SPAULDING MEMORIAL SCHOOL KINDERGARTEN REGISTRATION PACKET

REGISTRATION CHECKLIST

Date: _____

Child's Name _____

_____ Birth Certificate

_____ Registration Form

_____ Proof of Residency

_____ Medical Examination Form and Immunization Record

_____ School Health Record

_____ Developmental and Medical History

_____ Kindergarten Screening

_____ Legal/Court documentation

_____ Home Language Survey

SPAULDING MEMORIAL SCHOOL

APPOINTMENT

Kindergarten Screening

Date **Time**

North Middlesex Regional School District Home Language Survey

Massachusetts Department of Elementary and Secondary Education regulations require that *all* schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. If a language other than English is spoken in the home, the District is required to do further assessment of your child. Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

Student Information

First Name | Middle Name | Last Name | F ☐ M ☐ Gender

Country of Birth | Date of Birth (mm/dd/yyyy) | Date first enrolled in ANY U.S. school (mm/dd/yyyy)

School Information

Start Date in New School (mm/dd/yyyy) | Name of Former School and Town | Current Grade

Questions for Parents/Guardians

What is the native language(s) of each parent/guardian? (circle one) (mother / father / guardian) (mother / father / guardian)	Which language(s) are spoken with your child? (include relatives -*grandparents, uncles, aunts,etc.* - and caregivers) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always
What language did your child first understand and speak?	Which language do you use most with your child?
Which other languages does your child know? (circle all that apply) speak / read / write speak / read / write	Which languages does your child use? (circle one) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always
Will you require written information from school in your native language? Y ☐ N ☐	Will you require an interpreter/translator at Parent-Teacher meetings? Y ☐ N ☐
Parent/Guardian Signature: X	Today's Date: (mm/dd/yyyy)

To be completed by ELL Program Staff before placement:

School Enrollment Date: _____ Grade: _____

Relationship of Person Completing Survey: Mother Father Guardian Other

Recommendation: Proficiency Testing/ Records Review No ELL Services

_____

Signature of ELL Program Staff/Date

Rev. 12/2005

OFFICE USE ONLY

Grade:	Teacher:	Bus #
Birth Certificate Received:		Immunization Record Received:
Proof of Residency Received:		Date of Entrance:

North Middlesex Regional School District
Student Registration Form

Date: _____ Grade Entering _____

Student Information (Complete Names)

First: _____ Full Middle Name: _____ Last: _____

Sex: (Circle One) M F Date of Birth: _____ City of Birth: _____ State: _____

Address: _____ City/Town: (Residence): _____ Zip: _____

Mailing Address if Different: _____

Is Student a State Ward? (Circle One) YES NO Is student in foster care? (Circle One) YES NO

If yes, DSS Caseworker Name: _____

Ethnicity: (Circle One) Non- Hispanic Hispanic

Race: (Circle all that apply) American Indian or Alaska Native, Asian, White, Native Hawaiian or Other Pacific Islander, Black or African American

Parent(s) Status: ( ) Married ( ) Divorced ( ) Separated ( ) Other _____

Child is living with: ( ) Both Parents ( ) One Parent ( ) Other _____

Custodial Parents: ( ) Mother ( ) Father ( ) Other _____

Is there any court order in place? (Circle One) YES NO Divorce Decree on file in school? (Circle One) YES NO

If parents are divorced, does the non-custodial parent receive information on the child? (Circle One) YES NO

If so what address should it be sent to? (Court order must be on file in the school)

_____

Mother's/Guardian Information:

_____
Email address

Name: _____ Home Phone # _____

Education: _____ Occupation: _____ Work Phone # _____

Address if Different from above _____ Cell Phone # _____

Date of Birth: _____ Birthplace: _____ Migrant Worker: (Circle One) YES NO

Father's/Guardian Information:

_____
Email address

Name: _____ Home Phone # _____

Education: _____ Occupation: _____ Work Phone # _____

Address if Different from above _____ Cell Phone # _____

Date of Birth: _____ Birthplace: _____ Migrant Worker: (Circle One) YES NO

(over)

Student's Medical Information:

Any physical limitations or medical disorders (including allergies) ? (Circle One) YES NO If yes, explain:_____

_____

Does student regularly take any medications? (Circle One) YES NO If so please list:_____

_____

Student's Educational Information:

Has the student been enrolled in a State of Massachusetts school before? (Circle One) YES NO

Previous School Attended:_____ Grade Level_____

Previous School's Address:_____ Date Last Attended:_____

Special Services Received: (Please Check all those received past or present):

Speech/Language_____ Remedial Reading _____ Title One _____ Physical Therapy _____

Occupational Therapy _____ Learning Center or Resource Room _____ Guidance _____

Other:_____

Sibling Information:

Name:_____ Circle One (M F) Grade:_____ Date of Birth:_____

Name:_____ Circle One (M F) Grade:_____ Date of Birth:_____

Name:_____ Circle One (M F) Grade:_____ Date of Birth:_____

Are there any issues / concerns that the school should be aware of?

_____

_____

Signature:_____

Name (Print): _____ Your Relationship to Student:_____

First Language used in home (Ex. English)_____

Address (if different from above): _____Phone #:(if different from above) _____

If your child goes to a Babysitter/Daycare to/from school:

Name:_____ Address: _____ Phone #_____

Name:_____ Address: _____ Phone #_____

Please check all that apply:

	Monday	Tuesday	Wednesday	Thursday	Friday
To School from Day Care / Babysitter					
From School to Day Care / Babysitter					

(OVER)

North Middlesex Regional School District

Proof of Residency Form

Date : _____ Student Name: _____

Parent / Guardian Name : _____ _____

Current Address : _____ _____

Current Phone #: _____ Cell Phone # _____

Previous Address : _____ _____

Previous Phone #_____

Name of Property Owner:_____ _____

The undersigned do hereby certify that (Student's Name) _____

is living at _____ in _____, Massachusetts and that all

records relating to the enrollment of _____ in the North Middlesex

Regional School District are true.

Any falsifying of this information will subject me, as parent or guardian, to full tuition payment for the number of days he / she was not a legal resident of the Town of Townsend as well as removal of the student from the North Middlesex Regional School District.

_____ _____

Parent / Guardian Signature Date Property Owner's Signature Date

Two forms of identification are required from the property owner or renter. If the parent or homeowner cannot produce the two forms, notarization from the town clerk may be required.

1. Proof of ID: Driver's License / Passport_____

2. Proof of residency (one of the following)

Rental / Lease Agreement _____
Mortgage Statement _____
Purchase and Sales Agreement _____
Utility bill
(due after 30 days of actual residence) _____

Child's Name Date

DEVELOPMENTAL HISTORY

We would appreciate your cooperation in filling out the following questionnaire as completely as possible. It will help us to better understand your child. This is of particular importance for any child with a known disability. If, for some reason you are unable or object to answering certain questions, please leave them blank. Thank you.

Child's Name:_____School Spaulding Memorial School

Was there any unusual or significant problem during your pregnancy with this child or the delivery?

_____

_____

_____

I. DEVELOPMENT

1. At what (approximate) age did your child first learn to: Walk_____
First Word:_____Sentence_____Rhyme/Song_____

2. Mark one of the three boxes after each question and answer only those questions which apply to your child at his present age.

I feel my Child's	Above Average	Below Average	Average
Physical development is	_____	_____	_____
Mental development is	_____	_____	_____
Emotional development is	_____	_____	_____
Ability to get along with others is	_____	_____	_____
Ability to cope with new situations is	_____	_____	_____
Large muscle ability is (i.e., jumping, playing ball)	_____	_____	_____
Small muscle ability is (i.e., coloring, using scissors)	_____	_____	_____
Speaking ability is	_____	_____	_____
Ability of concentration on his/her work is	_____	_____	_____

	Yes	No		Yes	No
3. Do you feel your child was colicky (irritable) as a baby?	___	___	5.. Particularly active as a baby	___	___
4. Particularly quiet as a baby?	___	___	6. Constantly reaching, grabbing, whirling, moving, in his/her preschool years?	___	___

II. FAMILY HISTORY

1. How many children do you have? (circle one) 1 2 3 4 5 more.

2. Was this your ( )1st ( )2nd ( )3rd ( )4th ( )5th ( )or more.

3. Is this child adopted? ( )Yes ( )No

4. List name, age and sex of brothers and sisters. Indicate if full brother or sister:

	Name	Age	Sex	Full Yes	No
a.	_____	_____	_____	_____	_____
b.	_____	_____	_____	_____	_____
c.	_____	_____	_____	_____	_____
d.	_____	_____	_____	_____	_____
e.	_____	_____	_____	_____	_____

If necessary, please use additional sheet.

5. How many people live at home? 1 2 3 4 5 6 7 8 or more?

6. Please check if any of the child's blood relatives every had any of the following:

	Yes	No		Yes	No
Disorder of the nervous system	___	___	Obesity	___	___
Mental Retardation	___	___	Diabetes	___	___
Severe Anemia	___	___	Birth Deformity	___	___
Asthma, Hay Fever	___	___	Epilepsy (Convulsions)	___	___
Bleeding Tendency	___	___	Other hereditary disease	___	___
Mental Illness	___	___	If yes, What?_____		
Tuberculosis	___	___	Learning or reading problem	___	___
Kidney Disease (other than infection	___	___	Heart Attack before 50	___	___
			Unusually short stature	___	___
High Blood Pressure	___	___	Scoliosis	___	___

_____

Date _____

SPAULDING MEMORIAL SCHOOL

STUDENT'S NAME _____
DATE OF BIRTH _____

MEDICAL INFORMATION:

1. Any physical limitations that might affect your child's activity at school?

_____
_____
_____

2. Any allergies to (food, insect bites, etc.?) _____
_____
_____

3. Any medical disorders (asthma, seizures of any kind, diabetes, etc.? (Please specify _____
_____
_____

If you have any questions, please call me at 978-597-0380.

Thank you.

Cathryn Hampson, R.N.
School Nurse

_____

Name _____ Date _____

MEDICAL HISTORY

	Parents Complete		School Department Use Only Grade		
	Yes	No	4	7	10
VI PAST HISTORY					
1. Has your child ever had:	Yes	No	4	7	10
Meningitis or Encephalitis?	_____	_____	_____	_____	_____
Repeated Ear Infections (more than 3)?	_____	_____	_____	_____	_____
Asthma?	_____	_____	_____	_____	_____
Pneumonia?	_____	_____	_____	_____	_____
Repeated Strep Throat?	_____	_____	_____	_____	_____
Repeated Tonsillitis?	_____	_____	_____	_____	_____
Rheumatic Fever?	_____	_____	_____	_____	_____
Glomerulonephritis?	_____	_____	_____	_____	_____
Hepatitis?	_____	_____	_____	_____	_____
Arthritis?	_____	_____	_____	_____	_____
Urinary Tract Infections?	_____	_____	_____	_____	_____
If yes, is urine checked periodically?	_____	_____	_____	_____	_____
Eczema?	_____	_____	_____	_____	_____
Repeated colds (more than 6 per year)?	_____	_____	_____	_____	_____
Hay Fever?	_____	_____	_____	_____	_____
Red or Ten Day Measles?	_____	_____	_____	_____	_____
Chicken Pox?	_____	_____	_____	_____	_____
Mumps?	_____	_____	_____	_____	_____
Other illnesses?	_____	_____	_____	_____	_____
Does your child take any medication on a regular basis?	__	_____	_____	_____	_____

(If yes, please explain_____

_____

_____

_____

(if yes, what medications)_____

_____

MEDICAL HISTORY (Continued)

	Parents Complete		School Department Use Only		
			Grade		
	Yes	No	4	7	10
2. Accidents: Has your child ever:					
Swallowed anything harmful?	___	___	___	___	___
if yes, what?_____					
Broken a bone?	___	___	___	___	___
If yes, what bone and what age _____					
Had a concussion? (Knocked out)	___	___	___	___	___
If yes, was child hospitalized?	___	___	___	___	___
Had any other serious injury?	___	___	___	___	___
3. Surgery: Has your child ever had surgery?	___	___	___	___	___
If yes, what?_____					
4. Other: Has your child ever been hospitalized for any illness or injury not already mentioned?	___	___	___	___	___
If yes, What?_____					
5. Allergies: Does your child have an allergy to any medicine?	___	___	___	___	___
If yes, what?_____					
6. Miscellaneous: Has your child ever had difficulty with vision?	___	___	___	___	___
worn glasses?	___	___	___	___	___
had his/her eyes turned in or out?	___	___	___	___	___
Had problems hearing?	___	___	___	___	___
If yes, is problem still present?	___	___	___	___	___
Had frequent, severe headaches?	___	___	___	___	___
Had convulsions?	___	___	___	___	___
If yes, have all convulsions occurred with fever and under 5 years of age?	___	___	___	___	___
Is child taking medication for convulsions?	___	___	___	___	___
If yes, What?_____					
Had problems speaking clearly?	___	___	___	___	___
Gone to dentist regularly?	___	___	___	___	___
Complained of abdominal pain frequently?	___	___	___	___	___
Lost his/her appetite in recent months	___	___	___	___	___
Complained of burning on urinating?	___	___	___	___	___
Been exposed to Tuberculosis?	___	___	___	___	___
Eaten paint chips as an infant?	___	___	___	___	___

NORTH MIDDLESEX REGIONAL SCHOOL DISTRICT

Whitson's Culinary Group
Food Service Director, Michelle Curran
(508) 415-3390

TO: Parents/Guardians of all NMRSD students

FROM: NMRSD and Whitson's Culinary Group

RE: **Food Allergy Notification**

The North Middlesex Regional School District's food services program is provided by Whitson's Culinary Group, an independent, contracted company. It is important for Whitson's cafeteria personnel to be aware of your child's food allergy. This information is maintained in a computer software program that is used for school food services purposes only. Once this information is entered into the computer system by Whitsons this document will be destroyed. This information will be maintained in the computer system throughout your child's enrollment in North Middlesex Regional District Schools. It is the responsibility of the parent/guardian to notify, in writing, the Food Services Manager and School Nurse of any changes in your child's food allergy status. A copy of this document will be mantained in your child's permanent school health record. For further information about school menu allergen information please go to www.nmrsd.org and click on the interactive menu links.

Please indicate your agreement:

☐I agree to notify the Food Services Manager and School Nurse in writing of any changes in my child's food allergies.

☐ I give permission for Whitson's Culinary Group to document my child's food allergies in the food services computer system.

_____ _____

Please print parent/guardian name **Date**

_____

Parent /Guardian Signature

_____ _____

Child's Name **Child's Date of Birth**

Please write your child's documented food allergies as they will be entered in the food services computer system:

_____

_____