Pre K Registration Packet

526 East Main Street
Norwich, CT 06360
860.823.4386

School _____ **SASID#**_____ **State**____ **PS**____ Entry Date_____ **Class** _____

NORWICH PUBLIC SCHOOLS REGISTRATION FORM

Please print legibly. All items must be completed

Student's Legal Name: _____
Last First Full Middle

Student's Address: _____ **Mailing Address:** _____ **(if different)**

Date of Birth _____ **Male** ☐ **Female** ☐ **Birth City and State:** _____ **Grade**_____

ETHNICITY: Hispanic or Latino: Y or N **Language Spoken at Home** _____

RACE: Check ALL that apply:
☐ American Indian or Alaskan ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander

STUDENT LIVES WITH: ☐Parents ☐Mother ☐Father ☐Guardian ☐Foster ☐Other _____

Parent /Legal Guardian 1: M_____ **Relationship**_____

Address: _____ **Mailing Address:** _____ **(if different)**

Home Phone _____ Cell Phone _____ E-mail _____

Employer _____ Work Phone _____ Military? ☐ Y

Parent /Legal Guardian 2: M_____ **Relationship**_____

Address: _____ **Mailing Address:** _____ **(if different)**

Home Phone _____ Cell Phone _____ E-mail _____

Employer _____ Work Phone _____ Military? ☐ Y

Phone number to call first for attendance calls, school messages _____

Emergency Contact Information: (In case of illness or emergency and you are unable to be reached.

Name_____Relationship_____ Telephone _____

Name_____Relationship_____ Telephone _____

Has this pupil ever attended school in the Norwich School System? ☐ Y ☐N (If *Yes*, answer below)

Name of School _____Grade _____Year_____

School Last Attended (For Kindergarten Students include Preschool if applicable)

_____
Name of School City/State Phone # Grade

Other Children in Family:

Name_____ School _____Grade_____ Relationship_____
Name_____ School _____Grade_____ Relationship_____
Name_____ School _____Grade_____ Relationship_____

Day Care Provider ☐ **A.M.** ☐ **P.M.** _____
Name Address Phone Number

I give my permission to have my child taken to the nearest hospital in case of an emergency.

_____
Signature of Parent/Guardian Date

Pupil's Legal Name *Last* _____ *First* _____ *Full Middle* _____

SUPPORT SERVICES Please check all that apply:

☐ IEP ☐ 504
☐ Emotional Disturbance
☐ Other Health Impairment
☐ Hearing Impairment
☐ Orthopedic Impairment
☐ Speech or Language Impairment
☐ Visual Impairment
☐ Specific Learning Disability
☐ Other _____

Student's Physician: _____ **Phone:** _____

Student's Dentist: _____ **Phone:** _____

CIRCLE AREAS OF CONCERN. WRITE IN IF NOT LISTED.

1. General Health (e.g., fatigue, low energy level, poor sleeping habits, frequent illness, poor posture)
   _____
2. Behavior/personal relationships (e.g., very active, runs away, needs to be center of attention, loner, easily upset, shy has difficulty making friends) -
   _____
3. Specific physical condition/illness past or present (e.g., cerebral palsy, epilepsy, back abnormality, sickle cell anemia, asthma, diabetes, heart problems)
   _____
4. Does this child have a health problem which may require EMERGENCY ACTION while at school (e.g., respiratory or epileptic, heart problem)? ☐ YES ☐ NO If *yes*, please explain:
   _____
   _____
   _____
5. Allergy (e.g., insect stings, foods, drugs, pollen)? Please list:: _____
   _____
6. MEDICINE AT HOME: Please list any prescribed medicine your child may be taking before or after school (not vitamins).
   Medication: _____ Doctor: _____
   NOTE: Medicine may not be taken at school unless a **STATE AUTHORIZED FORM** is filled in by your doctor.
7. May the pupil participate in normal school activities? ☐ YES ☐ NO
   If *No*, PLEASE LIST EXCEPTIONS:
   _____
8. Vision, hearing, speech:
   _____
9. If female: Menstrual (e.g., pain, irregularity, late or early onset)
   _____
10. **If you would like to discuss your child's health with school or school health personnel, please check below**
    ☐ Nurse ☐ Teacher ☐ Principal ☐ Counselor

_____

Signature of Parent/Guardian **Date**

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone / Cell Phone	
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance?	Y	N
Does your child have dental insurance?	Y	N
Does your child have HUSKY insurance?	Y	N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part I — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

***HT**_____in/cm_____% ***Weight**_____lbs._____oz /_____% **BMI**____/____% ***HC**_____in/cm_____% (Birth – 24 months) ***Blood Pressure**_____/____ (Annually at 3 – 5 years)

Screenings

***Vision Screening**
❑ EPSDT Subjective Screen Completed (Birth to 3 yrs)
❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Unable to assess
❑ Referral made to: _____

***Hearing Screening**
❑ EPSDT Subjective Screen Completed (Birth to 4 yrs)
❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	❑ Pass	❑ Pass
	❑ Fail	❑ Fail

❑ Unable to assess
❑ Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ❑ No ❑ Yes

***TB:** High-risk group? ❑ No ❑
Yes Test done: ❑ No ❑ Yes Date: _____
Results: _____
Treatment: _____

***Dental Concerns** ❑ No ❑ Yes
❑ Referral made to: _____
Has this child received dental care in the last 6 months? ❑ No ❑ Yes

*Result/Level: *Date

Other:

***Developmental Assessment:** (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

*IMMUNIZATIONS ❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of an **Asthma Action Plan***
❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: _____
Epi Pen required: ❑ No ❑ Yes
History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:** _____
Seizures ❑ No ❑ Yes: Type: _____

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior
❑ This child has a developmental delay/disability that may require intervention at the program.
❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
❑ No ❑ Yes This child may fully participate in the program.
❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

Child's Name: _____ **Birth Date:** _____ REV. 3/2015

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Influenza						
Tdap/Td						

Disease history for varicella (chickenpox) _____
(Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____
†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born on or after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

NORWICH PUBLIC SCHOOLS
NORWICH SCHOOL HEALTH

YEARLY HEALTH UPDATE

Teacher_____Grade_____
Student Name _____ Date of Birth _____
Home Address_____
LIVING WITH (Please check all that apply)
Y Father Y Stepfather
Name_____Home Phone_____
Employer_____Work Phone_____
Cell Phone_____Beeper_____E-Mail_____
Y Mother Y Stepmother
Name_____Home Phone_____
Employer_____Work Phone_____
Cell Phone_____Beeper_____E-Mail_____
Y Other_____
Name_____Home Phone_____
Employer_____Work Phone_____
Cell Phone_____Beeper_____E-Mail_____

Student's Doctor_____Phone_____Last Visit Date_____
Student's Dentist_____Phone_____Last Visit Date_____
Health Insurance_____Policy #_____

Names of two people (other than parents) whom the school may call, if your child is ill or injured and no one is at home or we cannot reach you at work (local numbers please!) Means of Transportation Required!

1._____Relationship_____Phone_____

2._____Relationship_____Phone_____

IN THE EVENT OF AN EMERGENCY AND YOU CANNOT BE REACHED, YOUR CHILD WILL BE TAKEN TO THE NEAREST HOSPITAL!

OTHER CHILDREN IN THE FAMILY:

NAME	DATE OF BIRTH	RELATIONSHIP TO STUDENT	SCHOOL ATTENDING

IMMUNIZATIONS THAT YOUR CHILD HAS RECEIVED DURING THE PAST YEAR-PLEASE LIST

TYPE/NAME	DATE	PHYSICIAN

ARE YOU INTERESTED IN SCHOOL DENTAL SERVICES FOR YOUR CHILD? _____YES _____NO

Parent/GuardianSignature_____Date_____
_

IMPORTANTCOMPLETE OTHER SIDE
UPDATED HEALTH INFORMATION

FORM # 31-002 2014/2015

HEALTH HISTORY:

Allergies: Yes____ No____ To drugs, food, insects, pollen? Please list_____
_____
Has the allergy required emergency action in the past? Yes_____ No_____
Comments_____
Bee Sting Allergy: Yes____ No_____ Describe reaction_____
_____
Difficulty breathing: Yes____ No____ Emergency Medication? Yes____ No____
Asthma: Yes____ No____ Triggered by: _____
Treatment: _____
M.D. for Asthma: _____
Diabetes: Yes____ No____ Takes Insulin? Yes____ No____
M.D. for Diabetes_____
Epilepsy/Seizures: Yes____ No____ Describe seizure_____
_____
Date of last seizure_____
Medication taken_____
M.D. for seizure _____Phone_____
Heart Condition: Yes____ No____ Describe_____
Restrictions: _____
Medication: _____
M.D. for condition _____Phone_____
Bone/joint problem: Yes____ No____ Describe_____
_____
Restrictions: _____

Check off the following regarding health concerns that pertain to student:

Eyes: __Glasses ___Contacts ___Difficulty seeing ___Reading ___Crossed eyes ___Distance ___Lazy Eye

Ears: _____Frequent infections ____Hearing Aid _____tubes ____R ____L _____Hearing difficulty, explain_____
_____

Other:

____Nosebleed ____Eating ____Sleeping ____Bladder ____Requires Catheterizations
____Lungs ____Headaches ____Dental ____Bowel ____Requires Diapering
____Blood Disorder ____ADD/ADHD ____Menses ____Bedwetting
____Skin Problem ____Blood Pressure ____Phobias
____Frequent Stomach Aches **(Please list reason)** _____

Daily medication at home: Yes____ No____ At school? Yes ____ No____
Emergency Medication: Yes____ No____ At school? Yes ____ No____
Name of medication and reason for taking_____
_____
List serious illness/injuries (Chicken Pox, etc.)_____
_____
Operations/Surgery_____
Conditions preventing PE participation_____
Food Restrictions due to Religious Reasons **(If yes, please list)** _____
_____Requires Specialized Diet **(Please list reason)** _____
_____Requires Specialized Health Care **(Please explain)** _____
_____
Special Education or services: ____LD ____Speech/Language ____OT/PT ____Counseling

If a student requires medication +/or treatment at school or a change in PE participation, please obtain the appropriate forms in the school office.

HEALTH INSURANCE INFORMATION

Child's Name _____

Parent/ Guardian Name _____

Child's Primary Physician _____

Physician's Address _____

Physician's Phone Number _____

Health Insurance Provider _____

Husky _____ Private _____ Not Insured _____

Total# living in the household_____ Approximate annual family income_____

Permission to Release Child:

I (parent/ Guardian)_____ give permission for the following people to pick up my child (child's name)_____ at any time . I understand that the school will not call me to release my child to this person when they arrive. I understand that the pick up person must provide proper identification to the staff before my child will be released.

Name: Phone#

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Parent/ Guardian Signature:_____

Date: _____

NORWICH PUBLIC & NON-PUBLIC SCHOOLS

HEALTH REASONS FOR EXCLUSION FROM SCHOOL

ACUTE GASTROENTERITIS:	**Vomiting** – 2 or more times during the previous 24 hours during schools hours **after assessment by nurse (to determine cause)** **Diarrhea** – 2 or more times during previous 24 hours or if the stool cannot be contained by toilet use or diapers.
CONJUNTIVITIS: (Pink eye)	Exclusion until 24 hours after the start of medication therapy
CONSTANT COUGH:	If a student coughs constantly and disruptively, he should be at home until cough is controlled. **(Nurse must assess and make the decision)**
ERYTHEMA INFECTIOSUM: (Fifth Disease)	NO EXCLUSION
FEVER:	100 degrees or greater, student to remain at home until he/she has 24 hours **FREE** of fever (Afebrile). **Temperature must be within normal limits without the use of fever reducing medication.**
FLU SYMPTOMS:	Fever (Greater than 100°F or 37.7°C) Sore Throat, Cough, Body Aches, vomiting, or diarrhea **Student/Staff to be out for 7 days from onset of symptoms or until symptoms are gone for 24 hours**
HEPATITIS A:	Exclusion for 1 week after onset of illness and/or resolution of jaundice (yellow skin color). Physician note required for school re-entry **(NO EXCEPTIONS)**
HEPATITIS B: (ex. Biting)	NO EXCLUSION unless unusually aggressive behavior is present.
HEPATITIS C: (ex. Biting)	NO EXCLUSION unless unusually aggressive behavior is present.
HERPES SIMPLEX: (Oral, cold sores, fever blisters)	NO EXCLUSION
HERPES ZOSTER: (Varicella-Zoster, Shingles)	NO EXCLUSION (Areas are to be covered). If areas unable to be covered, exclusion for 7 days after onset of rash or until all areas have crusted.
IMPETIGO:	Exclusion until 24 hours after the start of medication therapy and until purulent drainage can be controlled.
MEASLES (Rubeola):	Exclusion for 7 days after onset of rash. Note from physician or school nurse required before re-entry to school.

MONONUCLEOSIS:	Physician to determine if exclusion necessary for health and convalescence of student. Physician note required for activity limitations at school.
MUMPS:	Exclusion until 9 days after onset of Parotitis (Inflammation and swelling of parotid gland). Physician note required for school re-entry.
PEDICULOSIS: **(Head Lice)**	Exclusion until after treatment and nit (egg) free. Parent/adult **MUST** accompany student to school for re-entry. The school nurse **MUST** examine student before school re-entry.
PERTUSSIS: **(Whooping Cough)**	Exclusion for 3 weeks after onset of disease or 5 days after start of medication. Physician note required for school re-entry.
RUBELLA: **(German Measles)**	Exclusion for 7 days after onset of rash. Physician note or exam by school nurse required for school re-entry.
SCABIES:	Exclusion until treatment completed (usually 24 hours)
SCARLET FEVER: **(Scarletina)**	Exclusion until 24 hours after start of medication therapy
STREPTOCOCCAL PHARYNGITIS: **(Strep. Throat)**	Exclusion until 24 hours after start of medication therapy
TINEA CORPORIS: **(Ring Worm)**	Areas must be covered during school hours. Exclusion until 24 hours after start of medication. NO CONTACT SPORTS (i.e. wrestling) until cleared.
TINEA CAPITUS: **(Ring Worm of the scalp)**	Exclusion until 24 hours after start of medication therapy
TUBERCULOSIS: **(Active)**	Exclusion until physician and/or health director state that student is not contagious.
TUBERCULOSIS: **(Contact)**	NO EXCLUSION. Situation will be re-evaluated if student doesn't follow through with diagnostic procedures and prophylaxis, if ordered
VARICELLA: **(Chicken Pox)**	Exclusion for 7 days after onset of rash and/or until all areas have crusted. Physician note or exam by school nurse required for school re-entry. If treated with Zovirax (Acyclovir), physician note required for re-entry stating that Zovirax/Acyclovir ordered.

**** REVIEWED AND REVISED AS NEEDED WITH MEDICAL ADVISORS ****

3/11

SchoolDistrict: _____ School: _____ Grade: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Dr ug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

ALLERGIES: ☐ NO ☐ YES (*specify*): _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(*Type or print*)

Telephone: _____ Fax: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____

Use for Prescriber's Stamp

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a 45 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: _____ Date: _____

Parent's Home Phone #: _____ Work #: _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse in accordance with Board policy.

Prescriber's authorization for self administration: ☐ Yes ☐ No _____
Signature Date

Parent/Guardian authorization for self administration: ☐ Yes ☐ No _____
Signature Date

School nurse approval for self administration: ☐ Yes ☐ No _____
Signature Date

English Language Learner's Survey and School History – English

Norwich Public Schools
ENGLISH LANGUAGE LEARNER'S SURVEY

Child's Name		student ID #	
School		Grade	

Dear Parents/Guardians: In compliance with Public Act 77-588, please complete this questionnaire on behalf of your child.

HOME LANGUAGE In what language do you speak to your child at home?	
In what language does your child respond to you at home?	
What language did your child first speak?	

CHILD'S SCHOOL HISTORY

Has the student ever been in **bilingual classes** (Classes taught in a language other than English)?					Yes		No
If ***yes***, where?	School						
	Town, State						
When?	Dates		Grades				

Has the student ever been enrolled in **ESL** (English as a Second Language) classes (special classes or extra help learning English) in another school district in the United States?					Yes		No
If ***yes***, where?	School						
	Town, State						
When?	Dates		Grades				

CHILD'S RESIDENCE

Is your child entering the United States from another country?		Yes	No
If ***yes***, from which country?			
On what date did your child first enter the United States?			
On what date did your child first attend public school in the United States?	When? Where?		

PARENTS' PREFERRED LANGUAGE FOR OFFICIAL NOTIFICATIONS

In which language would you prefer to receive official notifications from Norwich Public Schools? (Please choose one.)							
English		Spanish		Haitian Creole		Chinese	

SIGNATURE

Name of person completing this form			
Relationship to child		Date	

8/14

11/15

Norwich Public Schools

Student Media Release

School Year
2016/17

I hereby authorize Norwich Public Schools (NPS) to publish photographs or videos taken of my child, their work and etc., and their name, for use in printed publications, videos, and our website(s) and associated social media sites i.e. Blogger, Facebook, Twitter, YouTube, etc. I acknowledge that since my child's participation in media produced by NPS is voluntary, we will receive no financial compensation. This authorization is not revocable as to any use that has already occurred at the time of such revocation. I waive any confidentiality rights as I may have related to such photographs or videos.

I further agree that my child's participation in any media produced by NPS grants to me and/or my child no rights of ownership whatsoever and I and my child assign to NPS any rights of ownership we may have. I release NPS and their employees/contractors from any liability for any claims by me, my child or any third party in connection with such participation.

Does NPS have permission to publish your child? **YES or NO**

Student's Information

Name: _____

Grade: _____

Teacher: _____

School: _____

Parent/Guardian's Information

Name: _____

Phone: _____

Email: _____

Simple as 1, 2, 3...

1. Fill out Form

2. Print

3. Sign

4. Send in to Teacher

Parent/Guardian's Signature: _____

ABBY I. DOLLIVER
SUPERINTENDENT OF SCHOOLS

ATHENA L. NAGEL
BUSINESS ADMINISTRATOR

JOSEPH F. STEFON
DIRECTOR OF CURRICULUM AND INSTRUCTION

MARY DONNELLY
DIRECTOR OF STUDENT SERVICES AND SPECIAL EDUCATION

Bus Drop Off Policy for Pre-Kindergarten and

The safety and well being of kindergarten & preschool students while riding the school bus is very important to all concerned.

The Norwich Board of Education policy reads *"if there is no one home to receive the child, the bus driver returns the kindergarten/preschool child to school."* This practice ensures that the child is supervised and in a safe environment.

All kindergarten & preschool students should wear their nametags when riding the bus during the first week of school. They will receive these nametags from their teachers.

_____

I have read and understand this policy.

Child's Name_____**School**_____

Parent/Guardian's Name (please print) _____

Parent/Guardian's Signature_____**Date**_____

****

Pre School Survey

The Connecticut State Department of Education now requires the following information on all new Kindergarten students. Please complete the following form regarding your child's preschool experience.

Type of Center	*Name of Center*
Licensed Day Care Center	
Public School Preschool	
Head Start Program	
Other (NFA, Project Independence, Mohegan Community Child Center, etc.)	

Retain Original in Cumulative File

Norwich Public Schools

Preschool Program

Child's Name _____

First Aid /CPR Permission

I give Norwich Public Schools permission to administer first aid and or CPR to my Child in case of emergency.

Permission For Field Trips

School Year 2016-2017

My child has permission to take part in school field trips during the school year. I understand I will be notified before each field trip.

Sunscreen Permission

I give permission for the school staff to apply the sunscreen I have sent in with my child.

Parent/ Guardian Signature _____ Date _____

Full Day Preschool Program

Fee Form

Child's Name:_____

Parent/ Guardian's Name:_____

Signature:_____ Date:_____

Name of Each Person Living in the Household	Weekly Gross Income	Other Income such as alimony or unemployment

Family Name_____

Family Size_____ Annual Income_____

Weekly Fee_____

Full Day Preschool

Parent Employment Schedule

Parent/ Guardian's Name:_____

Place of Employment_____

		Parent's work schedule		
MON	**TUES**	**WED**	**THURS**	**FRI**

Parent/ Guardian's Name:_____

Place of Employment_____

		Parent's work schedule		
MON	**TUES**	**WED**	**THURS**	**FRI**

Child's Weekly Attendance Schedule

	Mon	**Tues**	**Wed**	**Thurs**	**Fri**
Daily arrival Time					
Daily Departure Time					

Total Hours Weekly _____

Parent/ Guardian Signature _____ Date _____