



# 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
- Deed
- Lease or Rental Payment Receipt
- Notarized letter from homeowner (if no lease)

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

- Utility Bill (Gas, oil, electric, etc. )
- Cable Bill
- Excise Tax 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:

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



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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: \_\_\_\_\_

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Student Lives Primarily With: \_\_\_\_\_

Other Children in Household: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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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:*

<input type="checkbox"/> nail biting	<input type="checkbox"/> becomes discouraged easily	<input type="checkbox"/> selfish
<input type="checkbox"/> thumb sucking	<input type="checkbox"/> has many fears	<input type="checkbox"/> excitable
<input type="checkbox"/> bed wetting	<input type="checkbox"/> is independent	<input type="checkbox"/> angers easily
<input type="checkbox"/> nightmares	<input type="checkbox"/> fearful of strangers	<input type="checkbox"/> very easy to manage
<input type="checkbox"/> shyness	<input type="checkbox"/> is generous with playmates	<input type="checkbox"/> is orderly
<input type="checkbox"/> happy disposition	<input type="checkbox"/> has many friends	<input type="checkbox"/> is a leader
<input type="checkbox"/> sleeps soundly	<input type="checkbox"/> prefers to be alone	<input type="checkbox"/> is jealous
<input type="checkbox"/> feeds him/herself	<input type="checkbox"/> helpful around home	<input type="checkbox"/> plays with older children
<input type="checkbox"/> plays only with siblings	<input type="checkbox"/> 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.?

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

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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?

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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?

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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?

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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?

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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			
_____ 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			
____/____/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 - <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?  _____		
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 <input type="checkbox"/> N <input type="checkbox"/>  If yes, what language? _____	Will you require an interpreter/translator at Parent-Teacher meetings?    Y <input type="checkbox"/> N <input type="checkbox"/>  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	<b>1-4 doses;</b> the number of doses is determined by vaccine product and age the series begins
DTaP	<b>4 doses</b>
Polio	<b>3 doses</b>
Hepatitis B	<b>3 doses;</b> laboratory evidence of immunity acceptable
MMR	<b>1 dose;</b> must be given on or after the 1 <sup>st</sup> birthday; laboratory evidence of immunity acceptable
Varicella	<b>1 dose;</b> must be given on or after the 1 <sup>st</sup> 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):

<input type="checkbox"/> ADD/ADHD		<input type="checkbox"/> Mental health condition	
<input type="checkbox"/> Asthma/Respiratory condition	<input type="checkbox"/> Inhaler	<input type="checkbox"/> Neurologic condition	
<input type="checkbox"/> Autism		<input type="checkbox"/> Operation	
<input type="checkbox"/> Blood disorder		<input type="checkbox"/> Scoliosis	
<input type="checkbox"/> Dental injuries, braces		<input type="checkbox"/> Seizure disorder	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Skin condition	
<input type="checkbox"/> Ear infections/impairment	<input type="checkbox"/> Hearing aids <input type="checkbox"/> cochlear implants	<input type="checkbox"/> Speech condition	
<input type="checkbox"/> Frequent sore throats/strep		<input type="checkbox"/> Substance abuse	
<input type="checkbox"/> GI conditions (crohn's, reflux)		<input type="checkbox"/> Urinary condition	
<input type="checkbox"/> Headaches/ migraines		<input type="checkbox"/> Vision impairment	<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts
<input type="checkbox"/> Heart condition		<input type="checkbox"/> Other:	
<input type="checkbox"/> 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)

\_\_\_\_\_ Tums

\_\_\_\_\_ Tylenol (acetaminophen)

\_\_\_\_\_ Sunscreen (>30 SPF)

\_\_\_\_\_ Cough syrup (Robitussin)

\_\_\_\_\_ Bug Repellent (<30 DEET)

\_\_\_\_\_ Cough drops

\_\_\_\_\_ 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.



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## Authorization for Release of Student Records

### KINDERGARTEN

THIS FORM SHOULD BE GIVEN TO YOUR CHILD'S PRESCHOOL

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Preschool Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Preschool Address: \_\_\_\_\_

**I authorize the above named preschool to release pertinent school information to the Ipswich Public Schools regarding my child.**

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

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### TO BE COMPLETED AND RETURNED BY PRESCHOOL

Dear Preschool,

**What information do you feel we should have to make this child's transition to kindergarten as comfortable as possible?**

Please attach extra sheets as necessary.

Preschool Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return to : Office of the Superintendent **OR** Email to [mmfayden@ipsk12.net](mailto:mmfayden@ipsk12.net)  
One Lord Square  
Ipswich, MA 01938