

FALL RIVER PUBLIC SCHOOLS
“The Scholarship City”

Fred Houle
Parent Information Center
and
Student Assignment

Kindergarten/Pre-School Registration



2012-2013

"SCHOOLS of CHOICE"

REGISTRATION FORM

Last Name of Child _____ First _____ Middle _____

Address _____ Phone # _____ Emergency # _____

Date of Birth ____/____/____ Age: _____ Gender M F Grade Entering: _____

Name of previous school _____

Address: _____

City/State/Zip: _____

- Schools of Choice:
1. _____
 2. _____
 3. _____

Do you have another child in your first choice school? YES ___ NO ___ Grade _____

Comments: _____

- | | | |
|--|-----|----|
| 1. Do you feel your child will benefit from any daycare programs? | Yes | No |
| 2. Does your child have a Health Plan | Yes | No |
| 3. Are you interested in Adult Basic Education Classes (GED__ESOL__) | Yes | No |
| 4. Are you sharing the housing of other persons due to loss of housing, economic hardship or similar reason? | Yes | No |

***If Yes to any of the above, would you like someone to contact you with information about services to which you may be entitled? Yes No

- I understand that all registration forms must be completed for placement of any child in a "School of Choice" based on criteria outlined in the student assignment policy. (Please check box)
- I understand that **TRANSPORTATION** is to be provided by **Parent/ Guardian**

Signature of Parent/Guardian

Relationship to Child

Date

Intake Person

Date

DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)

Effective Date: _____

Waiting List: _____

Date Release Sent: _____

Transportation: Bus # _____ Route: _____

Date Letter Sent: _____

School Assigned: Name: _____

Code: _____

District School: Name: _____

Code: _____

Computer Input Person: _____

Fall River Public School of Choice Registration Form

First Name _____

Child lives with _____

Middle Name _____

(parents, mother, father,...ect)

Last Name _____

Parent/ Guardian _____

Gender M F

Date of Birth (m/d/yr) ____/____/____

Address _____

Grade Entering _____

City **Fall River**

Home Phone _____

State **MA**

Emergency Phone _____

Zip Code _____

County **Bristol**

Home Language _____

Ethnicity: **Circle only one** Hispanic Non Hispanic

Student's city of birth _____

Race: **Circle all that apply** White Black or African American
Asian American Indian
Alaska Native Native Hawaiian
or Pacific Islander

Parents work for FR Schools Yes ____ No ____

Parent Signature _____

Parent Name (**Print**) _____

Registration Date _____

Staff Signature _____

For Office Use ONLY

Has student EVER been enrolled in FRPS? YES NO School _____ Grade _____ -

Has student EVER been enrolled in any MA school YES NO City _____ When _____

Immigrant Status (yes only if student **not** born in the US & **not** in US for 3 Years) **YES** **NO**
 If YES, in what country was student born?

English Proficiency (Can student perform his/her class work in English?) **YES** **NO**

Child is/has been enrolled in a Second Language Learning Program? **YES** **NO**

Child is receiving Special Education Services **YES** **NO**
 If yes...Prototype? _____

Child is receiving Title 1 Services? **YES** **NO**

State Ward/Foster Child / Department of Children & Families (DCF)? **YES** **NO**

RACE, COLOR, SEX, RELIGION, NATIONAL ORIGIN, OR HANDICAP, IN COMPLIANCE WITH THE CHAPTER THE FALL RIVER PUBLIC SCHOOLS ASSURE EQUAL EDUCATIONAL OPPORTUNITIES REGARDLESS OF 622 AND OTHER APPLICABLE STATE AND FEDERAL CIVIL RIGHTS LAWS

Fall River Public Schools

K-12 Student Google Apps for Education Acceptable Use Guidelines

The Fall River Public Schools will be using Google Apps for Education in Grades K-12. These accounts will be used for school related projects only and will provide students with very powerful collaboration and sharing tools including Spreadsheets, Documents, Forms and Presentations. The email feature on all grades 6-12 Google Apps accounts has been restricted to only allow students to send/receive to other @frpsstudents.org or @fallriverschools.org accounts. K-5 students will not be able to use the email feature of Google Apps.

Philosophy

The Fall River Public School District encourages the use of student K-12 Google Apps accounts as an effective and efficient way to improve communication between students and faculty. The primary purpose of student Google Apps is to support teaching and learning.

1. Google Apps Accounts

All K-12 students will be assigned an @frpsstudent.org student Google Apps account. Students will log in with their last two digits of YOG- and their full name @frpsstudent.org.

Example: 11frankfarias@frpsstudent.org.

2. Prohibited Conduct

- Unlawful activities
- Misrepresentation of the Fall River Public Schools
- Sending an attachment that contains a virus
- Unlawfully forwarding or copying material without permission
- Sending emails with any libelous, defamatory, offensive, racist or obscene remarks
- Disguising or attempting to disguise your identity when sending mail
- Attempting to send an email to any domain/address other than @fallriverschools.org or @frpsstudent.org
- Incidents of cyber-bullying* or inappropriate actions while using your account *See district cyber-bullying policy and FRPS Acceptable Use Policy

3. Access Restriction

Access to and use of Google Apps is considered a privilege accorded at the discretion of the Fall River Public Schools. The District maintains the right to immediately withdraw the access and use of Google Apps when there is reason to believe that violations of law or district policies have occurred. In such cases, the alleged violation will be referred to the building principal for further investigation and adjudication.

4. Security

Fall River Public Schools cannot and does not guarantee the security of electronic files located on the Google Apps system.

5. Privacy

The general right of privacy will be extended to the extent possible in the electronic environment. Fall River Public Schools and all electronic users should treat electronically stored information in individuals' files as confidential and private.

There is an acknowledged trade-off between the right of privacy of a user and the need of system administrators to gather necessary information to ensure the continued functioning of these resources. In the normal course of system administration, system administrators may have to examine activities, files, and electronic documents to gather sufficient information to diagnose and correct problems with system software and/or hardware.

Use of Google Apps accounts are strictly prohibited from accessing files and information other than their own. The district reserves the right to access the @frpsstudent.org Google Apps systems when there is reasonable suspicion that unacceptable use has occurred.

6. Questions

If you have any questions or comments about this Email Policy, please contact Frank Farias at 508-675-8420, ext 444, or via email at ffarias@fallriverschools.org. If you do not have any questions the Fall River Public Schools presume that you understand and are aware of the rules and guidelines in this Policy and will adhere to them.

These guidelines and updates will be available on the Fall River Public Schools Web site at <http://www.fallriverschools.org/frpsstudent.cfm>

DECLARATION

I have read, understand, and acknowledge receipt of the K-12 Google Apps for Education policy. I will comply with the guidelines set out in this policy and understand that failure to do so might result in disciplinary action.

Parent/Guardian:

___ I give permission for my child to be assigned an @frpsstudent.org Google Apps account.

Student name: _____ HR _____

Parent/Guardian signature: _____

Student:

I agree to adhere to the guidelines stated above for use of my @frpsstudent.org Google Apps account.

Student signature: _____

If you have any questions or concerns, please feel free to call Frank Farias, Google Apps Administrator, at 508-675-8420, ext 444, or email him at ffarias@fallriverschools.org

FALL RIVER PUBLIC SCHOOLS

"The Scholarship City"

Student Registration & Parent Center - 360 Elsbree Street, Fall River, MA 02720

Meg Mayo-Brown, Superintendent

Barbara Allard, Director

New Student Registration STUDENT CONTACT INFORMATION

Students will only be dismissed to contacts that have proper identification and proper contact information on file. Please notify the school of any changes to contact or student information during the school year. Thank you.

Parent/Guardian Signature _____ Date _____

★ STUDENT NAME _____ DOB _____ DATE _____

Parent/Guardian #1 _____ Relationship _____ Priority # _____

Yes No *Is this contact, also a contact for another student (present or former) in the FRPS?*

Yes No *Is this contact, also a staff member or student (present or within last 5 years) of the FRPS?*

Physical Address _____ City, State, Zip _____

Mailing Address _____ City, State, Zip _____

Write SAME in mailing address if it matches the physical address.

Phone 01 _____ Type _____ Phone 02 _____ Type _____

Home Language _____ E-Mail _____

Yes No *Lives With Student?* Yes No *Has Custody of Student?* Yes No *Can Pickup Student?*

Parent/Guardian #2 _____ Relationship _____ Priority # _____

Yes No *Is this contact, also a contact for another student (present or former) in the FRPS?*

Yes No *Is this contact, also a staff member or student (present or within last 5 years) of the FRPS?*

Physical Address _____ City, State, Zip _____

Mailing Address _____ City, State, Zip _____

Write SAME in mailing address if it matches the physical address.

Phone 01 _____ Type _____ Phone 02 _____ Type _____

Home Language _____ E-Mail _____

Yes No *Lives With Student?* Yes No *Has Custody of Student?* Yes No *Can Pickup Student?*

Codes for Emergency Priority#

0=Parent/Guardian

1=Family Members

2=Neighbors/Friends

3=Other

Additional Contact Information

Contact _____ **Relationship** _____ **Priority #** _____

Yes No *Is this contact, also a contact for another student (present or former) in the FRPS?*

Yes No *Is this contact, also a staff member or student (present or within last 5 years) of the FRPS ?*

Physical Address _____ **City, State, Zip** _____

Mailing Address _____ **City, State, Zip** _____

Write SAME in mailing address if it matches the physical address.

Phone 01 _____ **Type** _____ **Phone 02** _____ **Type** _____

Home Language _____ **E-Mail** _____

Yes No *Lives With Student?* Yes No *Has Custody of Student?* Yes No *Can Pickup Student?*

Contact _____ **Relationship** _____ **Priority #** _____

Yes No *Is this contact, also a contact for another student (present or former) in the FRPS?*

Yes No *Is this contact, also a staff member or student (present or within last 5 years) of the FRPS ?*

Physical Address _____ **City, State, Zip** _____

Mailing Address _____ **City, State, Zip** _____

Write SAME in mailing address if it matches the physical address.

Phone 01 _____ **Type** _____ **Phone 02** _____ **Type** _____

Home Language _____ **E-Mail** _____

Yes No *Lives With Student?* Yes No *Has Custody of Student?* Yes No *Can Pickup Student?*

Contact _____ **Relationship** _____ **Priority #** _____

Yes No *Is this contact, also a contact for another student (present or former) in the FRPS?*

Yes No *Is this contact, also a staff member or student (present or within last 5 years) of the FRPS ?*

Physical Address _____ **City, State, Zip** _____

Mailing Address _____ **City, State, Zip** _____

Write SAME in mailing address if it matches the physical address.

Phone 01 _____ **Type** _____ **Phone 02** _____ **Type** _____

Home Language _____ **E-Mail** _____

Yes No *Lives With Student?* Yes No *Has Custody of Student?* Yes No *Can Pickup Student?*

Codes for Emergency Priority#

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1=Family Members

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3=Other

FALL RIVER PUBLIC SCHOOLS

"The Scholarship City"

360 Elsbree Street, Fall River, MA 02720

HOME LANGUAGE SURVEY

Dear Parents and Guardians: In order to help your child succeed in school, we ask that you please answer the following questions for each child in your family. Your answers will help us in creating the best possible educational program for your child.

Child's Name (LAST) _____ (FIRST) _____ (MI) _____

Date of Birth _____ Gender: ___M ___F Grade _____

Birth Place _____ If outside US -Date of Entry in U.S. _____

Current/Previous School _____ Date first enrolled in any U.S. School _____

1. What language did your child first understand or speak? _____

2. What language do you use most often when speaking with your child at home? _____

3. What language does your child use most often when speaking with you at home? _____

4. What language does your child use most often when speaking with other family members? _____

5. What language does your child use most often when speaking with friends? _____

6. What language(s) does your child read? _____

7. What language(s) does your child write? _____

8. At what age did your child start attending school? _____

9. Has your child attended school every year since that age? _____ Yes _____ No

If no, please explain: _____

10. Would you prefer oral and written communication from the school in English or in your home language?

Please specify language preference: _____

Signature of Parent /Guardian _____

Date _____

Proficiency Testing Results and Placement Recommendation:

W-APT Proficiency Level Testing Result	Mass Level - Placement Recommendation
1. Composite Proficiency Level <input type="text"/>	L1 ___ Beginner L2 ___ Early Intermediate
2. Grade Adjusted Composite Proficiency Level <input type="text"/>	L3 ___ Intermediate L4 ___ Transitioning
	L5 ___ Not LEP (Reclassification Recommended)

CERTIFICATE OF RESIDENCY

It shall be the policy of the Fall River Committee that:

“all children who register and attend Fall River Public Schools at the expense of the citizens of Fall River be a legal resident whose actual principle residence is in Fall River. This policy shall provide equal opportunity to each child regardless of race, color, creed, national origin, sex or handicap.”

- 1. I understand that _____ must be a resident of the city of Fall River.
(name of student)
 - 2. I certify that _____ is residing with me at the following residence.
(name of student)
-

- 3. I certify that I am a legal resident of Fall River. (Attach proof of residency)
- 4. I am _____ am not _____ Parent/ Legal Guardian.
(name of student)

If guardianship exists, please attach legal documentation.

- 5. I certify that this living situation is not an arrangement of convenience for the sole purpose of having the Student residing with me to attend Fall River Public Schools.

List the reason (s) for the current living situation. (If this living situation as a result of a marital action for separation/divorce, attach documentation evidencing the custody arrangement)

I understand that enrolling the child named above in Fall River Public Schools is contingent upon the conditions of the Residency Policy, which I have read. I also understand that violation of this policy may result in termination of the child’s enrollment and that I may be liable for this child’s tuition reimbursements.

I hereby certify under the pains and penalties of perjury the information provided above is accurate and true.

(Signature of Guardian, Grandparent, Foster Parent, other relative or other Fall River resident) Date

(Signature of Parent) Date

FALL RIVER PUBLIC SCHOOLS

KINDERGARTEN/PRE-SCHOOL ENTRY QUESTIONNAIRE

(To be filled out by parent or guardian)

Date: _____

Child's full name _____

The following questionnaire is designed to help us get a better understanding of your child, his/her strengths, weaknesses and behavior so we can meet his/her needs in Kindergarten/pre-school.

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

FAMILY

1. Who is filling out this questionnaire? Mother _____ Father _____ Other _____

2. His/ Her Address _____ Telephone _____

3. Child lives with a parent _____ both parents _____ Other _____

4. Father/Guardian:

Occupation _____

Date of Birth _____ Place of Birth _____

Grade last completed _____

5. Mother/Guardian:

Occupation _____

Date of Birth _____ Place of Birth _____

Grade last completed _____

6. Other language(s) spoken at home (which) _____

7. Other children in the home:

Name: _____ Sex _____ Date of Birth _____ Grade _____ School _____

Name: _____ Sex _____ Date of Birth _____ Grade _____ School _____

Name: _____ Sex _____ Date of Birth _____ Grade _____ School _____

Name: _____ Sex _____ Date of Birth _____ Grade _____ School _____

HEALTH:

Check any area that apply to your child and comment:

- | | |
|---|-------------------------------------|
| a. Tires easily _____ | o. Allergies (asthma, eczema) _____ |
| b. Requires little sleep _____ | p. Extremely active _____ |
| c. Quite, lethargic _____ | q. Birth injuries _____ |
| d. Frequent colds _____ | r. Headaches _____ |
| e. Bedwetting _____ | s. Premature _____ |
| f. Soiling _____ | t. Poor appetite _____ |
| g. Ear infections _____ | |
| h. Any allergies in the family? _____ | |
| i. Any diabetes in the family? _____ | |
| j. Medications: Which? _____ | For what reason? _____ |
| k. Hospitalization: Age? _____ | Reason? _____ |
| l. Convulsions: Age? _____ | Reason? _____ |
| m. Accidents: Age? _____ | Reason? _____ |
| n. Physical defects (eyes, ears, other): Comment: _____ | |

CHILD GROWTH AND DEVELOPMENT

Age at which child:

- | | |
|-------------------------------------|-------------------------------------|
| 1. Sat up _____ | 5. Talked _____ |
| 2. Walked _____ | 6. Played with toys _____ |
| 3. Followed objects with eyes _____ | 7. Dressed self _____ |
| 4. Imitated speech _____ | 8. Toilet trained for daytime _____ |

EMOTIONAL AND SOCIAL DEVELOPMENT

Check areas that apply to your child and comment:

- | | | | |
|--|------------------------------------|---------------------------|-----------------|
| Is confident _____ | bites nails _____ | shares easily _____ | Daydreams _____ |
| _____ | suck thumb _____ | has nightmares _____ | |
| Is moody _____ | cries easily _____ | has temper tantrums _____ | |
| Has many friends _____ | prefers to play alone _____ | | |
| Joins group activities _____ | sticks to tasks once begun _____ | | |
| Clings to mother in new situations _____ | has an even calm disposition _____ | | |
| Is motivated to try something new _____ | | | |

Comments: _____

LANGUAGE DEVELOPMENT

1. Present speech patterns (please check)

Frequent hesitations _____

Frequent repetitions _____

Baby talk _____

Generally clear speech _____

Would someone unfamiliar with your child understand his/her speech? _____

2. Are you aware that your child has a speech problem:

Yes _____ No _____

(If so explain) _____

3. Which family members have experienced difficult with:

Speech _____

Reading _____

Spelling _____

Arithmetic _____

MOTOR DEVELOPMENT

1. Age at which child began to walk freely and easily _____

Coordination: (please check) jump _____ Can run _____ Can balance on one foot _____

Can use scissors well _____ Can use pencil or crayon well _____

DOMINANCE

1. Does one hand seem dominant? _____ **Which one?** _____

READINESS

1. Knows: (please check all that apply)

home address _____

telephone number _____

short messages _____

3. Shows imagination in:

storytelling _____

drawing _____

building _____

play activities _____

others _____

4. Can recognize:

alphabet _____

colors _____

numbers _____

words on labels _____

2. Can print name _____

5. Favorite activities: _____

PREVIOUS SCHOOL EXPERIENCE

YES _____ NO _____

Where (Name of school, city, state)

Dates: _____

May we contact school? YES _____ NO _____

Name of child's physician _____ Date of last exam _____

Additional information about your child that you feel would be helpful for his/her adjustment:

PLEASE: Return this form to the registration center

Parent or Guardian's Signature _____

FALL RIVER PUBLIC SCHOOLS

"The Scholarship City"

Student Registration & Parent Center - 360 Elsbree Street, Fall River, MA 02720

Meg Mayo-Brown, Superintendent

Barbara Allard, Director

PLEASE FILL THE BLANKS BELOW:

Full Name of Child _____ Telephone _____

Address _____

Date of Birth: Year ____ Month ____ Day ____ City of Birth _____

Name of Father/Guardian _____ Occupation _____

Name of Mother/Guardian _____ Occupation _____

Birthplace of Father/ Guardian _____

Birthplace of Mother/Guardian _____

of Sisters: Older _____ Younger _____ # of Brothers: Older _____ Younger _____

Notice: The following certificates are presented upon enrollment at the Parent Information Center

Birth Certificate _____ Tuberculin Certificate _____

Diphtheria Immunization Certificate _____ Polio Immunization Certificate _____

Measles Immunization Certificate _____ Rubella Immunization Certificate _____

Mumps Immunization Certificate _____ Lead Test _____

Hib _____ Hepatitis B _____

Varivax _____ 2nd M M R _____

Primary Language _____ Student Assignment Specialist _____

Date of last Physical Examination _____ Date _____

FALL RIVER PUBLIC SCHOOLS
STUDENT HEALTH INFORMATION SYSTEM

Please complete the following information below and return to school immediately

School: _____ Grade: _____ Rm: _____

Student's Name: _____

Home Address: _____ Last Middle First Home Telephone: _____

Date of Birth: _____ Sex: _____ Primary Language: _____

Does your child have health insurance: Yes _____ No _____

If yes, what is the name of the insurance company? _____

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

Mother/Guardian/Other _____

Father/Guardian/Other _____

Name & Date of Birth of students' **siblings** in the Fall River School system.

Name	Date of Birth	School

In case of emergency, the school will attempt to contact parent/guardian before calling student's primary care provider (physician). Your child will be transported by ambulance to an emergency care facility if necessary.

Physician Name: _____ **Phone:** _____

Dentist Name: _____ **Phone:** _____

Please list all medications that your child takes:

A written order from a doctor **AND** parent is necessary if medication is to be taken in school. Aspirin and/or over-the-counter medication cannot be given unless above orders and medication are provided by the parent/guardian. Please contact your child's school nurse for the appropriate forms.

Please check all that applies to your child:

Heart Condition Diabetes Asthma Seizure Disorder ADD/ADHD Migraines depression

Other (Specify) _____

Allergies (food, insects, medication, environment) (Specify) _____

Hearing problems (Specify) Left Ear _____ Right Ear _____ Hearing Aids _____

Vision problems (Specify) Wear Eyeglasses _____ Contact Lenses _____

Can your child participate in our physical education program? Yes _____ No _____ If no please explain

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 and to exchange information with my child's primary care physician for the purpose of referral, diagnosis, and treatment.

Parent/Guardian Signature: _____

Date: _____

Tuberculosis Screening for School Children

Recommended Screening Tool from the Medical Advisory Board of Massachusetts Committee for the elimination of Tuberculosis.

NAME OF CHILD: _____

ADDRESS: _____

DATE OF BIRTH: _____ PLACE OF BIRTH _____

HAVE YOU LIVED OR SPENT TIME WITH ADULTS WHO:

	YES	NO
1. Were homeless, either living on the streets or in a shelter?	_____	_____
2. Have AIDS or are HIV-infected?	_____	_____
3. Used intravenous drugs or other street drugs?	_____	_____
4. Lived in a correctional facility, nursing home or mental institution?	_____	_____
5. Have you ever had a positive tuberculosis skin test?	_____	_____
6. Have you lived or spent time with anyone who was sick or had a positive skin test?	_____	_____
7. Where you born in one of the countries listed on the next page?	_____	_____
8. Have you traveled or lived for more than one month in any of the countries listed on the next page?	_____	_____

YES -TO ANY QUESTIONS - Requires a tuberculin skin test or proof of a negative skin test or note from a doctor.

HIGH RISK

NO - TO ALL OF THE ABOVE QUESTIONS - Means that you are Considered low risk for tuberculosis, and a skin test should not be needed.

LOW RISK

PARENT OR GUARDIAN SIGNATURE: _____

DATE: _____

**Massachusetts Department of Public Health
Bureau of Infectious Disease Prevention, Response and Services
Division of Tuberculosis Prevention and Control**

The non-U.S. born (defined as persons born outside the United States and its territories) remains the group at highest risk for TB disease in Massachusetts. Of the 244 cases reported in 2009, 181 (74%) occurred in the non-U.S. born.

**Countries with high Rates of Tuberculosis (TB)±
TB Endemic Countries**

Afghanistan	Cote d'Ivoire	Lithuania	Rep. of Moldova
Algeria	Djibouti	Madagascar	Romania
Angola	Dominican Republic	Malawi	Russia Federation
Anguilla	DPR No. Korea	Malaysia	Rwanda
Armenia	DR Congo	Mali	Sao Tome & Principe
Azerbaijan	Ecuador	Marshall Islands	Senegal
Bahrain	El Salvador*	Mauritania	Seychelles
Bangladesh	Equatorial Guinea	Mauritius	Sierra Leone
Belarus	Eritrea	Mexico*	Solomon Islands
Belize	Ethiopia	Micronesia	Somalia
Benin	Gabon	Mongolia	South Africa
Bhutan	Gambia	Montserrat	Sri Lanka
Bolivia	Georgia	Morocco	Sudan
Bosnia & Herzegovina	Ghana	Mozambique	Suriname
Botswana	Guam	Myanmar	Swaziland
Brazil	Guatemala	Namibia	Tajikistan
British Virgin Islands	Guinea	Nauru	Thailand
Brunei Darussalam	Guinea-Bissau	Nepal	Timor-Leste
Bulgaria	Guyana	Nicaragua	Togo
Burkina Faso	Haiti	Niger	Turkmenistan
Burundi	Honduras	Nigeria	Tuvalu
Cambodia	India	North Mariana Island	Uganda
Cameroon	Indonesia	Pakistan	Ukraine
Cape Verde	Iraq	Palau	UR Tanzania
Central African Republic	Kazakhstan	Panama	Uzbekistan
Chad	Kenya	Papula New Guinea	Vanuatu
China	Kiribati	Paraguay	Vietnam
China, Hong Kong SAR	Kyrgyzstan	Peru	Yemen
China Macao SAR	Laos PDR	Phillippines	Zambia
Colombia*	Lesotho	Poland*	Zimbabwe
Comoros	Liberia	Portugal*	
Congo	Libyan Arab	Qatar	
Cook Islands	Jamahiriya	Rep. of S. Korea	

±World Health Organization, Global Tuberculosis Control: Estimated burden of TB in 2009
<http://www.who.int/tb/country/data/download/en/index.html>

Birth in TB endemic country (defined as TB case rate of 50 or more per 100,000 people) is a major risk factor for exposure to TB. *Countries with TB case rate <50 per 100,000 but where TB cases in Massachusetts are from May 2009.

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	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies: Please list: Medications _____ Food _____ Other _____ History of Anaphylaxis to _____ Epi-Pen®: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Asthma: Asthma Action Plan <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder: _____
<input type="checkbox"/>	<input type="checkbox"/>	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.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

Screening:

(Pass) (Fail)
Vision: Right Eye
Left Eye
Stereopsis

(Pass) (Fail)
Hearing: Right Ear
Left Ear

(Pass) (Fail)
Postural Screening:
(Scoliosis/Kyphosis/Lordosis)

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:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> 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 01/04/06

Massachusetts Department of Public Health
CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / /

Sex: female male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
	4			4	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td, Tdap)	1		Measles, Mumps, Rubella (MMR)	1	
	2			2	
	3		Varicella (Var)	1	
	4			2	
	5		Meningococcal Conjugate (MCV4) or or Polysaccharide (MPSV4)	1	
	6			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		Hepatitis A (HepA)	1	
	2			2	
	3		Pneumococcal Polysaccharide (PPV23)	1	
	4			2	
	5			1	
Pneumococcal Conjugate (PCV7)	1		Inactivated (Intramuscular) or	2	
	2			3	
	3		Other:		
	4				

Laboratory Results: Lead Date 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	
<input type="checkbox"/>	Check the box if this person has a physician-certified reliable history of chickenpox.
Reliable history may be based on:	
<ul style="list-style-type: none"> • 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: _____

Bring in the following to complete the Registration Process

- Child's Original Birth Certificate*
- Complete Immunization Record including Lead Test*
- Last Complete Physical Exam with Physician's Signature*
- Proof of Residence of Parent/Guardian (ex. Mortgage statement, Rent receipt, Utility bill)*

*As a Parent, your involvement
in your child's education
is the key to
your child's success in school*