Griswold Public Schools
Educating for Excellence

STUDENT REGISTRATION FORM

Proof of Residency: ❑	Birth Certificate: ❑	Date Entered:	Homeroom:

GHS Use:

Canterbury❑	Lisbon❑	Norwich❑	Sprague❑	Voluntown❑	Other:

Student Name: _____

Grade Entering: _____ Date: _____ M❑ / F❑

Home Address: _____

Date of Birth: _____ Place of Birth (City, State): _____

If not born in the USA; when did the student first attend school in the USA: _____

Student lives with: ❑Both Parents ❑Mother ❑Father ❑Other, please specify:_____

HOUSEHOLD:

Parent/Guardian: _____ Home Phone: _____

Relationship: _____

Address (if different from student): _____

Employer: _____ Work Phone: _____

❑Federal Employee ❑Member of the Armed Forces* Branch: _____

Cell Phone: _____ Messenger ❑

Email: _____ Messenger ❑

May Transport Student: Yes ❑ No ❑ If No: Court Documents on File? Yes ❑ No ❑

Parent/Guardian: _____ Home Phone: _____

Relationship: _____

Address (if different from student): _____

Employer: _____ Work Phone: _____

❑Federal Employee ❑Member of the Armed Forces* Branch: _____

Cell Phone: _____ Messenger ❑

Email: _____ Messenger ❑

May Transport Student: Yes ❑ No ❑ If No: Court Documents on File? Yes ❑ No ❑

Other Children Living in Household:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Ethnicity/Race:
Is this student Hispanic/Latino Yes ❑ No ❑
Please check one or more, even you answered "Yes" above:
❑African American ❑White ❑Native Hawaiian or Other Pacific Islander ❑Asian
❑American Indian or Alaskan Native

Primary household language: _____ Primary student language: _____
Student's first language: _____

Name of last school: _____ Grade last attended: _____
Address of last school: _____
Does the student have a pending or existing disciplinary consequence such as suspension or expulsion?
Yes ❑ No ❑

IS THE STUDENT IN A TYPE OF SPECIAL EDUCATION OR DO THEY RECEIVE ANY SUPPORT: Yes ❑ No ❑
If yes, what type: IEP ❑ 504 ❑ Academic Intervention Support ❑(Reading/Math)
Please provide any pertinent details regarding IEP, 504 or Academic Intervention Support: _____
_____

Is this student covered by health insurance? Yes ❑ No ❑
Primary Physician Name: _____
Address: _____

❑ In case of accident or serious illness, I request the school to contact me. In the event the school is unable to reach me, I hereby authorize the school to contact the student's physician and follow their instructions. If it is not possible to contact the physician the school may make whatever arrangements are deemed necessary.

Emergency Contacts (Other than Household members listed above):
-Must be at least 16 years old
-Listed in Call Order

	Name	Phone	Relationship	Pick Up Permission
1.				❑
2				❑
3.				❑
4.				❑

The State Department of Education has advised us that, due to privacy laws, the Griswold School System should seek parent/guardian permission to photograph/video students.

Photograph/Video Release: The Griswold Board of Education retains the absolute right and permission to copyright and use, reuse and publish portraits, pictures and videos of my child or in which my child may be included, in whole or part, without restrictions as to changes or alterations in composite of photograph or video. The Griswold School System will use these photographs/videos and no fees will be collected or profits made from these photographs/videos.

Photo Permission: ❑Yes ❑No

My student has permission to watch age-appropriate movies while at school.

❑G (GES) ❑PG (GMS) ❑PG13 (GMS) ❑R (GHS)

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name _____

*Armed Forces: Defined as the "Army, Navy, Air Force, Marine Corps and Coast Guard." "Active Duty" means full-time in the active military services of the United States, including full-time training duty, annual training duty, and attendance, while in the active military service, of a school designated as a service school by law or by the Secretary of the military department and considered active military service.

GRISWOLD PUBLIC SCHOOLS
Bus Transportation Form
Student Transportation of Ct.
860-376-2860

DATE:_____ School Year:_____

Please check one: ☐ GES ☐ GMS ☐ GHS ☐ GAS Grade:_____

Student's Full Name:_____

Home Address:_____

Parent(s)/Guardian(s) Full Name:_____

Parent(s)/Guardian(s) Phone:_____

IMPORTANT INFORMATION:

Due to a variety of factors, exact pick up and drop off times can fluctuate daily, therefore students should arrive at their scheduled bus stop at least 8 minutes prior to their pickup time and wait at least 8 minutes after their pickup time.

Parents/Guardians, please remember that preschool, kindergarten, special needs and Grade 1 students will not be dropped off at a bus stop unless they are met by an adult. If an adult is not present, students will remain on the bus and be returned to the school office for a parent to pick them up.

To ensure the safety of all students, requests for transportation changes must be submitted in writing to the appropriate School Office at least twenty-four (24) hours in advance. **Telephone requests will not be accepted.**

Please check one:

AM

☐ My child will be a Walker
☐ My child will be Parent Drop Off
☐ My child will be **picked up** at **designated bus stop** (assigned by the transportation department)
* **Bus Stop**_____
☐ My child will be **picked up** at **daycare**:
Name of Daycare Provider:_____
Address:_____
Phone:_____

PM

☐ My child will be a Walker
☐ My child will be Parent Pick Up
☐ My child will be **dropped off** at **designated bus stop** (assigned by the transportation department)
* **Bus Stop**_____
☐ My child will be **dropped off** at **daycare**:
Name of Daycare Provider:_____
Address:_____
Phone:_____

Office Use Only GES-yellow GAS-pink GMS/GHS-white

Bus# AM_____ AM Time_____
Bus# PM_____ PM Time_____

Griswold Public Schools
Student
Acceptable Use Policy for Computer, Network, Internet and E-Mail Services

Student access to the district computers, Network, Internet and other technology resources is provided to support student learning and research, and facilitate educational communication consistent with Griswold Public School's educational mission and curriculum goals.

I, _____as a user of the Griswold Public School District's electronic information resources and computer networks, have read and will abide by the Acceptable Use Policy of the Griswold Board of Education and agree to the following conditions:

Rules of Acceptable Use:

1. All electronic information resources shall be used for educational purposes only.
2. Users will act responsibly, ethically, and legally while using computers and network whether the property of Griswold Public Schools or personal equipment on campus.
3. Users will adhere to all copyright laws. Users must give credit to all work accessed via Internet. Permission should be obtained when appropriate.
4. Users will respect the privacy of others and protect password confidentiality.
    - Passwords are not to be shared with others.
    - Using another user's account or password is prohibited.
5. Users will be considerate of other technology users and will use polite and appropriate language at all times when accessing these resources.
6. Users will keep any personal information about themselves or others private while accessing the network or Internet.
7. Users will immediately report any problems or breaches of these responsibilities, or any inappropriate messages received, to the teacher or to the school personnel who are supervising use of these resources.
8. Users will take care of and respect all equipment or network resources at all times.
9. Users will not knowingly degrade or disrupt electronic information resources, services, or equipment, and understand that such activity may be considered to be a crime and includes, for example, tampering with computer hardware and software, vandalizing or modifying data without permission, invoking computer viruses, attempting to gain access to restricted or any unauthorized networks or network services, or violating copyright laws.
10. Users will act responsibly at all times and will avoid all other activities that are considered to be inappropriate in the electronic school environment, including purchasing products, harassing, bullying, discriminatory or threatening communications and behavior.
11. While network files will be respected, users must understand that all information may be accessed by technology staff and administration. Users should not assume that any information in network files is private or confidential.

Unacceptable Use Includes*:

1. Any use involving materials that are obscene, pornographic or otherwise inappropriate.
2. Using the computer to harm other people or their work.
3. Any action that interferes with the operation of the network, including sending chain letters to school users or outside parties.
4. Trespassing in another's folder, work or files.
5. Not obeying the rules of copyright regarding software; changing settings or installing software without permission.
6. Accessing, attempting to access or using another person's password to access any area or site that has been blocked, locked or to which access has been limited by the system administrator.
7. Users will not knowingly degrade or disrupt electronic information resources, services, or equipment, and understand that such activity may be considered to be a crime and includes, for

example, tampering with computer hardware and software; vandalizing or modifying data without permission; invoking computer viruses; and attempting to gain access to restricted or any unauthorized networks or network services, or violating copyright laws.

*This list is not all inclusive

The use of electronic resources, including the Internet and network, is a privilege, not a right, and unacceptable use will result in withdrawal of these privileges and/or other disciplinary actions. All users are expected to exercise good judgment. The user's parent or guardian may be held financially accountable for any intentional damage to technology resources, equipment or network. The district's Superintendent of schools or his/her designee will determine when disciplinary action is necessary.

I acknowledge that _____and _____have
Student Name (please print) *Guardian Name*
read, understand and will abide by the above policy when using Griswold Public Schools' network and computer systems.

Student Signature_____Grade_____

School _____

Parental Consent

I give the Griswold Public School District permission to allow my child to access and use electronic information resources for educational and research purposes.

I have read this Acceptable Use Agreement and have explained and discussed its importance with my child.

I understand, and have explained to my child, that he/she may lose his/her privilege to use these resources at school and may face disciplinary action if he/she does not follow this Agreement and the Board's Policy. I understand that I may be held liable for costs incurred by my child's deliberate misuse of electronic information resources or of the District's electronic equipment or software programs.

I understand that the District will employ filtering programs, access controls, and active supervision by staff to protect students from any misuses and abuses as a result of their use of the District's electronic information services. I also understand that these controls, filters, and monitors are not foolproof and that my child may access material which I might consider controversial and offensive. I understand that the Griswold Public Schools District has no control over the content of the information available on the Internet. I will not hold the Griswold Board Of Education Board liable for materials my child obtains or views from these electronic information resources.

Parent or Guardian's Signature_____ Date_____

Form

Chromebook/Tablet Acceptable Use Agreement

Griswold Public School District

I have read the Griswold Public School District Chromebook/Tablet Usage Standards, and Computer Acceptable Use Guidelines.

1. I have read and agree to comply with the Agreement for Use of Griswold Public Schools District Student Chromebook/Tablets.
2. I agree to comply with the Griswold Public School District's Acceptable Use Policy.
3. I understand that I may lose my Chromebook/Tablet privileges as a result of my inappropriate behavior, and may be financially responsible for damage or loss of any Griswold School District Chromebook/Tablet.
4. I will return the Chromebook/Tablet, power adapter and cable when requested at the end of the school year. I understand that I will be charged for any missing equipment or cables.

_____ _____

Student - Print your name here Signature and date here

I have read the Griswold Public School District Chromebook/Tablet Usage Standards, and Computer Acceptable Use Guidelines.

1. I understand the procedures and requirements to which my student must comply, including the Acceptable Use Policy.
2. I accept responsibility for any damage or neglect that may result from my student while the Chromebook/Tablet is in his/her possession or control, which may result in monetary charges.
3. I understand that my student may lose his/her Chromebook/Tablet privileges and/or incur financial fees as a result of inappropriate behavior, damage, neglect, or loss to any District Chromebook/Tablet.
4. I understand my student must return the Chromebook/Tablet, power adapter and cable when requested at the end of the school year. I understand that I will be charged for any missing equipment or cables.

Insurance Option:

Annual insurance policy (self-insured, managed by Griswold Public School District) -- $20 Students submit the $20 insurance payments or Declining insurance and assuming full responsibility for damage, theft or loss of the Chromebook/Tablet/Tablet

Insurance Option Selection (check one):

☐ Annual insurance policy (self-insured, managed by _____ School District) -- $20 Students submit the $20 insurance fee with their Fees and Photos payments

☐ Declining insurance and assuming full responsibility for damage, theft or loss of the iPad/Tablet/Tablet

_____ _____

Parent/Guardian - Print your name here Signature and date here

Current Address:_____Phone number: _____

Louis Zubek
Principal

Jeffrey Parkinson
Assistant Principal

Griswold Middle School
Educating for Excellence

211 Slater Avenue
Griswold, CT 06351
Phone 860-376-7630 / Fax 860-376-7631
www.griswoldpublicschools.org

Karen Scholl
School Counselor

John Howe
Psychologist

Rebecca Brigner
Psychologist

Date: _____

To: _____, Fax#: _____
(name of previous school)

The student listed below has entered our school. Please forward the following documents:

Scholastic Records
Health Records
Special Education Records
Special Services Records
Any Other Pertinent Information
SASID# (State of Connecticut only)

Schools within the State of Connecticut will forward original health folders as prescribed by law (Section 10-206d, Connecticut General Statutes.)

A photocopy of this release will be deemed to be the same as the original and can be used for this purpose.

Thank you.

Sincerely,

Louis Zubek
Principal

==========

I hereby authorize the release of all the above-mentioned records for my child:

Student Name: _____ Grade: _____

_____ _____
Signature of Parent/Guardian Date

_____
Name of Parent/Guardian

GRISWOLD MIDDLE SCHOOL
211 Slater Avenue
Griswold, CT 06351
860-376-7630

RECORD OF PARENT ANNUAL NOTICE
2021-2022 School Year

Dear Parent/Guardian,

The *Griswold Middle School Parent/Student Handbook* for the 2020-2021 school year has been posted electronically on the GMS website (www.griswold.k12.ct.us/gms). Parents can still request a hardcopy of the student handbook. Please check off the appropriate box below.

It is important that you and your child read and review the contents of the *Parent/Student Handbook*. The *Parent/Student Handbook* contains notices of rights that you and your child have under the law.

Relative to Griswold Board of Education policies,
I understand and consent to the responsibilities in the Griswold Board of Education's policies as outlined in this handbook. I also understand and agree that my child shall be held accountable for the behavior, interventions, and consequences outlined in the discipline policy at school and at school-sponsored or school-related activities, including school-sponsored travel, and for any school-related misconduct, regardless of time or location. I understand that any student who violates the school's rules of behavior shall be subject to disciplinary action, up to and including referral for criminal prosecution for violations of law.

Regarding student records,
I understand that certain information about students is considered directory information. Directory information includes: a student's name, address, telephone number, date and place of birth, participation in officially recognized activities and sports, dates of attendance, awards received at school, and most previous school attended. Directory information may be released by the district unless the parent or guardian objects to the release within ten days of the time this notice is issued.

Regarding the use of computers,
I understand the Griswold Public Schools provides computer access to students for educational purposes. I understand that any misuse of the computer network or software systems may subject students to Griswold Public Schools' sanctions as well as applicable **CT General Statutes, Section 53a-251 Computer Crime.**

Regarding video recorders on school buses,
I understand and acknowledge the district's procedures concerning the use of video recorders on school buses.
I also understand that my child shall be held accountable for his/her conduct on district transportation and for the consequences outlined in the district's discipline procedures for district-approved student transportation.

I have reviewed the ***Griswold Middle School Parent/Student Handbook and attendance policy*** **for 2021-2022.** My child has reviewed with me the student behavior expectations for GMS in this handbook.

Please sign and have your child return this notice to his/her home room teacher within the first week of school.

☐ I have read and reviewed the 2021-2022 Parent/Student handbook.
☐ I would like to receive a hardcopy of the 2021-2022 Parent/Student handbook.

Student Name	**Student Signature**	**Date**
Parent/Guardian Name	**Parent/Guardian Signature**	**Date**

Annual Health Questionnaire

Griswold Public Schools

[Information provided will be shared with appropriate staff as stated in the Family Education Right and Privacy Act (FERPA)]

Student Name: _____ Grade: _____ Teacher: _____

Please answer (Y) yes or (N) no, my child……	Y	N
1. Has been diagnosed with **ASTHMA**	☐	☐
2. Has had **SEIZURE** activity in the past 12 months.	☐	☐
Specify: _____		
Medication: _____		
3. Please list any **medication/s** your child will need to:		
TAKE IN SCHOOL_____		
4. Was seriously **ill**/**sustained injury** or **had surgery** in previous 12 months.	☐	☐
Specify: _____		
5. Is allergic to **Bees/Wasps**	☐	☐
Specify: _____		
Medication: _____		
6. Is allergic to **Medication/Latex/Other**	☐	☐
Specify: _____		
7. Allergic to foods		
Food(s):_____	☐	☐
Reaction(s):_____		
Medication: _____		
8. Is **DIABETIC: TYPE I**☐ **TYPE II**☐	☐	☐
9. Wears glasses/Contacts	☐	☐
10. Has a hearing aid and/or hearing problems	☐	☐
11. Has specialized equipment:		
(i.e. wheelchair, leg braces, assistive feeding devices, crutches, walker, catheterization, ostomy supplies, diabetic meters, etc.) Specify:	☐	☐
_____		
12. Has a diagnosis of **ADD/ADHD**	☐	☐
13. Has a diagnosis of **Depression**	☐	☐
14. Has a diagnosis of **Anxiety**	☐	☐
15. Has a diagnosis of **Manic Depression or Bipolar**	☐	☐
16. Has **Headaches/Migraines**	☐	☐
17. Is there anything you would like to speak to the Nurse about that is not on this list?	☐	☐
18. If necessary, may the school nurse have your permission to contact your child's physician in regard to their health?	☐	☐

Parent Signature: _____ Date: _____

Parent Name: _____

Griswold Middle School
211 Slater Avenue
Griswold CT, 06351

Dear Parents:

As of July 1, Public Act 15-215 requires **female** students in the 5th and 7th grades, and **male** students in the 9th grade to have a postural examination to determine the possibility of any spinal problems. In areas where screening is already being done, spinal variations have been detected in about four percent of the adolescent population and two percent have required active treatment or continued observation. The purpose of this program is to recognize the problem at its earliest stages so that the need for treatment can be determined and progressive spine deformity can be prevented.

The procedure for screening is a simple one. The school nurse inspects the child's spine as he/she stands and bends forward. If a spinal problem is suspected, the child will be rechecked at a second screening. If further consultation is recommended, parents of students who are found to have signs of a possible spinal abnormality will be notified and will be asked to see their own physicians for further evaluation.

This examination is being offered free to all **female** Griswold students in grades 5, and 7, and all **male** Griswold students in grade 9 and will be done before the end of each school year. When you return this slip it will give us permission to perform this screening from fifth through ninth grade. If at any time you wish to cancel this, you must contact the school nurse.

Sincerely,
School Nurse

DO NOT DETACH

1.☐ Please include my child in the postural screening being offered each year while my student is in grade 5, 7, (**female**) and grade 9 (**male**) in the Griswold School System.

2.☐ Do not include my child in the postural screening as we plan to have this done at a private physician's office and <u>will send the results to the school before June of each school year.</u>

3.☐ My child is currently under active treatment for a spinal problem.

_____

Signature of Parent/Guardian Date

Student Name: _____

Connecticut Tuberculosis (TB) Risk Assessment

See ***the Connecticut TB Risk Assessment User Guide*** for more information about using this tool.

- Use this tool to identify asymptomatic **adults and children** for latent TB infection (LTBI) testing.
- This tool can be used for school-aged children to determine if a student should have a TB test.
- This risk assessment does not supersede any TB testing mandated by statute, regulation or policy.
- **Do not repeat testing** unless there are **new risk factors** since the last test.
  If initial negative screening test occurred prior to 6 months of age, repeat testing should occur at age 6 months or older.
- Do not treat for LTBI until active TB disease has been excluded:
  For persons with TB symptoms or an abnormal chest x-ray, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum acid-fast bacilli (AFB) smears, cultures and nucleic acid amplification testing (NAAT). A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

LTBI testing is recommended if any of the boxes below are checked.
☐ **Birth, travel, or residence** for at least 1 month in a country with an elevated TB rate
• Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
• If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the Connecticut Tuberculosis Risk Assessment User Guide for this list).
• IGRA is preferred over TST for non-U.S.-born persons ≥2 years old
☐ **Immunosuppression,** current or planned
• HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥2 mg/kg/day, or ≥15 mg/day for ≥1 month) or other immunosuppressive medication
☐ **Close contact** to someone with infectious TB disease • Should test if patient has never been tested for this exposure
Treat for LTBI if TB test result is positive and active TB disease is ruled out.

☐ **None of the above**: No TB testing is indicated **at this time**.*

Please complete all information below:

Patient/Student Name:_____ Date of Birth: ____ /____ /____

Provider's Name: _____ Assessment Date: ____ /____ /____

***See The Connecticut TB Risk Assessment: User Guide section "Local recommendations, mandated testing and other risk factors."**

Connecticut Tuberculosis (TB) Risk Assessment User Guide

Avoid testing persons at low risk

Routine testing of persons without risk factors is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

If necessary, prioritize persons with risks for progression

If health system resources do not allow for testing of all non-U.S. born persons from a country with an elevated TB rate, prioritize patients with at least one of the following medical risks for progression:

- diabetes mellitus
- smoker within past 1 year
- end stage renal disease
- leukemia or lymphoma
- silicosis
- cancer of head or neck
- intestinal bypass/gastrectomy
- chronic malabsorption
- body mass index ≤20
- immunosuppression (see TB Risk Assessment)
- Upper lobe fibrotic lesion that has not shown at least one year of stability on two chest radiographs, after evaluation to ensure not active

United States Preventive Services Task Force (USPSTF)

The USPSTF has recommended testing persons born in, or former residents of, a country with an elevated TB rate (regardless of length of time in the U.S.) and persons who live in or have lived in high-risk congregate settings such as homeless shelters and correctional facilities. Because the increased risk of exposure to TB in congregate settings varies substantially by facility and local health jurisdiction, clinicians are encouraged to follow local recommendations when considering testing among persons from these congregate settings. The USPSTF did not review data supporting testing among close contacts to persons with infectious TB or among persons who are immunosuppressed because these persons are recommended to be screened by public health programs or by clinical standard of care.

Local recommendations, mandated testing and other risk factors

Several risk factors for TB that have been used to select patients for TB screening historically or in mandated programs are not included among the components of this risk assessment. This is purposeful in order to focus testing on patients at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Examples of these populations might include: primary and secondary school students, healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, and others.

For public schools, Connecticut General Statutes Section 10-206 (b) and (c) mandate that each student have a health assessment at three time periods during his/her primary and secondary school education: “prior to public school enrollment,” during Grade 6 or 7, and during Grade 9 or 10. Connecticut General Statutes Section 10-206 (c) states that: “The assessment shall also include tests for tuberculosis…where the local or regional board of education, in consultation with the school medical advisor and the local health department, or in the case of a regional board of education, each local health department, determines that said screening or test is necessary...” The results of the risk assessment and testing, when done, should be recorded on the Connecticut State Department of Education (CSDE) Health Assessment Record (HAR-3); or on the CSDE Early Childhood Health Assessment Record; and in the student’s Cumulative Health Record (CHR-1).

Public school personnel (e.g. teachers) are not required to be tested for TB by any Connecticut state statute or regulation.

Age as a factor

Age is not considered in this risk assessment. However, children and younger adults have more years of expected life during which progression from latent infection to active TB disease could develop. Some programs or clinicians may additionally prioritize testing of younger non-U.S.-born persons where all non-U.S.-born are not tested. An upper age limit for testing has not been established but could be appropriate depending on individual patient TB risks, comorbidities, and life expectancy. This risk assessment tool is valid for both adults and children.

When to repeat a risk assessment and testing

Risk assessments should be completed for new patients, patients thought to have new potential exposures to TB since last assessment, and during routine pediatric well-child visits. Repeat risk assessments should be based on the activities and risk factors specific to the person. Persons who volunteer or work in health care settings might require annual testing and should be considered separately. Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment (unless they were <6 months of age at the time of testing). In general, new risk factors would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel.

Immunosuppression

The exact level of immunosuppression that predisposes to increased risk for TB progression is unknown. The threshold of steroid dose and duration used in the Connecticut TB Risk Assessment are based on data in adults and in accordance with ACIP recommendations for live vaccines in children receiving immunosuppression.

Foreign travel or residence

Travel or residence in countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with persons with infectious TB, high prevalence of TB in travel location, non-tourist travel). The one month duration of travel or residence used in this risk assessment is intended to identify travel most likely to involve TB exposure. TB screening tests can be falsely negative within the 8 weeks after exposure, so are best obtained 8 weeks after a person's return.

IGRA preference in non-U.S.-born persons ≥2 years old

Because IGRAs has increased specificity for TB infection in persons vaccinated with Bacillus Calmette-Guérin (BCG), IGRA is preferred over the TST for non-U.S.-born persons ≥2 years of age. IGRAs can be used in persons <2 years of age, however, there is an overall lack of data in this age group, which complicates interpretation of test results. In BCG vaccinated immunocompetent persons with a positive TST, it may be appropriate to confirm a positive TST with an IGRA. If IGRA is not done the TST result should be considered the definitive result.

Negative test for LTBI does not rule out active TB

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. A negative TST or IGRA in a patient with active TB disease can be a sign of extensive disease. Any suspicion for active TB disease or extensive exposure to TB should prompt an evaluation for active TB disease, including physical exam, symptom review, and 2-view chest x-ray.

Most patients with LTBI should be treated

Persons with risk factors who test positive for LTBI should generally be treated once active TB disease has been ruled out with a physical exam, chest radiograph and, if indicated, sputum AFB smears, cultures, and NAAT. However, clinicians should not feel compelled to treat a person with a positive TB test who does not have identified TB risk factors, especially if at higher risk of adverse reactions.

Emphasis on short course regimens for LTBI treatment

Shorter regimens for treating LTBI have been shown to be as effective as 9 months of Isoniazid, and are more likely to be completed. Use of these shorter regimens is preferred in most patients, although the 12 week regimen is not recommended for children <2 years of age. It is under study in pregnancy. Drug-drug interactions and contact to drug resistant TB are other contra-indications for shorter regimens.

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + Rifapentine	Weekly	12 weeks**

**11-12 doses in 16 weeks required for completion.

Refusal of recommended LTBI treatment

Refusal should be documented. Recommendations for treatment should be made at future encounters with medical services. If treatment is later accepted, TB disease should be excluded and chest x-ray repeated if it has been more than 6 months from the initial evaluation for children or adults 5 years or older and 3 months for children less than 5 years of age.

Persons with a history of LTBI, with or without treatment

A person with a history of a documented positive TB test does not need to have a TB test repeated at any interval. If a person with a history of LTBI has a new TB exposure, they should have a symptom assessment to ensure they are well; for persons with a negative symptom assessment, repeat chest radiographs are rarely indicated. Persons with LTBI who completed treatment do not need to be treated again, except in rare circumstances (e.g. exposure to a drug resistant strain of TB).

Symptoms that should trigger evaluation for active TB

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, weight loss, lymphadenopathy, hemoptysis or excessive fatigue.

Resources

Connecticut State Department of Public Health: Tuberculosis Control Program
https://portal.ct.gov/en/DPH/Infectious-Diseases/Tuberculosis/Tuberculosis-Control-Program

Connecticut State Department of Education: School Nursing
www.ct.gov/sde/schoolnurse

Centers for Disease Control and Prevention (CDC) Basic Information and Facts about Tuberculosis
https://www.cdc.gov/tb/topic/basics/default.htm

CDC: Fact Sheets for LTBI Regimens, Isoniazid+Rifapentine, Rifampin, and Isoniazid are available at the following URL:
https://www.cdc.gov/tb/publications/factsheets/treatment.htm

National Tuberculosis Controller's Association Provider Guidance: *Using the Isoniazid/Rifapentine to Treat Latent Tuberculosis Infection (LTBI)*
https://www.surveygizmo.com/s3/4592623/2018-3HP-Provider-Guidance-Download

American Academy of Pediatrics, Red Book Online, Tuberculosis are available at the following URL:
https://redbook.solutions.aap.org/chapter.aspx?sectionid=189640207&bookid=2205

Abbreviations

AFB= acid-fast bacilli
BCG= Bacillus Calmette-Guérin
IGRA= interferon gamma release assay
LTBI= latent TB infection
NAAT= nucleic acid amplification testing
TB= tuberculosis
TNF= tumor necrosis factor inhibitors (?)
TST= tuberculin skin test

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	❑ 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? 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					
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

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

NEW STUDENT CHECKLIST

TO BE COMPLETED PARENT

NAME OF STUDENT_____ D.O.B_____

PARENT NAME_____ **PHONE NUMBER**_____

GRADE_____ PREVIOUS SCHOOL_____CITY/STATE_____

SCHOOL PHONE NUMBER ( ) _____

HAS STUDENT EVER ATTENDED GRISWOLD PUBLIC SCHOOLS? YES☐ NO☐ **If yes, what year**___

If student is from out of state, has the student ever attended a school in CONNECTICUT?

Yes☐ No☐ If yes, where_____

PLEASE SEND PARENT/GUARDIAN TO THE HEALTH OFFICE WITH AVAILABLE DOCUMENTS

TO BE COMPLETED BY THE HEALTH OFFICE

☐COPY OF PHYSICAL / DATE OF PHYSICAL _____
☐ IMMUNIZATION RECORD ☐SCOLIOSIS PERMISSION SLIP
☐TUBERCULOSIS RISK ASSESSMENT FORM ☐YEARLY HEALTH UPDATE

THE ABOVE STUDENT HAS BEEN CLEARED BY THE HEALTH OFFICE TO ENTER GRISWOLD PUBLIC SCHOOLS ON _____

Please Scan Physicals and Immunizations to rnormandie@griswoldpublicschools.org and jcarota@griswoldpublicschools.org for entry approval over the summer months.

Does Your Family Need Health Insurance?

Connecticut offers low-cost or free coverage!

Dear Parent / Guardian,

Is your child protected by health insurance? If not, your school and the State of Connecticut want to help. Connecticut's HUSKY Health program, for example, pays for doctor visits (including physical exams), prescriptions, emergency care, vision and dental care, mental healthcare, special healthcare needs and more. It's for children under age 19 in families of all incomes. Approximately 300,000 Connecticut children now have their healthcare covered by the HUSKY Health program. **There are two parts to the HUSKY Health program for children:**

I. **HUSKY A** (or Medicaid) - For children in families with limited income. Parents, relative caregivers and pregnant women may also be eligible.

II. **HUSKY B** (or Children's Health Insurance Program) - For children in families with higher incomes.

You can apply for HUSKY A or HUSKY B any time of the year.

- To apply **online**, please visit AccessHealthCT.com
- To apply by **phone**, please call **855-394-2428 (TTY: 855-789-2428)**
- For general information about HUSKY Health, please visit www.ct.gov/Husky

Your child needs YOU to stay healthy, too!

When you apply for HUSKY Health for your child, see what Access Health CT has to offer you.

Most Connecticut residents have to wait until the next Open Enrollment period (**November 1, 2020 - December 15, 2020**) to get healthcare coverage through Access Health CT. You may be able to get coverage earlier if you have a **Qualifying Life Event** OR if you qualify for Medicaid (HUSKY A or D) or CHIP (HUSKY B).

What is a Qualifying Life Event? Qualifying Events include:

- **Loss of Minimal Essential Coverage**
- **Marriage**
- **Permanent move to Connecticut**
- **Pregnancy, birth, adoption or foster care**
- **Newly eligible/ineligible for Premium Tax Credits as a result of Divorce, or other Legal Decree or Court Order**

> Loss of Coverage Due to Other Circumstances:

- **Expiration of COBRA**
- **No longer eligible for HUSKY Health**
- **No longer eligible for an Advance Premium Tax Credit (APTC) or a Cost-Sharing Reduction (CSR)**
- **Change in citizenship or lawful presence status**

For More Information, Visit Learn.AccessHealthCT.com/Special

This partnership to inform parents about health insurance options is in accordance with Section 119 of Public Act 07-02, June Special Session. Special thanks to the Connecticut Department of Education, Connecticut Department of Social Services, Access Health CT, Regional Education Service Centers, and all caring school personnel throughout the state as we join with parents to bring health coverage to Connecticut children. [2020]

Addendum C: Information on the Supplemental Nutrition Assistance Program (SNAP)

Dear Parent/Guardian:

If your children qualify for free school meals or milk, you might also qualify for **SNAP** (formerly called Food Stamps). SNAP helps people buy food for themselves and their families. SNAP benefits are issued each month on plastic debit cards. You can use SNAP benefits to buy food at major supermarkets, neighborhood grocery stores, and some farmers' markets authorized to accept SNAP.

How to Qualify

If and how much SNAP you qualify for depends on: your household's income;

- allowable deductions to your household's income (examples include monthly shelter expenses, medical bills, and court ordered child support);
- your household size; and
- at least 5 years U.S. residency for qualified non-citizens.

If you have access to the Internet, you can go online to see if you may be eligible for SNAP. Go to **www.connect.ct.gov** and click "Am I Eligible?" **Owning your own home or owning a car will not prevent you from being eligible for SNAP.**

Effective October 1, 2019

Household Size	Gross Monthly Income	Gross Annual Income
1	$1,926	$23,107
2	$2,607	$31,284
3	$3,289	$39,461
4	$3,970	$47,638
5	$4,652	$55,815
6	$5,333	$63,992
7	$6,015	$72,169
8	$6,696	$80,346
For each additional member	+682	+8,177
Larger households = higher incomes		

To Apply or Get More Information

- To find your local Connecticut Department of Social Services (DSS) office, call **United Way's free referral number 2-1-1** (free call statewide).

- You can find a list of all Connecticut Department of Social Services (DSS) offices, or you can apply online at **https://www.connect.ct.gov/access/jsp/access/Home.jsp** (click "Apply for Benefits"). You can get the paper SNAP application in English at **https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Common-Applications/W-1E.pdf** and in Spanish at **https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Common-Applications/W-1ES.pdf**.

- The following two organizations conduct outreach for DSS and can assist with applying for SNAP benefits:

    1. **End Hunger CT!** provides a SNAP eligibility screener (**www.ctsnap.org**) and call center (866-974-SNAP (7627)) to assist in determining eligibility. If you are eligible for SNAP, you will stretch your food dollars, support your school and community, and your kids get school meals at no cost. Many families are surprised they qualify – it is quick, easy and confidential to check by using the screener and call center.
    2. **The Connecticut Association for Community Action** (CAFCA) works with the following community action agencies that will help you enroll in SNAP:

Addendum C: Information on SNAP

Agency	Phone Number	Areas Served
Action for Bridgeport Community Development, Inc. (ABCD)	203-366-8241	Greater Bridgeport Area and Upper Fairfield County
The Access Community Action Agency (Access)	860-450-7400	Windham and Tolland Counties
Community Action Agency of New Haven, Inc. (CAANH)	203-387-7700	Greater New Haven Area
The Community Action Agency of Western Connecticut, Inc. (CAAWC)	203-744-4700	Northwestern CT and Lower Fairfield County
Community Renewal Team, Inc. (CRT)	860-560-5600	Hartford and Middlesex County
Human Resources Agency of New Britain, Inc. (HRA)	860-225-8601	New Britain and Bristol Areas
New Opportunities, Inc. (NOI)	203-575-9799	Greater Waterbury, Meriden, and Torrington Areas
Thames Valley Council for Community Action, Inc. (TVCCA)	860-889-1365	Southeastern CT- New London County
Training Education and Manpower, Inc. (TEAM)	203-736-5420	Naugatuck Valley

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

The Connecticut State Department of Education is committed to a policy of equal opportunity/affirmative action for all qualified persons. The Connecticut Department of Education does not discriminate in any employment practice, education program, or educational activity on the basis of age, ancestry, color, criminal record (in state employment and licensing), gender identity or expression, genetic information, intellectual disability, learning disability, marital status, mental disability (past or present), national origin, physical disability (including blindness), race, religious creed, retaliation for previously opposed discrimination or coercion, sex (pregnancy or sexual harassment), sexual orientation, veteran status or workplace hazards to reproductive systems, unless there is a bona fide occupational qualification excluding persons in any of the aforementioned protected classes.

Inquiries regarding the Connecticut State Department of Education's nondiscrimination policies should be directed to: Levy Gillespie, Equal Employment Opportunity Director/Americans with Disabilities Coordinator (ADA), Connecticut State Department of Education, 450 Columbus Boulevard, Suite 607, Hartford, CT 06103, 860-807-2071, levy.gillespie@ct. gov.

CSDE
CONNECTICUT STATE DEPARTMENT OF EDUCATION

This document is available at https://portal.ct.gov/-/media/SDE/Nutrition/NSLP/Forms/FreeRed/AddendumC.pdf.

Griswold Public Schools
Educating for Excellence

GRISWOLD MIDDLE SCHOOL
STUDENT REGISTRATION CHECKLIST

❑ 2 Forms of Proof of Residency
E.g.: Deed, Lease, Utility Bill, Driver's License

❑ Student's Birth Certificate

❑ Current Immunizations/Physical

❑ Registration Packet

- Student Registration Form
- Transportation Form
- Acceptable Use for Computer, Network, Internet, Email Services
- Release of Records
- Annual Notice/Handbook Sign Off
- Annual Health Questionnaire
- Postural Screening Permission
- TB Risk Assessment
- Health Office New Student Checklist
- Chrome Book Agreement

Griswold Middle School
211 Slater Avenue
Griswold, CT 06351
P: 860-376-7630 F: 860-376-7631
gmsattendance@griswoldpublicschools.org