R.D. Seymour School

Robert McGrath, Principal

185 Hartford Avenue
East Granby, CT 06026
Phone (860) 653-7214
Fax (860) 413-9084

Student Registration Grades 3-5
Welcome to the East Granby Public Schools
www.eastgranby.k12.ct.us

Thank you for your interest in the East Granby Public Schools. PLEASE NOTE: SOME OF THE FORMS ARE ALSO WEB-ENABLED, WHICH WILL ALLOW YOU TO COMPLETE THEM DIRECTLY AND THEN PRINT. TYPING IS STRONGLY RECOMMENDED TO ENSURE THE ACCURACY OF THE INFORMATION SUBMITTED.

Attached please find the registration packet for Grades 3-5 students which includes:

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

In addition, please be prepared to provide **proof of residency** (see below) and an **original birth certificate** (must be the long form with a raised seal). No copies will be accepted.

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/natural gas, cable or landline phone) in your name and showing services provided for your East Granby house/apartment. (optional)
- 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.** **

Please download and complete the forms (please print legibly) along with the proof of residency and birth certificate(s) and return them to the school office, as **registration must be completed in person**. The East Granby parent needs come to the school in

person to register the child and sign the forms. The process is not complete until all forms and documentation are received.

Thank you,

Robert McGrath

EAST GRANBY PUBLIC SCHOOLS

☐ Uses an Inhaler

☐ Needs EpiPen for: _____

☐ Daily Meds: _____

Please note that we must have all medication prescribed on hand for orientation day.

East Granby, Connecticut

REGISTRATION

Student/Parent Information

☐ Male

☐ Female

_____ _____ _____ _____

Student Name | Grade | Date of Birth | Place of Birth

Address: _____Home Phone #: _____

** If you are not currently occupying this East Granby residence, please provide current residence. Written permission must be obtained for the Superintendent of Schools if your current residence is not East Granby.*

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

Full Names 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: _____
Email: _____@_____
Employer: _____ Work Phone: _____

Father's Name (or Guardian): _____ Home Phone: _____
Home Address: _____ Cell Phone: _____
Email: _____@_____
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? (i.e. Speech, Birth to 3, etc) ☐ Yes ☐ No

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: _____

EAST GRANBY PUBLIC SCHOOLS

East Granby, CT.

RELEASE OF INFORMATION

Name of Student: _____ Date of Birth: _____

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

Name: _____ Address: _____ Zip Code: _____

☐ I give permission for the East Granby Public 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 CT.

_____

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

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

- ☐ Health Record
- ☐ Grades
- ☐ Achievement Scores
- ☐ 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

PLEASE RETURN THIS FORM AND ALL CORRESPONDENCE TO:

R.D. Seymour School
185 Hartford Ave.
East Granby, CT 06026

REVISED 1/2019 JSF

EAST GRANBY PUBLIC SCHOOLS

Parent Questionnaire for Preliminary Assessment of Dominant Language

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.

Student Name: _____ Grade:

What language did your child first 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/Guardian Signature Date

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 or F)*	**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*** ☐ **YES** ☐ **NO**	**Immigrant?** - ***YOU MUST CHOOSE ONE*** ☐ **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—Oct, 2017

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

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? 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