



Wachusett Regional School District

Holden, Paxton, Princeton, Rutland, Sterling

If you need these materials translated, please contact the main office of your child's school.

Albanian / shqiptar

Ne qofte se ju do te deshironit dokumentat te perkthyer ne gjuhen shqip. Ju mund ti kerkoni ne zyren qendrore te shkolles du eshte femija juaj.

Arabic / العربية

إذا كنت بحاجة الى هذه المواد المترجمة، يرجى الاتصال بالمكتب الرئيسي للمدرسة طفلك.

Chinese / 汉语

如果您需要翻译这些材料，请联系您孩子学校的主要办公室。

French / français

Si vous avez besoin de traduire ces documents, veuillez communiquer avec le bureau principal de l'école de votre enfant.

German / Deutsch

Wenn Sie diese Materialien benötigen, wenden Sie sich bitte an das Hauptbüro der Schule Ihres Kindes.

Greek / ελληνικά

Αν χρειάζεστε αυτά τα υλικά μεταφραστεί, παρακαλούμε επικοινωνήστε με το κεντρικό γραφείο του σχολείου του παιδιού σας.

Hindi / हिंदी

आप इन सामग्रियों अनुवाद की जरूरत है, अपने बच्चे के स्कूल के मुख्य कार्यालय से संपर्क करें।

Italian / italiano

Se avete bisogno di questi materiali tradotti, si prega di contattare la sede della scuola di vostro figlio.

Japanese / 日本語

これらの資料を翻訳する必要がある場合は、お子様の学校の本店にお問い合わせください。

Korean / 한국어

이러한 자료가 번역되어 필요하면 자녀 학교의 본사에 연락하십시오.

Polish / Polskie

Jeśli potrzebujesz tych materiałów przetłumaczone, skontaktuj się z głównym biurem w szkole Twojego dziecka.

Portuguese / português

Se você precisar traduzir esses materiais, entre em contato com o escritório principal da escola de seu filho.

Russian / русский

Если вам нужны эти материалы переведены, пожалуйста, обращайтесь в главный офис школы вашего ребенка.

Spanish / Español

Si necesita traducir estos materiales, comuníquese con la oficina principal de la escuela de su hijo.



Wachusett Regional School District

Holden, Paxton, Princeton, Rutland, Sterling

Residency Protocol and Enrollment

In order to attend schools in the Wachusett Regional School District, a student must actually reside in one of the five towns: Holden, Paxton, Princeton, Rutland, or Sterling. The residence of the minor child is presumed to be the legal, primary residence of the parent(s) or guardian(s) who have physical custody of the child.

“**Residence**” is the primary place where a person dwells permanently, not temporarily, and is the place that is the center of his or her domestic, social, and civic life. Temporary residence in any of the towns included in the District, solely for the purpose of attending Wachusett District schools, shall not be considered residency.

In determining residency, Wachusett Regional School District reserves the right to request a variety of documentation and to conduct an investigation into where a student actually resides. Because residency can, and does, change for students and their families during the course of the academic year, Wachusett Regional School District may continue to verify residency after the commencement of classes.

Verification

Before any child is assigned or invited to attend a school in the Wachusett Regional School District, his/her parent or legal guardian must provide one item from each column in the following table as proof of primary residence. Applications for registration cannot be processed without these documents.

Column A (must provide one)	Column B (must provide one)	Column C (must provide one)
Evidence of Residency	Evidence of Occupancy	Evidence of Identification
Record of recent mortgage payment and/or property tax bill	Recent bill dated within the past 60 days showing address within WRSD	Valid driver’s license
Copy of lease and record of recent rental payment	Gas bill	Valid MA photo ID card
Landlord Affidavit and recent rental payment	Oil bill	Valid passport
Section 8 Agreement	Electric bill	
	Home telephone bill (not cell phone)	
For all new construction , must provide a Certificate of Occupancy	Cable bill	
	Excise tax bill	

Further clarification:

Any student who has a split residency due to joint physical custody will be granted enrollment in the District and/or allowed to remain with proof that the child is living at least 50% of the time within the District. A court document that references 50/50 custody will verify the child's living arrangement.

This residency policy does not apply to homeless students.

Any family that is able to provide the required proofs of residency may download the registration form and other pertinent documents, complete them totally, and make an appointment directly with school in which the child will be enrolled.

If your personal circumstances make it impossible for you to provide the required proof of residency, consult the Student Services Manager at the Central Office, 1745 Main Street, Jefferson, Massachusetts 508-829-1670 x 237.

If you share housing with a friend or relative, you may use the landlord/shared tenancy affidavit to fulfill one of the proof of residency requirements. The person that you are living with must complete the residency affidavit to affirm your residence. If you are temporarily residing with a friend or relative due to economic hardship, loss of housing, or a similar reason, you may qualify as homeless under the No Child Left Behind Act. Homeless families are not required to produce the same proof of residency. Please contact the Student Services Manager at the Central Office, 1745 Main Street, Jefferson, Massachusetts 508-829-1670 x 237 for assistance in registering your child.

Penalties

Families found to be in violation of the residency policy will face strict penalties, including:

- Immediate dismissal from school
- Per diem fines for the educational and related services accessed as a nonresident, which are based on the number of days the student attended school and the average per pupil cost to the district
- Possible legal action

The following documents should be completed in full. An appointment can then be made with the school to submit the completed documents for consideration and enrollment.



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: _____ Birthplace: _____

School your child will attend: _____ Starting Date: _____

Entering Grade level: _____ Are you applying for full-day kindergarten: Yes No

Previous School _____ Phone _____

Previous School 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

Name of student _____

Family Information (please print)

Student Resides with: Both Parents Mother Father Guardian Other

Parents are: Together Separated Divorced Deceased

Parent _____ Home Phone _____ Cell Phone _____ Email Address _____ Employer _____ Work Phone _____	Parent _____ Home Phone _____ Cell Phone _____ Email Address _____ Employer _____ 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 : _____

School Messenger Information

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 _____



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Home Language Survey

Name of School _____

Date: _____

State and federal law 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 accurately. Thank you for your assistance.

Student Information

_____ F M
 First Name Middle Name Last Name 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 of each parent/guardian? (circle one)

_____ mother / father / guardian

_____ mother / father / guardian

Which languages 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?

Yes No

Will you require an interpreter/ translator at ParentTeacher meetings?

Yes No

Parent / Guardian Signature:

x _____

_____ / ____ / ____
Today's Date (mm/dd/yyyy)



Wachusett Regional School District

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REQUEST FOR STUDENT RECORDS

TO WHOM IT MAY CONCERN:

I hereby give permission to: _____

to forward the records specified below and belonging to:

Name of Student _____
Date of Birth

- Transcript of record
- Scores of standardized tests
- Health Record (including immunizations)
- Individualized Education Program and related assessments
- Other available guidance information (i.e. teacher/counselor evaluations, extracurricular activities, etc.)
- Disciplinary Record
- English Language Learner (ELL Information)
- Other (please specify) _____

Signature of Parent/Guardian or Student _____
Date

Send to school to be enrolled: _____

**WACHUSETT REGIONAL SCHOOL DISTRICT
KINDERGARTEN DEVELOPMENTAL HISTORY**

Student's Name _____ Male Female
Last First Middle

Home Address _____ Telephone No. _____

Birth Place _____ Birth Date _____

Do you feel that your child was delayed in any of the following:

Sitting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Toilet training	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Crawling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Feeding self	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Walking	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Premature birth	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Using simple words	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Normal delivery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Using full sentences	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments:	_____	

Has your child attended nursery school? Yes No Where? _____ For how long? _____

The following questions refer to problems in such areas as hearing, vision, speech, language, and physical, intellectual, social and emotional development.

Do you have any reason to suspect your child might be in need of any special services or considerations in his/her school setting or curriculum? Yes No If Yes, please explain: _____

Has your child ever been evaluated for any condition or problem which might have a bearing on school performance? Yes No If Yes, please explain: _____

Were the recommendations carried out? Yes No Please explain: _____

Would information regarding this evaluation and/or treatment be available for the appropriate school personnel? Yes No

If Yes, please give name(s) and address(es) of person(s) or agency(ies) from whom this information may be obtained:

Is your child presently enrolled in any special school program? Yes No
If Yes, please explain: _____

What words best describes your child?

<input type="checkbox"/> shy	<input type="checkbox"/> self-confident	<input type="checkbox"/> cooperative
<input type="checkbox"/> happy	<input type="checkbox"/> jealous	<input type="checkbox"/> affectionate
<input type="checkbox"/> excitable	<input type="checkbox"/> nervous	<input type="checkbox"/> negative
<input type="checkbox"/> talkative	<input type="checkbox"/> other _____	

Which hand does your child prefer? right left

What words best describe your child's feelings about coming to school?

<input type="checkbox"/> enthusiastic	<input type="checkbox"/> eager	<input type="checkbox"/> fearful	<input type="checkbox"/> happy
<input type="checkbox"/> indifferent	<input type="checkbox"/> apprehensive	<input type="checkbox"/> other _____	

Is your child's speech easily understood by strangers? _____

Does he/she have a speech difficulty? _____

Does your child have any fears, such as:

<input type="checkbox"/> thunderstorms	<input type="checkbox"/> being alone
<input type="checkbox"/> the dark	<input type="checkbox"/> dogs or other animals
<input type="checkbox"/> noises	<input type="checkbox"/> other _____

Does your child have any special problems?

- | | | |
|---|---|--|
| <input type="checkbox"/> vision | <input type="checkbox"/> hearing | <input type="checkbox"/> eating |
| <input type="checkbox"/> nail-biting | <input type="checkbox"/> finger-sucking | <input type="checkbox"/> bed-wetting |
| <input type="checkbox"/> speech | <input type="checkbox"/> stubbornness | <input type="checkbox"/> temper-tantrums |
| <input type="checkbox"/> "accidents" in pants | <input type="checkbox"/> environmental allergies (pollen, etc.) | |
| <input type="checkbox"/> other If so, please list _____ | | |

Does your child have any physical condition that would prevent him/her from participating in an active kindergarten program?

Yes No If Yes, please explain: _____

Does your child play with:

- | | | |
|---|--|---|
| <input type="checkbox"/> brother/sister | <input type="checkbox"/> alone | <input type="checkbox"/> younger children |
| <input type="checkbox"/> older children | <input type="checkbox"/> neighborhood children | <input type="checkbox"/> one close friend |

Has your child had any of the following experiences?

- | | | |
|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> library | <input type="checkbox"/> public park | <input type="checkbox"/> beach |
| <input type="checkbox"/> airplane trip | <input type="checkbox"/> bus trip | <input type="checkbox"/> bank |
| <input type="checkbox"/> camping | <input type="checkbox"/> train trip | <input type="checkbox"/> other _____ |

Can your child:

- | | | |
|---|--|---|
| <input type="checkbox"/> snap | <input type="checkbox"/> zip | <input type="checkbox"/> button |
| <input type="checkbox"/> tie shoes | <input type="checkbox"/> dress self | <input type="checkbox"/> stay willingly with a relative |
| <input type="checkbox"/> stay willingly with a babysitter | <input type="checkbox"/> take care of toilet needs | <input type="checkbox"/> stay willingly with others |

Does your child use at home:

- | | | |
|-----------------------------------|----------------------------------|--|
| <input type="checkbox"/> scissors | <input type="checkbox"/> crayons | <input type="checkbox"/> paste or glue |
| <input type="checkbox"/> puzzles | <input type="checkbox"/> pencils | <input type="checkbox"/> paint |
| <input type="checkbox"/> clay | <input type="checkbox"/> blocks | <input type="checkbox"/> books |

Previous School experiences:

- | | | |
|---|---|-------------------------------|
| <input type="checkbox"/> Head Start | <input type="checkbox"/> religious school | <input type="checkbox"/> None |
| <input type="checkbox"/> nursery school-where & for how long? _____ | | |

Please describe briefly your child's nursery/preschool experience: _____

May we have permission to contact your child's preschool? _____

Is your child able to:

- | | | |
|--|--|--|
| <input type="checkbox"/> identify colors | <input type="checkbox"/> print his/her name | <input type="checkbox"/> count to 10 |
| <input type="checkbox"/> count higher than 10 | <input type="checkbox"/> identify numbers 1-10 | <input type="checkbox"/> count objects to 10 |
| <input type="checkbox"/> identify numbers 10-20 | <input type="checkbox"/> identify alphabet letters | <input type="checkbox"/> count objects to 20 |
| <input type="checkbox"/> listen to and follow directions | <input type="checkbox"/> identify shapes | <input type="checkbox"/> pick up after him/herself |
| <input type="checkbox"/> complete tasks begun | <input type="checkbox"/> tell his/her full name | <input type="checkbox"/> tell his/her phone number |
| <input type="checkbox"/> occupy self with quiet play | <input type="checkbox"/> tell left from right | <input type="checkbox"/> sit and listen to a story |
| <input type="checkbox"/> tell his/her address | | |

Thank you for taking the time to supply us with this information. Your cooperation is appreciated. If there is any other information you feel the school should know, please note it at the bottom of this sheet.

Information supplied by:

Signature of Parent/Guardian **Relationship to Student** **Date**
DO NOT WRITE BELOW THIS LINE

GRADE _____ **BIRTH CERTIFICATE VERIFIED** _____ **NURSE INITIALS** _____ **DATE** _____

**Wachusett Regional School District
Health History**

Child's Name: _____

Sex: _____ **Birth date:** _____

Address: _____

Phone: _____

Physician: _____

Dentist: _____

Please check if your child has any of the following and explain below:

GENERAL HEALTH:

Hospitalizations/Operations? _____

Under care of specialist physician? _____

Take medication regularly? Yes/No

If yes, what is medication taken for?

Any physical restrictions? _____

Sleep well? _____

Good appetite? _____

Any accidents/fractures/injuries? _____

Explain:

ALLERGIES:

Food: _____

Bees: _____

Latex: _____

Eczema: _____

Medications: _____

Gluten: _____

Seasonal: _____

Prescribed Epi-Pen: _____

Explain:

RESPIRATORY:

Asthma? _____

Inhaler use regularly? _____

Nebulizer use? _____

Explain:

IMMUNIZATIONS:

Up to date: _____

Exemptions or defer vaccines: _____

Explain:

EARS, NOSE, THROAT:

Frequent ear infections? _____

Hearing/Speech Issues? _____

Ear tubes? _____

Frequent Strep Throat? _____

Frequent nosebleeds? _____

Dental Issues? _____

Explain:

URINARY/GASTROINTESTINAL:

Frequent UTIs: _____

Pain when urinating: _____

Pain with bowel movement: _____

Constipation Issues: _____

Frequent stomachaches: _____

Food Intolerance: _____

Ability to wipe/toilet independently? Yes/No

Explain:

SKIN:

Frequent rashes: _____

Eczema: _____

Hives: _____

Explain:

EYES:

Wear glasses/contacts: _____

Followed by ophthalmologist for vision concerns: _____

If so, physician name: _____

Referred school vision exam: _____

CARDIOVASCULAR:

Any current/past heart problems: _____

Followed by cardiologist: _____

Explain:

SKELETAL:

Complaints of leg, arm, back, or joint pains: _____

Any back problems/scoliosis: _____

Any limping/hip issues: _____

Explain:

NOTE: No medication can be given at school without written orders from the physician and parent signature. See medication order policy and forms.

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 | |
| <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

Vision:	Pass	Fail	Hearing:	Pass	Fail
Right Eye	<input type="checkbox"/>	<input type="checkbox"/>	Right Ear	<input type="checkbox"/>	<input type="checkbox"/>
Left Eye	<input type="checkbox"/>	<input type="checkbox"/>	Left Ear	<input type="checkbox"/>	<input type="checkbox"/>
Postural Screening (Scoliosis/Kyphosis/Lordosis):	<input type="checkbox"/>	<input type="checkbox"/>	Stereopsis	<input type="checkbox"/>	<input type="checkbox"/>

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:

- | | | | |
|---|-----------------------------------|--|---|
| <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.

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 influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
		4			
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		Measles, Mumps, Rubella (MMR)	1	
	2			2	
	3		Varicella (Var)	1	
	4			2	
	5		Hepatitis A (HepA)	1	
	6			2	
7					
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		Other:	3	
	2				
	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
<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/Practice Name: _____