Ipswich Public Schools

1 Lord Square, Ipswich MA 01938 Phone: 978-356-2935 Fax: 978-356-0445

ELEMENTARY SCHOOL
Student Enrollment Checklist

Student Full Name:
Date of Birth:
Grade Enrolling: __Kindergarten __Grade 1 __Grade 2 __Grade 3 ___Grade 4 __Grade 5

Residency Validation Documentation

You must provide ONE from each list

1. **Evidence of Residency (check one)**

☐ Mortgage Payment or Property Tax ☐ Lease or Rental Payment Receipt

☐ Deed ☐ Notarized letter from homeowner (if no lease)

2. **Evidence of Occupancy (check one)**

☐ Utility Bill (Gas, oil, electric, etc.) ☐ Excise Tax Bill

☐ Cable Bill

3. **Evidence of Parent/Guardian Identification (check one)**

☐ Valid Driver's License ☐ Valid MA Photo ID Card

☐ Passport

Enrollment Forms MUST Include the Following:

☐ Birth Certificate	☐ Home Language Survey
☐ Immunization Record	☐ Ethnicity Form
☐ Most Recent Physical (within 1 year)	☐ Military Status Survey
☐ Authorization for Release of Records	☐ Health History
☐ Student Enrollment Form	☐ Health Update/ Authorization for Medical Treatment
☐ Personal Inventory Form (**Grades K-5 ONLY)**	☐ Early Childhood Education Experience Survey **(K ONLY)**
☐ Contact Information Update Form	☐ Residency Validation Documents

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Authorization for Release of Student Records

Grades 1-12

__ Paul F. Doyon Memorial School
216 Linebrook Road
Ipswich, MA 01938 (fax) 978-356-8574

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

__ Ipswich Middle School
130 High Street
Ipswich, MA 01938 (fax) 978-412-8169

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

Student's Name:_____ Date of Birth:_____

New Address:_____ Phone:_____

Former Address:_____

*****

From Former School: _____ Phone:_____

Address:_____

To New School:_____ Phone:_____

Address_____ Fax:_____

*****

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 Record
__ Test Scores (Standardized)
__ Attendance Records
__ Discipline Records
__ Health Records
__ School Activities
__ Special Education Records, Education Plans, Evaluations
__ Other _____

*****

Authorized Signature:_____ Date: _____

Print Name:_____

Address:_____ Phone:_____

Relationship to Student: __ Parent __ Legal Guardian __ Student

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Student Enrollment Form

1. **Student Information:**

First Name:_____ Middle Name:_____ Last Name:_____

Preferred Name:_____ Gender: _____ Grade Entering:_____)_____

Date of Birth:_____ Place of Birth: _____

Home Address:_____

Primary Phone: _____ Email Address: _____

Language(s) Spoken at Home:_____

***

Student Lives Primarily With: _____

Other Children in Household: Date of Birth:

_____

_____

***

Please specify if student has a sibling at either DOYON or WINTHROP (**Elementary Enrollment ONLY**): _____

Does the student have the following: ___ Individualized Education Plan (IEP) ___504 Accommodation Plan

2. **Parent or Guardian Information:**

Parent 1:_____	Parent 2:_____
Home Address:_____	Home Address:_____
Primary Phone:_____	Primary Phone:_____
Second Phone:_____	Second Phone:_____
Email:_____	Email:_____
Occupation:_____	Occupation:_____
Place of Employment:_____	Place of Employment:_____

3. **Emergency Contact:**

Emergency Contact:_____ Relationship: _____

Primary Telephone: _____ Second Telephone:_____

Address:_____

Emergency Contact:_____ Relationship: _____

Primary Telephone: _____ Second Telephone:_____

Address:_____

4. **Family Educational Rights and Privacy Act (FERPA)**

The Family Educational Rights and Privacy Act (FERPA), the federal law concerning access to student records, directs that:
An educational agency or institution shall give full rights under the Act to either parent, unless the agency or institution has been provided with evidence that there is a court order, state statute or legally binding document relating to such matters as divorce, separation, or custody that specifically revokes these rights.

Similarly, the Massachusetts Student Records Regulations (603 CMR 23.00) define a "parent" as:
A student's father or mother, or guardian, or person or agency legally authorized to act on behalf of the child in place of or in conjunction with the father, mother, or guardian. The term as used in 603 CMR 23.02 shall include a divorced or separated parent, subject to any written agreement between parents or court order governing the rights of such a parent that is brought to the attention of the school principal.

As of 1998, Massachusetts law (General Laws Chapter 71, Section 34H) specified detailed procedures that govern access to student records by parents who do not have physical custody of their children.

So that we can implement student records laws appropriately and communicate with you concerning news and school events pertaining to your child, please provide the following information.

Please check one (1) of the following:

The student lives with:

☐ Both Parents Parent 1: _____ Parent 2: _____

☐ Guardian(s):_____

☐ Parents share custody of this child

Parent 1 Address:_____

Parent 2 Address:_____

☐ Parents do NOT share custody. However, the non-custodial parent may have access to school records, teacher conferences, report cards, etc. (If not, as the custodial parent you must provide the school with legal documentation that supports your position.

☐ There are issues of custody. (Please speak with the school principal)

Parent/Guardian Signature:_____ Date:_____

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Elementary School Personal Inventory Form

The following information will help the school understand your child better.

Please check which of the following you observe in your child:

___ nail biting	___ becomes discouraged easily	___ selfish
___ thumb sucking	___ has many fears	___ excitable
___ bed wetting	___ is independent	___ angers easily
___ nightmares	___ fearful of strangers	___ very easy to manage
___ shyness	___ is generous with playmates	___ is orderly
___ happy disposition	___ has many friends	___ is a leader
___ sleeps soundly	___ prefers to be alone	___ is jealous
___ feeds him/herself	___ helpful around home	___ plays with older children
___ plays only with siblings	___ prefers screen time over play	

What time does your child usually go to bed? _____ And get up? _____

Do they eat breakfast? _____ Lunch?_____ Dinner? _____

Do you wish to comment on your child's eating habits, appetite, favorite foods, etc.?

_____

_____

What does your child like to do when they are not in school?

_____

_____

What has been your child's reaction to previous group experiences (camp, preschool, etc.)?

_____

_____

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Elementary School Personal Inventory Form

Developmental History:

Were there any difficulties in connection with the pregnancy or birth of this child? If so, what?

_____

_____

Was this a premature birth? _____ If so, how many weeks/months premature? _____

At what age did your child first...

First put words together:_____ Acquire bowel control:_____

First walked:_____ Acquire bladder control:_____

What problems, if any, did you have in feeding your child during infancy?

_____

_____

Pediatrician's Name:_____ Phone Number: _____

Date of last visit to the Pediatrician: _____

For what reason did you last take your child to a private physician or clinic?

_____

_____

Do you take your child to the dentist? _____ How often? _____ Date of last visit: _____

Dentist's Name:_____ Phone Number:_____

Are there any concerns or other matters which you would like to discuss with the school staff?

_____

_____

_____

_____

Parent/Guardian Signature:_____ Date:_____

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Contact Information Update

The Blackboard Connect system allows for two types of messages to be sent, an outreach message or an emergency message. **An outreach message will be sent only to the Primary phone contact and the Primary email address**. An emergency message will be sent out to all contact numbers and email addresses.

Please list below your contact information in the order of which you wish to be contacted. Please indicate all phone numbers as a home, cell, or work number.

Phone Numbers

Used for the Blackboard Connect Outreach/Emergency system

Primary Contact:

Name:_____ Phone Number:_____

Please circle one: Cell Home Work

Second Contact:

Name:_____ Phone Number:_____

Please circle one: Cell Home Work

Third Contact:

Name:_____ Phone Number:_____

Please circle one: Cell Home Work

Email Address

Used for the Blackboard Connect Outreach/Emergency system

Primary Contact:

Name:_____ Email:_____

Second Contact:

Name:_____ Email:_____

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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

_____ 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 primary language used in the home, regardless of the language spoken by the student? _____	**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?** _____
How many years has the student been in U.S. Schools? (not including pre-kindergarten) _____	**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** ☐ **If yes, what language?** _____	**Will you require an interpreter/translator at Parent-Teacher meetings?** **Y** ☐ **N** ☐ **If yes, what language?** _____
Parent/Guardian Signature: **X**	____/____/20____ **Today's Date:** (mm/dd/yyyy)

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Student Ethnicity Form

Student Name:_____

School:_____ Grade: _____

Please answer BOTH questions 1 and 2:

1. **Is this student Hispanic or Latino? (please 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? (please all that apply)**

☐ 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 people of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam)

☐ Black or African American (a person having origins in any of the original people 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 Signature: _____ Date: _____

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Military Status Survey

Student Name:_____ Date:_____

Massachusetts is a member of the Interstate Compact on Educational Opportunity for Military Children (ICEOMC). This compact is an agreement among U.S. states that aims to remove barriers to educational success for children of military families. The goal is to make transitions easier for military children by standardizing certain educational policies, such as school enrollment, course placement, and graduation requirements, to reduce the impact of frequent relocations.

Please complete this form ONLY if any of the following statements apply:

There is a Parent/Guardian in the student's household who (Check ALL that apply):

- ☐ Is an active member of the uniformed services, including members of the National Guard and Reserve on active full-time duty orders and uniformed members of the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA), and the United States Public Health Services (USPHS)

- ☐ Is a member or veteran who is medically discharged or retired for a period of one year after discharged or retirement date**

- ☐ Is a member who died on active duty for a period of one year after date of death**

**Date of discharge, retirement, death, or deployment:_____

Parent/Guardian Signature:_____ Date:_____

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Welcome to Ipswich Elementary School Health Services

Please complete the Annual Health History Update and Authorization for Emergency Treatment forms included in this packet. In addition, please include the following information/documents:

❒ Current proof of physical from your child's Primary Care Provider (PCP). Physicals must be dated within 13 months of enrollment date.

❒ Up to date immunization record; see below for requirements. For vaccine exemption, proper documentation must be on file prior to enrollment as per state law.

❒ Parent and Provider Forms for students who require prescription medications during the school day. (Please contact School Nurse for these forms)

Hib	**1-4 doses;** the number of doses is determined by vaccine product and age the series begins
DTaP	**4 doses**
Polio	**3 doses**
Hepatitis B	**3 doses;** laboratory evidence of immunity acceptable
MMR	**1 dose;** must be given on or after the 1st birthday; laboratory evidence of immunity acceptable
Varicella	**1 dose;** must be given on or after the 1st birthday; a reliable history of chickenpox* or laboratory evidence of immunity acceptable

For questions or concerns, please contact your child's school specific nurse.

Paul F. Doyon Memorial School: Mary Sforza, BSN, RN, (978) 356-5506

Winthrop School: Jon Stafford, BSN, RN, (978) 356-2976

Ipswich Public Schools
Health History Form

Student Name:_____ **DOB:**_____ **Age:**_____ **Grade:**_____

Allergies: Please list and describe any allergies (food, drug and/or environmental):

Allergy	**Reaction** Include trigger(s) for food allergies	**Treatment**

Food Restrictions (vegetarian, etc.)**:**_____
Health Conditions (Check all that apply)**:**

__ ADD/ADHD		__ Mental health condition	
__ Asthma/Respiratory condition	__Inhaler	__ Neurologic condition	
__ Autism		__ Operation	
__ Blood disorder		__ Scoliosis	
__ Dental injuries, braces		__ Seizure disorder	
__ Diabetes		__ Skin condition	
__ Ear infections/impairment	__ Hearing aids __cochlear implants	__ Speech condition	
__ Frequent sore throats/strep		__ Substance abuse	
__ GI conditions (crohn's. reflux)		__ Urinary condition	
__ Headaches/ migraines		__ Vision impairment	__Glasses __ Contacts
__Heart condition		__Other:	
__ Hospitalization			

Current Medications: If your child requires specific medication during the school day, please contact your school nurse. Certain forms MUST be completed for medication to be dispensed during school hours.

	Name(s) and Dose(s)
Given at school:	
Taken at home:	

Is there any condition that would prevent your child from participating in physical education or sports?
If yes, please describe:_____

Is your child followed by any specialty physicians/providers?
If yes, please list:_____

Please list any additional concerns or pertinent information:_____
_____
_____

***I give permission for the school nurse to share information with the child's teacher(s) as needed for the benefit of my child's health and educational needs.* _____ YES _____ NO**

Parent Signature:_____ Printed Name:_____ Date:_____

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Student Name:_____ Date of Birth:_____ Grade:_____

Home Address: _____

Parent/Guardian 1:_____ Relationship:_____

Primary Contact Number:_____ Secondary Contact Number :_____

Parent/Guardian 2: _____ Relationship:_____

Primary Contact Number : _____ Secondary Contact Number :_____

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

Relationship: _____ Phone Number:_____

Permission to Receive Over the Counter (OTC) Medications

The School Nurse has my permission to administer the following medications (check all that apply):

_____ Ibuprofen (Advil, Motrin)

_____ Tylenol (acetaminophen)

_____ Cough syrup (Robitussin)

_____ Cough drops

_____ Tums

_____ Sunscreen (>30 SPF)

_____ Bug Repellent (<30 DEET)

_____ Other:

Parent Signature:_____ **Date:**_____

Consent for Medical Professional Collaboration

There may be occasions on which the school nurse may need to contact your physician or dentist for health information. If you agree to this communication, please sign below.

I give permission for the school nurse to contact my child's provider(s) when necessary: **___ YES ___ NO**

Signature:_____ Date:_____

Insurance Carrier:_____ Physician:_____

Other Instructions/Concerns:_____

I HEREBY AUTHORIZE EMERGENCY TREATMENT FOR THE ABOVE NAMED STUDENT.

Signature of Parent/Guardian:_____ Date:_____

If your contact information has changed from last year, please indication by checking here:_____

Early Childhood Education Experience Survey

Please check next to the option that best describes your child's preschool experience in the school year prior to entering Kindergarten. Select one option only, and indicate hours where applicable. Thank you!

Name of child: _____ Date of Birth: _____

☐ My child did not have any formal early childhood program experience

☐ My child did not have formal early childhood program experience but participated in Coordinated Family and Community Engagement (CFCE) services.

☐ My child did not have formal early childhood program experience but participated in Parent Child Home Program (PCHP) services.

☐ My child did not have formal early childhood program experience but participated in **BOTH** Coordinated Family and Community Engagement (CFCE) **AND** Parent Child Home Program (PCHP) services.

☐ My child attended a Licensed Family Child Care Provider **(indicate hours below)**

___ for less than 20 hours per week

___ for 20+ hours per week

☐ My child attended a Center Based Program **(indicate hours below)**

___ for less than 20 hours per week

___ for 20+ hours per week

☐ My child attended **BOTH** a Licensed Family Child Care Provider **AND** a Center Based Program **(indicate hours below)**

___ for less than 20 hours per week

___ for 20+ hours per week

Definitions:

Coordinated Family and Community Engagement (CFCE) Services: locally based programs serving families with children birth through school age (e.g. parent/child playgroups, parent-child activities).

Parent Child Home Program (PCHP): home visiting model program funded through the Department of Early Education and Care.

Licensed Family Childcare**:** refers to EEC licensed child care in a group setting in a home. It may include care in the home of a family member, if the provider is both a relative and an EEC licensed child care provider providing care to children from multiple families.

Center-Based Care: refers to care for children in a group setting, including public and private preschools, Head Start, day care centers, and integrated public preschools.