Douglas Public Schools
Student Registration Form

School Year _____

Student Information: **ID #:** _____

_____ _____ _____

First Name **Full Middle Name** **Last Name**

(Full Legal Name as shown on birth certificate)

Gender: ___ Female ___ Male

Birthday: _____/_____/_____
month day year

Ethnicity: (select one)
___ Hispanic/Latino
___ Non-Hispanic/Latino

Nickname: _____
classroom use only

Race: (select all that apply)
___ American Indian/Alaskan Native
___ Asian
___ Black/African-American
___ Hawaiian/Pacific Islander
___ White

Select the grade that student is enrolling into:
___ PS3 ___ PK4 ___ K ___ 1

Student Address Information:

House #		PO Box #	
Street		City, State, Zip Code	
Apartment #			
City, State, Zip Code			

Massachusetts Department of Education Data:

Last School Attended: _____
School Name **City, State**

If student is entering from a Massachusetts Public School, complete the following information:
Visa Type: _____ Admin #: _____

What is the language first used by parent/guardian with the child? _____
What language is primarily spoken in your home? _____

_____ _____ _____
Birth City Birth State (US Only) Birth Country*

*If birth country is not in the United States;

- Has this student completed 3 years of schooling in the United States? ___Yes ___No
- Identify the first grade level and year completed in the United States: _____

Guardian/Custodial Information:

	Parent/Guardian- 1	Parent/Guardian- 2
Relationship to Student		
Name: Last, First		
Title: Mr., Mrs., Ms., Dr., etc.		
House #		
Street		
Apartment #		
City, State, Zip		
PO Box #		
City, State, Zip		
Phone #1	home/cell/work	home/cell/work
Phone #2	home/cell/work	home/cell/work
Work Place		
Email		

Please check all that apply:

	Parent/Guardian- 1	Parent/Guardian- 2
	___ Has custody of student*	___ Has custody of student*
	___ Lives with student	___ Lives with student
	___ Should receive mailings	___ Should receive mailings

*If sole custody, please provide office with original agreement

Legal restrictions in place regarding non-custodial parent ___Yes ___ No

Other children residing with enrolling student:

Name	**Relationship to Student**	**Date of Birth**	**School/Grade**

Emergency Contacts:

Name: Last, First		Phone #1	home/cell/work
Relationship to Student		Phone #2	home/cell/work
Can dismiss student?	___Yes ___ No		
Can receive student?	___Yes ___ No		

Name: Last, First		Phone #1	home/cell/work
Relationship to Student		Phone #2	home/cell/work
Can dismiss student?	___Yes ___ No		
Can receive student?	___Yes ___ No		

Name: Last, First		Phone #1	home/cell/work
Relationship to Student		Phone #2	home/cell/work
Can dismiss student?	___Yes ___ No		
Can receive student?	___Yes ___ No		

***Please note:** Anyone picking up your child must do so at the school office and show a photo ID.

Integrity Call Notification Data Sheet

Parent/Guardians Names: _____

Please circle: MOTHER / FATHER / GUARDIAN

_____

Please circle: MOTHER / FATHER / GUARDIAN

Children enrolled in Douglas Public Schools:

_____	_____
Child's Name	School
_____	_____
Child's Name	School
_____	_____
Child's Name	School
_____	_____
Child's Name	School
_____	_____
Child's Name	School

Please indicate the two (2) phone numbers you wish to use for this service. Both numbers will be called (do not use numbers which require an extension).

_____	_____
Please circle: HOME / CELL / WORK	Please circle: HOME / CELL / WORK

If you wish email notification, please list your email address:

_____

If you wish to opt out of routine messages (such as closing or delay) please check and sign. You must still provide the information so we can reach you in the event of an emergency ((school evacuation, etc.)

☐ **I wish to opt out of routine messages as described above.**

_____

Signature

Thank you for your prompt return of this information to your child's teacher.

DOUGLAS PUBLIC SCHOOLS
DEPARTMENT OF STUDENT SUPPORT SERVICES
17 Gleason Court
Douglas, MA 01516

Nealy E. Koumanelis-Urquhart, M. Ed.
Director of Student Support Services

Telephone: (508) 476-4034
Fax: (508) 476-4032

HOME LANGUAGE SURVEY

As part of our effort to provide equal educational opportunities for students in the Douglas Public Schools, we need to know what language(s) you and your child speak. In addition, as required by law the school may determine that it needs to assess your child's English proficiency. Completion of this form is a requirement of all students enrolling in school.

A. Student Background Information

Student Name _____ Telephone No.: _____

Address: _____

Highest Grade Completed: _____ When: _____ Where: _____

Date of Birth: _____ City and Country of Birth: _____

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

Person completing form (if other than parent/guardian): _____

Relationship to Student: _____ Telephone No.: _____

- Si usted necesita traduciendo e□sta planilla, por favor contacte a la secretaria del edificio la cual le facilitara□ asistencia.

- Se você precisa de alguma ajuda em traduzir este formula□rio, entree m contato com a secreta□ria e ela ajuda em procurer assistência.

HOME LANUAGE SURVEY

B. English Language Survey

Please complete the survey below by checking the appropriate column. If your answer is "other", please complete the last column.

	English	Other	Please Specify:
1. What language did the child learn when he/she first began to talk?	_____	_____	_____
2. What language did the child speak most of the time while growing-up?	_____	_____	_____
3. What language does the family speak at home most of the time?	_____	_____	_____
4. What language does the parent(s) speak to his/her child most of the time?	_____	_____	_____
5. What language does the child speak to his/her parent(s) most of the time?	_____	_____	_____
6. What language does the child speak to his/her brother(s)/sister(s) or other children in the home most of the time?	_____	_____	_____
7. What language does the child speak to his/her friends most of the time?	_____	_____	_____

HOME LANGUAGE SURVEY

C. Parent(s)/Guardian(s) Language Background Survey

Please answer the questions below. If the answer to any question is no, please fill in the "other" column, giving the other language.

	Yes	No	Other:
1. Can an adult family member speak English?	____	____	_____
2. Can an extended family member speak English?	____	____	_____
3. Can a family member read and understand English?	____	____	_____
4. Can an extended family member read and understand English?	____	____	_____
5. Do the parent(s)/guardian(s) request written communication from school be in English?	____	____	_____
6. Do the parent(s)/guardian(s) request oral communication from the school be in English?	____	____	_____
7. Do you need a translator?	____	____	_____
8. Do you have a friend or relative who can translate for you?	____	____	_____
9. Do you need a translator arranged by the school for you?	____	____	_____
10. Will you be willing to serve as a translator?	____	____	_____

If your answer in questions 7 and 10 is yes, would you please indicate in what language:

_____.

DOUGLAS PUBLIC SCHOOLS
STUDENT HEALTH QUESTIONAIRE

Student's Name_____D.O.B._____

Parent or Guardian_____

Address_____Telephone_____

Name of Student's Pediatrician_____

Address_____Telephone_____

- Does your child have any pre-existing conditions?_____ If yes, please explain:

  _____

- Does your child have any allergies? ?_____ If yes, please explain:
  - *Type of Allergy*_____
  - *Reaction*_____
  - *Treatment*_____
- If your child needs emergency treatment for his/her reaction, please contact Mrs. Gilrein, R.N. at 508-476-2154
- Has your child met all the immunization requirements for kindergarten entry? Yes___ No__
- If no, when is your child's next appointment?_____
  * An appointment must be made before school starts; otherwise your child will be excluded from school. All children must have current physical examination in their health record.
- Did your child have a complete eye exam before entering kindergarten?_____ If yes, when?_____ Results_____
- Has your child ever been tested for lead? Yes_____ No_____. Please be sure a lead test is recorded on your child's health record.
- If your child has not had a lead test he/she will need one for school.
- Has your child ever had the chicken pox?_____ If no, your child should have had the Varicella Vaccine.

Thank you for providing the above information to complete your child's medical record. Please be sure to schedule your child's physical exam and immunizations appointment BEFORE school begins to avoid any delay in your child's starting date. Massachusetts State Law requires all children to be completely up to date on all immunizations before school begins.

Douglas Public Schools
Health Office - Emergency Information

Student's Name _____ Grade: _____
Last First Middle

Date of Birth _____ Place of Birth _____ M or F

Address _____

Town _____ State _____ Zip Code _____

Mailing Address (if different) _____

Home Phone _____ Primary Language _____

Mother's Cell # _____ Father's Cell# _____

Mother's Work # _____ Father's Work # _____

E-Mail _____ E-Mail _____

Name/Grade of siblings _____

Name of Parent(s) or Guardian(s) with whom child lives _____

Name, Address, and Phone of Non-Custodial Parent _____

_____

Does your child have Health Insurance? Yes or No Name _____

If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please call HealthConnector at 1-877-623-6765 or contact the school nurse for more information about these programs. All communications will be confidential.

In the event that my child needs to be dismissed for an illness or injury, and I cannot be reached, the following people may pick up my child:

Name _____

Relationship _____ DaytimePhone _____

Name _____

Relationship _____ DaytimePhone _____

Hospital Preference _____

Student's Physician _____ Phone _____
Student's Dentist _____ Phone _____

Please list all medications that your child takes: _____

_____

Allergies or Medical Conditions: (i.e., Heart Condition, Diabetes, Asthma, Seizure Disorder, Life Threatening Allergy, etc.) Please specify here:

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis, and treatment.

Parent's signature _____ **Date** _____

Permission for Over the Counter (OTC) Medications

Please note: Medications may be given only once during the school day AND students must bring in their own supply of Tylenol or Advil to be kept in the health office (per policy in Douglas Public Schools Handbooks). Also, the school nurse may use first aid treatments including topicals like Calamine lotion for allergic rashes and insect bites, Orajel for toothaches, antibiotic ointments to prevent possible wound infections and burn ointment for minor burns unless otherwise indicated by parent/guardian.

My child has permission to take the following medications or generic substitutions and the school nurse will notify parent/guardian if administered. However, the school nurse will always contact a Parent/Guardian for permission prior to medicating a child in grades PreK-5.

Tylenol _____ **Advil** _____ **Antacid** _____

Parent's signature _____ **Date** _____

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):
Date of PPD: ____; Results: ____mm.
Referred for evaluation to: _____ ☐ Low risk (no PPD 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 03/19/10*

CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth:** / / **Sex:** M F

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date	Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		
	2		
	3		
	4		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1		
	2		
	3		
	4		
	5		
	6		
	7		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib)	1		
	2		
	3		
	4		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1		
	2		
	3		
	4		
	5		
Pneumococcal Conjugate (e.g., PCV7, PCV13)	1		
	2		
	3		
	4		

Vaccine		Date	Vaccine Type
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2		
	3		
Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
	2		
Varicella (e.g., Var, MMRV)	1		
	2		
Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2		
Seasonal Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	2		
	3		
	4		
H1N1 Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	2		
Pneumococcal Polysaccharide (PPSV23)	1		
	2		
Hepatitis A (e.g., HepA, HepA-HepB)	1		
	2		
Human Papillomavirus (e.g., HPV quadrivalent, HPV bivalent,)	1		
	2		
	3		
Other:			

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)*: **Date:** / /

Signature:

Facility name: