



Ipswich Public Schools

IPSWICH MIDDLE SCHOOL/HIGH SCHOOL FORMS CHECKLIST

(Must include one document from each in order to enroll student):

PLEASE CHECK OFF ALL THAT WAS COMPLETED IN THE ATTACHED PACKET

Residency Validation Documents:

1. Evidence of Residency (*check one*)

Mortgage payment or property tax
Lease or Rental payment receipt
Landlord Affidavit and Recent Rental Payment Receipt
Section 8 Housing Agreement

2. Evidence of Occupancy (*check one*)

Recent bill dated within the past 60 days showing Ipswich Address

Gas Bill
Oil bill
Electric Bill
Home Phone Bill
Cable Bill
Excise Tax Bill

3. Evidence of Identification (*check one*)

Valid Drivers License
Valid MA Photo ID Card
Passport

Enrollment Forms

(Please check all forms that were completed in the packet, All forms must be completed in order to enroll the student)

Birth Certificate
Enrollment Form
Authorization for Release of Student Records
Home Language Survey
Ethnicity Form
Mass School Health Record (Health Care Provider's Exam)
Certificate of Immunization
Authorization for Emergency Treatment
Over the Counter Medications
Asthma Record
Military Status Form
Release of Student Information to Military Recruiter (**HIGH SCHOOL STUDENTS ONLY**)
Athletic Student Eligibility Transfer (**HIGH SCHOOL STUDENTS ONLY**)

Please contact Pam Lynch at (978) 356-2935, extension 1110 with any questions. All enrollment forms should be mailed or delivered to the Central Office, One Lord Sq. Ipswich, MA 01938



Ipswich Public Schools

Office of the Superintendent

INFORMATION FROM THE SUPERINTENDENT

RESIDENCY VALIDATION

Please be advised that, according to Massachusetts General Laws Chapter 75, Section 5, the Ipswich Public District is not required to enroll a student who does not reside in our community. The only exception is those students legally enrolled through the State's school choice program.

Under Massachusetts General Laws Chapter 76, Section 5, only students who actually reside in Ipswich may enroll in the Ipswich School District. In order to verify residency within the Town, a student enrolling in the Ipswich School District must provide documentation of actual residence. In addition to providing such documentation at the time of initial enrollment, the school administration may request verification at any later time if there is doubt of actual residence. The School District reserves the right to require additional information to establish residence.

All applicants for enrollment must submit at least one document each from Column A, B, and C and any other documents that may be requested, including but not limited to those from Column A, B, or C (noted below). A parent, guardian, or student who is unable to produce the required documents should contact the Superintendent of Schools.

Column A	Column B	Column C
<u>Evidence of Residency</u>	<u>Evidence of Occupancy</u>	<u>Evidence of Identification</u> (Photo ID)
Record of recent mortgage payment and/or property tax bill	Recent bill dated within the past 60 days showing Ipswich address	Valid Driver's License
Copy of Lease and record of recent rental payment	Gas Bill	Valid MA Photo ID Card
Landlord Affidavit and recent rental payment	Oil Bill	Passport
Section 8 Housing Agreement	Electric Bill	
	Home Phone Bill (Not Cell)	
	Cable Bill	
	Excise Tax Bill	

January 2015



Ipswich Public Schools

STUDENT ENROLLMENT FORM

Date: _____

ID# _____ Homeroom _____ Locker# _____ GRADE _____

Student's First Name _____ Middle Name _____ Last Name _____

Date of Birth _____ Place of Birth _____

Home Address _____ Home Telephone _____

E-Mail Address _____

School Previously Attended: Town/ State _____

Emergency Contact _____ (Relationship) _____

Telephone _____ Cell Phone _____

Emergency Address _____

PARENT OR GUARDIAN INFORMATION

Father/Guardian _____ Mother/Guardian _____

Home Address _____ Home Address _____

Home Phone _____ Home Phone _____

Cell Phone _____ Cell Phone _____

E-Mail Address _____ E-Mail Address _____

Place of Employment _____ Place of Employment _____

Address _____ Address _____

Business Telephone _____ Business Telephone _____

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

Before your son/daughter registers at Ipswich High School, you need to submit the following items:

_____ Transcript

_____ Medical Records



Ipswich Public Schools

☐ Doyon Elementary School
216 Linebrook Road
Ipswich, MA 01938 (fax) (978)-356-8574

☐ Winthrop Elementary School
65 Central Street
Ipswich, MA 01938 (fax) (978) 356-8739

☐ Ipswich Middle School
130 High Street
Ipswich, MA 01938 (fax) (412) 356-8169

☐ Ipswich High School
134 High Street
Ipswich, MA 01938 (fax) (978) 356-3720

AUTHORIZATION FOR RELEASE OF STUDENT RECORDS

Student's Name: _____ Date of Birth: _____

New Address: _____ Phone: _____

Former Address: _____

Check One:

☐ Date of Transfer: _____ Grade: _____

☐ Date of Withdrawal: _____ Grade: _____

From Former School: _____ Phone: _____

Address: _____

To New School: _____ Phone: _____ Fax: _____

Address: _____

RECORDS

Student records are requested upon transfer, outside evaluation, admission to further education or employment. I hereby request that the records indicated below be forwarded to/from the Ipswich Public Schools (as indicated above):

☐ **All contents of cumulative record, including those listed below**

☐ Grade Records

☐ Health Records

☐ Test Scores (Standardized)

☐ School Activities

☐ Attendance Records

☐ Special Education Records, Evaluations, Educational Plans

☐ Discipline Records

☐ Other: _____

Authorized Signature: _____ Date: _____

Print Name: _____

Address: _____ Phone: _____

Relationship to Student: ☐ Parent ☐ Legal Guardian ☐ Student

Home Language Survey

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.

Student Information			
First Name _____	Middle Name _____	Last Name _____	Gender F <input type="checkbox"/> M <input type="checkbox"/>
Country of Birth _____	Date of Birth (mm/dd/yyyy) _____	Date first enrolled in ANY U.S. school (mm/dd/yyyy) _____	
School Information			
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 - <i>grandparents, uncles, aunts, etc.</i> - 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 <input type="checkbox"/> N <input type="checkbox"/>		Will you require an interpreter/translator at Parent-Teacher meetings? Y <input type="checkbox"/> N <input type="checkbox"/>	
Parent/Guardian Signature: X		_____ / _____ /20 Today's Date: (mm/dd/yyyy)	



Ipswich Public Schools

Student's Name: _____

School: _____ Grade: _____

Please answer BOTH questions 1 and 2.

1. Is this student Hispanic or Latino? *(choose only one)*

No, not Hispanic or Latino

Yes, Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)

2. What is the student's race? *(choose one or more)*

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)

Black or African American (a person having origins in any of the black racial groups of Africa)

Native Hawaiian or Other Pacific Islander (a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands)

White (a person having origins in any of the original peoples of Europe, the Middle East, or North Africa)

Parent/Guardian Signature: _____ Date: _____



Ipswich Public Schools

Welcome to Ipswich Middle School/High School Health Services

The State of Massachusetts requires the following health information for all new students:

Grade 6: A current physical (this is defined as a physical given within the current calendar year). All immunizations.

Grade 7: A current physical (see grade 6), plus the following immunizations: A series of three Hepatitis b shots, a second dose of MMR, a Tdap given within the last five years, and physician proof of having had the Chicken Pox or the vaccine.

Grade 8: Same as Grade 7

Grade 9-12: A current physical (defined above). Also immunizations must be current for the student's age and meet the State of Massachusetts requirements.

The above requirements must be on file in the health rooms before your student will be allowed to start school. Please contact Jennifer Reed R.N. at 978-356-3535x253 for any questions or concerns regarding the Middle School.

Marnie Stasiuk L.P.N. can be contacted at 978-356-3137x157 with any questions or concerns regarding the High School.

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.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

Screening:

(Pass) (Fail)
Vision: Right Eye ☐ ☐
Left Eye ☐ ☐
Stereopsis ☐ ☐

(Pass) (Fail)
Hearing: Right Ear ☐ ☐
Left Ear ☐ ☐

(Pass) (Fail)
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:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> 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

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			Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2				2		
	3				3		
	4			Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1				2		
	2			Varicella (e.g., Var, MMRV)	1		
	3				2		
	4			Meningococcal Conjugate (MCV4), Hib-MenCY or Polysaccharide (MPSV4)	1		
	5				2		
	6			Seasonal Influenza <u>Inactivated</u> IIV3, IIV4, cclIV3-IM, IIV3-ID, IIV3-HD RIV3-IM <u>Live Attenuated</u> LAIV, LAIV4	1		
	7				2		
Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1				3		
	2				4		
	3			2009 H1N1 Influenza Inactivated or Live	1		
	4				2		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1			Pneumococcal Polysaccharide (PPSV23)	1		
	2				2		
	3			Hepatitis A (e.g., HepA, HepA-HepB)	1		
	4				2		
	5			Human Papillomavirus (HPV4, HPV2)	1		
Pneumococcal Conjugate (PCV7, PCV13)	1				2		
	2				3		
	3			Other:			
	4						

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

* Must also check Chickenpox History box.

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: <ul style="list-style-type: none"> • 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: _____



Ipswich Public Schools

Emergency Information

In the unlikely event that your child is injured or becomes sick at school, every effort will be made to contact you. Should you be unavailable, and the situation warrant, emergency treatment will be obtained. Depending on the circumstances, your child's physician or dentist identified below will be notified.

To ensure prompt care, please complete the authorization for emergency treatment form below and return it to school.

AUTHORIZATION FOR EMERGENCY TREATMENT

Student's Name: _____ Date of Birth: _____

Home Address: _____

Homeroom Teacher: _____ Grade: _____

Name of Parent/Guardian to be Contacted: _____

Daytime Phone Number: (Home) _____ (Work) _____

Insurance Carrier: _____ Policy # _____

Local person to contact in case parent/guardian cannot be reached: _____

Phone number for emergency contact: _____

Physician: _____ Telephone Number: _____

Dentist: _____ Telephone Number: _____

Other Instructions: _____

I HEREBY AUTHORIZE EMERGENCY TREATMENT FOR THE ABOVE NAMED STUDENT.

(Signature of Parent/Guardian)

(Date)

_____ High School

_____ Middle School

_____ Doyon School

_____ Winthrop School

<p>POLICY MANUAL</p>	<p>Ipswich Public Schools</p> <p>FILE CODE: JHCD</p>
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ADMINISTERING MEDICATION TO STUDENTS

Medication is recognized as beneficial and necessary, but also potentially dangerous and often abused in our society. The Ipswich School Committee wishes to take steps which prevent abuse while ensuring safety and appropriate access for students. Therefore, the following guidelines shall be in effect:

1. The school nurse shall be the supervisor of the medication administration program in the school.
2. No medication shall be allowed or used on school property during school activities without written consent on file from parent or legal guardian. Consent for Medication Administration Forms are available from the school nurse.
3. Medication must be delivered to school in a pharmacy- or manufacturer-labeled container by parent or legal guardian. A parent or legal guardian may designate another adult (age 18 or older) to deliver medication provided the nurse is notified in advance by the parent or legal guardian of the arrangement and the quantity of medication being delivered. No more than a 30-day supply of medication should be delivered.
4. All medications shall be stored in the health office in a securely locked cabinet used exclusively for that purpose. Medication requiring refrigeration shall be stored either in a locked box within a refrigerator or in a locked refrigerator. The sole exception to this shall be epinephrine for the treatment of anaphylaxis, henceforth referred to as EpiPens. EpiPens shall not be stored in a locked cabinet, and may be stored in multiple locations where they can be easily accessed in an emergency.
5. The school nurse shall ensure that there is a proper medication order from a licensed prescriber which is renewed as necessary, including at the beginning of each academic year.
6. A pharmacy-labeled container may be used in lieu of a licensed prescriber's order for short-term medication (those to be administered for ten or fewer school days).
7. Standing orders for non-prescription medications shall be written annually as deemed appropriate by the school physician. Parents shall be advised of standing orders. All other non-prescription medications shall be administered only with the written consent of a licensed prescriber. All medication, whether prescription or non-prescription, shall be administered only upon written consent of a parent or legal guardian.

8. Medication administration may be delegated to teaching and administrative staff as determined by the school nurse per guidelines established by the Massachusetts Department of Public Health. The school nurse, in consultation with the school physician, shall have final decision-making authority with respect to the delegation of administration of medication to unlicensed personnel.
9. The school nurse shall supervise the training of unlicensed personnel consistent with the Massachusetts Department of Public Health's requirement in CMR 210.07 of the Regulations Governing the Administration of Prescription Medications in Public and Private Schools.
10. A school nurse shall be on duty in the school system while medication is being administered by designated unlicensed school personnel, and shall be available by phone should consultation be required.
11. Administration of insulin, Glucagon, Diastat or any other parenteral or non-oral medication may not be delegated, with the exception of EpiPens.
12. Students on field trips may receive medication from the teaching staff as delegated by the school nurse, in accordance with MDPH Regulation CMR 210.005E. The school nurse shall hand this medication to the administering delegated staff, who shall carry the medication. Students shall not carry their own medication on field trips (one day or overnight) except as outlined in #13, below.
13. A student who requires medication – such as an inhaler, EpiPen, cystic fibrosis enzymes, or insulin – may be responsible for taking his/her own medication if the school nurse has determined the following requirements are met:
 1. The student, school nurse and parent/guardian have entered into an agreement which specifies the conditions under which medication may be self administered.
 2. The school nurse has evaluated the student's health status and capabilities and has determined that self-administration is safe and appropriate.
 3. Written consent for self-administration of medication has been obtained from the parent or legal guardian.
 4. Written consent for self-administration has been obtained from the licensed prescriber.
14. All unused, discontinued or outdated medication shall be returned to the parent or legal guardian and the return documented. If the parent or legal guardian cannot be reached or have not picked up such medication after a reasonable amount of time, the medication shall be destroyed by the school nurse and the manner of disposal documented.

15. In the event of a medication error, appropriate and immediate action shall be taken to ensure the health and safety of the student or students involved. All appropriate persons shall be notified, including the school principal, school physician, and the parents or legal guardians of the student or students involved. The error shall be documented by the school nurse on the Medication Incident Form.

Please see 105 CMR 210 for a definition of terms.

Adopted: December 2, 1982

Revision Adopted: April 7, 1988, October 21, 1993

Revision Adopted: November 8, 2001

Revision Adopted: May 5, 2005

Reviewed by Policy Subcommittee on January 12, 2009

Revision Adopted: November 19, 2009



Ipswich Public Schools

FOR MIDDLE SCHOOL STUDENTS ONLY

This year Dr. Spencer Amesbury, School Physician has given his approval for the following Over the Counter Medications to be dispensed in the Health Room with written permission from a student's parent or guardian. Please check which Medications listed below you would allow your son/daughter to receive from the School Nurse.

Jennifer Reed, RN
School Nurse

Student's Name _____

My child may be given: Tylenol _____

 Cepacol Throat Lozenges _____

 Antacids _____

 Midol _____

 Cough Medicine _____

 Anbesol _____

Parent's Signature: _____

Daytime Telephone Number: _____

Date: _____

THIS FORM MUST BE FILLED OUT AT THE START OF EACH NEW SCHOOL YEAR.

Revised 09/12



Ipswich Public Schools

FOR HIGH SCHOOL STUDENTS ONLY

This year Dr. Spencer Amesbury, School Physician has given his approval for the following Over the Counter Medications to be dispensed in the Health Room with written permission from a student's parent or guardian. Please check which Medications listed below you would allow your son/daughter to receive from the School Nurse.

Marnie Stasiuk, LPN

Student's Name _____

My child may be given: Tylenol _____

Advil _____

Cepacol Throat Lozenges _____

Antacids _____

Midol _____

Cough Medicine _____

Anbesol _____

Parent's Signature: _____

Daytime Telephone Number: _____

Date: _____

THIS FORM MUST BE FILLED OUT AT THE START OF EACH NEW SCHOOL YEAR.

Revised 09/12



Ipswich Public Schools

SCHOOL ASTHMA RECORD

Child's Name _____

Date _____

Parent's Name _____

Telephone (home) _____

Address _____

Telephone (cell) _____

Primary Physician _____

1. Briefly describe the child's asthma symptoms: _____

2. Does he/she do breathing exercises that are helpful in managing the asthma? _____
3. Is this child able to participate fully in sports? _____
4. Do certain weather conditions affect your child's asthma? (if so, list them) _____

5. Does exercise induce episodes of asthma? (If so, list the exercises that have done this) _____

6. Describe the daily asthma medication regimen: _____

7. Does your child suffer any side effects to these medications? (If so, list them) _____

8. Does your child understand asthma and his/her management of asthma? _____
9. How do you treat a mild episode ("attack")? _____

10. How do you treat a more serious episode ("attack")? _____

11. Approximately how frequently does the child have an acute episode? _____
12. Please outline what you would like done if the child has a mild episode of asthma/a serious episode of asthma. _____



Ipswich Public Schools

MILITARY STATUS SURVEY

Student Name: _____

1. Do your children have a family member who is or has been in the military that makes them eligible for assistance under the compact?

Yes _____ No _____

2. Choose yes if one of the following applies:

- Active duty members of the uniformed services, National Guard and Reserve on active duty orders
- Members or veterans who are medically discharged or retired within the past year
- Members who have died not covered above
- Department of Defense personnel, federal agency civilians, and contract employees not defined as active duty.



Ipswich Public Schools

FOR HIGH SCHOOL STUDENTS ONLY Consent or Denial of Consent for Release of Student Information to Military Recruiter Or College/University Recruiters

[Copies of this form should be given to student in school as well as being provided to parent]

Under the federal "*No Child Left Behind*" Act, public high schools must give the names, addresses and telephone numbers of students to the U.S. military and college/university recruiters if the recruiters request the information. However, students or their parents have the right to instruct the school in writing that this information is **not** to be released to either the military or colleges or both.

If you do not consent to the release of this information to military recruiters and/or colleges, please check the appropriate box or boxes below. To be certain your wishes are respected, return this form to Ipswich High by 10/14, although signed forms returned after that date will be effective after receipt by the Ipswich High School Office.

- ☐ DO NOT release student contact information to Military Recruiters
- ☐ DO NOT release student contact information to College or University Recruiters

Student's name: _____

Name of School: _____

Signature of Student or Parent***: _____

Date signed: _____

***Students have the right to request that their contact information not be released to recruiters. Parents can override a child's decision by notifying the school in writing, only if the student is under 18. We encourage Parents and students to discuss this information.

“No Child Left Behind” Act
Passed January 2002
20 USC §7908

§7908. ARMED FORCES RECRUITER ACCESS TO STUDENTS AND STUDENT
RECRUITING INFORMATION

(a) Policy.

- (1) Access to students recruiting information. Notwithstanding section 444 (a)(5)(B) of the General Education Provisions Act and except as provided in paragraph (2), each local educational agency receiving assistance under this Act shall provide on a request made by military recruiter or an institution of high education, access to secondary school students names, addresses, and telephone listings.
 - (2) Consent. A secondary school student or the parent of the student may request that the student’s name, address, and telephone listing described in paragraph (1) not be released without prior written parental consent, and the local educational agency or private school shall notify parents of the option to make a request and shall comply with any request.
 - (3) Same access to students. Each local educational agency receiving assistance under this Act shall provide military recruiters the same access to secondary school students as is provided generally to post secondary educational institutions or to prospective employers of those students.
- (b) Notification. The Secretary, in consultation with the Secretary of Defense, shall, not later than 120 days after the date of enactment of the No Child Left Behind Act of 2001 [enacted Jan. 8, 2002], notify principals, school administrators, and other educators about the requirements of this section.
- (c) Exception. The requirements of this sections do not apply to a private secondary school that maintains a religious objection to service in the Armed Forces if the objections is verifiable through the corporate or other organizational documents or materials of that school.
- (d) Special rule. A local educational agency prohibited by Connecticut Stat law (either explicitly by statute or through statutory interpretation by the State Supreme Court or State Attorney General) from providing military recruiters with information or access as required by this section shall have until May 31, 2002, to comply with that requirement.

Ipswich High School Athletic Department

134 High Street Ipswich, MA 01938

Phone: 978 356-3137 ext. 193

Fax: 978 356-3720

Email: ipsath@ipswichschools.org

Thomas E. Gallagher, Jr.
Director of Athletics

Student Eligibility/Transfer Form

Name: _____ Address: _____

City: _____ Home Phone: _____

Work/Cell Phone: _____ Email: _____

Student's Current Age: _____ Student's Date of Birth: _____

Date Enrolling at Ipswich High School: _____

Name and location of your previous school: _____

Are you interested in participating in our athletic program? Yes No

If you answered "yes" please complete the following questions:

1. Which sport(s) do you wish to play? _____

2. Name the sports/levels played at your previous school: _____

3. Reason for transfer to Ipswich High School: _____

4. Have you ever repeated a grade? _____

5. Have you ever not attended school on a regular basis? _____

For office use only:

THIS FORM SHOULD BE FORWARDED TO THE ATHLETIC DIRECTOR