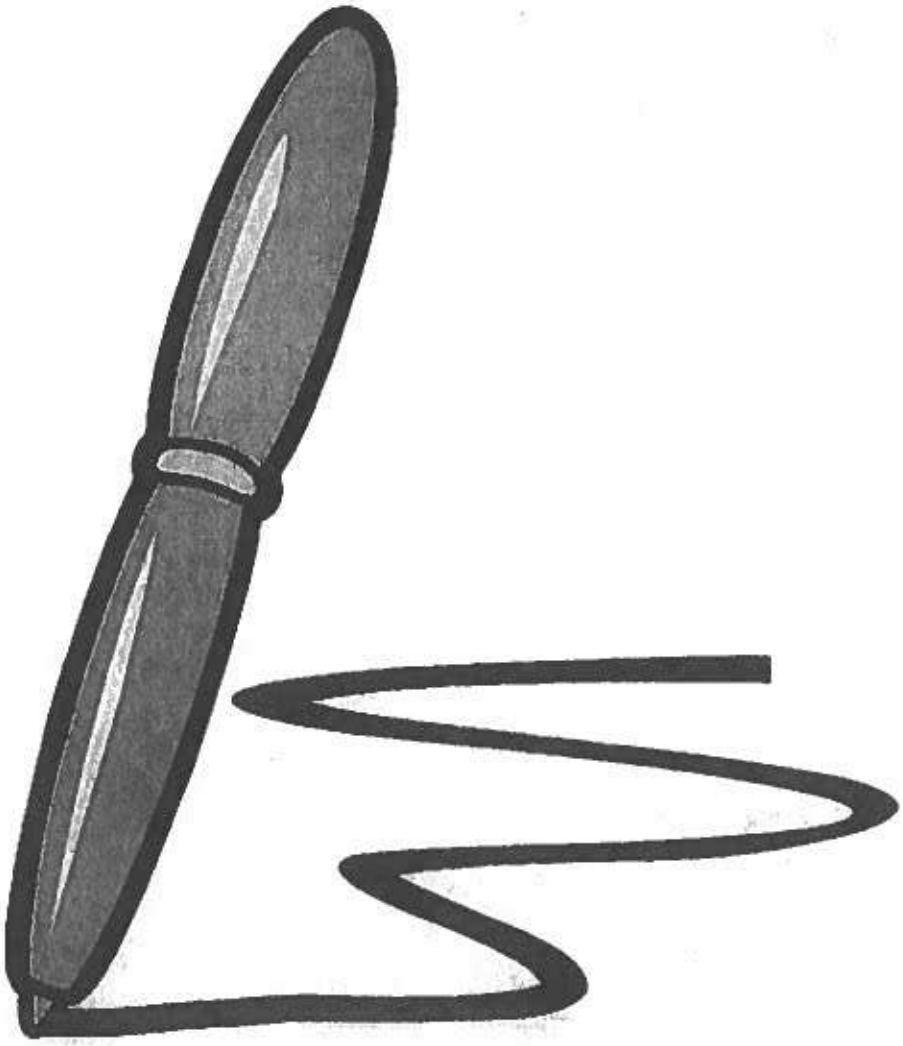
REGISTRATION PACKET

PRE-K THROUGH GRADE 5



NEW STUDENT REGISTRATION

The Following Checklist must be completed for each student registering in the Saugus Public Schools. Please check each item received. Place this form in the cumulative folder.

STUDENT NAME: _____

SCHOOL : _____ **Grade:** _____ **DOB**_____

SCHOOL & CITY TRANSFERRING FROM: _____

(Check if Received)

_____ **1. Early Childhood Data Collection Sheet /PK & Kindergarten immunization requirement (if applicable)**

_____ **2. Registration Form**

_____ **3. Emergency Form**

_____ **4. Admission Information**

_____ **5. Custody/Court Documents (if applicable)**

_____ **6. Residency (Utility Bill)**

_____ **7. Residency Verification**

_____ **8. Media/Photo Release**

_____ **9. Weapon Policy**

_____ **10. Completed Health Record (Verified by Nurse)**

_____ **11. Mass Health (Medicaid) Benefits**

_____ **12. Federal Ethnicity/Race**

_____ **13. Language Survey**

_____ **14. Birth Certificate**

_____ **15. Copy of Parent or Guardian License or Passport**

_____ **16. Release for ALL Student Records including Special Education Testing & IEP/504**

_____ **17. Release for Saugus to Communicate with Student's Dr. or Agency**

_____ **18. Use of Network Agreement**

_____ **19. ELL Placement (if applicable)**

_____ **20. Parent/Student Sign off sheet (if applicable)**

_____ **21. Free & Reduced Lunch Application**

Saugus Public Schools
Saugus, MA 01906
Early Childhood Data Collection Sheet

PLEASE PRINT

Students Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____ _____ _____
(Month) (Day) (Year)

Please complete the questions below. This information will be used for Department of Elementary & Secondary Education data collection.

Check One:
Does your child currently attend an Early Childhood Preschool Program? Yes _____ No _____

Does your child currently attend an Early Childhood Kindergarten program? Yes _____ No _____

If the answer is yes, please indicate the setting and the approximate time he/she spends in this setting.
Check all that apply:

Type of Program	Name of Program	# Hours per day	#Days per week
____ Head Start	_____	_____Hours	_____Days
____ Kindergarten	_____	_____Hours	_____Days
____ Public Pre School	_____	_____Hours	_____Days
____ Private Pre School	_____	_____Hours	_____Days
* ____ Group Child Care	_____	_____Hours	_____Days

*(i.e. A licensed daycare setting where other children are not related to one another. This does not include in-home babysitting, nannies, or the home of a neighborhood Baby sitter or relative providing daycare.)

____ Other _____ _____Hours _____Days
If you choose other, please describe below. **(Please Print)**

Additional Comments: **(Please Print)**

(Please Print) Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

SAUGUS PUBLIC SCHOOLS REGISTRATION FORM

PLEASE PRINT

Date Completed: _____

Student's Name: _____

Student's Preferred Name, if different from above: _____

Student's Address: _____
Street City State

Home Telephone #: (___) _____ Cell Phone #: (___)_____

Student's Email Address: _____

Date of Birth: _____
Month Day Year

Birthplace: _____

Citizenship Status – Is student a U.S. Citizen? Yes _____ No _____
If no, Country or Citizenship: _____
Is the student an immigrant? Yes _____ No _____
If yes, year entered into U.S.: _____ Immigrant from: _____
Year started school: _____
Parent(s)/Guardian(s) Name: _____ _____
Mother Father
Parent(s)/Guardian(s) Address: (Mother)_____
Street City State
(Father)_____
Street City State
Parent(s)/Guardian(s) Home telephone #: (Mother) _____ Father: _____
Cell Phone #: (Mother) _____ Father: _____
Work telephone #: (Mother) _____ Father: _____
Parent(s)/Guardian(s) Email Address: (Mother) _____
(Father) _____
Does the student reside with both parents? Yes _____ No _____
If no, name of person(s) student resides with: _____
Name of person(s) who has legal custody: _____
Address of person(s) who have legal custody of student, if different from above:

_____
Street City State
Telephone numbers of Person(s) who have legal custody of student, if different from above:
Home #: _____ Cell # _____

"The Saugus Public Schools does not discriminate on the basis of race, color, religion, sexual orientation, national origin, age, gender or handicap in, admission to, access to, treatment in or employment in its programs and activities."

SAUGUS PUBLIC SCHOOLS

EMERGENCY FORM

PLEASE PRINT

Alternate contacts, in case of emergency and PERMISSION TO DISMISS (include 2 other than parents/guardians)

1. Name: _____

Relationship to Student: _____ Email Address: _____

Address: _____

Home Telephone#: _____ Cell #: _____

2. Name: _____

Relationship to Student: _____ Email Address: _____

Address: _____

Home Telephone#: _____ Cell #: _____

Is any person(s) legally prevented from having contact with the student? Yes _____ No _____

(If yes, legal documentation must be provided and a copy of the documentation is kept in the school file.)

TRANSFERRED FROM

Name of School: _____

School Address: _____

School Phone #: _____ Grade: _____

Grade Student will be entering: ____ Has student attended Saugus Public Schools before Yes ___ No ___

If yes, please list year of attendance. _____

Is the student transferring from another state other than Massachusetts? Yes ____ No ____

If yes, has the student attended school in Massachusetts before? Yes ____ No ____

If yes, city or town in Massachusetts _____ Year(s) _____

Is this the first time the student has enrolled in a public school in Massachusetts? Yes ____ No ____

Is this the first time the student has enrolled in a public school in USA? Yes ____ No ____

Languages

Home Language _____

Native Language _____

Other Language(s) spoken _____

***McKinney Vento _____

(Please check if applicable and contact Pupil Personnel Office. Student should beging school as soon as possible.)

***State Ward Yes _____ No _____

STUDENT SIBLINGS

Name _____ School _____ Grade _____

Name _____ School _____ Grade _____

Name _____ School _____ Grade _____

MY CHILD MAY NOT BE DISMISSED TO

Name _____ * Valid Restraining Order Yes ____ No ____

Name _____ * Valid Restraining Order Yes ____ No ____

Name _____ * Valid Restraining Order Yes ____ No ____

**** IF YES PLEASE ATTACH A COPY OF UDATED RESTRAINING ORDER**

Parent/Guardian Signature _____ Date _____

Saugus Public Schools

23 Main Street
Saugus, Massachusetts 01906
(781) 231-5000
Fax: 781-233-9424
www.saugus.k12.ma.us

From the office of the
Superintendent of Schools

ADMISSION INFORMATION

PLEASE PRINT

1. Does the student have an Individual Education Plan? Yes _____ No _____
   If yes, a copy of the Individual Education Plan must be reviewed for placement purposes.

2. Does the student have a 504 Accommodation Plan? Yes _____ No _____

3. Name of Person registering student: _____

   Phone #'s of person registering student: _____

   Relationship to student: _____

   Signature of Person registering student: _____

   Date: _____

Section: JF

STUDENT ENROLLMENT POLICY

When new students are enrolled in the Saugus Public Schools the following guidelines shall apply:

1. All students must be an actual resident of the Town of Saugus. Upon enrollment proof of residency must be supplied. This is accomplished by providing the school with a utility bill, lease or landlord verification form or any other form of documentation the school department deems appropriate.

2. Upon enrollment all students under 18 must submit the name of the individual responsible for the student at the student's actual place of residence, along with a description of the relationship to the student.

3. If a student is not living in Saugus at the beginning of the academic year, and only at the beginning of the academic year, but will be before mid-point of the first quarter he/she will be allowed to register in the Saugus Public Schools. If the student is still not living in Saugus after the mid-point of the first quarter is reached, he/she must withdraw from the Saugus Public Schools until such time as residency is established. There is no possibility of an extension and there will be no exceptions.

4. All special needs students must be enrolled through Pupil Personnel Services. The Director of Pupil Personnel Services/Administrator of Special Education must determine the student's proper placement as directed by the Individual Education, (IEP) written by the sending school system.

5. Except as noted above, no student may attend the Saugus Public Schools who is not actually living in Saugus. Any student found in violation of the policy will be expelled from the Saugus Public Schools immediately.

This policy supersedes all other policies regarding residency and student enrollment.

Note: Policy JFABD McKinney-Vento Homeless Education Assistance Act Enrollment Rights and Services.

Approved by the School Committee:

8/30/01

Saugus Public Schools

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www.saugus.k12.ma.us

From the office of the
Superintendent of Schools

Residency

Chapter 76, School Attendance, Section 5, Place of attendance: discrimination
Section 5

Every person shall have a right to attend the public schools of the town where he/she actually resides, subject to the following section. No school committee is required to enroll a person who does not actually reside in the town unless said enrollment is authorized by law or by the school committee. Any person who violates or assists in the violation of this provision may be required to remit full restitution to the town of the improperly attended public school. No person shall be excluded from or discriminated against in admission to a public school of any town, or in obtaining the advantages, privileges and courses of study of such public school on account of race, color, sex, religion, national origin or sexual orientation.

I have read the above, Massachusetts General Law, and attest to the fact that:

_____ resides in The Town of Saugus.
Name of Student (Please Print)

Name of Parent/Guardian: (Please Print) _____

Address: _____

Signature: _____ Date: _____

Saugus Public Schools
Residency Verification Form

PLEASE PRINT

Part 1: (Resident Information)

Name: _____

Address: _____ Apt.# _____

Home Phone #: _____ Cell Phone #: _____

Part 2: (Resident Authorization to Release Information)

I, _____, give permission to the requester to

obtain and verify this information.

_____ _____

Signature Date

**** Part 3: (To be completed by the Landlord)**

The above property is rented to _____,

and to the best of my knowledge and belief the above named person resides there.

_____ _____

Landlord's Name Landlord's Phone #

_____ _____

Landlord's Street Address City or Town/State

_____ _____

Landlord's Signature Date

****PLEASE ATTACH A PROOF OF RESIDENCY with the Resident/Landlord (if same as Resident) address – UTILITY BILL (cable, electric, gas, oil)**

Saugus Public Schools - Saugus, Massachusetts

ALL INFORMATION MUST BE COMPLETED AND RETURNED IMMEDIATELY
THIS INFORMATION WILL BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL ON A NEED TO KNOW BASIS TO PROTECT THE WELL-BEING AND SAFETY OF THE STUDENT.

Health Modification and Medical Consent Form

GENERAL INFORMATION

Name of Student _____ School _____ Grade _____ Home Room _____

Date of Birth _____

Primary Care Physician _____ Physician's Telephone# _____

Please list any known Food/Drug Allergies (be specific) _____

_____

HEALTH MODIFICATIONS

1. If your child has any kind of medical condition, please write below [include treatments, if applicable]

2. I give permission for the nurse to share medical information to school personnel and emergency medical personnel ____ Yes ____ No

3. My son/daughter is currently receiving the following medication(s) [to be completed if not in violation of confidentiality] Please list all medications student is receiving including those at home and school

Medication	Dosage	Time

CONSENT

1. I give permission to have the school nurse give the following medication which has been prescribed by my child's physician _____

2. I give permission for my son/daughter to receive the following [according to age and weight] at the nurse's discretion for minor discomfort Tylenol ___ Yes ___ No Ibuprofen ___Yes ___No Tums ___Yes ___No Cough Drops ___Yes ___No

3. I give permission for the school nurse *to* apply topical solutions such as bacitracin, eye wash, hydrogen peroxide, calamine caladryl, hydrocortisone, and antibacterial soap when administering basic first aid *to* my child ___Yes____No

4. I give permission for the school nurse to give my child Benadryl 12.5-50mg according to age for mild to severe allergic reaction ____Yes ____No

QUESTION 5. APPLIES ONLY TO STUDENTS WHO MAY REQUIRE INHALER MEDICATION DURING SCHOOL HOURS

5. I give permission for my child to self-administer inhaler medication if the school nurse determines it is safe and appropriate ____ Yes ____No

(Please note: I understand that I may retrieve the medication from the school nurse at any time and that the medication will be destroyed if it is not picked up within one week following termination of the order or on the last day of school).

Name of Parent/ Guardian _____ Date _____
Please Print

Signature of Parent/Guardian _____

Relationship to Student _____

Telephone Home _____ Work _____ Cell _____

Emergency Contact Name: (Print) _____

Relationship to Student _____ Telephone _____

FIELD TRIPS AND MEDICATION

I give permission to have school personnel designated by the school nurse give my child physician ordered medications during field trips ___Yes ___No

Parent/Guardian Signature _____ Date _____

Saugus Public Schools - Saugus, Massachusetts

TODA LA INFORMACIÓN DEBE SER COMPLETADA Y REGRESADA DE INMEDIATO
ESTA INFORMACIÓN SERÁ COMPARTIDA CON EL PERSONAL ESCOLAR APROPIADO SEGÚN SE NECESITE PARA PROTEGER EL BIENESTAR Y LA SEGURIDAD DEL ESTUDIANTE.

Formulario de Modificación de Salud y Consentimiento Médico

INFORMACIÓN GENERAL

Nombre del Estudiante_____Escuela:_____ Grado:_____ Salón:_____
Fecha de Nacimiento:_____

Médico de Atención Primaria:_____ Teléfono del médico:_____

Por favor enumere cualquier Alergia conocida a Alimentos o Medicamentos [especifique] _____

_____

MODIFICACIONES DE LA SALUD

1. Si su hijo tiene algún tipo de condición médica, escriba a continuación [incluya los tratamientos, si corresponde]

2. Doy permiso a la enfermera para compartir información médica con el personal de la escuela y los servicios médicos de emergencia ___ Sí ___No

3. Mi hijo(a) está actualmente recibiendo la(s) siguiente(s) medicina(s) [se completará si no viola la confidencialidad]. Por favor enumere todos los medicamentos que el estudiante recibe, incluyendo los que están en casa y en la escuela.

Medicamento	Dosis	Hora

CONSENTIMIENTO

1. Doy permiso para que la enfermera de la escuela dé el siguiente medicamento que ha sido recetado por el médico de mi hijo.

2. Doy permiso a mi hija(a) para recibir lo siguiente [según la edad y el peso] a discreción de la enfermera por malestias menores:
Tylenol ___Sí ___No Ibuprofeno ___Sí ___No Tums ___Sí ___No Pastilla para la tos ___Si ___No

3. Doy permiso para que la enfermera de la escuela *aplique* soluciones tópicas tales como bacitracina, lavado de ojos, peróxido de hidrógeno, calamina, Caladryl, hidrocortisona, y jabón antibacteriano cuando se administre primeros auxilios básicos *a* mi hijo.____Sí___ No

4. Doy permiso a la enfermera de la escuela para dar a mi hijo Benadryl 12.5-50mg, de acuerdo a la edad para la reacción alérgica ligera a severa.____Sí____ No

LA PREGUNTA 5 APLICA ÚNICAMENTE A ESTUDIANTES QUE PUDIERAN REQUERIR MEDICAMENTOS DE INHALADOR DURANTE LAS HORAS ESCOLARES

5. Doy permiso para que mi hijo se auto-administre medicamento de inhalador si la enfermera de la escuela determina que es seguro y apropiado.____Si ___No

[Tenga en cuenta lo siguiente: Entiendo que puedo recuperar el medicamento de la enfermera escolar en cualquier momento y que el medicamento será destruido si no se recoge dentro de una semana después de la terminación de la orden o en el último día de la escuela].

Nombre del Padre/Tutor _____ Fecha:_____
Use Letra Imprenta
Firma del Padre/Tutor:_____
Relación con el Estudiante:_____
Teléfono de Casa:_____Trabajo:_____Celular:_____
Nombre de Contacto de Emergencia : [Imprenta]_____
Relación con el Estudiante_____ Teléfono:_____

VIAJES DE CAMPO Y MEDICAMENTOS

Doy permiso para que el personal de la escuela designado por la enfermera escolar le dé a mi hijo(a) los medicamentos prescritos por el médico durante las excursiones. ____Sí _____No

Firma del Padre/Tutor_____ Fecha:_____

Saugus Public Schools

23 Main Street
Saugus, Massachusetts 01906
(781) 231-5000
Fax: (781) 233-9424
www.saugus.k12.ma.us

From the office of the
Superintendent of Schools

TO WHOM IT MAY CONCERN:

I hereby authorize _____ to release
School & City Transferring from

copies of ALL records concerning my son/daughter _____,

to the Saugus Public Schools 23 Main Street, Saugus, MA 01906.

(PLEASE SEND THE FOLLOWING DOCUMENTS)

Transfer Card Health Records Official Transcript Grades to Date _____

Attendance Profile Discipline Report MCAS Scores

IEP 504 (current & signed) Special Education Testing

_____ _____
Parent/Guardian Signature Date

Massachusetts School Immunization Requirements 2020-2021§

Massachusetts school immunization requirements are created under authority of 105 CMR 220.000 Immunization of Students Before Admission to School

Requirements apply to all students including individuals from another country attending or visiting classes or educational programs as part of an academic visitation or exchange program. Requirements apply to all students, even if over 18 years of age.

Childcare/Preschool¶†

Attendees <2 years should be immunized for their age according to the ACIP Recommended Immunization Schedule. Requirements listed in the table below apply to all attendees ≥2 years. These requirements also apply to children in preschool classes called K0 or K1.

Hib	**1-4 doses;** the number of doses is determined by vaccine product and age the series begins
DTaP	**4 doses**
Polio	**3 doses**
Hepatitis B	**3 doses;** laboratory evidence of immunity acceptable
MMR	**1 dose;** must be given on or after the 1st birthday; laboratory evidence of immunity acceptable
Varicella	**1 dose;** must be given on or after the 1st birthday; a reliable history of chickenpox* or laboratory evidence of immunity acceptable

Grades Kindergarten – 6¶†

In ungraded classrooms, Kindergarten requirements apply to all students ≥5 years.

DTaP	**5 doses;** 4 doses are acceptable if the fourth dose is given on or after the 4th birthday. DT is only acceptable with a letter stating a medical contraindication to DTaP
Polio	**4 doses;** fourth dose must be given on or after the 4th birthday and ≥6 months after the previous dose, or a fifth dose is required. 3 doses are acceptable if the third dose is given on or after the 4th birthday and ≥6 months after the previous dose
Hepatitis B	**3 doses;** laboratory evidence of immunity acceptable
MMR	**2 doses;** first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; laboratory evidence of immunity acceptable
Varicella	**2 doses;** first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; a reliable history of chickenpox* or laboratory evidence of immunity acceptable

§ Address questions about enforcement with your legal counsel. School requirements are enforced at the local level.

¶ Meningococcal vaccine requirements (see Grades 7-10 and 11-12) also apply to residential students in Grades pre-K through 8 if the school combines these grades in the same school as students in Grades 9-12.

†Medical exemptions (statement from a physician stating that a vaccine is medically contraindicated for a student) and religious exemptions (statement from a student, or parent/guardian if the student is <18 years of age, stating that a vaccine is against sincerely held religious beliefs) should be renewed annually at the start of the school year.

* A reliable history of chickenpox includes a diagnosis of chickenpox, or interpretation of parent/guardian description of chickenpox, by a physician, nurse practitioner, physician assistant, or designee.

See page 2 for Grades 7-10, Grades 11-12, and page 3 for College (Postsecondary Institutions)

Massachusetts School Immunization Requirements 2020-2021§

Requirements apply to all students including individuals from another country attending or visiting classes or educational programs as part of an academic visitation or exchange program. Requirements apply to all students, even if over 18 years of age.

Grades 7 – 12†

In ungraded classrooms, Grade 7 requirements apply to all students ≥12 years.

Tdap	**1 dose;** and history of DTaP primary series or age appropriate catch-up vaccination. Tdap given at ≥7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catch-up schedule. Td or Tdap should be given if it has been ≥10 years since last Tdap
Polio	**4 doses;** fourth dose must be given on or after the 4th birthday and ≥6 months after the previous dose, or a fifth dose is required. 3 doses are acceptable if the third dose is given on or after the 4th birthday and ≥6 months after the previous dose
Hepatitis B	**3 doses;** laboratory evidence of immunity acceptable. 2 doses of Heplisav-B given on or after 18 years of age are acceptable
MMR	**2 doses;** first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; laboratory evidence of immunity acceptable
Varicella	**2 doses;** first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; a reliable history of chickenpox* or laboratory evidence of immunity acceptable

NEW – Meningococcal Requirements

Grade 7	**1 dose;** 1 dose MenACWY (formerly MCV4) required. Meningococcal B vaccine is not required and does not meet this requirement.
Grade 11‡	**2 doses;** second dose MenACWY (formerly MCV4) must be given on or after the 16th birthday and ≥ 8 weeks after the previous dose. 1 dose is acceptable if it was given on or after the 16th birthday. Meningococcal B vaccine is not required and does not meet this requirement.

Meningococcal Vaccine Phase-In Schedule

	2020-2021	2021-2022	2022-2023	2023-2024
1 Dose MenACWY	Grade 7	Grades 7-8	Grades 7-9	Grades 7-10
2 Doses MenACWY	Grade 11	Grades 11-12	Grades 11-12	Grades 11-12

§ Address questions about enforcement with your legal counsel. School requirements are enforced at the local level.

†Medical exemptions (statement from a physician stating that a vaccine is medically contraindicated for a student) and religious exemptions (statement from a student, or parent/guardian if the student is <18 years of age, stating that a vaccine is against sincerely held religious beliefs) should be renewed annually at the start of the school year.

* A reliable history of chickenpox includes a diagnosis of chickenpox, or interpretation of parent/guardian description of chickenpox, by a physician, nurse practitioner, physician assistant, or designee.

‡ Students who are 15 years old in grade 11 are in compliance until they turn 16 years old.

Massachusetts School Immunization Requirements 2020-2021§

Requirements apply to all students including individuals from another country attending or visiting classes or educational programs as part of an academic visitation or exchange program. Requirements apply to all students, even if over 18 years of age.

College (Postsecondary Institutions)†

Requirements apply to all full-time undergraduate and graduate students under 30 years of age and all full- and part-time health science students. Meningococcal requirements apply to the group specified in the table below.

Tdap	**1 dose;** and history of a DTaP primary series or age appropriate catch-up vaccination. Tdap given at ≥7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catch-up schedule. Td or Tdap should be given if it has been ≥10 years since Tdap.
Hepatitis B	**3 doses;** laboratory evidence of immunity acceptable; 2 doses of Heplisav-B given on or after 18 years of age are acceptable
MMR	**2 doses;** first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; laboratory evidence of immunity acceptable. Birth in the U.S. before 1957 acceptable only for non-health science students
Varicella	**2 doses;** first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; a reliable history of chickenpox* or laboratory evidence of immunity acceptable. Birth in the U.S. before 1980 acceptable only for non-health science students
Meningococcal	**1 dose;** 1 dose MenACWY (formerly MCV4) required for all full-time students 21 years of age or younger. The dose of MenACWY vaccine must have been received on or after the student's 16th birthday. Doses received at younger ages do not count towards this requirement. Students may decline MenACWY vaccine after they have read and signed the MDPH Meningococcal Information and Waiver Form provided by their institution. Meningococcal B vaccine is not required and does not meet this requirement

§ Address questions about enforcement with your legal counsel. School requirements are enforced at the local level.

†Medical exemptions (statement from a physician stating that a vaccine is medically contraindicated for a student) and religious exemptions (statement from a student, or parent/guardian if the student is <18 years of age, stating that a vaccine is against sincerely held religious beliefs) should be renewed annually at the start of the school year.

* A reliable history of chickenpox includes a diagnosis of chickenpox, or interpretation of parent/guardian description of chickenpox, by a physician, nurse practitioner, physician assistant, or designee.

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ ☐ Male ☐ Female **Date of Birth:** _____

Medical History

Pertinent Family History

Current Health Issues

Y N

☐ ☐ Allergies: Please list: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: _____

☐ ☐ Other (*Please specify*) _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school. a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:** _____

Hgt: _____(____%) Wgt: _____(____%) BMI: _____(____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General _____ ☐ Lungs _____ ☐ Extremities _____
☐ Skin _____ ☐ Heart _____ ☐ Neurologic _____
☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____
☐ Dental/Oral _____ ☐ Genitalia _____

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other _____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
TB Test Type: ☐ TST ☐ IGRA Date: _____ Result: ☐ Positive ☐ Negative ☐ Indeterminate/Borderline
Referred for evaluation to: _____ Date: _____ ☐ Low risk (no TB test done)

This student has the following problems that may impact his/her educational experience:
☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations:

☐ Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** _____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.**

_____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____ _____
Group Practice Telephone

_____ _____ _____ _____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 08/15/13*

Massachusetts Parental Notice with One-Time Consent to Allow the School district to Access MassHealth (Medicaid) Benefits

Saugus Public Schools
District Code 0252

Dear Parent/Guardian:

The purpose of this letter is to ask your permission to bill MassHealth for the cost of special education services that the district provides your child under the IEP that we developed with you. If you agree, MassHealth will reimburse the cost of services that they cover, such as therapy services as well as the cost of time spent by providers of such services to participate in Team meetings. We cannot send records and information about your child and your child's IEP services to MassHealth to ask for reimbursement without your consent and without first notifying you of the following:

1. The school district cannot require you to sign up for MassHealth in order for your child to receive the special education services to which your child is entitled;

2. The school district cannot require you to pay anything towards the cost of your child's special education services. This means that the school district cannot require you to pay a co-pay or deductible so that it can bill MassHealth. The school district can agree to pay the co-pay or deductible if any such cost is expected.

3. If the school district receives your consent:
   a. Your consent will not decrease your child's available lifetime coverage or other MassHealth benefits; nor will it in any way limit your own family's use of Mass Health benefits outside of school
   b. Your consent does not affect your child's special education services or IEP rights in any way
   c. Your consent will not lead to any changes in your child's MassHealth rights; and
   d. Your consent will not lead to any risk of losing eligibility for other Medicaid or MassHealth funded programs.

4. If you consent, you have the right to change your mind and withdraw your consent at any time.

5. If you withdraw your consent, or refuse to agree to allow the school district to share your child's records and information with MassHealth for the purpose of billing the cost of his/her IEP services, the school district will continue to be responsible for providing your child the special education services in his/her IEP at no cost to you.

I have read the notice and understand it. I have had my questions, if any, answered. I agree to give my consent to the school district to share records and information concerning my child and his/her IEP services as necessary to bill MassHealth to obtain federal reimbursement for the cost of the IEP services that MassHealth covers.

Parent/Guardian Signature: _____ _____
Date

Student Name: DOB

Student Name_____

Federal Ethnicity/Race

In order to comply with the Department of Education Student Information Management Systems it is necessary that we have you complete the following information.

*Race and ethnicity are collected under the authority of state and federal laws, including Massachusetts General Laws, Chapter 69, sections 1A, 1B, sections 37D; Chapter 71A and 71S. The data is used for education equity monitoring as well as statistical analysis, reporting and planning Standards Handbook Massachusetts Student Information Management System Reference Guide, October 21, 1998.

Please answer BOTH questions 1 and 2

1. Is this student Hispanic or Latino? (choose only one)

   ____No, not Hispanic/ Latino

   _____Yes Hispanic/Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American , or Spanish culture or origin, regardless of race.

2. What is the student's race? (choose one or more)

   _____American Indian or Alaska Native - A person having any of the original peoples of North and South American and including Central America, and who maintains tribal affiliation or community attachment.

   _____Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian sub-continent including, for example, Cambodia, China India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand or Vietnam.

   ____Black or African American - A person having origins in any of the black racial groups of Africa.

   ____Native Hawaiian or Other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

   ____White A person having origins in any of the original peoples of Europe, North Africa, or Middle East

   Check if applicable

   ____Low Income Status the student is eligible for free/reduced lunch, or receives Transitional Aid to Families eligible for food stamps.

   ____Perkins Low Income Status - the family has an annual income below the federal poverty guidelines, or the Transitional Aid to Families, or the student is a state Ward (foster child), or is in a n institution for the neglected or the student is eligible for free or reduced lunch.

   ____Migrant Status – an indication of whether an individual or a parent/guardian accompanying an individual for employment in one or more agricultural or fishing activities on a seasonal or other temporary basis a temporary residence for the purpose of employment.

   ____Immigrant Status – an indication of whether a student is eligible for Emergency Immigrant Education students must not have been born in any state (any of the 50 states, the Commonwealth of Puerto Rico, Columbia, Guam, American Samoa, the Virgin Island, the North Mariana Islands, or the territory of the Pa not having completed three full academic years of school in any state).

Home Language Survey

Massachusetts Department of Elementary and Secondary Education regulations require that all schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. If a language other than English is spoken in the home, the District is required to do further assessment of your child. Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

Student Information

First Name _____ Middle Name _____ Last Name _____ F ☐ M ☐ Gender

Country of Birth _____ Date of Birth (mm/dd/yyyy) ___/___/___ Date first enrolled in ANY U.S. school (mm/dd/yyyy) ___/___/___

School Information

Start Date in New School (mm/dd/yyyy) ___/___/20___ Name of Former School and Town _____ Current Grade _____

Questions for Parents/Guardians

What is the native language(s) of each parent/guardian? (circle one) _____ (mother father guardian) _____ (mother father guardian)	Which language(s) are spoken with your child? (include relatives -*grandparents, uncles, aunts,etc.* - and caregivers) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always
What language did your child first understand and speak?	Which language do you use most with your child?
Which other languages does your child know? (circle all that apply) _____ speak read write _____ speak read write	Which languages does your child use? (circle one) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always
Will you require written information from school in your native language? Y ☐ N ☐	Will you require an interpreter/translator at Parent-Teacher meetings? Y ☐ N ☐
Parent/Guardian Signature: X	___/___/20___ Today's Date: (mm/dd/yyyy)

家庭语言调查

马萨诸塞州小学与中学教育服务部规程要求*所有*学校鉴别每个学生在家常说的语言，以确定其具体的语言需要。为使各个学校为所有学生提供有意义的教学，提供这些信息至关重要。如果在家里说非英语的语言，则学区必须对孩子做进一步的评估。请回答下列问题以帮助我们达到此重要要求。感谢您的协助。

学生信息

名	中间名	姓	女 ☐ 男 ☐ 性别
出生国家	出生日期 (月/日/年)	首次就读任何美国学校的日期 (月/日/年)	

学校信息

新学校开始日期 (月/日/年)	先前学校与镇区名称	当前年级

家长/监护人的问题

每位家长/监护人的母语是什么？（圈选一个） _____ （家长/父亲/监护人） _____ （家长/父亲/监护人）	与您的孩子交谈用哪种语言？ （包括亲属 *祖父母、叔叔、阿姨等等*，以及照顾者） _____ 很少/有时/经常/总是 _____ 很少/有时/经常/总是
您的孩子首先理解和说哪种语言？	您与孩子之间使用最多的语言是什么？
您的孩子还懂其他哪种语言？（圈选所有适用项）： _____ 说/读/写 _____ 说/读/写	您的孩子使用哪种语言？（圈选一个） _____ 很少/有时/经常/总是 _____ 很少/有时/经常/总是
您想要从学校索取以您母语提供的书面资料吗？ 是 ☐ 否 ☐	在家长教师会议中您需要口译员/翻译吗？ 是 ☐ 否 ☐
家长/监护人签字： X	____/____/20____ 今天的日期：（月 日 年）

Simplified Chinese

家庭語言調查

麻省小學與中學教育服務部規程要求*所有*學校鑒別每個學生在家常說的語言，以確定其具體的語言需要，為使各個學校為所有學生提供有意義的教學，提供這些資訊至關重要。如果在家說非英語的語言，則學區必須對孩子做進一步的評估，跟回答下列問題以幫助我們達到此重要要求，感謝您的協助。

學生資訊

名	中間名	姓	性別 女 ☐ 男 ☐
出生國家	出生日期(月/日/年)	首次就讀任何美國學校的日期(月/日/年)	

學校資訊

新學校開始日期(月/日/年)	先前學校與城區名稱	當前年級
____/____/20____		

父母/監護人的問題

每位父母/監護人的母語是什麼？(圈選一個) _____(父母/父親/監護人) _____(父母/父親/監護人)	與您的孩子交談用哪種語言？ (包括視頻- *祖父母*、*叔叔*、*阿姨*等*家*、以及照顧者) _____很少/有時/經常/總是 _____很少/有時/經常/總是
您的孩子首先理解和說哪種語言？	您與孩子之間使用最多的語言是什麼？
您的孩子還懂其他哪種語言？(圈選所有適用項)： _____說/讀/寫 _____說/讀/寫	您的孩子使用哪種語言？(圈選一個) _____很少/有時/經常/總是 _____很少/有時/經常/總是
您想要從學校索取以您母語提供的書面資料嗎？ 是 ☐ 否 ☐	在父母教師會議中您需要口譯員協助嗎？ 是 ☐ 否 ☐
父母/監護人簽字： X	____/____/20____ 今天的日期：(月/日/年)

Traditional Chinese

Enquête sur les langues parlées à la maison

Le règlement du Massachusetts Department of Elementary and Secondary Education exige que *toutes* les écoles déterminent la ou les langues parlées au domicile de chaque élève afin d'établir ses besoins particuliers en matière de langue. Cette information est essentielle pour que les écoles puissent offrir un enseignement de qualité à tous les élèves. Si une langue autre que l'anglais est parlée à la maison, le District doit évaluer davantage votre enfant. Veuillez nous aider à répondre à cette exigence importante en répondant aux questions suivantes. Merci pour votre aide.

Renseignements sur l'élève

Prénom	Second prénom	Nom	Genre
			F ☐ M ☐

Pays de naissance	Date de naissance mm/j/aaaa	Date de la première inscription dans une école américaine (mm/j/aaaa)
	/ /	/ /

Renseignements sur l'école

Date de commencement dans la nouvelle école (mm/j/aaaa)	Nom de l'ancienne école et de la ville	Année actuelle
/ /20		

Questions pour les parents/tuteurs

Quelle est la langue maternelle de chacun des parents/tuteurs? (encerclez une réponse) _____ (mère / père tuteur) _____ (mère / père tuteur	**Quelle(s) langue(s) parlez-vous avec votre enfant?** (y compris les membres de la famille – *grands-parents, oncles, tantes, etc.* – et parents substituts) _____ rarement / parfois / souvent / toujours _____ rarement / parfois / souvent / toujours
Quelle langue votre enfant a-t-il apprise et parlée en premier?	**Quelle langue utilisez-vous le plus souvent avec votre enfant?**
Quelles autres langues votre enfant connaît-il? (encerclez toutes les réponses applicables) _____ parlée / lue / écrite _____ parlée / lue / écrite	**Quelles langues votre enfant utilise-t-il? (encerclez une réponse)** _____ rarement / parfois / souvent toujours _____ rarement / parfois / souvent toujours
Avez-vous besoin de renseignements écrits de l'école dans votre langue maternelle? Oui ☐ Non ☐	**Você deseja um intérprete/tradutor presente nas reuniões entre pais-professores?** Oui ☐ Non ☐
Signature du parent/tuteur : X	/ /20 **Date d'aujourd'hui :** (mm/j/aaaa)

French

Sondaj pou Lang nan Lakay

Lalwa pou Massachusetts Department of Elemantary and Secondary Education di tout lekòl dwe determine lang yo pale nan chak lakay elev pou idantifiye lang a pabitilye ki pale la. Enfòmasyon sa ase nesesè pou lekòl yo founi ensfòmkson korèk pou tout elev.Si yon lang ki pa angle ap pale nan lakay la, Distrik la dwe fè tes ti moun an plis. Tanpri ede nou obeyi lalwa sa a avek ou repons a kesyon yo an ba. Mèsi pou ed ou

Enfòmasyon Elev

Prenom _____ Nom Mitan _____ Nom Fanmi _____ F ☐ M ☐ Gason oswa fi

Peyi de Nesans _____ Dat de Nesans (mm/dd/yyyy) ___/___/___ Dat Enrole nan NENPÒT lekòl ETAS UNI (mm/dd/yyyy) ___/___/___

Enfòmasyon Lekòl

Dat li komanse nan Lekòl Nouvo (mm/dd/yyyy) ___/___/20___ Nom pou Lekol la e Vil anvann sa _____ Klas Kourran _____

Kesyon yo pou Paron/Gadyen

Ki lang oswa lang yo natif la pou chak paron/gadyen? (fè yon sèrk otou youn) _____ (maman / papa / gadyen) _____ (maman / papa gadyen)	Ki lang oswa lang yo ou pale avek ti moun ou? (enkli fanmi –gran moun, tonton yo, tant yo, e plis – epi moun kap bay ed) _____ pa souvan / kèk fwa / souvan / tout tan _____ pa souvan / kèk fwa / souvan / tout tan
Ki lang ti moun konprann e pale premye?	Ki lang ou pate pliz avek ti moun ou?
Ki lòt lang ti moun ou kone? (fè youn sèrk otou tout li kone) _____ pale / li / ekri _____ pale li / ekri	Ki lang yo ti moun ou itilize ? (fè youn sèrk otou tout li kone) _____ pa souvan / kèk fwa / souvan / tout tan _____ pa souvan / kèk fwa / souvan / tout tan
Eska w va beswen enfòmasyon ki ekri nan lang ou pa lekòl la? Wi ☐ Non ☐	Eska ou va beswen yon tradiktè a rendevou Paron- Pwofesè? Wi ☐ Non ☐
Siyati Paron/Gadyen: X	___/___/20___ Dat Jòdi a: (mm/dd/yyyy)

Haitian

Pesquisa de idioma doméstico

Os regulamentos do departamento de Educação E ementar e Secundária de Massachusetts exige que todas as escolas determinem os idiomas falados no domicílio de cada aluno para identificar suas necessidades de idioma específicas. Essa informação é essencial para que as escolas ofereçam instrução significativa para todos os alunos. Se outro idioma que não seja inglês for falado em casa, o distrito precisará realizar uma avaliação mais detalhada do seu filho. Por gentileza, ajude-nos a atender esse requisito importante, respondendo às seguintes perguntas. Agradecemos a sua ajuda.

Informações do aluno

Nome	Nome do meio	Sobrenome	F ☐ M ☐ Sexo
País de nascimento	Data de nascimento (mm/dd/aaaa)		Data do primeiro registro em QUALQUER escola norte americana (mm/dd/aaaa)

Informações da escola

___/___/20___ Data de início na nova escola (mm/dd/aaaa)	Nome da escola e cidade antiga	Grau escolar atual

Perguntas para os pais/tutores

Quais são os idiomas nativos de cada pai/tutor? (circule uma) _____ (mãe / pai / tutor) _____ (mãe / pai / tutor)	**Quais idiomas são falados com seu filho?** **(inclua parentes -avós, tios, tias, etc. - e babás)** _____ pouca frequência / algumas vezes com frequência / sempre _____ pouca frequência / algumas vezes com frequência / sempre
Qual foi o primeiro idioma que seu filho compreendeu e falou?	**Qual idioma você usa com mais frequência com seu filho?**
Quais são os outros idiomas que seu filho conhece? (circule todas as opções aplicáveis) _____ fala / lê / escreve _____ fala / lê / escreve	**Quais são os idiomas que seu filho usa? (circule uma)** _____ pouca frequência / algumas vezes com frequência / sempre _____ pouca frequência / algumas vezes com frequência / sempre
Você deseja receber informações por escrito da escola em seu idioma nativo? S ☐ N ☐	**Você deseja um intérprete/tradutor presente nas reuniões entre pais-professores?** S ☐ N ☐
Assinatura dos pais/tutores: X	___/___/20___ **Data de hoje:** (mm/dd/aaaa)

Portuguese

Encuesta del idioma hablado en el hogar

Los reglamentos del Departamento de Educación Primaria y Secundaria de Massachusetts exigen que *todas* las escuelas determinen los idiomas que se hablan en los hogares de los estudiantes para así identificar sus necesidades específicas relacionadas con el idioma. Esta información es esencial para que las escuelas puedan proveer instrucción que todos los estudiantes puedan aprovechar. Si en su hogar se habla otro idioma que no sea inglés, se requiere que el Distrito evalúe a su hijo más a fondo. Ayúdenos a cumplir con este importante requisito respondiendo a las siguientes preguntas. Gracias por su ayuda.

Información del estudiante

Nombre	Segundo nombre	Apellido	F ☐ M ☐ Sexo
País de nacimiento	Fecha de nacimiento (mm/dd/aaaa)		Fecha de matriculación inicial en CUALQUIER escuela de EE.UU. (mm/dd/aaaa)

Información de la escuela

Fecha de comienzo en la escuela nueva (mm/dd/aaaa)	Nombre de la escuela y ciudad anterior	Grado actual

Preguntas para los padres/encargados

¿Cuál es el idioma natal del padre/la madre/los encargados? (enciérre en un círculo) _____ (madre / padre / encargado) _____ (madre / padre / encargado)	¿Qué idioma(s) se habla(n) con su hijo? (incluya parientes -abuelos, tíos, tías, etc. - y encargados del cuidado) _____ infrecuentemente / algunas veces / frecuentemente / siempre _____ infrecuentemente / algunas veces / frecuentemente / siempre
¿Cuál fue el primer idioma que entendió y habló su hijo?	¿Qué idioma usa usted principalmente con su hijo?
¿Qué otros idiomas sabe su hijo? (enciérre en un círculo todo lo que corresponda) _____ habla / lee / escribe _____ habla / lee / escribe	¿Qué idiomas usa su hijo? (enciérre uno en un círculo) _____ infrecuentemente / algunas veces frecuentemente / siempre _____ infrecuentemente / algunas veces frecuentemente / siempre
¿Requerirá usted la información impresa de la escuela en su idioma natal? Sí ☐ No ☐	¿Requerirá usted un intérprete/traductor en reuniones de padres y maestros? Sí ☐ No ☐
Firma del padre/la madre/encargado: X	_____ / _____ /20_____ Fecha de hoy: (mm/dd/aaaa)

Spanish