CBRSD STUDENT REGISTRATION FORM

LASID (Student Number): _____ SASID: _____

STUDENT INFORMATION

Student Name: _____ Grade: _____
Last First Full Middle

Gender: _____ Date of Birth: _____ Place of Birth: _____
City state country

Residential Address: _____ / /
(*Proof of residency is required. See note below.) Number street apt# town zip code
If born outside of United States, give date of US entry.

Mailing Address: _____ Home Phone: _____
Number street apt# town zip code

Previous Address: _____
Number street apt# town zip code

Ethnicity and Race: PLEASE SEE BACK OF THIS FORM Home Language: _____

FAMILY INFORMATION

Household 1 *(Student's Primary Residence)***:**

Home Phone: _____ Address: _____

Parent 1: _____ Relationship to child: _____

Cell Phone: _____ Work Phone: _____ E-mail: _____

Parent's Military Status: ___ *Active Duty* _____ *Died on Active Duty (DATE)* _____ *Discharged/Retired (DATE)* ___ *None*

Parent 2: _____ Relationship to child: _____

Cell Phone: _____ Work Phone: _____ E-mail: _____

Household 2:

Home Phone: _____ Address: _____

Parent 1: _____ Relationship to child: _____

Cell Phone: _____ Work Phone: _____ E-mail: _____

Parent's Military Status: ___ *Active Duty* _____ *Died on Active Duty (DATE)* _____ *Discharged/Retired (DATE)* ___ *None*

Parent 2: _____ Relationship to child: _____

Cell Phone: _____ Work Phone: _____ E-mail: _____

Guardian/Custodian (Name & Relationship):** _____

**(If student is a ward of the state please note on line above)

Address: _____ Home Phone: _____ Cell Phone: _____

Emergency Contacts:

_____
Name Relationship Phone

_____
Name Relationship Phone

_____
Name Relationship Phone

Siblings in CBRSD:

_____
Name Grade School

_____
Name Grade School

Previous School Information

Last School Attended: _____ Grade: _____

Address of School: _____

Reason for Enrollment:
(Check all that apply) ___ Transfer in District ___ Transfer from Out of State ___ Transfer from a school in Massachusetts

Has student ever attended a school or educational program in Massachusetts? _____

Does student have an I.E.P. (Individual Education Plan)? _____

***(Please provide a copy of your recent real estate tax bill or lease agreement.)**

The revised federal guidelines for reporting student race/ethnicity require that schools offer individuals the opportunity to select one or more races when reporting information on race in federal/state data collections. In addition, race and Hispanic origin are to be considered as two separate and district concepts. This change is being made to comply with the federal Office of Management and Budget (OMB) revisions to the standards for classification of Federal data on race and ethnicity announced in the Federal Register Notice of October 30, 1997.

Therefore, we ask that you please complete the questions below.

Is this student Hispanic or Latino? Select only one below.

_____ **No, not Hispanic or Latino**	(A person having origins in any of the original peoples of Europe, the Middle East, or North America)
_____ **Yes, Hispanic or Latino**	(A person of Cuban, Mexican, Chicano, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

What is this student's race? You may select one or more races below.

_____ **White**	(A person having origins in any of the origin peoples of Europe, the Middle East, or North Africa.)
_____ **Black or African American**	(A person having origins in any of the black racial groups of Africa.)
_____ **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.)
_____ **Native Hawaiian**	(A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

_____ _____

Parent/Guardian's Signature Date

If student has any health or medical issues and/or medication, please see school nurse.

CERTIFICATE OF IMMUNIZATION

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

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			**Measles, Mumps, Rubella** (e.g., MMR, MMRV)	1		
	2				2		
	3			**Varicella** (Var, MMRV)	1		
	4				2		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1			**Meningococcal Quadrivalent** MenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2				2		
	3			**Meningococcal Serogroup B (Men B)** MenB-FHbp MenB-4C	1		
	4				2		
	5				3		
	6			**Seasonal Influenza** Inactivated IIV4, IIV4-ID, IIV3, IIV3-ID, IIV3-HD, RIV3-IM, ccIIV3-IM Live Attenuated LAIV, LAIV4 (quadrivalent)	1		
	7				2		
	8				3		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1				4		
	2				5		
	3				6		
	4				7		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1			**2009 H1N1 Influenza** Inactivated or Live	1		
	2				2		
	3			**Pneumococcal Polysaccharide** (PPSV23)	1		
	4				2		
	5			**Hepatitis A** (HepA, HepA-HepB)	1		
Pneumococcal Conjugate (PCV13, PCV7)	1				2		
	2			**Human Papillomavirus** (9vHPV, 4vHPV, 2vHPV)	1		
	3				2		
	4				3		
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1			**Zoster** (shingles)	1		
	2			**Other:**	1		
	3				2		

Please see next page ➡

CERTIFICATE OF IMMUNIZATION (continued)

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 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)
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):
TB Test Type: ☐ TST ☐ IGRA Date: _____ Result: ☐Positive ☐Negative ☐Indeterminate/Borderline
Referred for evaluation to: _____ Date:_____ ☐ Low risk (no TB test 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 08/15/13*

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF COMMUNICABLE AND VENEREAL DISEASES
600 Washington Street
Boston, Massachusetts 02111

SCHOOL IMMUNIZATION LAW

CHAPTER 76, SECTION 15 OF THE GENERAL LAWS OF MASSACHUSETTS

Section 15.

No child shall, except as hereinafter provided, be admitted to school except upon presentation of a physician's certificate that the child has been successfully immunized against diphtheria, pertussis, tetanus, measles and poliomyelitis and such other communicable diseases as may be specified from time to time by the department of public health.

A child shall be admitted to school upon certification by a physician that he has personally examined such child and that in his opinion the physical condition of the child is such that his health would be endangered by such vaccination or by any of such immunizations. Such certification shall be submitted at the beginning of each school year to the physician in charge of the school health program. If the physician in charge of the school health program does not agree with the opinion of the child's physician, the matter shall be referred to the department of public health, whose decision will be final.

In the absence of an emergency or epidemic of disease declared by the department of public health, no child whose parent or guardian states in writing that vaccination or immunization conflicts with his sincere religious beliefs shall be required to present said physician's certificate in order to be admitted to school.

Central Berkshire Regional School District
Primary Home Language Survey

English Form

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.

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

____/____/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) _____ (mother / father / guardian) _____ (mother / father / guardian)	**Which language(s) 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? **Y** ☐ **N** ☐	**Will you require an interpreter/translator at Parent-Teacher meetings?** **Y** ☐ **N** ☐
At what age did your child start attending school? ☐	**Has your child attended school every year since starting school?** **Y** ☐ **N** ☐
Parent/Guardian Signature: **X**	____/____/20____ **Today's Date:** (mm/dd/yyyy)

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.

School Personnel Completing this survey: _____

Date: _____

If any language other than English is marked, immediately notify the ELE Director (*Stefanie Wondriska-Clark)* and ELE teacher (*Susan Yzerman)*.