QUABBIN REGIONAL SCHOOL DISTRICT
KINDERGARTEN REGISTRATION
FOR THE 2009-2010 SCHOOL YEAR

March 3, 2009

Dear Parents:

Kindergarten registration for the 2009-10 school year has begun in the Quabbin Regional School District. Parents of children who will reach their fifth birthday on or before August 31, 2009, should contact the appropriate school as soon as possible to arrange for a registration appointment. Please note: There are no exemptions or exceptions to this age requirement for kindergarten registration.

For your convenience, a listing of the schools in the Quabbin Regional School District, along with their phone numbers, is provided below:

BARRE
Ruggles Lane School
(978) 355-2934

HARDWICK
Hardwick Elementary School
(413) 477-6351

HUBBARDSTON
Hubbardston Center School
(978) 928-4487

NEW BRAINTREE
New Braintree Grade School
(508) 867-2553

OAKHAM
Oakham Center School
(508) 882-3392

Kindergarten registration materials are now available at the District website (www.qrsd.org). Parents who cannot access Kindergarten registration forms by visiting the District website may call the school where their child will enroll to request a packet of materials. Parents are strongly encouraged to complete the entire Kindergarten registration packet prior to their appointment. Please remember to bring the completed Kindergarten registration forms to the appointment.

At the time of registration, parents are required to bring their child's notarized birth certificate, an updated list of immunizations and proof of vision, hearing and lead screenings. Please request these screenings at your child's pre-enrollment physical. The enclosed Massachusetts School Health Record-Health Care Provider's Examination form includes an area for physicians to record the results of vision, hearing and lead screening tests. Parents who have questions should call the main office of the appropriate school or the District's Central Office.

Please contact the school nurse if your child has specific medical conditions or concerns that may require a parent conference.

Kindergarten Screening will be conducted during May and June 2009 at the school where the child will be enrolled. Appointments for Kindergarten Screening will be made by the school during the Kindergarten registration appointment.

Quabbin Regional School District
872 South Street, Barre, MA 01005
Telephone: (9788) 355-4668 Facsimile: (978) 355-6756
www.qrsd.org

QUABBIN REGIONAL SCHOOL DISTRICT

Please bring the following completed documents with you when you bring your child to register for kindergarten:

- Completed *Kindergarten Developmental History* Form;

A completed *Home Language Survey*

- A completed *Student Health History* Form;
- A completed *Massachusetts School Health Record* Form (to be completed by student's physician), which includes:
    - *Health Care Provider's Examination* Form
    - *Certificate of Immunization* Form
- A copy of the student's *Birth Certificate*

At the time of registration, the *Emergency Information* Form will be completed.

DEVELOPMENTAL HISTORY - CONFIDENTIAL (To be kept on file in the Principal's Office)

Parent's KINDERGARTEN ENTRY SCREENING QUESTIONNAIRE

Quabbin Regional School District - Barre, Hardwick, Hubbardston, New Braintree, Oakham

As children grow in different ways and in different rates, we do not expect that all children will respond to school alike. In order to better know your child and provide for him or her as an individual, the following questionnaire has been prepared. We are hopeful that through the cooperative efforts of the home and the school, we will be able to make his or her first experience in school enjoyable and valuable.

Please answer all the items as best as possible. Thank you for your cooperation.

I. **YOUR CHILD'S** PERSONAL DATA:

1. Child's name _______________ _______________ _______________ 2. Date of birth ____________
first middle last Mo/Day/Yr

3. Child's Address ____
Street P.O. Box Town/State/Zip

4. Child's Place of Birth ______________________________ Nickname ______________

5. Father's Name ____
First Middle Last

6. Mother's Name ____
First Middle Last

7. List brothers and/or sisters (names and dates of birth)

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

8. Lives with ( ) Mother & Father, ( ) Mother, ( ) Father, ( ) Step Father/Mother, ( ) Other. If Other, please specify:

Name ____

Relationship ____

Address ______________________________ Phone ______________

9. Is the language spoken at home English? ( ) Yes, ( ) No If No, specify ____________________

II. DEVELOPMENTAL HISTORY:

1. Was your pregnancy without complications? ( ) Yes, ( ) No. If No, please explain

____

2. Were there any complications during labor or delivery? ( ) Yes, ( ) No. If Yes, please explain

____

3. What was your child's weight at birth? ____________ lbs ____________ ozs.

4. Developmental milestones. Please list the ages your child was able to do the following. If you do not know, try to estimate whether it occurred EARLY, NORMAL or LATE.

Sat without support	____________	Used full sentences	____________
Crawled	____________	Rode tricycle	____________
Stood alone	____________	Counted to ten	____________
Walked alone	____________	Toilet trained day	____________
Used single words	____________	night	____________

5. Would you describe your child as a ( ) poor, ( ) normal or ( ) excellent eater?

Don't forget the other side, too =====>

6. Please mention any severe illnesses, high fevers, accidents or hospitalizations that your child has experienced.

Please indicate age at time of illness or injury ____

____

7. Has your child ever been separated from his or her parents for a long or traumatic period of time?

( ) Yes, ( ) No. If Yes, please explain ____

____

III. GENERAL INFORMATION:

1. What words best describe your child?
   ( ) Shy ( ) Confident ( ) Highly active ( ) Excitative
   ( ) Nervous ( ) Cooperative ( ) Affectionate ( ) Distractible ( ) Friendly

2. Is your child ( ) left-handed, ( ) right-handed, ( ) not established.

3. How does your child seem to feel about coming to school?
   ( ) Enthusiastic ( ) Indifferent ( ) Nervous ( ) Fearful
   ( ) Eager ( ) Happy

4. Is your child afraid of:
   ( ) Thunderstorms ( ) Being alone ( ) The dark ( ) Animals ( ) Noises ( ) Insects

5. Does he or she have any special problems? (Please elaborate)
   ( ) Vision ( ) Speech ( ) Hearing ( ) Allergies ( ) Other____________________

   Comments ____

6. Does your child:
   ( ) Finger suck ( ) Bed wet ( ) Have temper tantrums

7. Does he or she enjoy playing:
   ( ) Alone ( ) With other children ( ) One close friend ( ) With brothers & sisters

8. Can he or she:
   Dress him/herself.......Yes No   Zip......Yes No   Button.......Yes No
   Tie shoes....................Yes No   Take care of toilet needs....Yes No

9. Has he or she had previous school experience?
   Head Start..................Yes No   None..........................Yes No   Nursery................Yes No
   Other..........................Yes No   Religious....................Yes No   If yes, please explain
   ____

10. Do you feel that your child can usually:
    Identify colors........................Yes No   Count to ten.....................Yes No
    Identify alphabet letters.........Yes No   Sit and listen to a story....Yes No
    Listen and follow directions...Yes No   Print his/her name...........Yes No
    Tell his/her full name.............Yes No   Tell his/her address.........Yes No
    Occupy him/herself with quiet activities...........Yes No

Thank you for taking the time to complete this questionnaire. Because we expect that all children have a vast range of abilities and experiences, we are hopeful that this information will help us to better provide for him or her as an individual. If you have any questions, please don't hesitate to ask them or to request an appointment.

---> Parent/Guardian Signature ______________________________ ***Date*** ____________

QUABBIN REGIONAL SCHOOL DISTRICT
HOME LANGUAGE SURVEY

Message to Parents

This survey will be used to determine whether or not your child is eligible for English Language Learner (ELL) services from the district. Your child may be eligible because: (1) the student was born outside of the United States; (2) the language the student first learned to speak was other than English (Native Language); or (3) a language, other than English, is spoken by the student or in the home (Home Language). Please complete this form and return it to school promptly. It will then be placed in the child's cumulative folder. Thank you for your cooperation.

Student Information

NAME: ______________________________ DATE: ____________

SCHOOL: ____________________ DATE of BIRTH ____________ GRADE: ____________

I. Student's Place of Birth: ______________________________

If not in US, date of first entry to a US school: ____________________

II. Other than English, are other languages spoken by student or in the home: YES NO

If "YES", what are they? ______________________________

1. What language did the student first learn to speak? ____________________

2. What language does the parent/guardian most often use when speaking to the student?

____

3. What language does the student most often use when speaking to her/his parent/guardian in the home? ______________________________

4. What language does the student most often use when speaking to other family members? ______________________________

5. What language does the student most often use when speaking to friends?

____

6. In what language would the parent/guardian like to receive notices from school?

____

I understand that my child will be given an initial assessment to determine eligibility for ELL services.
The assessment will take place at the child's school during school hours.

Parent Signature ____________________ Date ____________

After an initial assessment, the District will determine if further testing is needed. If the district determines that further assessment is not necessary, parents who wish additional testing may indicate this below:

I request an additional language assessment be completed for my daughter/son.
Parent Initials ____________________ Date ____________

==

To be completed by the English Language Learner Specialist:

Initial assessment completed by: ______________________________

Name Date

Based on initial assessment, additional assessments are needed: Yes No

If Yes, date on which additional assessments will be completed: ____________________

Based on assessments, are additional services needed? Yes No

If Yes, date on which plan was completed (attach copy): ____________________

____

Signature of English Language Learner Specialist Date

KINDERGARTEN REGISTRATION

HEALTH AND WELLNESS ISSUES

1. State requirements for school attendance:

- A physical examination is required for all children within six months of entering school.

- All children must be immunized against diphtheria, pertussis, tetanus (DPT: five doses);

- Measles, mumps and rubella (MMR 2 doses) polio, hepatitis B and show proof of lead screening, unless an exemption is applicable, a varicella vaccine or chicken pox with month and year. Please see page titled "immunization requirements". Documentation of varicella disease or immunization.

2. Childhood communicable/contagious conditions:

Due to the natural curiosity of young children and their willingness to share, it is imperative that contagious/communicable conditions be isolated so as not to spread these conditions.

- Children will be excluded from school for contagious/communicable condition until the condition is resolved or no longer contagious or communicable.

- Acquired Immune Deficiency Syndrome – "all children diagnosed as having AIDS and receiving medical attention are able to attend regular classes." Please refer to policy JHCC on communicable diseases.

3. Medication Policy:

- A Doctor's note is required
-
- The medication must be in the original prescription container.

4. School Screenings:

- Height, weight, hearing and vision screening will be conducted with all kindergarten students.

5. Emergency Cards:

- It is important that the school be able to reach all parents in the event of illness or accidents.
-
- Emergency contacts should be those people with whom you have made arrangements for the care of your child should your child need to be sent home from school.
-

STUDENT HEALTH HISTORY

Dear Parent or Guardian,

To provide better health services to your child, we ask that you complete the following health history form and return to the school nurse. Please use additional paper for details if necessary. Thanks.

STUDENT'S NAME: ____

Date of Birth: _________________________ Grade: __________

Date of Last Physical Exam: ____________________

Does your child have any allergies?..please circle...................YES NO
(Please include bees, animals, wasps, insects, food, medicines, hay fever, ragweed, grass, etc.)
If yes, specify and explain (describe typical reaction, date of last reaction and treatment): __________________
____

Does your child have any health problems, chronic illnesses or physical limitations of which the school should be aware?...please circle...........................YES NO

If yes, specify and give details on reverse side. Condition: ____
Will your child be excused regularly from gym for any reason?…………..please circle.........................YES NO

If yes, explain: ____

Has your child had any operations?...please circle....................................YES NO
If yes, give date(s) & details: Operation ____________________ Year ____ Doctor _____________________

Hospital ____

Has your child been hospitalized for any reason?:.....................................please circle.......................YES NO

If yes, give date(s) and details: ____

Has your child had any accidents?:...please circle.......................YES NO

If yes, list date(s) and injuries: ____

Does your child wear glasses?:...please circle.......................YES NO
If yes: circle all that apply............FULL TIME..........PART TIME..........CLOSE..........DISTANCE
Does your child have any problems with eyes or vision?:..........…..............please circle.......................YES NO

If yes, give details: ____

Does your child have a hearing problem or frequent earaches?:…………..please circle.......................YES NO

If yes, explain: ____

Has your child had trouble with:

Frequent colds........................	YES	NO	Skin rashes.................................	YES	NO
Frequent headaches................	YES	NO	Sleeping problems......................	YES	NO
Frequent nosebleeds...............	YES	NO	Stomach aches...........................	YES	NO
Frequent ear infections...........	YES	NO	Urination....................................	YES	NO
Frequent sore throats..............	YES	NO	Bowel movements......................	YES	NO
Tooth aches...........................	YES	NO	Diarrhea/constipation................	YES	NO

Other (please list): ____

Please explain any of the above circled YES or listed: ____

Don’t forget the other side, too =====>

Please check any of the following your child has had and give date:

[ ] Measles __________	[ ] Diabetes __________	[ ] Pneumonia __________
[ ] German Measles __________	[ ] Seizures __________	[ ] Rheumatic Fever __________
[ ] Scarlet Fever __________	[ ] Epilepsy __________	[ ] Kidney Infection __________
[ ] Whooping Cough __________	[ ] Meningitis __________	[ ] Strep Infection __________
[ ] Mumps __________	[ ] Tonsillitis __________	[ ] Heart trouble (murmur, etc.) ______
[ ] Shortness of breath __________	[ ] Anemia __________	[ ] Asthma __________
[ ] Chicken Pox __________	[ ] Lead Poisoning ________	[ ] Other: ___________________

Does your child receive any medication regularly at home?......………please circle...........................YES NO
If yes, give details: ____

Will your child be receiving any medication regularly at school?......…………..please circle..............YES NO
(NOTE: No medication can be given at school without a written doctor's order and written parent consent. Forms are available from the school nurse.)
If yes, give details: Medication ____
Reason ____

Does your child have dental problems?...please circle.......................YES NO
Date of last check up: ____

If you do not currently have health insurance, the school has information about two opportunities to obtain coverage for your child. Each fall information is sent home with all students about low cost school time or 24 hour accident insurance. In addition, information is available anytime about the Mass Health and the Children's Medical Security Plan (CMSP) for children 19 years and under. Mass Health can give health care coverage for families, children and individuals. CMSP is a no cost/low cost plan providing a variety of out-patients benefits including well-child visits, office visits for illness, emergency care, diagnostic tests and medications. CMSP 1-800-909-2677; Mass Health 1-888-665-9993.

Would you like to receive information on Mass Health/CMSP? [ ] YES [ ] NOT at this time, but I'll call if information is needed.

Please add any other problems or comments you would like to bring to the attention of the school nurse: ______

____

____

____

____

____

____

____

____

____

____ ____________

====>Signature of parent or guardian ***Date***

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) (Pass) (Fail) (Pass) (Fail)

Vision: Right Eye ☐ ☐ Hearing: Right Ear ☐ ☐ Postural Screening: ☐ ☐

Left Eye ☐ ☐ Left Ear ☐ ☐ (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.

______________________________________ ______________________________________

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 01/25/07

CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth:** / / **Sex:** M F

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, HepA-HepB)	1		**Rotavirus** (e.g., RV5: 3-dose series, RV1: 2-dose series)	1	
	2			2	
	3			3	
	4		**Measles, Mumps, Rubella** (MMR, MMRV)	1	
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, Td, Tdap)	1			2	
	2		**Varicella** (Var, MMRV)	1	
	3			2	
	4		**Meningococcal** Conjugate (MCV4) or Polysaccharide (MPSV4)	1	
	5			2	
	6		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	7			2	
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib)	1			3	
	2			4	
	3			5	
	4			6	
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Hepatitis A** (HepA, HepA-HepB)	1	
	4			2	
	5		**Human Papillomavirus** (HPV)	1	
Pneumococcal Conjugate (PCV7)	1			2	
	2			3	
	3		**Other:**		
	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 name:

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
Immunization Requirements for Entry
In the 2009/2010 School Year

Immunization	Kindergarten
Hepatitis B	3 doses
DtaP/DTP/DT/Td	5 doses
Polio	4 doses
Hib	------------
MMR	2 doses measles
	1 dose mumps
	1 dose rubella
Varicella (**OR** physician certified history of Chicken Pox disease)	1 dose

<u>IMPORTANT LEAD PAINT SCREENING INFORMATION</u>

The Department of Public Health requires that all children be screened for lead paint poisoning prior to entering kindergarten. This regulation became effective in 1989.
The lead paint screening is a simple procedure and may be done in the pediatrician's office at the time of a regular visit. Please be sure to have this test completed prior to your child entering kindergarten.