East Granby Middle School

Timothy Phelan, Principal

95 South Main Street
East Granby, CT 06026
Phone (860) 653-7113
Fax (860) 413-9126

Student Registration Grades 6-8
Welcome to the East Granby Public Schools

www.eastgranby.k12.ct.us

Please complete each of the required* forms and any optional forms that apply to your child. Only one student per form please. All registration forms are web-enabled and can be completed, saved, and emailed.

1. Release of Information*
2. Student Information Request Form*
3. State of CT Health Assessment Record *
4. Technology & Internet Usage Permission Form *
5. Emergency Contact Form*
6. Authorization to Administer Medication Form
7. Media Consent Form
8. Dominant Language Form

In addition, please bring **proof of residency** (see below) and an original **birth certificate** (must be the long form with a raised seal) to the school office in person. Registration is not complete until all forms and documentation are received.

Proof of Residency (Please provide the following):

- Copy of a valid current lease agreement for your rental home/apartment in East Granby with the signatures of the lessee and lessor.
- Copy of a recent utility bill (electric, water, oil/gas, cable, landline phone) in your name and showing services provided for your East Granby house/apartment
- Copy of sales contract for your home in East Granby.
- Contract with closing date (within 60 days of registration). After the closing, parent must provide proof of residency.
  ****Permission to enroll must be granted by the Superintendent if requesting to start school before taking occupancy of the East Granby house/apartment. ****

Thank you,
Timothy F. Phelan, Principal

East Granby Middle School

95 South Main Street, East Granby, Connecticut 06026
(860) 653-7113 * Fax (860) 413-9126

RELEASE OF INFORMATION

NAME OF STUDENT _____ ***DOB*** _____

☐ ***I PERMIT THE EAST GRANBY PUBLIC SCHOOLS TO RECEIVE THE RECORDS INDICATED BELOW FROM:***

☐ ***I PERMIT THE EAST GRANBY SCHOOLS TO RELEASE THE RECORDS INDICATED BELOW TO:***

NAME ***ADDRESS*** ***ZIP CODE***

Name of school the student attends, or will be attending, in East Granby, Connecticut:

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

IMPORTANT: Please indicate (X) items you wish to be received or released:

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

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 material 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.

_____ _____
Date Parent/ Guardian Signature

RETURN THIS FORM AND ALL RECORDS/CORRESPONDENCE TO:

Main Office
East Granby Middle School
95 South Main St.
East Granby, CT 06026

<u>For Office Use Only</u>
Date Received_____
Date Records Processed: _____
Records Processed by: _____

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 *(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)

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 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

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 ☐ American Indian/ Alaskan Native ☐ Hispanic/Latino	☐ Black, not of Hispanic origin ☐ White, not of Hispanic origin ☐ Asian/Pacific Islander ☐ Other
Primary Care Provider		
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 1 — 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 2 — 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 1 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			*__Postural__ ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made		
Genitalia/ hernia					
Skin					

Screenings

*__Vision Screening__			*__Auditory Screening__			History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	Date
Type:	Right	Left	Type:	Right	Left		
With glasses	20/	20/		❑ Pass ❑ Fail	❑ Pass ❑ Fail	*__HCT/HGB:__	
Without glasses	20/	20/				*__Speech__ (school entry only)	
❑ Referral made			❑ Referral made			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

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	☐ Male ☐ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No

Risk Assessment	**Describe Risk Factors**	
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other _____

Recommendation(s) by health care provider: _____

_____

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

_____

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

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 7/2018

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

East Granby Public Schools

East Granby, Connecticut

TECHNOLOGY & INTERNET USER AGREEMENT FOR STUDENTS & PARENTS/GUARDIANS

After reading the *Rules and Codes of Ethics for School Computer Users,* as well as the language presented in the East Granby Board of Education (EGBOE) Policy 6141.321, including all appendices, please complete this form to indicate that you agree with the terms and conditions outlined in the aforementioned articles. The signatures of students, parent(s)/guardians, are mandatory before access may be granted. This document reflects the entire agreement and understanding of all parties.

Students & Parents

I have read this Technology and Internet User Agreement and I understand that access is for educational purposes only. The East Granby Public School District (the "District") has taken precautions to eliminate controversial material. However, I also recognize it is impossible for the District to restrict access to all controversial and inappropriate materials. I will hold harmless the District, its employees, agents, or EGBOE members, for any harm caused by materials or software obtained via any and all electronic sources. I accept that it is the full responsibility of the parent/guardian to supervise student use of electronic devices and networks when not in the school setting.

I understand the District and/or its agents may access and monitor my use of any electronic devices, District-assigned services, and District internet usage, including email, files, and downloaded material, without prior notice to me. I further understand that, should I commit any violation, my access privileges may be revoked and school disciplinary action, and/or appropriate legal action may be taken. In consideration for using the District's electronic devices and computer network, I hereby release the District and its EGBOE members, employees, and agents from any claims and damages arising from the use, or restriction from use, of the aforementioned services.

As a parent/legal guardian of the student signing on the indicated line below, I grant permission for my child to utilize electronic devices and computer networks, including email and the Internet. I have read and agree to all rules, codes, and policies referenced by this document. I agree to accept responsibility for guiding my child and conveying appropriate standards for selecting, sharing, and/or exploring information and media I agree to hold harmless the East Granby Public Schools and employees of the school district for any misuse of access that my child commits. I understand that, once signed, this agreement is legally binding.

Student Name (Print First & Last):_____Grade: _____

Student Signature:_____Date: _____

Parent/Guardian Name (Print First & Last): _____

Parent Signature*:_____ Date: _____
Parent Street Address: _____
Home Telephone:_____Mobile Telephone: _____
****Signature denotes agreement through tenure in East Granby Public Schools***.
*Not required if the student is 18 years of age or older at current date.

After completion of this form, it must be returned to the student's school office. If you have questions or need further information regarding the content or policies indicated above, please contact the East Granby Board of Education Office at 860-653-6486. Last update: 4/2018

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**

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse to administer medications or in her absence the principal or teacher to administer medications. Medications must be in pharmacy prepared containers and labeled with name of child, name of drug, strength, dosage, frequency, physician's or dentist's name and date of original prescription.

PHYSICIAN OR DENTIST'S ORDER

Name of Child_____,Date_____

Date of Birth_____

Condition for which drug is being administered during school hours_____

_____

DRUG: name, dose and method of administration

Time of administration_____

Medication shall be administered from.....to.,_____

(Date) *(Date)*

Relevant side effects to be observed, if any _____

_____

If there are side effects, plan for management_____

_____

Is this a controlled drug? _____If yes, DEA number _____

Physician's/Dentist's Name,_____ Tel._____

(Type or print)

Address._____

Physician or Dentist's Signature_____Date._____

Nurse/Principal/Teacher_____Date._____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION BY SCHOOL PERSONNEL:

Date:_____

To School Personnel:

I hereby request that the above medication, ordered by the physician/dentist for by child_____be administered by school personnel. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 45 school day supply of said medication.

I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Name:_____

(Type or Print)

Signature:_____Relationship to child:_____

Address:_____Telephone:_____

East Granby Middle School

Student Media Consent and Release Form

Throughout the school year, students may be highlighted in efforts to promote East Granby Middle School activities and achievements. For example, students may be featured in materials to train teachers and/or increase public awareness of our school through newspapers, radio, TV, the web, DVDs, displays, brochures, and other types of media.

As the parent or guardian of_____, grade_____,

(Please check one)

☐ I hereby GIVE East Granby Middle School and its employees, representatives, and authorized media organizations permission to print, photograph, and record my child for use in audio, video, film, or any otherelectronic, digital and printed media.

☐ I hereby DENY East Granby Middle School and its employees, representatives, and authorized media organizations permission to print, photograph, and record my child for use in audio, video, film, or any otherelectronic, digital and printed media.

I certify that I have read the Media Consent and Release Liability statement and fully understand its terms and conditions.

Please understand that failure to return this release form within one week will constitute APPROVAL of the above requests.

(Please Print)

Name of child _____ Grade _____

Address _____

City, State, Zip _____

Phone number _____

Print name of parent or guardian _____

Signature of parent or guardian _____ Date _____

East Granby Middle School

Preliminary Assessment of Dominant Language

Welcome to our school!

We have a few questions about languages spoken at home. We are required by the US Department of Education to ask for this information because it will help us know how we can best support your child. This assessment is made in order to ascertain the need to provide a required bilingual education for studentswho are limited English proficient.

Please share with us about the language(s) spoken by your family and in your home.

Student Information:

First Name:_____ Last Name:_____

_____Date of Birth:_____

_____Grade:_____

1. What is the primary language used in the home, regardless of the language spoken by the student?

2. What is the language the student learned to speak first?

3. What is the language most often used by the student?

4. What language do you prefer written communication from school?

N

5. Will you require interpretation/translation at Parent-Teacher meetings?

_____

Parent/Guardian name (please print)

_____

Parent/Guardian signature Date