address of record****. If, over the course of the summer, your transportation needs change, please notify the school office IN WRITING two weeks prior to the start of school. Thank you for your continued support in making transportation safe for our students.*

| | |
|---|---|
| Student Name: | Grade Level: for the ⬇ ⬇ ⬇ |
| Home Address: | Current School Year ☐ Next School Year ☐ |

***My child will travel to school:***

**☐ By bus** **☐ By parent drop-off**

I request that my child be picked up by the bus from:

| | | | |
|---|---|---|---|
| Address: | Home ☐ | Daycare ☐ | Alternate location ☐ |

Phone:

***If*** alternate location: please print name / contact number and signature of receiving adult at above address:

| | |
|---|---|
| Name: | Best Contact Number: |

Signature of receiving adult:

| | |
|---|---|
| **☐ Daily** **OR** | Only on the following days: (please circle) **M T W TH F** |

***My child will travel from school:***

**☐ By bus** from school

| | |
|---|---|
| Address: | Home Daycare Alternate location |

Phone:

***If*** alternate location: please print name/contact number and signature of receiving adult at above address:

| | |
|---|---|
| Name: | Best Contact Number: |

Signature of receiving adult:

| | |
|---|---|
| **☐ Daily** **OR** | Only on the following days: (please circle) **M T W TH F** |

**For Allgrove School and Seymour School Students ONLY**

☐ I will **PICK UP** my child from school

☐ I have made arrangements to have my child picked up from school by: _____

_____(Phone#)_____

| | |
|---|---|
| **☐ Daily** **OR** | Only on the following days: (please circle) **M T W TH F** |

**AND/OR**

☐ My child attends the YMCA Afterschool Program

Reminder: Your child must be **enrolled** in the YMCA and on their list.

| | |
|---|---|
| **☐ Daily** **OR** | Only on the following days: (please circle) **M T W TH F** |

**Required for all requests**

| | |
|---|---|
| Parent Name (Print): | Contact Number: |
| Parent Signature: | Date: |

Rev. 1/6/20

# 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, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base 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 | ❑ White, not of Hispanic origin |
| | ❑ Hispanic/Latino | ❑ Asian/Pacific Islander |
| | | ❑ Other |
| Health Insurance Company/Number* or Medicaid/Number* | | |
| Does your child have health insurance?<br>Does your child have dental insurance? | 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 | Hospitalization or Emergency Room visit | Concussion |
| Allergies to food or bee stings | Any broken bones or dislocations | Fainting or blacking out |
| Allergies to medication | Any muscle or joint injuries | Chest pain |
| Any other allergies | Any neck or back injuries | Heart problems |
| Any daily medications | Problems running | High blood pressure |
| Any problems with vision | "Mono" (past 1 year) | Bleeding more than expected |
| Uses contacts or glasses | Has only 1 kidney or testicle | Problems breathing or coughing |
| Any problems hearing | Excessive weight gain/loss | Any smoking |
| Any problems with speech | Dental braces, caps, or bridges | Asthma treatment (past 3 years) |
| **Family History** | | Seizure treatment (past 2 years) |
| Any relative ever have a sudden unexplained death (less than 50 years old) | | Diabetes |
| Any immediate family members have high cholesterol | | ADHD/ADD |

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? 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 |
|---|---|
| History of Lead level ≥ 5µg/dL ❑ No ❑ Yes | |
| ***HCT/HGB:** | |
| ***Speech** (school entry only) | |
| 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

**Student Name:** _____ **Birth Date:** _____ HAR-3 REV. 4/2017

# 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** | * | | | | Required 7th-12th grade | |
| **IPV/OPV** | * | * | * | | | |
| **MMR** | * | * | | | Required K-12th grade | |
| **Measles** | * | * | | | Required K-12th grade | |
| **Mumps** | * | * | | | Required K-12th grade | |
| **Rubella** | * | * | | | Required K-12th grade | |
| **HIB** | * | | | | PK and K (Students under age 5) | |
| **Hep A** | * | * | | | See below for specific grade requirement | |
| **Hep B** | * | * | * | | Required PK-12th grade | |
| **Varicella** | * | * | | | Required K-12th grade | |
| **PCV** | * | | | | PK and K (Students under age 5) | |
| **Meningococcal** | * | | | | Required 7th-12th grade | |
| **HPV** | | | | | | |
| **Flu** | * | | | | PK students 24-59 months old – given annually | |
| **Other** | | | | | | |

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

**Exemption:** Religious _____ **Medical:** Permanent _____ Temporary _____ **Date:** _____

**Renew Date:** _____ _____ _____ _____

**Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.**
**Medical exemptions that are temporary in nature must be renewed annually.**

## Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

### KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

### GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

### HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

**Note:** The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

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

Print