FALL RIVER PUBLIC SCHOOLS

"The Scholarship City"

Fred Houle
Parent Information Center
and
Student Assignment

Out of District Transfer 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: ________

School Assigned: Name: ____________________

Code: ____________________

District School: Name: ____________________

Code: ____________________

Fall River Public School of Choice Registration Form

First Name ______________________________ Child lives with ______________________________
(parents, mother, father,…ect)

Middle Name ______________________________

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 of 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 fell 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 who 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#

0=Parent/Guardian **1=Family Members** **2=Neighbors/Friends** **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 ☐ **2. Grade Adjusted Composite Proficiency Level** ☐	**L1_____Beginner L2_____Early Intermediate** **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

____

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 ____

Phone: 508-675-8421 • Fax: 508-675-8488 • www.fallriverschools.org

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: ____

Last Middle First

Home Address: ___________________________________ 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 261 cases reported in 2008. 215 (82%) occurred in the non-U.S. born (outside of the United States).

Countries with High Rates of Tuberculine (TB)
TB Endemic Countries

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

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name ______________________ ☐ Male ☐ Female Date of Birth: ______________

Medical History ______________________

Pertinent Family History

Current Health Issues

Y N

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

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

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: ______________________

☐ ☐ Other (*Please specify*) ______________________

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

Physical Examination **Date of Examination:** ______________

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

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

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

Screening:

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

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
Date of PPD: ____; Results: ____mm.
Referred for evaluation to: ______________________ ☐ Low risk (no PPD done)

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

Comments/Recommendations: ______________________

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

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

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

____
Group Practice Telephone

____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 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		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
Pneumococcal Conjugate (PCV7)	1			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

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

Reliable history may be based on:

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

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

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

Signature:

Facility name:

RELEASE OF INFORMATION

NAME OF CHILD ____D.O.B.____________

ADDRESS____

To assist the above named individual in education and occupational placement, school authorities are requesting your authorization for release of information in accordance with chapter 71 of the General Laws of the Commonwealth of Massachusetts.

I hereby authorize the release of information as requested by colleges, schools, employers and military services to which the above-named individual has applied.

____

PARENT/ GUARDIAN SIGNATURE **DATE**

Send student records to:

Mrs. Barbara Allard
Fall River Public Schools
Student Assignment/
Parent Information Center
417 Rock St.
Fall River, MA 02720

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)*
- ☐ *I.E.P. – Individualized Educational Plan (if there is one)*

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

Prepared by the Fall River Public Schools- Fred Houle Parent Information Center & Student Assignment