Registration Checklist

Child's name: ________________________________ Grade: ________

_____ RES Enrollment Form (in packet)

_____ Home Language Survey (in packet)

_____ Health Survey (in packet)

_____ Current Physical Exam with Immunization Record and Vision Screening (within the last 12 months, including a Lead Screen and Tuberculosis (TB) Test and results or completed risk assessment form)

_____ Dental Certificate (within the last 12 months, to be completed by Dentist) (in packet)

_____ Medical Exemption (if applicable): A written statement from a physician indicating the reasons why one or more of the immunizations should not be given is required before admission to school. Such certification is required each year thereafter.

_____ Religious Exemption (if applicable): A religious exemption is allowed if a parent submits a signed statement to the school stating that immunizations are contrary to their sincere religious beliefs. Available in RES office

_____ Kindergarten Entrance Information (in packet)

_____ Child’s Birth Certificate or Passport (please bring original)

_____ Custody/Legal Documentation (if applicable)

Proof of Residency: _______ Signed Proof of Residency Statement (in packet)

Two (2) proofs of residency needed: Choose from the following

_____ Record of Mortgage Payment _____ Lease/Rental Agreement _____ Utility Bill

_____ Voter Registration _____ Valid Driver’s License or ID

_____ Other: Please List ____________________________________________

Entering Kindergarten students must be 5 years old on or before August 31st

Dec 2019
ROCKPORT PUBLIC SCHOOLS
STUDENT ENROLLMENT FORM

<table>
<thead>
<tr>
<th>School:</th>
<th>Homeroom:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td>Grade:</td>
</tr>
<tr>
<td>First Name:</td>
<td>Gender: Male or Female (circle one)</td>
</tr>
<tr>
<td>Middle Name:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Preferred Name:</td>
<td>City of Birth:</td>
</tr>
</tbody>
</table>

**Has student ever attended Rockport Public Schools? If so which one and when?**

**Primary Language:**

Other Language Spoken at home:

Is there any other information you would like us to know about your child? (non-medical)

__________________________________________________________

__________________________________________________________

**Ethnic Categories (Select only one)**

- [ ] Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."
- [ ] Not Hispanic or Latino

**Race: Current Status Reported:** (select only one)

- [ ] 01-White
- [ ] 02-Black or African American
- [ ] 03-Asian
- [ ] 04-American Indian or Alaska Native
- [ ] 05-Native Hawaiian or Other Pacific Islander
- [ ] 06-White/Black or African American
- [ ] 07-White/Asian
- [ ] 08-Not Hispanic/White/American Indian
- [ ] 14 Asian/Native Hawaiian or Other Pacific Islander
- [ ] 33- Hispanic/white
- [ ] 34-Hispanic/Black or African American
- [ ] Other __________________________

**Country of Origin** (only needed if student has immigrant status):

__________________________________________________________

**Immigrant Status:** to meet the federal definition, a student must not have been born in any state, AND not have completed three full academic years of school in any state.

**Select only if applicable:** [ ] Student is an immigrant student under the federal definition.

**Low Income:** Families receiving Transitional Assistance or SNAP (Food Stamps) qualify for free or reduced benefits. A meal benefit application must be on file. Applications may be completed by logging into www.lunchapp.com. If you do not have access to a computer you may contact Abbey Pelletier at 978-546-1243 for a paper application.

---

**FOR OFFICE USE ONLY:**

<table>
<thead>
<tr>
<th>Kindergarten forms: Permission to screen:</th>
<th>Health Forms: Health &amp; Development Questionnaire:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Y [ ] N</td>
<td>[ ] Y [ ] N</td>
</tr>
</tbody>
</table>

Name Tag Request: [ ] Y [ ] N

All Schools:

Birth Certificate: [ ] Y [ ] N

Proof of Residency: [ ] Y [ ] N

Home Language Survey: [ ] Y [ ] N

Proof of Immunization: [ ] Y [ ] N

Dental Certificate: [ ] Y [ ] N

Current Physical Exam: (within one calendar year) [ ] Y [ ] N
### Parent Information

<table>
<thead>
<tr>
<th>Name of Parent 1 /Guardian:</th>
<th>Name of Parent 2 /Guardian:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relation to Student:</td>
<td>Relation to Student:</td>
</tr>
<tr>
<td>Custody of Student: Y or N (circle one)</td>
<td>Custody of Student: Y or N (circle one)</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>City, State Zip:</td>
<td>City, State, Zip:</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Home Phone:</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td>Cell phone:</td>
</tr>
<tr>
<td>Email Address:</td>
<td>Email Address:</td>
</tr>
<tr>
<td>Employer Name:</td>
<td>Employer Name:</td>
</tr>
<tr>
<td>Employer Position:</td>
<td>Employer Position:</td>
</tr>
<tr>
<td>Employer Phone:</td>
<td>Employer Phone:</td>
</tr>
<tr>
<td>Emergency Contact 1: Person agreed to care for child in case a parent cannot be reached</td>
<td>Emergency Phone Number:</td>
</tr>
<tr>
<td>Relation to Student:</td>
<td></td>
</tr>
</tbody>
</table>

#### Custody Information

<table>
<thead>
<tr>
<th>Student Resides with if other than parent:</th>
<th>Is he/she living with both parents: Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>If no, are there any custody restrictions?</td>
</tr>
</tbody>
</table>

#### Sibling Information

<table>
<thead>
<tr>
<th>List of Brothers and Sisters</th>
<th>Date of Birth</th>
<th>School Attending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Has your child received special services? If yes please explain: ____________________________

Signature of Parent/Guardian1: ____________________________ Date: __________

Signature of Parent/Guardian2: ____________________________ Date: __________

For New Transfer students only: All Students:

<table>
<thead>
<tr>
<th>School Last Attended:</th>
<th>May we release student’s information to Parent Association: Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Email List: Yes</td>
<td>No</td>
</tr>
<tr>
<td>City:</td>
<td>Directory: Yes</td>
<td>No</td>
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<tr>
<td>State:</td>
<td></td>
<td></td>
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<tr>
<td>Zip:</td>
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<tr>
<td>SASID#:</td>
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<tr>
<td>LASID #:</td>
<td></td>
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</tbody>
</table>

SENT TO: SPED ________ IT ________ NURSE ________ CAFE ________ DATE: __________
Emergency Contact Information

Please fill out if you need to add or change an emergency contact

In case of an emergency, illness or accident, or if a child has to be sent home during the course of the day, a responsible adult, OTHER THAN student’s parent/guardian, must be listed. Please be sure that the following people are aware that they may be called to care for your child IN THE EVENT THAT YOU CANNOT BE REACHED.

Student Name: ____________________________________________

Emergency Contact No. 1:

Name: ____________________________________________
Daytime Phone: ___________________________ Relationship: __________

Emergency Contact No. 2:

Name: ____________________________________________
Daytime Phone: ___________________________ Relationship: __________

Please list all siblings who attend school in the Rockport School District:

Grade ____ Age ____ Student Name ____________________________

Grade ____ Age ____ Student Name ____________________________

Grade ____ Age ____ Student Name ____________________________
# 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

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Gender</th>
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</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Country of Birth school (mm/dd/yyyy)</th>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>Date first enrolled in ANY U.S.</th>
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<tbody>
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</table>

## School Information

<table>
<thead>
<tr>
<th>Start Date in New School (mm/dd/yyyy)</th>
<th>Name of Former School and Town</th>
<th>Current Grade</th>
</tr>
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</tbody>
</table>

## Questions for Parents/Guardians

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

(include relatives - grandparents, uncles, aunts, etc. - and caregivers)

- _______ seldom / sometimes / often / always

**What language did your child first understand and speak?**

______________________________

**Which language do you use most with your child?**

______________________________

**How many years has the student been in U.S. Schools? (not including pre-kindergarten)**

**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

If yes, what language?

______________________________

**Will you require an interpreter/translator at Parent-Teacher meetings?**

- Y
- N

If yes, what language?

______________________________

**Parent/Guardian Signature:**

X

**Today’s Date:** (mm/dd/yyyy)

Dec 2019
Welcome! This contains important information from your School Nurse.

Mission Statement
Your professional school nurses are dedicated to promoting wellness for our children, their families, our school and our community by providing a safe, nurturing environment for all children to maximize life-long learning and the pursuit of health, knowledge, and achievement.

Services
The school nurse works closely with Students, their families and medical care teams and school staff as well as the Massachusetts Department of Public Health, the Rockport Board of Health, the Board of Registration in Nursing and the Department of Elementary and Secondary Education to provide the following comprehensive school health services for Rockport Public Schools during school hours.

- Provide nursing assessment, intervention, treatment, evaluation and medical referrals
- Conduct state recommended health screenings
- Administer first aid or referrals for injuries
- Provide assessment, advocacy, and planning for students with chronic health care needs
- Participate and co-create Individual Health Care Plans, 504 Plans, and IEP Plans
- Administer prescribed medication in collaboration with physicians
- Provide health insurance information and community resources to families
- Provide individual health education
- Provide mental health assessment, intervention, counseling and referrals
- Monitor compliance with student immunization and physical exam updates
- Collaborate with family, school and community members to improve school climate.

Please provide important health information to your School Nurse.

- Please inform the school nurse if a child has been sick or injured and will miss school or need accommodations to return to school.
- If your child needs to leave school for any type of health emergency or medical appointment, please follow-up with the nurse. A note should be obtained from the medical provider with his or her signature stating the child has received medical/dental/psychiatric services and may safely return to school.
- Upon registration and annually, please complete a Confidential Student Information Form, indicating important names, addresses, and phone numbers, to be used if there is an emergency or illness with your child. Please make sure the information contained on the “Student Information Card” remains current throughout the school year. The health office relies on this information to contact parents in the event of illness or emergency.
- If your child is under care by a health care professional for a condition or is currently taking medication that may affect him or her throughout the please contact the school nurse.
First Aid
First aid is defined as immediate and temporary care given in the case of accident or sudden illness. If an accident does occur, the school nurse or responsible person will administer first aid. Any care beyond first aid is the responsibility of the parent(s) or guardian(s).

Emergency Situations
As a precautionary measure, we want to ensure that all students have access to medical care, if needed. In the event of injury, illness, or other problems requiring medical intervention, every effort will be made to notify the parent(s) or guardian(s). In the event this is not possible, or should an emergency arise, EMS will be notified and medical attention will be provided by the attending physician at a local hospital.

Guidelines for School Attendance
If a student has had any of the following symptoms during the previous 24 hours, he/she should stay home:

- Vomiting/diarrhea—a student must be symptom free for 24 hours before returning to school.
- Fever 100.0 (Child must be fever-free without analgesics for 24 hours.)
- Strep Throat, Conjunctivitis, or Impetigo require 24 hours of medication before a student may return to school.
- Head lice (live head lice require treatment before a child can return to school). We have information and resources to help you.

If cold and cough symptoms are persistent and associated with a fever the child should see a physician. Students with persistent cough or copious nasal discharge should remain at home.

- Chickenpox cases must stay home until all lesions are scabbed over, 7 days from the last eruption.
- A child with a rash or skin condition that is undiagnosed by a physician should remain home until diagnosed or resolved.
- All cases of fifth disease should be referred to the school nurse.
- Any child who does not have proof of required immunizations or medical waivers certified by a physician should not attend school and may be excluded if certain diseases are present in the school.

Parents whose children have any of the above conditions should contact the school nurse so that we may take measures to decrease the spread of illness in the classroom and ease the student's transition back to school. We have many resources to help your family deal with illness and return to school.

Required Immunizations & Physical Exams
Please see the requirements for the grade in which your student is attending this Fall. Please call your school nurse if you have questions about the requirements or go to www.mass.gov and search for 105 CMR 200.000. School nurses will inform you by mail once if your child is missing the documentation below. Your student will then be subject to administrative action if required current immunizations and physical exams are not on file in the school health record.

Pre-K, Kindergarten and New Students
(Pre-K students need to provide this info. annually)

- Current Immunizations—must be current and complete before entry
  - There are two types of exemption allowable under Massachusetts Law. (105CMR 220.15) for students attending public school; Medical and Religious. A medical exemption requires a letter form the physician stating that immunization is medically
contraindicated. A religious exemption requires a letter that states immunization is against your sincere religious beliefs.

- Current Physical Exam—within the past year or within 30 days of entry
  - Including hearing & vision screening results with stenopias and lead level.
  - Written documentation of allergies or food sensitivities and existing medical conditions if appropriate.

- Dental Certificate—or letter from dentist stating that your child is under care

- RPS—Confidential Student Health Information Form (upon registration and annually)

Grade 3 & 4 Requirements

- Please provide the School Nurse with the most current physical exam in 3rd grade, within the past year or within 30 days of entry to 4th grade when records will be audited. (September 1 of 3rd grade through October 30th of 4th grade).

Grade 6 & 7 Requirements

- Please provide the School Nurse with the most current physical exam in 6th grade, within the past year or within 30 days of entry to 7th grade when records will be audited. (September 1 of 6th grade through October 30th of 7th grade)
  - Current Immunizations must be current and complete

Grade 9 & 10 Requirements

- Please provide the School Nurse with the most current physical exam in 9th grade; within the past year or within 30 days of entry to 10th grade. (September 1 of 9th grade through October 30th of 10th grade)
  - Current Immunizations must be current and complete

Grade 12 Records

Your student will be given the School Health Record during senior week to ease the acquisition of required documents and immunizations for college applications. Many colleges require updated immunizations and current physical exam performed within one year prior to entry.

MANDATED SCHOOL HEALTH SCREENINGS*

Health Screenings will be conducted in accordance with the Massachusetts Department of Public Health recommendations and Massachusetts General Laws;

- Vision screening will be conducted annually through grade 5, and in Grades 7 & 10.
- Hearing screening will be conducted annually through grade 3, and in Grades 7 & 10.
- Screenings of sight and hearing shall be performed by teachers, physicians, optometrists, nurses or others approved by the Department of Public Health for this purpose, in accordance with guidelines of the Department.
- Spinal screening will be conducted by a Nurse on all students in grades 5 through 9 with the utmost respect for dignity and privacy of the student while viewing the spine.

SBIRT Screening—Adolescent Screening, Brief Intervention, and Referral to Treatment

- Reinforces prevention, early detection of risk assessment for substance use, provides brief counseling and referral intervention as necessary and will be conducted by trained nurses or counselors using a validated screening tool with students in grades 7 & 10. All screening results are confidential.

- Height, Weight and BMI will be measured for students in grades 1, 4, 7 & 10 and kept in the school health record.
Parents and legal guardians may request, in writing annually, that their child not participate in the screening program. Please send the note to the school nurse in the first day folder. See Screening authorization on Confidential School Health Form.

**Medication Administration**

Rockport Public Schools has developed prescription medication administration policies in accordance with MGL 105 CMR. The policies in place are to ensure the health and safety of children needing medication during the school day. Medication administration plan forms must be renewed annually and may be obtained from the Nurse or on the Health Services web-page. All medication must be delivered to the school by an adult. Inhalers, Epi-pens and appropriate medical supplies are the only exception and parents whose students self-carry these must inform the school nurse and provide signed authorization from the physician and parent and discuss the plan of care with the School Nurse.

**Prescription Medication**

All medication to be administered during the day requires a proper medication order from a licensed prescriber and written authorization from the parent prior to administering the medication at school. (Students may not self-carry prescription or over the counter medication during the schools day.) No more than a 30 day supply may be delivered to school. For short-term prescription medications, i.e. those requiring administration for ten school days or fewer, the pharmacy-labeled container may be used in lieu of a licensed prescriber's order nurse may request a licensed prescriber’s order. The medication should be brought to the nurse’s office by the parent, accompanied by the parent’s written authorization. All medication forms may be obtained from the School Nurse or found on the, on the district web site www.rpk12.org Health Services, forms page. Please contact your School Nurse with questions.

Any change in the student’s medication plan should be brought to the attention of the school nurse to monitor for side effects or to support the student during the transition if needed.

**Over-the-Counter Medication**

Many over-the-counter medications are listed on the Confidential Health Information Form included in the first day packet. Those medications will be given at school as needed based on Nursing assessment and parent signature on the form. Our School Physician, Dr. Jeffery Stockman has approved the protocols for giving these specific over the counter medications at school only with parental permission. Other over-the-counter medication that must be given during school hours, should be accompanied by a parent authorization and delivered to the Nurse by an adult and in the original labeled container. Students may not carry medication with them during the school day. Please use the Medication authorization form located on the web site.

RES Nurse Contact:
Ruth Wagner, rwagner@rpk12.org
Nurse’s Office: 978-546-1223, Fax: 978-546-8140

RMS/RHS Nursing Office:
Jeanne Pratt, jpratt@rpk12.org, Jennifer Johnson, jjohnson@rpk12.org
Nurse’s Office: 978-546-1236, Fax: 978-546-3805
RPS Health Services Authorization to Treat Form

Student Name: ___________________________ Grade: ____________ Teacher: ____________ Birthdate: ____________

Preferred contact number during school hours for illness or injury:

Name: ___________________________ Phone: ___________________________ Relation to student: ____________

Name: ___________________________ Phone: ___________________________ Relation to student: ____________

Authorization for Health Screenings: I hereby authorize the Rockport Public Schools to conduct the following health screenings in accordance with the Massachusetts Department of Public Health: height & weight (grades 1, 4, 7, 10), hearing & vision (grades PK-5, 7, 10), postural (grades 5-9), SBIRT using the CRAFFT tool to interview for at risk behavior (grades 7, 10). I also understand that I may request further information by contacting the school nurse or by looking on the school website.

Parent/Guardian Signature: ___________________________ Date: ____________

Authorization for transportation and treatment in case of emergency: I hereby authorize the Rockport Public Schools, through its nursing staff and/or the local hospital, its physicians and staff, to treat illness or injury and to act in the best interest of my child. Should my child experience severe illness or injury needing immediate medical attention, I give my permission to the school nurse to contact my child’s healthcare providers and transport by ambulance to the hospital if necessary. The school will make every attempt to call/notify parents/guardians in such an event.

Parent/Guardian Signature: ___________________________ Date: ____________

Authorization for MD communication: I hereby authorize the Rockport Public Schools' Nursing staff to call my child’s physician or relevant healthcare provider in regards to health concerns/questions, acquiring medical records, medical history, immunization records and doctor's orders for my child.

Parent/Guardian Signature: ___________________________ Date: ____________

Authorization for medication administration: I hereby authorize the school nurse to administer the following over the counter medications to my child in the event of illness or injury during school hours and according to established protocols and school physician orders. To my knowledge, my child has no allergies/sensitivities to the medication listed below. I have crossed out any medication that I do not want my child to receive.

Parent/Guardian Signature: ___________________________ Date: ____________

Acetaminophen (generic for Tylenol) Given orally according to age, weight and package directions as needed for relief of pain or fever.

Aloe Vera Gel (or generic) Applied topically to relieve sunburn or burn pain and irritation as needed.

Bacitracin Ointment (or generic) Applied to superficial cuts, scrapes, abrasions and wounds to treat/prevent minor skin infections.

Benadryl (Diphenhydramine HCL) Given orally per package insert to treat allergic reactions.

Calamine lotion (or generic) Applied topically as needed to relieve itching from bug bites, minor skin irritations and poison: ivy, sumac, oak.

Caladryl Clear Gel (or generic) Applied topically as needed to relieve itching from bug bites, minor skin irritations and poison: ivy, sumac, oak.

Cough Drops Two cough drops given per request of middle and high school students only.

Hand Sanitizing gel/foam Applied topically as needed before food service to reduce bacteria on hands.

Hydrocortisone 1% Applied topically for severe skin irritation.

Ibuprofen (generic for Advil/Motrin) Given orally according to age, weight and package directions as needed for relief of pain or fever.

Oral (or generic) Applied topically to oral cavity as needed for toothache or canker sore pain as per package directions.

Potassium Iodide One tablet of 130 mg, given once ONLY in the event of a nuclear emergency when directed by Public Health officials to Administer and ONLY with parent consent on file.

Sting-Kill Wipes Applied topically as needed for temporary relief of pain and itching due to minor burns, sunburn, cuts, insect bites and minor skin irritation.

Tums (or generic) Given orally as needed for sour stomach, acid indigestion and heartburn symptoms as per package directions.

Emergency Medications to be given per protocol in life threatening emergent events based on nursing assessment:

Epinephrine Auto Injector: Given intramuscularly for anaphylactic reaction to allergy or uncontrolled respiratory distress in life threatening event as per package directions.

Naloxone: Given for suspected opioid overdose resulting in a life threatening event as per package directions.

*Please Note: All medications not listed above that may need to be given during school hours, require a written order from a licensed prescriber (physician, dentist, nurse practitioner, psychiatrist) AND written parental permission on the school Medication Administration Form prior to administration at school.

Rockport Public Schools, 24 Jardin Lane, Rockport MA, 01966

Updated by Jennifer M. Johnson BSN, RN on 11/2018
Health/Medical Conditions: Check here ☐ if no conditions or complete form below.

Student Health Information for School nurse and appropriate school personnel needed to meet my child’s health and safety needs. Please check all that apply to your child AND specify below.

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>NO</th>
<th>Health History (Dates)</th>
<th>Currently Treated/ Diagnosed</th>
<th>New This Year</th>
<th>CONDITION</th>
<th>NO</th>
<th>Health History (Dates)</th>
<th>Currently Treated/ Diagnosed</th>
<th>New This Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD</td>
<td></td>
<td></td>
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<td></td>
<td>Fractures (Broken Bones)</td>
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</tr>
<tr>
<td>Allergies (Life Threatening)</td>
<td><em>Please Specify Below</em></td>
<td></td>
<td>Gastrointestinal Issues (IBS, Constipation, Encopresis, Crohn’s, Gastroparesis, etc.)</td>
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<tr>
<td>Allergies-Other</td>
<td><em>Please Specify Below</em></td>
<td></td>
<td>Gynecological/Menstrual Issues</td>
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<tr>
<td>Anaphylaxis</td>
<td><em>Please Specify Below</em></td>
<td></td>
<td>Headaches/Migraines</td>
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<tr>
<td>Anxiety: GAD, Panic attacks, Phobia, etc.</td>
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<td></td>
<td>Hearing Difficulty/Hearing aid</td>
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<tr>
<td>Asthma or Reactive Airway Disease</td>
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<td></td>
<td>Kidney/Urinary Disease or Conditions</td>
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<td></td>
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<tr>
<td>Autism Spectrum Disorder</td>
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<td>Lyme Disease: Acute or Chronic</td>
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<td>Autoimmune Disorder (Arthritis, Lupus, etc.)</td>
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<td>Neuromuscular Disorders</td>
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<tr>
<td>Behavioral Issues/Concerns</td>
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<td>Nutrition/Metabolic Issue</td>
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<tr>
<td>Blood Dyscrasias</td>
<td><em>Please Specify Type Below</em></td>
<td></td>
<td>Orthotic/Prosthetic Use</td>
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<tr>
<td>Cancer</td>
<td><em>Please Specify Type Below</em></td>
<td></td>
<td>Prolonged Medication</td>
<td></td>
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<tr>
<td>Cardiac Condition</td>
<td><em>Please Specify Below</em></td>
<td></td>
<td>Social/Emotional/Mental Health Conditions/Concerns: (Depression, PTSD, Eating Disorders, etc.)</td>
<td><em>Please Specify Below</em></td>
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<tr>
<td>Chronic, Inherited, or recurring illness</td>
<td></td>
<td></td>
<td>Neurological Conditions: (Epilepsy/seizures, spina bifida)</td>
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<tr>
<td>Concussion/Head Injury</td>
<td></td>
<td></td>
<td>Serious Accident/Injury</td>
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<tr>
<td>Dental/Oral Issues</td>
<td></td>
<td></td>
<td>Specialized Education Plan (IEP, 504, etc.)</td>
<td><em>Please Specify</em></td>
<td></td>
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<tr>
<td>Diabetes</td>
<td><em>Please Specify Type Below</em></td>
<td></td>
<td>Speech Difficulty</td>
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<tr>
<td>Ear Infections/Tubes</td>
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<td></td>
<td>Surgery/Hospitalization</td>
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<tr>
<td>Early Childhood Stress/Trauma</td>
<td></td>
<td></td>
<td>Thyroid Condition</td>
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<tr>
<td>Early Intervention/ Premature Birth</td>
<td></td>
<td></td>
<td>Vision Difficulty; Weans: Glasses ☐ Contacts ☐</td>
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</tbody>
</table>

Please further explain conditions above or any conditions that your child may have that were not listed above.

Current Medications: ____________________________ Dose/Frequency/Time: ____________________________ Reason for taking: ____________________________
Rockport Public Schools
Please return this form to RES

Dental Examination Request

Student's name: __________________________

Date of Exam: ___________________________

Please have your dentist complete this form and sign below. Return form to RES.

This is to certify that I have examined and found the condition(s) checked below:

_____ No dental defects

_____ Dental defects have been completely treated

_____ Treatment has been started

_____ Treatment is needed but no provision is made for it.

_______________________________
Signature of Dentist

_______________________________
Printed name of Dentist

_______________________________
Phone number

Dec. 2018
Rockport Elementary School
Kindergarten Entrance Information

Date: ____________

Name of child: ___________________________ D.O.B. _____ Sex: M F

Has your child attended a pre-school/school setting before? Yes No
Has your child attended a daycare program? Yes No

If “yes” for either of the above, please complete the following:

Preschool:
Name of school ___________________________ Contact ___________________________
Address of school ___________________________ Phone ___________________________
Dates of Attendance: From ___________ to ___________ Hours per week ___________

Nursery School:
Name of school ___________________________ Contact ___________________________
Address of school ___________________________ Phone ___________________________
Dates of Attendance: From ___________ to ___________ Hours per week ___________

Daycare:
Name of Provider ___________________________ Contact ___________________________
Address of school ___________________________ Phone ___________________________
Dates of Attendance: From ___________ to ___________ Hours per week ___________
Is there any experience you feel would be helpful for us to know? ___________________________

As part of the enrollment process, we may wish to contact the above. Please indicate your permission for us to contact any of the individuals listed above by signing below.

Parent ___________________________ Date ___________________________

Dec 2019
CERTIFICATION OF ADDRESS

To determine the correct name and address of students, parents, and/or guardians, the information below is required to complete a school registration as well as provide the Rockport Public Schools with two proofs of residency which may include a purchase and sales agreement, record of recent mortgage payment, property tax bill, rental and lease agreement, utility bill under parent/guardian name, voter registration, and valid driver’s license or passport (School Policy File JF School Admissions). A separate Certification of Address form is necessary for each student enrolled.

Only students residing in Rockport may enroll without written permission from the Superintendent of Schools.

Full name of student: ____________________________________________________________

Student’s residence as defined below: ____________________________________________

Street and Number ____________________________________________________________

Town __________________________ State _______ Zip Code ____________

Telephone Number __________________________

Name and Address of person with legal custody as defined below:

Name
Street and Number
Town
Telephone Number

I understand that it is my obligation to promptly notify the school principal of any changes in the above information. Furthermore, I hereby certify under penalty of perjury that the above information is true and accurate.

Signature of Parent/Guardian __________________________ Date

Signature of School Personnel/Notary __________________________ Date

Legal Custodian: Parent(s), guardian or person assigned custody by court
Residence: Place where student eats morning and evening meals and sleeps during the week and where his or her clothes are kept.
RESIDENCY/ADMISSION

Admission of Students:

All children who reside in the district and are of legal age are eligible to attend school.

The admission of pupils shall be in accordance with the provision of the education statutes.

Children between the ages of 7 and 16 (except those exempt by law) are required to attend full-time day school.

Noncompliance of Residency Requirement:

If the administration determines that the student is not residing in Rockport it should notify the parent/s or guardian/s and the student over fourteen (14) years of age in writing that the student is not eligible to attend the Rockport Public Schools.

Waivers of Residency:

A. Students who move out of Rockport during the school year will be allowed to finish the current marking period.

B. The principal may approve longer waivers of residency in conjunction with the Superintendent.

C. Students who are entitled to attend the Rockport Public Schools under the McKinney-Vento Homeless Assistance Act.

Adopted: January 17, 2001

Revised: January 22, 2014

SOURCE: Adapted from existing policy

LEGAL REFS.: M.G.L. 76:5

CROSS REF: JF School Admissions
SCHOOL ADMISSIONS

All children of school age who reside in the Town of Rockport are entitled to attend the public schools, as will certain children who do not reside in the Town but who are admitted under School Committee policies relating to nonresident students or by the specific action of the School Committee.

Advance registration for prospective kindergarten students will take place in April. Every student seeking admission to school for the first time must present the following at the time of enrollment: a transfer card (if coming from a Massachusetts public school), a birth certificate or equivalent proof of age acceptable to the Principal, proof of vaccination and immunizations as required by the state and the School Committee. Two forms documenting proof of residency or legal guardianship will also be required by the school administration. A parent, guardian, or student who is unable to produce the required documents should contact the Superintendent of Schools.

Examples of these documents include:

- Purchase and Sale Agreement
- Record of recent mortgage payment
- Property tax bill
- Rental and Lease Agreement
- Utility bill under parent/guardian name
- Voter registration
- Valid driver's license or passport

If a child is residing in the home of a guardian, a notarized Massachusetts Caregiver Authorization affidavit or a formal Department of Children and Families (DCF) notification will be required along with proof of residency. Proof of residency and/or guardianship may be required by school officials at any time.

Adopted: January 17, 2001
Revised: January 22, 2014
SOURCE: Adapted from MASC Policy
LEGAL REFS.: M.G.L. 15:1G; 76:1; 76:5; 76:13, 76:15; 76:15A
603 CMR 26:01; 26:02; 26:03
CROSS REFS.: JF: School Admissions
JFBB, School Choice
JLCA, Physical Examination of Students
JLCB, Inoculations of students