

NEW STUDENT REGISTRATION **PITTSFIELD ELEMENTARY SCHOOL**



1.) You will need the following required documents before making an appointment to register your child:

- _____ Birth certificate and legal documentation of any subsequent name change
- _____ Immunization record showing up-to-date immunization dates
- _____ Physical Examination acceptable if completed in past year
- _____ Proof of residence-**Must be a rental/lease agreement OR tax bill** (utility bills or post-marked mail are *NOT* acceptable) NOTE: If living with another family you will need a letter from the family *in addition to* their rental/lease agreement or tax bill
- _____ Custody documentation and/or parenting plan when parents are separated or divorced
- _____ Completion of this registration packet

Required documents included in registration packet:

- ☐ Student registration forms
- ☐ Student release & authorization form
- ☐ Disclosure of directory information
- ☐ Student health & healthcare management forms
- ☐ School/family learning compact
- ☐ Student records release

The following are not required, but are helpful during the registration process:

- Most recent report card
- Individualized Education Plan (IEP)
- Section 504 Accommodation Plan
- Current schedule from previous school
- Test scores (NECAP, NWEA, Smarter Balanced, ACT)

3.) Once the required documents are received, the main office will schedule the registration.

(NOTE: Missing required documents may result in the delay of the registration appointment and/or the student's start date)

4.) If your child has an Individualized Education Plan (IEP) or 504 Accommodation Plan, the Student Services office will contact you to schedule a meeting within 30 days of your child's start date.

NEW STUDENT REGISTRATION FORM

SECTION 1: STUDENT INFORMATION

Student Name: _____
LAST FIRST MIDDLE

Gender: _____ Grade Level: _____ DOB: _____/_____/_____

Birthplace: City/Town: _____ State: _____

Preferred Name (i.e. Liz vs. Elizabeth): _____ Student Cell: _____

Primary Phone Number (to contact parent/guardian): _____

Is the student Hispanic or Latino? (*Circle one*) **YES** **NO**

What is the student's race? (*Check all that apply*) ☐ American Indian/Alaskan Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian/Other Pac Islander ☐ White

SECTION 2: RESIDENCY AFFIDAVIT

Physical Address: _____

Town: _____ State: _____ Zip: _____

Mailing Address (if different from above): _____

Town: _____ State: _____ Zip: _____

Is this a temporary or permanent living arrangement? _____ TEMPORARY _____ PERMANENT

Proof of residence submitted: ☐ Lease agreement ☐ Tax Bill ☐ Already on file at school

I certify that the above information is true and correct and of my own personal knowledge.

Legal Guardian Signature: _____ Date: _____

SECTION 3: GUARDIAN INFORMATION

Please list the guardians below as notated on the student's birth certificate and/or legal adoption

Mother Name: _____ Email: _____

Mother address: _____
Street Town State Zip

Mother Home #: _____ Work #: _____ Cell #: _____

Student lives with Mother? ☐ YES ☐ NO Mother to receive school mailings? ☐ YES ☐ NO

Can we contact the mother for student information (academic, discipline, medical)? ☐ YES ☐ NO

Father Name: _____ Email: _____

Father address: _____
Street Town State Zip

Father Home #: _____ Work #: _____ Cell #: _____

Student lives with Father? ☐ YES ☐ NO Father to receive school mailings? ☐ YES ☐ NO

Can we contact the father for student information (academic, discipline, medical)? ☐ YES ☐ NO

IF SEPARATED, WHO IS THE PRIMARY CUSTODIAL PARENT? _____

GUARDIAN INFORMATION CONTINUED ON FOLLOWING PAGE

SECTION 3: LEGAL GUARDIAN INFORMATION CONTINUED

If student does not live with either parent:

Legal Guardian Name: _____

Relationship to Student: _____

Guardian Home #: _____ Work #: _____ Cell #: _____

SECTION 4: ADDITIONAL HOUSEHOLD MEMBERS

Please list any other adults that live in the same household as the student.

Name: _____ Relationship to student: _____

Home #: _____ Work #: _____ Cell #: _____

Name: _____ Relationship to student: _____

Home #: _____ Work #: _____ Cell #: _____

Name of brothers/sisters at home:

Name: _____ DOB: _____ Grade: _____

Name: _____ DOB: _____ Grade: _____

Name: _____ DOB: _____ Grade: _____

SECTION 5: EMERGENCY CONTACT INFORMATION

In the event of an emergency, the school will attempt to notify the members of the household first.

Please list 3 additional emergency contacts below.

#1 Name: _____ Relationship to student: _____

Physical address: _____

Street

Town

State

Zip

Home #: _____ Work #: _____ Cell #: _____

#2 Name: _____ Relationship to student: _____

Physical address: _____

Street

Town

State

Zip

Home #: _____ Work #: _____ Cell #: _____

#3 Name: _____ Relationship to student: _____

Physical address: _____

Street

Town

State

Zip

Home #: _____ Work #: _____ Cell #: _____

SECTION 6: PREVIOUS SCHOOL INFORMATION

Last school attended: _____ Last day: _____

School address: _____

Street

Town

State

Zip

School Phone: _____ Fax: _____

Does your child have a 504 plan? ☐ YES ☐ NO

Does your child have an IEP? ☐ YES ☐ NO

Does your child receive special education services? ☐ YES ☐ NO

If yes, please state what service(s):

☐ Counseling

☐ Occupational Therapy

☐ Physical Therapy

☐ Resource Room

☐ Self-Contained Room

☐ Speech Therapy

☐ Title I

☐ Para support

☐ Other -specify: _____ ☐ Medical concerns: _____

SECTION 7: HOME LANGUAGE SURVEY

Please list all languages spoken in your home: _____

Which language did your child first hear or speak? _____

If English is the only answer listed above, stop here and sign below. If another language is listed, please answer the remaining questions and sign below.

Which language(s) do you speak to your child? _____

Which language(s) does your child speak at home with adults? _____

Which language(s) does your child speak at home with other children? _____

If a language other than English is listed above, an ESOL teacher will test your child to find out if he or she can speak, understand, read, and write well in English. The results will be sent to you within 30 days. Based on the test results, your child may be eligible to enroll in an English language (ESOL) class at school. Parents/guardians may accept or decline ESOL program services for their child.

Parent/Guardian Signature _____ Date _____

SECTION 8: SCHOOL MESSENGER

Pittsfield School District uses School Messenger, a system used to send messages to guardians via phone calls and emails in the case of an emergency or for Pittsfield School District announcements. Please identify the phone numbers and email addresses you wish to receive these messages.

NOTE: The PRIMARY phone number will receive ALL messages, including emergencies. The EMERGENCY number will ONLY receive emergency messages.

PRIMARY #1: _____ PRIMARY #2: _____

EMERGENCY #1: _____ EMERGENCY #2: _____

EMERGENCY #3: _____

EMAIL 1: _____ EMAIL 2: _____

SECTION 9: SAFETY AND TRANSPORTATION

Pittsfield Elementary School uses a code word, unique to each student, to identify people who have the ability to access information and for purposes of dismissal. Please select a code word below:

PES CODE WORD: _____

TRANSPORTATION INFORMATION

Everyday dismissal, unless I send a note or make a phone call, for my child will be:

- | | | |
|--|---|--|
| <input type="checkbox"/> Walk home | <input type="checkbox"/> Picked up in the Cafeteria | <input type="checkbox"/> Car pick up |
| <input type="checkbox"/> Attend kYdstop | <input type="checkbox"/> Ride the bus home | <input type="checkbox"/> Pre-school parent pick up |
| <input type="checkbox"/> Ride the bus to another location: _____ | | |

In the event that we have an early dismissal because of weather or other emergency, my child will:

- | | | |
|--|---|--|
| <input type="checkbox"/> Walk home | <input type="checkbox"/> Picked up in the Cafeteria | <input type="checkbox"/> Car pick up |
| <input type="checkbox"/> Attend kYdstop | <input type="checkbox"/> Ride the bus home | <input type="checkbox"/> Pre-school parent pick up |
| <input type="checkbox"/> Ride the bus to another location: _____ | | |

STUDENT RELEASE & AUTHORIZATION FORM

WALKING FIELD TRIP

Pittsfield School District students participate in many activities in and around our community. Please sign below only if your child does NOT have permission to participate in walking field trips.

TO OPT OUT OF WALKING FIELD TRIPS, SIGN HERE: _____

INTERNET ACCESS

Pittsfield School District students utilize the internet for many learning experiences. Please refer to the Pittsfield School District Acceptable Use Policy regarding the use of computers, networks, and telecommunications. Please sign below only if your child does NOT have permission to have internet access as outlined by the Acceptable Use Policy.

TO OPT OUT OF INTERNET ACCESS, SIGN HERE: _____

GOOGLE APPS

The Pittsfield School District is a Google Apps for Education School. Students will be assigned Google email accounts as well as collaborative tools associated with Google Docs and calendars. Google Apps are essential for students to create and store digital work for their courses as well as their electronic portfolio. Please sign below only if your child does NOT have permission to use Google Apps.

TO OPT OUT OF GOOGLE APPS, SIGN HERE: _____

INTERNAL VIDEO/AUDIO USE

Our students and teachers recognize that video and audio recordings of students in our classrooms may serve a variety of educational purposes. These recordings are generally used for student performances and instructional or assessment purposes. Parental authorization is required for video and audio recording in school classrooms. This permission does not extend to media releases (see below) and includes only recordings used within our schools and school programs. Please sign below only if your child does NOT have permission to participate in internal video/audio recordings.

TO OPT OUT OF INTERNAL VIDEO/AUDIO RECORDINGS, SIGN HERE: _____

MEDIA RELEASE

The Pittsfield School District takes pride in the work and achievements of its students. Today, we have opportunities to share this work beyond our school community. Examples include exhibition projects, instructional footage, musical concerts, and honor roll lists. We request that you grant permission for your child's name and picture/video footage to be shared with local newspapers, on the school website, and/or with other organizations.

Please sign ONE of the following options:

AUTHORIZATION : MY CHILD'S NAME AND PICTURE/VIDEO CAN BE PUBLISHED SIMULTANEOUSLY.

SIGN HERE: _____

LIMITED AUTHORIZATION : MY CHILD'S NAME AND PICTURE/VIDEO MAY BE PUBLISHED BUT NOT SIMULTANEOUSLY.

SIGN HERE: _____

NO AUTHORIZATION : MY CHILD'S NAME AND/OR PICTURE/VIDEO MAY NOT BE PUBLISHED.

SIGN HERE: _____

STUDENT NAME: _____

Student Signature

Date

Parent/Guardian Signature

Date



DISCLOSURE OF DIRECTORY INFORMATION

The Pittsfield School District recognizes our responsibility to protect the privacy of student information records in accordance with the Family Educational Rights and Privacy Act (FERPA). This and other laws ensure that information collected by the Pittsfield School District can be released only for specific and legally defined purposes.

Under the Family Educational Rights and Privacy Act, the following information is defined as an educational record:

- ◆ Date and place of birth; parent(s) and/or guardian(s) addresses, and parent/guardian emergency contact information
- ◆ Grades, test scores, courses taken, academic activities, and official letters regarding a student's status in school
- ◆ Special education records
- ◆ Disciplinary records
- ◆ Medical and health records collected or maintained at school
- ◆ Documentation of attendance, schools attended, and awards conferred
- ◆ Proof of residency
- ◆ Personal information, such as birth certificates and photographs that would make it easy to identify or locate a student

The Pittsfield School District only classifies the following information found in the student's educational record as directory information. This information identified below will not be released without parental/guardian consent.

- **Name**
- **Grade level**
- **Class assignments**
- **Academic and cocurricular activities**
- **Participation in officially recognized and school-sponsored activities (including sports)**
- **Awards conferred**
- **Student photograph**

Directory information is information contained in the student's educational record that is not considered harmful or an invasion of privacy if disclosed. The primary purpose of directory information is to allow the school district and outside organizations to include information from your child's educational record in certain school publications. Directory information may be provided for the following:

- *Playbill showing your student's role in a drama production or musical concert*
- *Yearbook*
- *Companies who manufacture class rings*
- *Honor roll or award recognition list*
- *Graduation programs*
- *Sports activity sheets*

STUDENT NAME: _____

PLEASE SIGN ONE OF THE FOLLOWING OPTIONS:

I approve the release of directory information as identified by the Pittsfield School District:

SIGN HERE: _____ **DATE:** _____

I do NOT approve the release of directory information as identified by the Pittsfield School District:

SIGN HERE: _____ **DATE:** _____

STUDENT HEALTH FORM

Parent or Guardian to Complete

Student's Name: Last:		First:	Middle:	Sex: M or F	DOB:
School Year:	Grade Level:	Teacher Name:			
Home Phone:	Father's Work/Cell Phone:	Mother's Work/Cell Phone:			
Parent/Guardian(s) Name(s):					

Complete all boxes that apply to your child. Parent or guardian is responsible for providing the school with any medication, special food, or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms.

Over the counter medications available from School Health Office: All doses given per label recommendation, according to age and weight. Please check the ones you give permission for your child to receive at school.

- | | | |
|---|--|--|
| <input type="checkbox"/> ACETAMINOPHEN (Tylenol) | <input type="checkbox"/> CALAMINE LOTION | <input type="checkbox"/> COUGH DROPS |
| <input type="checkbox"/> VASELINE/LIP BALM (Chapped lips) | <input type="checkbox"/> TRIPLE ANTIBIOTIC OINTMENT | <input type="checkbox"/> TUMS |
| <input type="checkbox"/> BENADRYL (Allergic reaction) | <input type="checkbox"/> LIDOCAINE (Burn/Sunburn treatment) | <input type="checkbox"/> IBUPROFEN (Advil) |
| <input type="checkbox"/> BENZOCAINE (Oral pain) | <input type="checkbox"/> HYDROCORTISONE CREAM (Itching/Rashes) | <input type="checkbox"/> SUDAFED PE |
| <input type="checkbox"/> SUNSCREEN | | |

I agree by signing this statement that I will not hold liable the school nurse, deans, or designee, in assisting my child in taking the above named non-prescription medicine.

Student: _____ Parent/Guardian (Print): _____

Parent/Guardian Signature: _____ Date: _____

☐ **I DO NOT** give permission to administer medication at school

My child has a medical condition that may affect his or her school day: ☐ YES ☐ NO (Please Indicate Below)

ALLERGIES

Allergy Type:

- ☐ Bee Sting
- ☐ Medication List medication(s): _____
- ☐ Food List food(s): _____
- ☐ Other List Other: _____

Reactions: ☐ Coughing ☐ Hives ☐ Rash ☐ Difficulty Breathing ☐ Local Swelling ☐ Wheezing

Will supply epinephrine at school ☐ YES ☐ NO *If yes, please complete the Health Management form*

ASTHMA

Triggers: ☐ Exercise ☐ Environmental ☐ Other (list) _____

Physical Education Restrictions: ☐ None ☐ Self-limits ☐ Other _____

Symptoms or reactions:

- ☐ Chest tightness, discomfort or pain ☐ Difficulty breathing ☐ Throat itch, tightness or soreness
- ☐ Coughing hoarseness ☐ Wheezing ☐ Other _____

Date of last hospitalization related to asthma: _____

Will supply inhaler at school ☐ YES ☐ NO *If yes, please complete the Health Management form*

CONTINUE ON REVERSE

DIABETES	
Currently prescribed treatment to be used <i>IN SCHOOL</i> :	
Insulin: <input type="checkbox"/> Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Pump <input type="checkbox"/> Pod <input type="checkbox"/> Blood sugar testing <input type="checkbox"/> Glucagon <input type="checkbox"/> Oral medication(s)	
SEIZURE DISORDER	
Type of seizure: <input type="checkbox"/> Absence (staring, unresponsive) <input type="checkbox"/> Complex partial <input type="checkbox"/> Generalized tonic-clonic (grand mal, convulsive) <input type="checkbox"/> Other (explain): _____	
Date of last seizure: _____ Length of seizure: _____	
MENTAL HEALTH CONCERNS	
<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bi-Polar <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Autism Other: _____	
VISION/HEARING CONDITIONS	
<input type="checkbox"/> Contacts <input type="checkbox"/> Glasses <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Other: _____	
PHYSICAL EDUCATION RESTRICTIONS	
<input type="checkbox"/> NO <input type="checkbox"/> YES (Please explain) _____	
OTHER CONDITIONS OR SPECIAL PROCEDURES	
Please explain: _____	
MEDICAL RELEASE	
I authorize the school's representative(s) to transport, request and authorize treatment for my son/daughter in the event of an accidental injury or illness. I agree that I will not hold this person(s) liable while he/she is acting in accordance to these directions. Copy of this authorization is of equal validity as original document.	
Please check the box that applies: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Parent/Guardian Signature _____	Date _____
Parent/Guardian Name (Please print): _____	
PROVIDER EXCHANGE PERMISSION	
I authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form and any medically relevant concern. <i>This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.</i>	
Please check the box that applies: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Parent/Guardian Signature _____	Date _____
Parent/Guardian Name (Please print): _____	
Physicals and Immunizations: All new registrations to the district must provide a copy of your child's most recent physical exam. Immunization records on file must be current in order to be in compliance with the state law. Your child may not be allowed to begin school or may be excluded from attending until the school nurse receives them. Please refer to the Department of Health and Human Services at www.dhhs.nh.gov or by calling 1-800-852-3345 ext. 4482 for more information.	

Parent or Guardian to Complete

Student's Name: Last:	First:	Middle:	Sex: M or F	DOB:
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School Year:	Grade Level:	Parent/Guardian(s) Name(s):
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MEDICAL PROVIDER(S)

Physician Name: _____

Address: _____ Phone: _____

Dentist Name: _____

Address: _____ Phone: _____

Student's Insurance Company: ☐ No Health Insurance ☐ Medicaid Carrier: _____

☐ Private/HMO: Name of Company: _____

MEDICATIONS

Medications to be given as needed *IN SCHOOL*: (rescue inhaler, epi pen, etc...)

Medication Name: _____ Dose: _____

What does this medication treat? _____

Medication Name: _____ Dose: _____

What does this medication treat? _____

Medications scheduled *IN SCHOOL*: (to be taken at a set time on a regular schedule)

Medication Name: _____ Dose: _____

What does this medication treat? _____

Medication Name: _____ Dose: _____

What does this medication treat? _____

Medications *TAKEN AT HOME*:

Medication Name: _____ Dose: _____

What does this medication treat? _____ Time Given _____

Medication Name: _____ Dose: _____

What does this medication treat? _____ Time Given _____

Please Note: No medication will be given at school until the school nurse receives the appropriate Medication Permission Form and the medication **in the original container, labeled with the student's full name**. Medications that are prescribed by a provider will require an order from the provider. *All medication, prescription or over the counter, must be transported to and from school by a parent/guardian and will be kept in the Health Services office. Certain emergency medications may be carried on the person only with the medical provider's written consent.*

Non-prescription Medication: All non-prescription medication should be delivered to the school nurse directly. It should be in the original container, should include the student's name, name of medication, and reason and times it should be given. The school nurse **MUST** receive the appropriate Medication Permission form for any over the counter medications that are not supplied by the Health Office (*medications that are supplied can be found on the Medical History form*).



SCHOOL/FAMILY LEARNING COMPACT

This Learning Compact is a voluntary agreement between family and school. The purpose of the agreement is to identify a means for family and school to work together to support children's education.

Child's Role. I agree to:

- Come to school ready to learn;
- Maintain a positive attitude;
- Respect myself and others;
- Work hard on school assignments and projects;
- Ask for help when needed;
- Talk with my family about school;
- Complete homework and long-term projects to the best of my ability.

Family Role. I / We agree to:

- Provide a supportive learning environment at home;
- Send my/our child to school regularly;
- Send my/our child to school clean, properly dressed, well fed, and well rested;
- Send my/our child to school prepared to learn with the necessary learning materials;
- Read and respond to communications from school;
- Communicate with school staff in a timely manner regarding any concerns;
- Read to or with my/our child at least four times per week.

School Role. We agree to:

- Provide ways for families to participate in decisions affecting your child's education;
- Provide flexible times for family activities;
- Support all efforts made to help your child learn;
- Support teachers in adapting curriculum to meet the needs of all children;
- Provide the school staff with ongoing professional development around family involvement;
- Assist families in meeting their needs;
- Communicate clearly with children and families;
- Encourage active family participation in all aspects of children's education;
- Help children be prepared to learn.

It is the goal of the Pittsfield Elementary School to promote school success through family involvement and to provide opportunities for family involvement in the social, emotional, and academic growth of children.

By signing this voluntary Learning Compact, we agree to this partnership for school success.

Child Signature

Date

Parent/Guardian Signature

Date

Teacher Signature

Date

Dean of Instruction Signature

Date



PERMISSION TO RELEASE SCHOOL RECORDS

STUDENT'S NAME: _____

DATE OF BIRTH: _____ GRADE: _____

PREVIOUS SCHOOL: _____

SCHOOL ADDRESS: _____

PHONE NUMBER: _____ FAX: _____

THE ABOVE STUDENT HAS ENROLLED IN OUR SCHOOL. PLEASE SEND ALL THEIR PERTINENT ADMINISTRATIVE, EDUCATIONAL, PSYCHOLOGICAL, HEALTH, SPECIAL EDUCATION, TITLE I AND ALL OTHER PERMANENT RECORDS AND TEST RESULTS TO THE FOLLOWING SCHOOL:

PITTSFIELD ELEMENTARY SCHOOL

34 BOW STREET

PITTSFIELD, NH 03263

Phone: 603-435-8432

Fax: 603-435-7358

AUTHORIZATION TO RELEASE STUDENT RECORDS:

Parental permission is no longer required when records are requested by authorized school personnel (Family Educational Rights & Privacy Act, Final Rule on Educational Records, Federal Register, June 17, 1976, vol. 41, No. 118 Page 2473).

School Official Signature _____ Date: _____

School Official Name: _____

School Official Title: _____

FOR OFFICE USE ONLY:

Date Release Sent: _____ Date Records Received: _____