PLYMOUTH PUBLIC SCHOOLS
CENTRAL OFFICE
27 NORTH HARWINTON AVENUE
TERRYVILLE, CONNECTICUT 06786

REGISTRATION PACKET CHECKLIST

Please note the following items are needed to officially enroll your child in a Plymouth Public School. These items need to be returned to the school and verified prior to your child being admitted to any school in our district. For students enrolling at the Middle School or High School, you must call the school to set up a meeting with a School Counselor.

_____Copy of Birth Certificate
_____Verification of Residence Form
_____Proof of Residency: **+** _____Utility Bill **+** _____ Driver License

*Section 1 (*a, b, or c)

_____a. Property Statement/Deed to home or dated rental agreement showing student(s) name
_____b. Escrow papers or signed mortgage commitment
_____c. Notarized letter from landlord or owner acknowledging parent/guardian's and student's residence

OR

Section 2

_____Certificate of Residency (if applicable)

OR

Section 3

_____Residency Affidavit (if applicable)
_____Host's Statement (if applicable)
_____Parent Statement (if applicable)

_____ Permanent Registration Form (3 pages) **The entire Registration Packet must be completed in full.**
_____ Release of Student Information form
_____ Student Support Services form
_____ New Student Transportation Request form (even if you are not requesting transportation at the time of registration)
_____ SchoolMessenger – Communication System Form
_____ Free & Reduced Lunch Application (if applicable)

****The School Nurse Requires 4 items:****

_____ Health/Medical Questionnaire
_____ **Health Assessment Record
_____ **Part II – Medical Evaluation – Physical Form
_____ **Immunization Record

**A student will not be allowed to attend school until these are completed and on file with the school nurse. If you are NOT coming from another Connecticut school, you will need to have a State of Connecticut physical done within 30 days from the first day of enrollment.

MISCELLANEOUS FORMS

_____Network/Internet Use Agreement (4 pages – please return page 4 signed by parent & student if applicable) supplied by school at the time of registration.
_____Chromebook Student User Agreement and Parent Permission Form (please return page 5 signed) supplied by the school at the time of registration.

PLYMOUTH PUBLIC SCHOOLS
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Plymouth Public Schools

Verification of Residence

NEW ENROLLEE/STUDENT TRANSFER/CHANGE OF ADDRESS

Parent/Legal Guardian/Host Statement

I (print name) _____ the parent/legal guardian/host of

(Name) _____ (Address) _____

certify that the above named student actually lives full time (typically 7 days per week) at the above address. The telephone number at the same address is _____ and the telephone number in an emergency is _____. Grade _____

This information and the documents provided are accurate. I authorize representatives of the Plymouth Public Schools to verify this information. I understand that a perjured or fraudulent statement may lead to the disenrollment of the above named student(s) and may lead to my prosecution under the criminal statutes of the State of Connecticut, which is stated below. I also understand that this document may be used as evidence in a court of law.

Larceny 1st Degree 53a122 -- The property or service is obtained by defrauding a public community and such property exceeds $2,000.
Class B. Felony -- not less than one year or more than 20 years and/or a fine up to $10,000.

Parent/Guardian/Host Signature: _____ Date: _____

For Transfers *Only*

Current School (send records) _____ New School _____

FOR OFFICE USE ONLY

In order to verify district residence, the student over 18, parents, guardians, hosts, or an emancipated minor must sign above and provide documents from either #1 or #2 below.

_____1. Copy of one of the following at address within the district in the parent's, guardian's/host's or adult student's name **and** a current utility bill:

_____a. Property Statement/Deed to home or dated rental agreement showing student(s) name
_____b. Escrow papers or signed mortgage commitment
_____c. Notarized letter from landlord or owner acknowledging parent/guardian's and student's residence

Documents seen by: _____ on _____

_____2. Certificate of Residency or Residency Affidavits to be completed by person with whom family and/or student reside (host). Verification visit by Residency Confirmation staff may follow.

Verification visit completed by: _____ on _____.

PLYMOUTH PUBLIC SCHOOLS
CENTRAL OFFICE
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CERTIFICATE OF RESIDENCY

(Student and parent/guardian living in dwelling owned or rented and occupied by another person)

If the student and the parent/guardian are living in a dwelling that is rented or owned and occupied by another person, the person who owns or rents the dwelling must bring the required documentation, present photo identification and complete/sign Certificate of Residency form.

School: _____**School Year**: _____

As part of our residency verification process, we are requesting that you as the owner/renter of the residence in Plymouth verify that:

Name of Student (s):_____

And Student (s) Parent / Guardian:_____

reside with me at_____
Address, Apt/Unit #, Town

_____ certify that the above named student(s) and parents(s)/guardian(s) reside with me at the above listed address, in a residence owned or occupied by me in the Town of Plymouth. I realize that if I make a false statement as to residency, I may be held liable for a share of the cost for the education of the said student(s) if they, in fact, do not reside in Plymouth.

I agree that the living arrangement with the student and his/her parent/guardian is:

- Permanent
- Provided without pay and
- Not for the sole purpose of obtaining school accommodations

I agree to notify the school immediately regarding the termination of the student's full time physical presence (permanent residency) in the town of Plymouth in which event the student will no longer be eligible for free school privileges. Finally, I understand that should the student be found to be attending Plymouth schools illegally, the Town of Plymouth reserves the right to recover the costs of such education from me, the undersigned.

I understand that a perjured or fraudulent statement may lead to the disenrollment of the above named student(s) and may lead to my prosecution under the criminal statutes of the State of Connecticut which is stated below. I also understand that this document may be used as evidence in a court of law.

Larceny 1st Degree 53a122 -- The property or service is obtained by defrauding a public community and such property exceeds $2,000.

Class B. Felony -- not less than one year or more than 20 years and/or a fine up to $10,000.

Signed: _____ Date: _____
Legal Resident of Plymouth, CT

Signed: _____ Date: _____
Parent / Guardian of Student(s)

PLYMOUTH PUBLIC SCHOOLS
CENTRAL OFFICE
27 NORTH HARWINTON AVENUE
TERRYVILLE, CONNECTICUT 06786

Plymouth Public Schools

Confidential

Residency Affidavit

The Plymouth Public Schools, in compliance with statute 10-253(d) of the State of Connecticut, requires this form to be completed for **any student who claims residence in Plymouth and is not residing with his or her parent(s) and whose parents are not residing in Plymouth**. This form is required when there is a question about the student's actual residence. The student, parent and person with whom the student is living must fill out this form together.

Date:_____

1. Student's Name_____ DOB:_____
   (last) (First) (Middle)

2. Student's Address_____
   (No. and Street)
   Telephone #_____

3. Name of Person With Whom Student Lives_____
   Relationship_____
   Address_____
   Telephone_____

4. Date Student Moved To_____
   Month Day Year

5. Student's Former Address_____
   No. & Street Town State

6. Former School_____ Grade_____

7. Name of Student's Father_____
   Father's Address_____
   Telephone Number_____

8. Name of Student's Mother_____
   Mother's Address_____
   Telephone Number_____

9. Name, Address, Telephone # of Student's Court Appointed Legal Guardian (if applicable)_____
   _____

PLYMOUTH PUBLIC SCHOOLS
CENTRAL OFFICE
27 NORTH HARWINTON AVENUE
TERRYVILLE, CONNECTICUT 06786

PARENT'S/ADULT STUDENT'S STATEMENT

I hereby certify that _____ is my _____
(Name) (Relationship)
and he/she/I reside(s) with _____who is _____
(Name of Person) (Relationship)

at _____
(No. & Street Address) (Telephone #)

I further certify that this is intended to be a bona fide permanent address at which the student will be living for _____ days and _____ nights per week and that I am not providing payment for having the student reside with _____.

For Parents:

I further certify that my son/daughter is not living with me because_____
_____

For Adult Students:

I certify that I am not living with my parents because_____

As a parent of the student and/or adult student named on this form, and as a nonresident of the Town of Plymouth, I attest to the accuracy of the information contained in this form. Further, I certify that, as a permanent resident of the Town of Plymouth, the student is eligible for free school privileges. I agree to notify school officials immediately regarding the termination of the student's permanent residency in the Town of Plymouth, in which event the student will no longer be eligible for free school privileges. Finally, I understand that, should the student be found to be attending Plymouth Public Schools illegally, the Plymouth Public Schools reserves the right to recover the costs for such education from me, the undersigned.

I also understand that this document may be used in a court of law as evidence against me.

_____ _____
Parent's Signature Date

_____ _____
Adult Student Signature Date

OPTIONAL: I hereby certify that the said _____ has full right to act in my child's behalf
(Person's name)
concerning any and all school disciplinary, administrative, and medical matters.

_____ _____
Parent's Signature Date

Witnessed by:

_____ _____
Witness (Notary Public) Date

PLYMOUTH PUBLIC SCHOOLS
CENTRAL OFFICE
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TERRYVILLE, CONNECTICUT 06786

HOST'S STATEMENT

I hereby certify that _____ is my _____
(Student's Name) (Relationship)

and that he/she resides with me at _____
(No. and Street)

I further certify that this is intended as a bona fide permanent address, that this student will be living with me _____days and _____ nights per week, and that I am not receiving payment for having this student reside with me.

I certify that this student is residing with me because_____
_____

As the host of the student named on this form, and as a resident of the Town of Plymouth, I attest to the accuracy of the information contained in this form. Further, I certify that, as a permanent resident of the Town of Plymouth, the student is eligible for free school privileges. I agree to notify school officials immediately regarding the termination of the student's permanent residency in the Town of Plymouth in which event the student will no longer be eligible for free school privileges. Finally, I understand that should the student be found to be attending Plymouth Public Schools illegally, the Plymouth Public School reserves the right to recover the costs of such education from me, the undersigned.

I also understand that this document may be used in a court of law as evidence against me.

****** If you are the guardian of the student, please indicate the date and source of your authority.
Date:_____ Authority_____

Optional: I, _____, understand that I have full
(Name of Person)
responsibility for this student concerning any and all school disciplinary, administrative, and medical matters.

_____ _____
Host's Signature Date

Witnessed by:

_____ _____
Witness (Notary Public) Date

Plymouth Public Schools District
New Student Registration Form

SCHOOL (Circle One): Terryville High School **Eli Terry Jr Middle School**

Harry S Fisher Elementary School **Plymouth Center Elementary School**

STUDENT INFORMATION

Student's Last Name:	Grade student will be entering:
Student's First Name:	Date of Birth:
Student's Middle Name:	Gender: Female Male
Telephone #: _____ Cell Phone #:	Home phone unlisted? _____ No or ____ Yes
Home Address: _____ Apt #: _____ City:	State: _____ Zip: _____

Ethnicity and Race:

Is this student Hispanic/Latino? _____ No or _____ Yes

Please select one or more that apply:

_____ American Indian or Alaskan Native
_____ Asian
_____ Black or African American
_____ Native Hawaiian or Other Pacific Islander
_____ White

Place of Birth:

Is the child a U.S. Citizen? _____ No or _____ Yes Country of Birth:	State of Birth: _____ City of Birth:

Prior School Information

Has your child ever attended School? ____ No or _____ Yes
Was the school a Plymouth/Terryville Public School? ____ No or _____ Yes Last Grade: _____
Name of Previous School: _____ City of Prev. School: _____
Country of Prev. School: _____ State of Prev. School: _____
Phone # of Prev. School:

Support Service

Is the student identified as Special Education? _____ No or _____ Yes
Is there a current IEP on file at the previous school? _____ No or _____ Yes
What services did the student receive: _____
_____
Is the student receiving tutoring services at the previous school? ____ No or _____ Yes
What services did the student receive: _____
_____
Any years of prior Special Education Services? _____ No or _____ Yes
Is there a current 504 plan on file at the student's previous school? _____ No or _____ Yes
What services did the student receive: _____

Language Survey:

What is the child's primary language? _____
What language does the child speak at home? _____
What is the child's first language? _____
What language do the parents/guardians speak at home?

Family Contact Information:

Father
First Name: _____
Last Name: _____
Father/Foster-Father/Step-Father:_____
Home Phone: _____
Cell Phone: _____
Email: _____
Is this parent/guardian responsible for this child?
____ No or _____ Yes

Is this parent/guardian's address the same as the student's? ____ No or _____ Yes:

Employer: _____
Employer City:_____
Work Phone: _____
If address is not the same as the student's:
Street:_____
City: _____
State: _____
Zip: _____
If different, do you want to receive mailings:
____ No or _____ Yes:
Are there any legal parental restrictions (court orders ONLY) _____ No or _____ Yes:

Mother
First Name: _____
Last Name: _____
Mother/Foster-Mother/Step-Mother:_____
Home Phone: _____
Cell Phone: _____
Email: _____
Is this parent/guardian responsible for this child?
____ No or _____ Yes

Is this parent/guardian's address the same as the student's? ____ No or _____ Yes:

Employer: _____
Employer City:_____
Work Phone: _____
If address is not the same as the student's:
Street:_____
City: _____
State: _____
Zip: _____
If different, do you want to receive mailings:
____ No or _____ Yes:
Are there any legal parental restrictions (court orders ONLY) _____ No or _____ Yes:

Additional Parent/Guardian 3
First Name: _____
Last Name: _____
Relationship to student:_____
Home Phone: _____
Cell Phone: _____
Email: _____
Is this parent/guardian responsible for this child?
____ No or _____ Yes

Is this parent/guardian's address the same as the student's? ____ No or _____ Yes:

Employer: _____
Employer City:_____
Work Phone: _____
If address is not the same as the student's:
Street:_____
City: _____
State: _____
Zip: _____
If different, do you want to receive mailings:
____ No or _____ Yes:
Are there any legal parental restrictions (court orders ONLY) _____ No or _____ Yes:

Additional Parent/Guardian 4
First Name: _____
Last Name: _____
Relationship to student:_____
Home Phone: _____
Cell Phone: _____
Email: _____
Is this parent/guardian responsible for this child?
____ No or _____ Yes

Is this parent/guardian's address the same as the student's? ____ No or _____ Yes:

Employer: _____
Employer City:_____
Work Phone: _____
If address is not the same as the student's:
Street:_____
City: _____
State: _____
Zip: _____
If different, do you want to receive mailings:
____ No or _____ Yes:
Are there any legal parental restrictions (court orders ONLY) _____ No or _____ Yes:

Sibling Information
How many school aged brothers and sisters does the student have? _____
Name: _____ DOB: _____ Name: _____ DOB: _____
Name: _____ DOB: _____ Name: _____ DOB: _____

Media – My child may be photographed, videoed and/or interviewed during the year when it comes to school activities and programs: Yes or No

Emergency Contacts – Not a parent/guardian

Please provide contact information for at least two persons to be contacted in the event parents or guardians cannot be contacted

Contact #1 First Name: _____ Last Name: _____ Relationship to student: _____ Primary Phone: _____ Cell Phone: _____	Street: _____ City: _____ State: _____ Zip: _____
Contact #2 First Name: _____ Last Name: _____ Relationship to student: _____ Primary Phone: _____ Cell Phone: _____	Street: _____ City: _____ State: _____ Zip: _____
Contact #3 First Name: _____ Last Name: _____ Relationship to student: _____ Primary Phone: _____ Cell Phone: _____	Street: _____ City: _____ State: _____ Zip: _____
Contact #4 First Name: _____ Last Name: _____ Relationship to student: _____ Primary Phone: _____ Cell Phone: _____	Street: _____ City: _____ State: _____ Zip: _____

Authorized Pick Up – Not a parent/guardian

Person #1 First Name: _____ Last Name: _____ Relationship to student: _____	**Person #2** First Name: _____ Last Name: _____ Relationship to student: _____
Person #3 First Name: _____ Last Name: _____ Relationship to student: _____	Please provide authorized pick up in the events parents are not available.

Medical Information

Physician Name: _____

Physician Phone Number: _____

Dentist Name: _____

Dentist Phone Number: _____

Signature:_____ Date: _____

First Name: _____ Last Name: _____

(Signature of person completing this Student Registration Packet – must be 18 or older)

SCHOOLMESSENGER® COMMUNICATION SYSTEM

SchoolMessenger is a system-wide phone, email and SMS (text) messaging system which allows you to receive important school related information such as weather cancellations and delays, general school announcements and lunch balance alerts. You can change this information by logging into your PowerSchool account** and going into the SchoolMessenger "Contact Manager". (Click the large, white bent arrow in the upper right of the screen and choose "Contact Manager". ** You can create a PowerSchool Account once your child is entered into PowerSchool. Please contact your school for more information, or email support@plymouth.k12.ct.us and we can help set up your account.)

Parent/Guardian Name: _____

Student's Name: _____ Grade: _____ Homeroom: _____

Please enter up to six phone numbers you would like entered in the SchoolMessenger system:

Phone number 1: (___)_____ Phone number 2: (___)_____

Phone number 3: (___)_____ *Phone number 4: (___)_____

*Phone number 5: (___)_____ *Phone number 6: (___)_____

*Phone numbers 4, 5 and 6 will initially receive emergency calls only. You can change this by logging into your Power PowerSchool account** and going into the SchoolMessenger "Contact Manager". (Click the large, white bent arrow in the upper right of the screen and choose "Contact Manager".

Please enter up to four email addresses you would like entered in the SchoolMessenger system:

Email 1: _____ Email 2: _____

Email 3: _____ Email 4: _____

Please enter up to three SMS (text) numbers you would like entered in the SchoolMessenger system:

SMS 1: (___)_____ SMS 2: (___)_____

SMS 3: (___)_____

If you have any questions, please contact tech support at support@plymouth.k12.ct.us

12/28/2013

5125
FORM #2

PLYMOUTH PUBLIC SCHOOLS
Transfer of Confidential Student Information

Date: _____

Pursuant to the Family Educational Rights and Privacy Act ("FERPA"), I hereby authorize the Plymouth Public Schools to **release** and/or **obtain** the following confidential records regarding my child for the purpose of _____.

Name of Child: _____

Address: _____

_____

_____

DOB: _____

Parents(s)/Guardian(s): _____

School: _____

Please check all that apply:

	Obtain	**Release**
All Records	☐	☐
Cumulative File	☐	☐
Pupil Personnel/Special Education	☐	☐
Disciplinary	☐	☐
Health/Medical*	☐	☐
Other (please specify)	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

To/From: _____
Name

Address: _____
Street *Town/City* *State/Zip Code*

Telephone: (___) _____ Fax: (___) _____

I understand that the information to be disclosed is protected as an "educational record" under FERPA, and that such information shall not be redisclosed unless permitted under FERPA. I further understand that the officers, employees and agents of any party that receives protected information under FERPA may use such information only for purposed for which the disclosure is made.

_____ _____
Signature of Parent/Guardian Date

_____
Print Name of Parent/Guardian

If this authorization is being used to obtain Protected Health Information form a child's physician or other covered entity under HIPAA, the following section must also be completed:

I, the undersigned, specifically authorize _____ to disclose my
Name of Physician
child's medical information, as specified above, to my child's school _____
Name of School

at the above address for the purposes described below (i.e., health assessment for school entry, special education evaluation etc.):

By signing below, I agree that a photocopy of this authorization will be valid as the original. This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying the physician's office in writing, but if I do, it will not have any effect on actions taken by the Physician prior to receiving such revocation.

I understand that under applicable law, the information disclosed under this authorization may be subject to further disclosure.by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that my child's treatment or continued treatment with any health care provider or enrollment or eligibility for benefits with any health plan may not be conditioned upon whether or not I sign this authorization and that I may refuse to sign it.

Any information receive by the school pursuant to this authorization is subject to all applicable state and federal confidentiality laws governing further use and disclosure of such information.

_____ _____
Signature of Parent/Guardian Date

_____
Print Name of Parent/Guardian

Permanent Student Registration Information
Plymouth Public Schools
Student Support Services

Student's Name: _____ Enter Grade:_____

Please check the answer to the following questions:

1) Is the student identified Special Education: ____ No or _____ Yes

   If yes, what services did the student receive? _____

   _____

2) Years of any prior Special Education Services? ____ No or _____ Yes

3) Is there a current IEP on file at the previous school? ____ No or _____ Yes

4) Is the student receiving tutoring services at the previous school? ____ No or _____ Yes

5) Is there a current 504 plan on file at the student's previous school? ____ No or _____ Yes

- The school will forward this information to Central Office, Att: Jan Basoli upon receiving it.

PLYMOUTH PUBLIC SCHOOLS
NEW STUDENT
TRANSPORTATION REQUEST

Student Name: _____

Parent/Guardian Name: _____

Address: _____

Phone Number: _____

School: _____ Grade: _____

If child attends daycare: Daycare name: _____

Address: _____

AM _____ PM _____

Beginning Date: _____ Ending Date: _____

Parent/Guardian: _____ Date: _____
Signature

BOE Business Office Approval Date: _____

Approval/Notification To Bus Company: _____

Long Term (over one month) – 30 days prior to starting date

Short Term (less than one month) – 10 days prior to starting date

Return to: Plymouth Public Schools
27 North Harwinton Avenue
Terryville, CT 06786
Fax: 860-585-4011

Note: This form must be completed and filed with the Business Office in June of each school year for bus assignment consideration in the following school year. Only requests for transportation within child's regular school district can be accommodated.

PLYMOUTH PUBLIC SCHOOLS STUDENT HEALTH QUESTIONNAIRE YEARLY UPDATE

Please complete and return to the school nurse

Student Name_____ Date of Birth_____ M_____F_____ Date_____

Address_____

Teacher_____ Grade_____

Student Health Information

Known Medical Conditions (List)_____

_____

Medications (name, dose, reason for taking)_____

_____

List any changes that have occurred in your child's physical condition since the last school year

_____

Known Allergies and Medications Needed_____

_____

Food Allergy information will be shared with food service department

Student's Physician_____Telephone_____

Does your child have Medical Insurance? _____ Yes _____ No Insurance Company_____

Emergency Medical Contact Authorization

In case of illness or accident during school hours, please indicate below who should be contacted with all possible phone numbers according to priority. **This will be the order in which we call parents to inform of any concern and to request transport of your child.** Please list the parent's full name and relationship to the child. (mother, father, guardian, step-parent, foster-parent, etc.)

Parent Information _____

Home _____Work _____Cell_____

Parent Information _____

Home _____Work _____Cell_____

Other Emergency Contacts-List contacts in the order you would like us to call. This will be the approved list of people who can transport your child.

Name	**Relationship**	**Telephone**

1._____

2._____

3._____

- In an emergency, your child will be transported to the nearest medical facility to obtain appropriate treatment as deemed necessary by the local ambulance service.
- I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school, including contacting my child's listed physician.
- I, the undersigned, do hereby authorize employees of the Plymouth Board of Education to contact directly the persons named on this form and do authorize the named physician to render such treatment as may be deemed necessary in an emergency for the health of the said child.
- In the event that the physician, other persons named on this form, or parents cannot be contacted, the school employees are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

Signature of Parent/Guardian Date

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	❑ Black, not of Hispanic origin
Primary Care Provider	❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____
Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No

Risk Assessment	**Describe Risk Factors**	
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other _____

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian Date

_____

Signature of health care provider DMD / DDS / MD / DO / APRN / PA / RDH Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 7/2018

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption: Religious _____ **Medical:** Permanent _____ Temporary _____ **Date:** _____

Renew Date: _____ _____ _____ _____

Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.
Medical exemptions that are temporary in nature must be renewed annually.

Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number