# Wachusett Regional School District

Holden, Paxton, Princeton, Rutland, Sterling

## STUDENT REGISTRATION

**Student Information (please print)**

**Name:** _____
*Last name* *First name* *Middle Name*

**Preferred Name:** _____

**Primary Phone:** _____

**Age:** _____ **Date of Birth:** _____ **Gender:** _____ **Grade level:** _____

**Birthplace:** _____

**Previous School** _____ **Phone**_____

**Address:** _____
*Street* *City* *State* *Zip*

**Home Address**

**Street, Apt/Suite:** _____

**City, State, Zip:** _____

**Mailing Address**

**Street, Apt/Suite:** _____

**City, State, Zip:** _____

**Additional Mailing Information**

**Name, City, State, Zip:** _____

**Additional Information**

**Is there documentation as it pertains to a separated/divorced status and custodial rights? _____Yes _____No**
**Is the student a foster child under the Massachusetts Division of Social Services? _____Yes _____No**
**Is the student a "Ward of the Court"? _____Yes _____No**

**Federal Ethnicity and Race Information**

**Is this student Hispanic or Latino? _____Yes _____No**
**Student's race: _____ (A) Asian _____ (B) Black / African American _____ (I) American Indian / Alaska Native**
**_____ (P) Native Hawaiian / Other Pacific Islander _____ (W) White**

**Family Information (please print)**

**Student Resides with:** _____ Parent(s) _____ Guardian(s) _____ Other

| | |
|---|---|
| Parent _____ | Parent _____ |
| Home Phone _____ | Home Phone _____ |
| Cell Phone _____ | Cell Phone _____ |
| Email Address _____ | Email Address _____ |
| Employer _____ | Employer _____ |
| Work Phone _____ | Work Phone _____ |

Step-parent _____ Step-parent _____

Step-parent Home Phone: _____ Step-parent Home Phone: _____

Step-parent Cell: _____ Step-parent Cell: _____

Step-parent email: _____ Step-parent email: _____

Step-parent Employer: _____ Step-parent Employer: _____

Step-parent Work Phone: _____ Step-parent Work Phone: _____

Other Guardian _____ Other Guardian _____

Other Guardian Home Phone: _____ Other Guardian Home Phone: _____

**Emergency Contact Information (other than parent)**

Emergency Contact 1 : _____ Relationship: _____

Emergency Contact 1 Phone: _____ ___ Work ___ Home ___ Cell

Emergency Contact 2 : _____ Relationship: _____

Emergency Contact 2 Phone: _____ ___ Work ___ Home ___ Cell

Doctor: _____ Phone: _____

Dentist: _____ Phone : _____

Medical Condition : _____

<u>School Messenger Information</u>

***School Messenger is an automated telephone notification system used by schools to contact parents in the event of inclement weather cancellations or delays as well as important events happening in the school or the district. The notifications will be delivered to the primary phone number listed on front page of the registration form.***

Signature of Parent / Guardian _____ Date _____

**School:**_____

# WACHUSETT 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

_____ ☐ F ☐ M

**First Name** **Middle Name** **Last Name** **Gender**

_____ ___/___/___ ___/___/___

**Country of Birth** (mm/dd/yyyy) **Date of Birth** (mm/dd/yyyy) **Date 1ST enrolled in ANY U.S. school**

## School Information

___/___/20___ _____ _____

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)**<br>_____ (mother / father / guardian)<br>_____ (mother / father / guardian) | **Which language(s) are spoken with your child?** (include relatives -*grandparents, uncles, aunts,etc.* - and caregivers)<br>_____<br>seldom / sometimes / often / always<br>_____<br>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)**<br>_____ speak / read / write<br>_____ speak / read / write | **Which languages does your child use? (circle one)**<br>_____<br>seldom / sometimes / often / always<br>_____<br>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:**<br>**X** | ___/___/20___<br>**Today's Date:** (mm/dd/yyyy) |

- Home Language Survey translations available in 28 languages on the MA DESE ELL website http://www.doe.mass.edu/ell/hlsurvey/

**WACHUSETT REGIONAL SCHOOL DISTRICT**
**HEALTH HISTORY**

**Student's Name** _____ **Class**_____

Dear Parent/Guardian:

In order to provide better health services to your child, we ask that you complete the following health history. Please give dates if possible.

Date of last physical examination:_____ Physician's Name:_____

Date of last dental examination:_____ Dentist's Name:_____

Hearing/Vision Problems: _____ Hospitalizations:_____

Allergic reactions:_____ Operations:_____

Asthma Attacks: _____ Other respiratory:_____

Bone/Joint disease/injury:_____ Please give dates of Immunizations:

DPT: 1_____2_____3_____4_____5_____

Communicable Diseases: _____ Oral Polio:1___2_____3_____4_____5_____

Convulsions/seizures: _____ Hep B: 1_____2_____3_____

Diabetes: _____ MMR: 1_____2_____

Dental Problems: _____ Hib: 1_____2_____3_____4_____

Ear Infections: _____ TB test: 1_____2_____

Throat Infections: _____ Lead Paint Test: 1_____2_____

Frequent headaches?_____

Results of examination by physician for:

Kidney problems: _____Hearing: _____Date:_____

Heart Problems/Murmur: _____Vision: _____Date:_____

Currently under treatment: _____

Does your child take medication for any reason? _____
***NOTE: No medication can be given at school without written orders from your MD***

Does your child have physical limitations that may require program modifications or restrictions? _____
Please add any other comments you would like to bring to the attention of the school nurse or physician:

Parent/Guardian signature: _____Date:_____

## 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

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

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.

_____
Printed Name of Examiner Signature of Examiner *Circle:* MD, DO, NP, PA Date

_____
Group/Practice Telephone

_____
Address City State Zip Code

*Please attach additional information as needed for the health and safety of the student* MDPH 01/25/07

**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 influenza* type b** (e.g., Hib, HepB-Hib, DTaP-Hib) | 1 | |
| | 2 | | | 2 | |
| | 3 | | | 3 | |
| **Diphtheria, Tetanus, Pertussis** (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td) | 1 | | | 4 | |
| | 2 | | **Measles, Mumps, Rubella** (MMR) | 1 | |
| | 3 | | | 2 | |
| | 4 | | **Varicella** (Var) | 1 | |
| | 5 | | | 2 | |
| | 6 | | **Hepatitis A** (HepA) | 1 | |
| | 7 | | | 2 | |
| **Polio** (e.g., IPV, DTaP-HepB-IPV) | 1 | | **Pneumococcal Polysaccharide** (PPV23) | 1 | |
| | 2 | | | 2 | |
| | 3 | | **Influenza** Inactivated (Intramuscular) or Live (Intranasal) | 1 | |
| | 4 | | | 2 | |
| **Pneumococcal Conjugate** (PCV7) | 1 | | | 3 | |
| | 2 | | **Other:** | | |
| | 3 | | | | |
| | 4 | | | | |

| **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/Practice Name:**_____