CHECK LIST FOR
KINDERGARTEN
REGISTRATION

	Received Completed	Missing	Initials
1. Child's Original Birth Certificate	______	______	______
2. Child's Immunization Record	______	______	______
3. Health Record/Physical Exam Form	______	______	______
4. Kindergarten Registration Form	______	______	______
5. Schedule Screening Appointment	Date_____	Time_____	______
6. Home Language/Ethnicity Survey	______	______	______
7. CHECK OUT	______	______	______

Child's Name ______________________________________

Parent Signature ___________________________________

Date: ____

Countdown to Kindergarten!

Welcome to 2014 - 2015 Kindergarten Registration

What you need to do today-

1. Complete the paperwork while you are here
2. Sign up for 1 hour of time for Kindergarten Screening for your child
3. Take a folder home to read for more information

What you need to do next

1. Bring your child back for 1 hour for Kindergarten Screening –at the date and time which you sign up for
2. Watch for upcoming events - community fun activities at the library, YMCA, schools, and community

At the end of the summer –

1. Bus lists are printed in the Athol Daily News the week before school starts and are also available on the district website www.arrsd.org
2. Kindergarten Orientation will be held on the first 2 days of school. Classes begin on the third full day of the new school year.

Amherst-Royalston Regional School District- KINDERGARTEN REGISTRATION FORM

STUDENT NAME ____
Last / First / Full Middle

Male___ Female___ Date of Birth: Month____________ Day______ Year________

Place of Birth ______________________ Country of Origin ______________

Address ____
Street / Town / Zip Code

Phone ____________ Cell Phone ____________ E-Mail ______________

Any custodial legality (restraining orders, custody orders, etc.) the school should be aware of?
No ______ Yes ______ Please submit copies of legal documents to school. Any DCF involvement?________
DCF Worker______________ Phone:________

With whom does student live? (circle all that apply)
Both Parents, Mom, Dad, Step mom, Step dad, Legal Guardian, Grandparent, Foster Parent, Other ________

Parent/ Guardian #1 Name ______________________________________
Address: ______________________________ Phone __________
Employer:______________________________ Phone __________
Cell Phone: ______________________

Parent/ Guardian #2 Name ______________________________________
Address: ______________________________ Phone __________
Employer:______________________________ Phone __________
Cell Phone: ______________________

1. Will your child receive medication during the school day? Yes_____ No ______ If yes, please see the school nurse to fill out proper forms.
2. Does your child wear glasses? Yes _______ No _______
3. List Health Problems and/or Allergies ______________________________
____
4. Does your child's allergy or health condition constitute an emergency that warrants immediate attention? Yes _______ No ________
Doctor's name ______________________________ Phone __________
Dentist's name ______________________________ Phone __________

Please check any services your child receives:
IEP ______ 504 ______ Speech _______ DCF ______ English Language Learner Services ___

Has your child attended a Preschool or Child Care? ___Yes ___No
If yes, for how long? ____6 months ___1 year ____2 years ____more than 2 years
Name of child's present or most recent school: ______________________________

List names/schools of brothers and/or sisters:
____
____

Parent Signature ______________________________ Date __________

Date of Birth: / / Sex: M F

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date	Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		
	2		
	3		
	4		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1		
	2		
	3		
	4		
	5		
	6		
	7		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib)	1		
	2		
	3		
	4		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1		
	2		
	3		
	4		
	5		
Pneumococcal Conjugate (e.g., PCV7, PCV13)	1		
	2		
	3		
	4		

Vaccine		Date	Vaccine Type
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2		
	3		
Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
	2		
Varicella (e.g., Var, MMRV)	1		
	2		
Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2		
Seasonal Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	2		
	3		
	4		
H1N1 Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	2		
Pneumococcal Polysaccharide (PPSV23)	1		
	2		
Hepatitis A (e.g., HepA, HepA-HepB)	1		
	2		
Human Papillomavirus (e.g., HPV quadrivalent, HPV bivalent,)	1		
	2		
	3		
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:

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)	☐	☐

Laboratory Results: ☐ Lead ______ Date __________ ☐ Other __________

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 12/14/04*

ATHOL ROYALSTON REGIONAL SCHOOL DISTRICT

HOME LANGUAGE SURVEY

SPANISH

Date __________ Student ____________________ School ____________________

Birth date ______________ Country of Birth ______________

Foreign Born Status: If foreign born, year first entered USA _______ Years attended school in USA _____

The Massachusetts Department of Education requires that schools determine the language(s) spoken at home by each student. 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 son/daughter.

Your cooperation in helping us meet this important requirement is requested. Please answer the following questions. Thank you for your help.

NAME OF STUDENT: ____
FIRST MIDDLE LAST

GRADE: ________________ AGE: ____________

Which language did your son or daughter learn when he/she first began to speak? ______________

What language does your son or daughter most frequently use at home? ______________

What language do you use most frequently to speak to your son or daughter? ______________

Name the language most often spoken by the adults at home? ______________

Parent telephone number: ____________ Parent/Guardian Signature ______________

El Departamento de Educación de Massachussets requiere que las escuelas determinen el/los lenguaje(s) que se hablan en la casa de cada estudiante. Esta información es esencial a fin de que las escuelas provean instrucción significativa para todos los estudiantes. Si otro lenguaje diferente al inglés se habla en casa, el Distrito requiere que se haga otro asesoramiento a su hijo(a).

Le pedimos su cooperación para ayudarnos a cumplir este importante requerimiento. Por favor conteste las siguientes preguntas. Gracias por su ayuda.

NOMBRE DEL ESTUDIANTE: ____
NOMBRE DE PILA APELLIDO PATERNO APELLIDO MATERNO

GRADO: ______________ EDAD: ______________

¿Cuál lenguaje aprendió su hijo(a) cuando empezó a hablar? ______________

¿Cuál lenguaje habla con más frecuencia su hijo(a) en casa? ______________

¿Cuál lenguaje usa usted con más frecuencia cuando le habla a su hijo(a)? ______________

¿Nombre del lenguaje que con más frecuencia hablan los adultos en casa? ______________

Número de teléfono ______________ Firma del padre o guardián ______________

Student's name: ______________________________ Grade: __________

Please answer BOTH questions 1 and 2.

1. Is this student Hispanic or Latino? *(choose only one)*
   - ☐ No, not Hispanic or Latino
   - ☐ Yes, Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.)

2. What is the student's race? *(choose one or more)*
   - ☐ American Indian or Alaska Native (A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.)
   - ☐ Asian (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam)
   - ☐ Black or African American (A person having origins in any of the black racial groups of Africa.)
   - ☐ Native Hawaiian or Other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
   - ☐ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa)

'arent/Guardian Signature: ______________________________ Date: __________