

FALL RIVER PUBLIC SCHOOLS

“The Scholarship City”

Fred Houle
Parent Information Center
and
Student Assignment

Out of District Transfer Registration



2014-2015

“SCHOOLS of CHOICE”

REGISTRATION FORM

Last Name of Child _____ First _____ Middle _____

Address _____ Phone # _____ Attendance # _____

Date of Birth ____/____/____ Age: _____ Gender M F Grade Entering: _____

Name of previous school _____

Address: _____

City/State/Zip: _____

Schools of Choice: 1. _____
2. _____
3. _____

Do you have another child in your first choice school? YES ___ NO ___ Grade _____

Comments: _____

- | | | |
|--|-----|----|
| 1. Do you feel your child will benefit from any daycare programs? | Yes | No |
| 2. Does your child have a Health Plan | Yes | No |
| 3. Are you interested in Adult Basic Education Classes (GED__ESOL__) | Yes | No |
| 4. Are you sharing the housing of other persons due to loss of housing, economic hardship or similar reason? | Yes | No |

***If Yes to any of the above, would you like someone to contact you with information about services to which you may be entitled? Yes No

- I understand that all registration forms must be completed for placement of any child in a "School of Choice" based on criteria outlined in the student assignment policy. (Please check box)
- I understand that **TRANSPORTATION** is to be provided by **Parent/ Guardian**

Signature of Parent/Guardian

Relationship to Child

Date

Intake Person

Date

DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)

Effective Date: _____

Waiting List: _____

Date Release Sent: _____

SPED ELL 504 Plan

Date Letter Sent: _____

School Assigned: Name: _____

Code: _____

District School: Name: _____

Code: _____

Computer Input Person: _____

Fall River Public School of Choice Registration Form

First Name _____

Child lives with _____

Middle Name _____

(parents, mother, father,...ect)

Last Name _____

Parent/ Guardian _____

Gender M F

Date of Birth (m/d/yr) _____ / _____ / _____

Address _____

Grade Entering _____

City **Fall River**

Home Phone _____

State **MA**

Emergency Phone _____

Zip Code _____

County **Bristol**

Home Language _____

Ethnicity: **Circle only one** Hispanic Non Hispanic

Student's city of birth _____

Race: **Circle all that apply** White Black or African American
 Asian American Indian
 Alaska Native Native Hawaiian
 or Pacific Islander

Do parents work for FR Schools? Yes _____ No _____

Parent Signature _____

Parent Name (**Print**) _____

Registration Date _____

Staff Signature _____

For Office Use ONLY

Has student EVER been enrolled in FRPS? YES NO School _____ Grade _____

Has student EVER been enrolled in any MA school YES NO City _____ When _____

Immigrant Status (yes only if student **not** born in the US & **not** in US for 3 Years) **YES** **NO**
 If YES, in what country was student born?

English Proficiency (Can student perform his/her class work in English?) **YES** **NO**

Child is/has been enrolled in a Second Language Learning Program? **YES** **NO**

Child is receiving Special Education Services **YES** **NO**
 If yes...Prototype? _____

Child is receiving Title 1 Services? **YES** **NO**

State Ward/Foster Child / Department of Children & Families (DCF)? **YES** **NO**

RACE, COLOR, SEX, RELIGION, NATIONAL ORIGIN, OR HANDICAP, IN COMPLIANCE WITH THE CHAPTER THE FALL RIVER PUBLIC SCHOOLS ASSURE EQUAL EDUCATIONAL OPPORTUNITIES REGARDLESS OF 622 AND OTHER APPLICABLE STATE AND FEDERAL CIVIL RIGHTS LAWS

Fall River Public Schools

K-12 Student Google Apps for Education Acceptable Use Guidelines

The Fall River Public Schools will be using Google Apps for Education in Grades K-12. These accounts will be used for school related projects only and will provide students with very powerful collaboration and sharing tools including Spreadsheets, Documents, Forms and Presentations. The email feature on all grades 6-12 Google Apps accounts has been restricted to only allow students to send/receive to other @frpsstudents.org or @fallriverschools.org accounts. K-5 students will not be able to use the email feature of Google Apps.

Philosophy

The Fall River Public School District encourages the use of student K-12 Google Apps accounts as an effective and efficient way to improve communication between students and faculty. The primary purpose of student Google Apps is to support teaching and learning.

1. Google Apps Accounts

All K-12 students will be assigned an @frpsstudent.org student Google Apps account. Students will log in with their last two digits of YOG- and their full name @frpsstudent.org.

Example: 11frankfarias@frpsstudent.org.

2. Prohibited Conduct

- Unlawful activities
- Misrepresentation of the Fall River Public Schools
- Sending an attachment that contains a virus
- Unlawfully forwarding or copying material without permission
- Sending emails with any libelous, defamatory, offensive, racist or obscene remarks
- Disguising or attempting to disguise your identity when sending mail
- Attempting to send an email to any domain/address other than @fallriverschools.org or @frpsstudent.org
- Incidents of cyber-bullying* or inappropriate actions while using your account *See district cyber-bullying policy and FRPS Acceptable Use Policy

3. Access Restriction

Access to and use of Google Apps is considered a privilege accorded at the discretion of the Fall River Public Schools. The District maintains the right to immediately withdraw the access and use of Google Apps when there is reason to believe that violations of law or district policies have occurred. In such cases, the alleged violation will be referred to the building principal for further investigation and adjudication.

4. Security

Fall River Public Schools cannot and does not guarantee the security of electronic files located on the Google Apps system.

5. Privacy

The general right of privacy will be extended to the extent possible in the electronic environment. Fall River Public Schools and all electronic users should treat electronically stored information in individuals' files as confidential and private.

There is an acknowledged trade-off between the right of privacy of a user and the need of system administrators to gather necessary information to ensure the continued functioning of these resources. In the normal course of system administration, system administrators may have to examine activities, files, and electronic documents to gather sufficient information to diagnose and correct problems with system software and/or hardware.

Use of Google Apps accounts are strictly prohibited from accessing files and information other than their own. The district reserves the right to access the @frpsstudent.org Google Apps systems when there is reasonable suspicion that unacceptable use has occurred.

6. Questions

If you have any questions or comments about this Email Policy, please contact Frank Farias at 508-675-8420, ext 444, or via email at ffarias@fallriverschools.org. If you do not have any questions the Fall River Public Schools presume that you understand and are aware of the rules and guidelines in this Policy and will adhere to them.

These guidelines and updates will be available on the Fall River Public Schools Web site at <http://www.fallriverschools.org/frpsstudent.cfm>

DECLARATION

I have read, understand, and acknowledge receipt of the K-12 Google Apps for Education policy. I will comply with the guidelines set out in this policy and understand that failure to do so might result in disciplinary action.

Parent/Guardian:

___ I give permission for my child to be assigned an @frpsstudent.org Google Apps account.

Student name: _____HR_____

Parent/Guardian signature: _____

Student:

I agree to adhere to the guidelines stated above for use of my @frpsstudent.org Google Apps account.

Student signature: _____

If you have any questions or concerns, please feel free to call Frank Farias, Google Apps Administrator, at 508-675-8420, ext 444, or email him at ffarias@fallriverschools.org

FALL RIVER PUBLIC SCHOOLS

"The Scholarship City"

Student Registration & Parent Center - 360 Elsbree Street, Fall River, MA 02720

Meg Mayo-Brown, Superintendent

Barbara Allard, Director

New Student Registration STUDENT CONTACT INFORMATION

Students will only be dismissed to contacts who have proper identification and proper contact information on file. Please notify the school of any changes to contact or student information during the school year. Thank you.

Parent/Guardian Signature _____ Date _____

★STUDENT NAME _____ DOB _____ DATE _____

Parent/Guardian #1 _____ Relationship _____ Priority # _____

Yes No *Is this contact, also a contact for another student (present or former) in the FRPS?*

Yes No *Is this contact, also a staff member or student (present or within last 5 years) of the FRPS ?*

Home Address _____ City, State, Zip _____

Mailing Address _____ City, State, Zip _____

Write SAME in mailing address if it matches the home address.

Phone 01 _____ Type _____ Phone 02 _____ Type _____

Home Language _____ E-Mail _____

Yes No *Lives With Student?* Yes No *Has Custody of Student?* Yes No *Can Pickup Student?*

Parent/Guardian #2 _____ Relationship _____ Priority # _____

Yes No *Is this contact, also a contact for another student (present or former) in the FRPS?*

Yes No *Is this contact, also a staff member or student (present or within last 5 years) of the FRPS?*

Home Address _____ City, State, Zip _____

Mailing Address _____ City, State, Zip _____

Write SAME in mailing address if it matches the home address.

Phone 01 _____ Type _____ Phone 02 _____ Type _____

Home Language _____ E-Mail _____

Yes No *Lives With Student?* Yes No *Has Custody of Student?* Yes No *Can Pickup Student?*

Codes for Emergency Priority#

0=Parent/Guardian

1=Family Members

2=Neighbors/Friends

3=Other

Additional Contact Information

Contact _____ **Relationship** _____ **Priority #** _____

Yes No *Is this contact, also a contact for another student (present or former) in the FRPS?*

Yes No *Is this contact, also a staff member or student (present or within last 5 years) of the FRPS ?*

Home Address _____ **City, State, Zip** _____

Mailing Address _____ **City, State, Zip** _____

Write SAME in mailing address if it matches the home address.

Phone 01 _____ **Type** _____ **Phone 02** _____ **Type** _____

Home Language _____ **E-Mail** _____

Yes No *Lives With Student?* Yes No *Has Custody of Student?* Yes No *Can Pickup Student?*

Contact _____ **Relationship** _____ **Priority #** _____

Yes No *Is this contact, also a contact for another student (present or former) in the FRPS?*

Yes No *Is this contact, also a staff member or student (present or within last 5 years) of the FRPS ?*

Home Address _____ **City, State, Zip** _____

Mailing Address _____ **City, State, Zip** _____

Write SAME in mailing address if it matches the home address.

Phone 01 _____ **Type** _____ **Phone 02** _____ **Type** _____

Home Language _____ **E-Mail** _____

Yes No *Lives With Student?* Yes No *Has Custody of Student?* Yes No *Can Pickup Student?*

Contact _____ **Relationship** _____ **Priority #** _____

Yes No *Is this contact, also a contact for another student (present or former) in the FRPS?*

Yes No *Is this contact, also a staff member or student (present or within last 5 years) of the FRPS ?*

Home Address _____ **City, State, Zip** _____

Mailing Address _____ **City, State, Zip** _____

Write SAME in mailing address if it matches the home address.

Phone 01 _____ **Type** _____ **Phone 02** _____ **Type** _____

Home Language _____ **E-Mail** _____

Yes No *Lives With Student?* Yes No *Has Custody of Student?* Yes No *Can Pickup Student?*

Codes for Emergency Priority#

0=Parent/Guardian 1=Family Members 2=Neighbors/Friends 3=Other

FALL RIVER PUBLIC SCHOOLS

"The Scholarship City"

360 Elsbree Street, Fall River, MA 02720

HOME LANGUAGE SURVEY

Dear Parents and Guardians: In order to help your child succeed in school, we ask that you please answer the following questions for each child in your family. Your answers will help us in creating the best possible educational program for your child.

Child's Name (LAST) _____ (FIRST) _____ (MI) _____

Date of Birth _____ Gender: M F Grade _____

Birth Place _____ If outside US -Date of Entry in U.S. _____

Current/Previous School _____ Date first enrolled in any U.S. School _____

1. What language did your child first understand or speak? _____

2. What language do you use most often when speaking with your child at home? _____

3. What language does your child use most often when speaking with you at home? _____

4. What language does your child use most often when speaking with other family members? _____

5. What language does your child use most often when speaking with friends? _____

6. What language(s) does your child read? _____

7. What language(s) does your child write? _____

8. At what age did your child start attending school? _____

9. Has your child attended school every year since that age? Yes No

If no, please explain: _____

10. Would you prefer oral and written communication from the school in English or in your home language?

Please specify language preference: _____

Signature of Parent /Guardian

Date

Proficiency Testing Results and Placement Recommendation:

W-APT Proficiency Level Testing Result	Mass Level - Placement Recommendation
1. Composite Proficiency Level <input type="text"/>	L1 <input type="checkbox"/> Beginner L2 <input type="checkbox"/> Early Intermediate
2. Grade Adjusted Composite Proficiency Level <input type="text"/>	L3 <input type="checkbox"/> Intermediate L4 <input type="checkbox"/> Transitioning
	L5 <input type="checkbox"/> Not LEP (Reclassification Recommended)

CERTIFICATE OF RESIDENCY

It shall be the policy of the Fall River Committee that:

“all children who register and attend Fall River Public Schools at the expense of the citizens of Fall River be a legal resident whose actual principle residence is in Fall River. This policy shall provide equal opportunity to each child regardless of race, color, creed, national origin, sex or handicap.”

1. I understand that _____ must be a resident of the city of Fall River.
(name of student)

2. I certify that _____ is residing with me at the following residence.
(name of student)

3. I certify that I am a legal resident of Fall River. (Attach proof of residency)

4. I am _____ am not _____ Parent/ Legal Guardian.
(name of student)

If guardianship exists, please attach legal documentation.

5. I certify that this living situation is not an arrangement of convenience for the sole purpose of having the Student residing with me to attend Fall River Public Schools.

List the reason (s) for the current living situation. (If this living situation as a result of a marital action for separation/divorce, attach documentation evidencing the custody arrangement)

I understand that enrolling the child named above in Fall River Public Schools is contingent upon the conditions of the Residency Policy, which I have read. I also understand that violation of this policy may result in termination of the child’s enrollment and that I may be liable for this child’s tuition reimbursements.

I hereby certify under the pains and penalties of perjury the information provided above is accurate and true.

(Signature of Guardian, Grandparent, Foster Parent, other relative or other Fall River resident)

Date

FALL RIVER PUBLIC SCHOOLS

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Student Registration & Parent Center - 360 Elsbree Street, Fall River, MA 02720

Meg Mayo-Brown, Superintendent

Barbara Allard, Director

PLEASE FILL THE BLANKS BELOW:

Full Name of Child _____ Telephone _____

Address _____

Date of Birth: Year _____ Month _____ Day _____ City of Birth _____

Name of Father/Guardian _____ Occupation _____

Name of Mother/Guardian _____ Occupation _____

Birthplace of Father/ Guardian _____

Birthplace of Mother/Guardian _____

of Sisters: Older _____ Younger _____ # of Brothers: Older _____ Younger _____

Notice: The following certificates are presented upon enrollment at the Parent Information Center

Birth Certificate _____ Tuberculin Certificate _____

Diphtheria Immunization Certificate _____ Polio Immunization Certificate _____

Measles Immunization Certificate _____ Rubella Immunization Certificate _____

Mumps Immunization Certificate _____ Lead Test _____

Hib _____ Hepatitis B _____

Varivax _____ 2nd M M R _____

Primary Language _____ Student Assignment Specialist _____

Date of last Physical Examination _____ Date _____

FALL RIVER PUBLIC SCHOOLS

Student Registration & Parent Center – 360 Elsbree Street, Fall River, MA 02720

Meg Mayo-Brown, Superintendent

Barbara Allard, Director

RELEASE OF INFORMATION

NAME OF CHILD _____ D.O.B. _____

ADDRESS _____

To assist the above named individual in education and occupational placement, school authorities are requesting your authorization for release of information in accordance with chapter 71 of the General Laws of the Commonwealth of Massachusetts.

I hereby authorize the release of information as requested by colleges, schools, employers and military services to which the above-named individual has applied.

PARENT/ GUARDIAN SIGNATURE

DATE

Send student records to:

Mrs. Barbara Allard
Fall River Public Schools
Student Assignment/
Parent Information Center
360 Elsbree Street
Fall River, MA 02720

FALL RIVER PUBLIC SCHOOLS
STUDENT HEALTH INFORMATION SYSTEM

Please complete the following information below and return to school immediately

School: _____ Grade: _____ Rm: _____

Student's Name: _____
Last Middle First

Home Address: _____ Home Telephone: _____

Date of Birth: _____ Sex: _____ Primary Language: _____

Does your child have health insurance: Yes _____ No _____

If yes, what is the name of the insurance company? _____

If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the school nurse for more information about these programs. All communications will be confidential.

Mother/Guardian/Other _____

Father/Guardian/Other _____

Name & Date of Birth of students' **siblings** in the Fall River School system.

Name	Date of Birth	School

In case of emergency, the school will attempt to contact parent/guardian before calling student's primary care provider (physician). Your child will be transported by ambulance to an emergency care facility if necessary.

Physician Name: _____ **Phone:** _____

Dentist Name: _____ **Phone:** _____

Please list all medications that your child takes:

A written order from a doctor **AND** parent is necessary if medication is to be taken in school. Aspirin and/or over-the-counter medication cannot be given unless above orders and medication are provided by the parent/guardian. Please contact your child's school nurse for the appropriate forms.

Please check all that applies to your child:

Heart Condition Diabetes Asthma Seizure Disorder ADD/ADHD Migraines depression

Other (Specify) _____

Allergies (food, insects, medication, environment) (Specify) _____

Hearing problems (Specify) Left Ear _____ Right Ear _____ Hearing Aids _____

Vision problems (Specify) Wear Eyeglasses _____ Contact Lenses _____

Can your child participate in our physical education program? Yes _____ No _____ If no please explain

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs and to exchange information with my child's primary care physician for the purpose of referral, diagnosis, and treatment.

Parent/Guardian Signature: _____

Date: _____

Tuberculosis Screening for School Children

Recommended Screening Tool from the Medical Advisory Board of Massachusetts Committee for the elimination of Tuberculosis.

NAME OF CHILD: _____

ADDRESS: _____

DATE OF BIRTH: _____ PLACE OF BIRTH _____

HAS YOUR CHILD LIVED OR SPENT TIME WITH ADULTS WHO:

	YES	NO
1. Were homeless, either living on the streets or in a shelter?	_____	_____
2. Have AIDS or are HIV-infected?	_____	_____
3. Used intravenous drugs or other street drugs?	_____	_____
4. Lived in a correctional facility, nursing home or mental institution?	_____	_____
5. Have you ever had a positive tuberculosis skin test?	_____	_____
6. Have you lived or spent time with anyone who was sick or had a positive skin test?	_____	_____
7. Where you born in one of the countries listed on the next page?	_____	_____
8. Have you traveled or lived for more than one month in any of the countries listed on the next page?	_____	_____

YES - TO ANY QUESTIONS - Requires a tuberculin skin test or proof of a negative skin test or note from a doctor.

HIGH RISK

NO - TO ALL OF THE ABOVE QUESTIONS-Means that you are Considered low risk for tuberculosis, and a skin test should not be needed.

LOW RISK

PARENT OR GUARDIAN SIGNATURE: _____

DATE: _____

Massachusetts Department of Public Health**Bureau of Infectious Disease Prevention, Response and services****Division of Tuberculosis Prevention and Control**

The non-U.S. born (defined as persons born outside the United States and its territories) remains the group at highest risk for TB disease in Massachusetts. Of the 261 cases reported in 2008, 215 (82%) occurred in the non-U.S. born (outside of the United States).

Countries with High Rates of Tubercule (TB)**TB Endemic Countries**

Afghanistan	Djibouti	Madagascar	Russia Federation
Algeria	Dominican Republic	Malawi	Rwanda
Angola	DPR No. Korea	Malaysia	Sao Tome & Principe
Armenia	DR Congo	Mali	Saudi Arabia
Azerbaijan	Ecuador	Marshall Islands	Senegal
Bahamas	El Salvador	Mauritania	Seychelles
Bahrain	Equatorial Guinea	Mauritius	Sierra Leone
Bangladesh	Eritrea	Mexico	Solomon Island
Belarus	Ethiopia	Micronesia	Somalia
Benin	Gabon	Mongolia	South Africa
Bhutan	Gambia	Morocco	Sri Lanka
Bolivia	Georgia	Mozambique	Sudan
Bosnia & Herzegovina	Ghana	Myanmar	Suriname
Botswana	Guatemala	Namibia	Swaziland
Brazil	Guinea	Nepal	Tajikistan
Brunei Darussalam	Guinea-Bissau	Nicaragua	Thailand
Burkina Faso	Guyana	Niger	Timor-Leste
Burundi	Haiti	Nigeria	Togo
Cambodia	Honduras	North Mariana Island	Turkmenistan
Cameroon	India	Pakistan	Tuvalu
Cape Verde	Indonesia	Palau	Uganda
Central African Republic	Iraq	Papua New Guinea	Ukraine
Chad	Kazakhstan	Paraguay	UR Tanzania
China	Kenya	Peru	Uzbekistan
China, Hong Kong SAR	Kiribati	Phillippines	Vanuatu
China Macao SAR	Kyrgyzstan	Poland	Vietnam
Colombia	Laos PDR	Portugal	Yemen
Comoros	Lativa	Qatar	Zambia
Congo	Lesotho	Rep.of S. Korea	Zimbabwe
Cote d'Ivoire	Liberia	Rep. of Moldova	
Croatia	Lithuania	Romania	

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ Male Female Date of Birth: _____

Medical

History _____

Pertinent Family History

Current Health History

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
Stereo sis

(Pass) (Fail)

Hearing: Right Ear
Left Ear

(Pass) (Fail)

Postural Screening
(Scoliosis/Kyphosis/Lordosis)

The entire examination was normal:

Targeted TB Skin Testing: Med-to-High risk (exposure to TB; born, lived, traveled 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 01/04/06

Massachusetts Department of Public Health
CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: ____/____/____

Sex: female male

If combination 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			4	
Diphtheria, Tetanus, Pertussis (eg, DTaP, DT, DTaP-Hib DTaP-HepB-IPV,Td, Tdap)	1		Measles, Mumps, Rubella (MMR)	1	
	2			2	
	3		Varcella (Var)	1	
	4			2	
	5		Meningococal Conjugate (MCV4) or Polysaccharide (MP.SV4)	1	
	6			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		Hepatitis A (HepA)	1	
	2			2	
	3		Pneumococcal Polysaccharide (PPV23)	1	
	4			2	
	5		Influenza Inactivated (Intramuscular or Live (Intranasal)	1	
		2			
		3			
Pneumococcal Conjugate (PCV7)	1		Other:		
	2				
	3				
	4				

Laboratory Results: Lead _____ Date _____ 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
<input type="checkbox"/> Check the box if this person has a physician-certified 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: _____

Bring in the following to complete the Registration Process

- Child's Original Birth Certificate*
- Complete Immunization Record including Lead Test*
- Last Complete Physical Exam with Physician's Signature*
- Proof of Residence of Parent/Guardian (ex. Mortgage statement, Rent receipt, Utility bill)*
- I.E.P. – Individualized Educational Plan (if there is one)*

*As a Parent, your involvement
in your child's education
is the key to your
child's success in school.*