JOHNSTON PUBLIC SCHOOLS

THIS SECTION FOR OFFICE USE ONLY

REGISTRATION DATE: _/____/____ **TIME:**__________**AM / PM** **START DATE:**____/____/____ **GRADE:**____________**Session: AM / PM**

IDENTIFICATION
- ☐ Birth Certificate (Original)
- ☐ Passport
- ☐ DCYF Intrastate ID Card *(also serves as proof of residency)*

IMMUNIZATIONS
Checked by:__________________
Checked on:______/_____/______
- ☐ Complete
- ☐ DCYF

PROOF OF RESIDENCY
- ☐ Purchase and sales agreement
- ☐ Property tax bill *(in name)*
- ☐ Current gas / electric / land-line telephone bill
- ☐ Residency affidavit
- ☐ Bank Closing Settlement Sheet
- ☐ DCYF Intrastate ID Card

PLACEMENT
Special Ed placement______________
- ☐ IEP
- ☐ 504

Out-of-district__________________
- ☐ ELL *(check if required)*

Confirmed with__________________

SCHOOL
- ☐ ECC 16114
- ☐ BARNES 16108
- ☐ BROWN AVE 16106
- ☐ THORNTON 16103
- ☐ WINSOR HILL 16109
- ☐ FERRI MS 16111
- ☐ JOHNSTON HS 16112
- ☐ OTHER______________

PLEASE PRINT and COMPLETE EACH SECTION

STEP 1: Student Information

ASPEN ID#_______________

☐ **Male** ☐ **Female** **Date of Birth:** (Month)_________/(Day)________/(Year)___________ **Grade:** _________________

Student Name:____
(LAST) (FIRST) (MIDDLE)

Address:____
(STREET) (APT or UNIT #) (TOWN/STATE) (ZIP CODE)

School Last Attended: ____
(NAME OF SCHOOL) (TOWN/STATE) (ZIP CODE) (PHONE NUMBER)

Custody Arrangement *(CIRCLE ONE)*: SOLE DUAL N/A If living with foster parents, agency name: ______________________________

New Federal standards require that school districts collect and report information regarding race and ethnicity.

Is your child Hispanic or Latino? Yes ☐ No ☐

What is your child's race? American Indian *or* Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian *or* Other Pacific Islander ☐ White ☐

Has your child ever been registered and/or enrolled in the Johnston Public Schools? No_______Yes _______

Do you have other children attending Johnston Public Schools? No_______Yes ______ If yes, please list student names:

FULL NAME:__________________________ **RELATIONSHIP:**________________ **SCHOOL:**____________
FULL NAME:__________________________ **RELATIONSHIP:**________________ **SCHOOL:**____________
FULL NAME:__________________________ **RELATIONSHIP:**________________ **SCHOOL:**____________
FULL NAME:__________________________ **RELATIONSHIP:**________________ **SCHOOL:**____________

IF MORE SPACE NEEDED, PLEASE WRITE ON REVERSE SIDE ➔

STEP 2: Family Information

1. ***Parent/Guardian*** ☐ **Father** ☐ **Mother**

Name:____ **EMAIL ADDRESS:**____________________
(LAST) (FIRST) (MIDDLE)

Address **(if different from student):** ______________________________________
(STREET) (APT or UNIT #) (TOWN/STATE) (ZIP CODE)

Home Phone:______________________Work Phone:______________________Cell Phone:______________________

2. ***Parent/Guardian*** ☐ **Father** ☐ **Mother**

Name:____ **EMAIL ADDRESS:**____________________
(LAST) (FIRST) (MIDDLE)

Address **(if different from student):** ______________________________________
(STREET) (APT or UNIT #) (TOWN/STATE) (ZIP CODE)

Home Phone:______________________Work Phone:______________________Cell Phone:______________________

Language Spoken at Home: ____

I certify that the information I have provided in this document is accurate, and that the child named above will be permanently residing at the indicated address. It is my responsibility to notify the school of any change of information.

Parent/Legal Guardian Signature:____**Date:**____________________

Student Name:____ **Date of Birth:**_______________ **Grade:** ________

STEP 3: Specialized Services Section

Does your child presently have an *Individualized Education Plan* (IEP)?	☐ Yes	☐ No
Are you providing a copy of your child's IEP?	☐ Yes	☐ No
Has your child had a screening test with *Child Outreach*?	☐ Yes	☐ No
Does your child have a *Section 504 Plan*?	☐ Yes	☐ No
Does your child presently receive any *English Language Learner* (ELL) instruction?	☐ Yes	☐ No
Does your child receive any other services not already mentioned? If yes, please explain:	☐ Yes	☐ No

____

____

STEP 4: Emergency Contacts & Release Procedures

In the event of a major illness or injury, ***9-1-1*** will be called first. If you are unavailable, we will contact the individuals below in the order listed in the event of an illness or emergency involving your child. The people listed should be available during school hours. Your child may also be released to these individuals under other circumstances at your request or the school's request. Suitable identification (*e.g.,* driver's license) will be necessary before the child is released. These are the **only** people authorized to pick up your child from school. Please complete this section as accurately as possible.

I,____ **authorize the school to release my child to the**

PARENT / GUARDIAN NAME *(PLEASE PRINT)*

individuals named below:

	NAME	RELATIONSHIP TO CHILD	DAYTIME PHONE NUMBER(S) Indicate if ***HOME***, ***WORK*** or ***CELL*** number
1.			
2.			
3.			
4.			

Step 5: Permission to Photograph/Videotape Your Child

We are proud of our students and the special events that take place at our schools. Occasionally throughout the year, we invite the press to report on our events. CHECK THE BOX BELOW IF YOU **DO NOT** GIVE PERMISSION FOR YOUR CHILD TO BE PHOTOGRAPHED, VIDEOTAPED AND/OR ON THE DISTRICT WEB SITE. **If we have your permission to photograph your child, you need not do anything.**

☐ I **DONOT** give my consent allowing my child to be photographed or videotaped at school events and published in media and on the school website.

Parent/Legal Guardian Signature:____ **Date:**____________________

Revised: 5/2013

Student Name:______________________________ **Date of Birth:**________________ **Grade:** ________

STEP 6: Home Language Survey

PLEASE COMPLETE THIS FORM **WHETHER OR NOT** YOU SPEAK A LANGUAGE OTHER THAN ENGLISH.

RI DEPARTMENT OF EDUCATION HOME LANGUAGE SURVEY

Encuesta del Departamento de Educación de Rhode Island Sobre el Idioma Hablado en el Hogar

The information requested on this form is necessary for the most appropriate placement for your child as required by Rhode Island Law (R.I.G.L. § 16-54-2) and the Equal Educational Opportunity Act (20 U.S.C. §1703(f)) and will not be used for any other purposes.

La información solicitada en este formulario es necesaria para ubicar a su hijo/a en el lugar más adecuado para éste/a, de conformidad con la legislación de Rhode Island (Sección 16-54-2 de las Leyes Generales de Rhode Island) y la Ley de Igualdad de Oportunidades Educativas (Título 20, Sección 1703(f) del Código de los Estados Unidos), y no será empleada para ningún otro propósito.

1a. What language do you use most often when speaking to your child?______________________

1b. ¿Qué idioma utiliza usted con más frecuencia cuando le habla a su hijo/a?______________________

2a. What language did your child first learn to speak?______________________

2b. ¿Cuál fue el primer idioma que aprendió a hablar su hijo/a?______________________

3a. What language does your child use most often when speaking to you?______________________

3b. ¿Qué idioma utiliza su hijo/a con más frecuencia cuando le habla a usted?______________________

4a. What language does your child use most often when speaking to other adults in the home or to their primary caretaker?

____

4b. ¿Qué idioma utiliza su hijo/a con más frecuencia cuando habla con otros adultos del hogar o con la persona que está primordialmente a cargo de su cuidado?______________________

5a. What language does your child use most often when speaking to siblings or other children in the home?______________________

5b. ¿Qué idioma utiliza su hijo/a con más frecuencia cuando habla con sus hermanos u otros niños del hogar?______________________

6a. What language does your child use most often when speaking to friends or neighbors outside the home?______________________

6b. ¿Qué idioma utiliza su hijo/a con más frecuencia cuando habla con amigos o vecinos fuera del hogar?______________________

______________________________ ______________________

SIGNATURE OF PARENT/GUARDIAN / FIRMA DEL PADRE O TUTOR **DATE** / FECHA

____

PRINT PARENT/GUARDIAN NAME / ESCRIBA EN LETRAS DE MOLDE EL NOMBRE DEL PADRE/TUTOR

STEP 7: Health History Information

STUDENT NAME: *(PLEASE PRINT)* ____Male ____Female **DATE OF BIRTH:**

_____________ _____________ _____ ____/____/____

Last Name *First Name* *M.I.* *Month* *Day* *Year*

HOME ADDRESS & TELEPHONE NUMBER:

_____________ _____________ _____ _____

Street Address *City/Town* *State* *Zip Code*

PARENT/GUARDIAN INFORMATION: *(PLEASE PRINT)*

Name *Home Number* *Work Number* *Mobile Number*

Street Address (IF DIFFERENT FROM STUDENT) *City/Town* *State* *Zip Code*

Name *Home Number* *Work Number* *Mobile Number*

Street Address (IF DIFFERENT FROM STUDENT) *City/Town* *State* *Zip Code*

HEALTH CARE PROVIDER/CLINIC: *(PLEASE PRINT)*

Name *Telephone Number*

Street Address *City/Town* *State* *Zip Code*

Name *Telephone Number*

Street Address *City/Town* *State* *Zip Code*

MEDICAL HISTORY *(Please check one response for each of the following diseases or conditions)*

Chickenpox	__Yes	__No	Tuberculosis	__Yes	__No	Headaches	__Yes	__No
German Measles *(Rubella)*	__Yes	__No	Whooping Cough	__Yes	__No	Diabetes	__Yes	__No
Measles	__Yes	__No	Vision Problems	__Yes	__No	Frequent Sore Throat	__Yes	__No
Mumps	__Yes	__No	Hearing Problems	__Yes	__No	Kidney Problems	__Yes	__No
Pneumonia	__Yes	__No	Asthma	__Yes	__No	Heart Problems	__Yes	__No
Rheumatic Fever	__Yes	__No	Eczema	__Yes	__No	Speech Problems	__Yes	__No
Scarlet Fever	__Yes	__No	Seizure Disorder	__Yes	__No	Other:_____________	__Yes	__No

Allergies**:* Yes No If Yes, please ***circle all that apply: BEE/INSECT STINGS PEANUTS/PEANUT BUTTERNUTS:____________________

FRUITS:________________________________ OTHER FOODS:________________________ LATEX ENVIRONMENTAL ALLERGIES

What type of reaction does your child have?____ ***Epipen**:* Yes No

*Surgeries or Serious Illness:*____*year:* ________________

____*year:* ________________

____*year:* ________________

*Accidents or Injuries:*____*year:* ________________

____*year:* ________________

Has your child had lead screening? Yes No If Yes, please provide the date: ______________________________

Student Name:____**Date of Birth:**_______________**Grade:** _______

STEP 7: Health History Information *(continued)*

- Does your child have ***asthma***? Yes No If Yes, list the *triggers*: ______________________________

Medication(s) prescribed:______________________________Meds required during school day? Yes No

Time of year asthmatic episodes occur:____

- Does your child have ***diabetes***? Yes No If Yes, age of diagnosis:________ **Type 1** ____ ***or*** **Type 2** ____

Insulin dependent: Yes No If yes, pump or injection: ____________________

- Does your child have any ***vision defects***? Yes No If Yes, please specify: ______________________________

Does your child wear contacts? Yes No Glasses? Yes No Is it necessary for your child to sit near board? Yes No

- Does your child have any ***hearing defects***? Yes No If Yes, please specify: ______________________________

Does your child wear hearing aids? Yes No Use an FM device? Yes No

Is it necessary for your child to sit near front of room? Yes __No If Yes, preferably **left** side or **right** side? ________________

MEDICATIONS

Is the student currently taking any medications? Yes No *If yes, please provide the medication name(s) below:*

1. ______________________________***Dosage:***____________________***How many times a day?*** __________

   *Prescribing physician:*________________________*Reason for the medication:* ________________________

2. ______________________________***Dosage:***____________________***How many times a day?*** __________

   *Prescribing physician:*________________________*Reason for the medication:* ________________________

3. ______________________________***Dosage:***____________________***How many times a day?*** __________

   *Prescribing physician:*________________________*Reason for the medication:* ________________________

IN THE SPACE BELOW, PLEASE PROVIDE ANY ADDITIONAL HEALTH INFORMATION,
WHICH YOU FEEL WOULD BE HELPFUL TO THE SCHOOL NURSE-TEACHER:

____

____

____

____

What school did your child last attend? ____

________________________ ______________ __________________
City/Town State Telephone Number

I UNDERSTAND THIS INFORMATION MAY BE SHARED AND DISCUSSED WITH SCHOOL PERSONNEL IF NECESSARY. I GIVE PERMISSION TO APPROPRIATE SCHOOL PERSONNEL TO COMMUNICATE AND EXCHANGE INFORMATION WITH THE STUDENT'S PHYSICIAN, IF NECESSARY.

____ __________________
SIGNATURE PARENT/GUARDIAN **DATE**

Revised: 5/2013

JOHNSTON PUBLIC SCHOOLS

10 MEMORIAL AVENUE
JOHNSTON, RHODE ISLAND 02919-3222

AFFIDAVIT AFFIRMING RESIDENCY

PART A – TO BE COMPLETED BY PARENT / GUARDIAN

(1) I ________________________ certify that I reside at _______________________________,
(Name of parent/guardian) (Street address)

Which is located in Johnston, Rhode Island, and I further certify that the following child(ren) reside at this address with me:

Name	**Date of Birth**	**Relationship**

(2) PLEASE CHECK ONE:

☐ I own and reside at the residence located at the address listed above.

☐ I rent or otherwise reside at all or a portion of the residence located at the address listed above, but I am not the owner.

(3) I have enclosed copies of the following documents as proof of residence for the child(ren) listed above: ***(Please provide at least three (3) documents from the following list. Monthly bills must be dated within the previous thirty (30) days)***

Copy of deed and most recent mortgage payment
Copy of lease agreement and proof of most recent rental payment
Section 8 Agreement
Recent Insurance bill/policy
W-2 Tax return for previous year
Current property or motor vehicle tax bill
Bank Statement
Current Payroll Stub
Current Vehicle Registration
Credit Card Statement
Electric, cable, gas or water bill
Current proof of SNAP/SSI Benefits

ACKNOWLEDGEMENT

I certify that the above information is true and correct. I understand that this information will be verified by the Registrar, and if found to be fraudulent, I understand that the falsification of any information on this form may result in me being liable to the Town of Johnston for the reimbursement of any expenses incurred by the Town in educating the listed child(ren) and/or being subject to criminal prosecution resulting from any fraud or negligent misrepresentation contained on this form. I acknowledge that as Parent/Guardian, I must immediately notify the Johnston Public Schools of any change in residency and provide proof in support of any new residency.

___________________________________ ______________________________
(Signature of Parent/Guardian) ***(Date)***

Subscribed and sworn to before me on this __________day of _____________, 20__.

____
(Notary Public)

My commission expires:_________________

JOHNSTON PUBLIC SCHOOLS

10 MEMORIAL AVENUE
JOHNSTON, RHODE ISLAND 02919-3222

AFFIDAVIT AFFIRMING RESIDENCY

PART B – TO BE COMPLETED BY HOMEOWNER (IF DIFFERENT FROM PARENT/GUARDIAN)

(1) I ________________________________ certify that I am the owner of the property located at

____, which is located in Johnston, Rhode Island,

and I further certify that ______________________________ resides full-time at this property with the

following child(ren):____.
.

(2) PLEASE CHECK ONE:

- ☐ I own the property at the address listed above and I reside there.
- ☐ I own the property at the address listed above, but I reside elsewhere, I reside at the following address: ____ .

(3) PLEASE CHECK ONE:

- ☐ I have a current rental agreement with the parent or guardian / tenant named above for the house or apartment located at the address listed above.
- ☐ The parent or guardian / tenant and the child(ren) listed above reside with me at the above–stated address. Please state the reason that the parent or guardian / tenant and the child(ren) reside at this address with you:

____

____

____

ACKNOWLEDGEMENT

I certify that the above information is true and correct. I understand that the Registrar for the Johnston Public Schools will verify by homeownership status with the Registry of Deeds and the Tax Assessor for the Town of Johnston, and if the information I have given is found to be fraudulent, I understand that the falsification of any information on this form may result in me being liable to the Town of Johnston for the reimbursement of any expenses incurred by the Town in educating the listed child(ren), and/or being subject to criminal prosecution resulting from any fraud or negligent misrepresentation contained on this form.

_____________________________________ _______________________________

(Signature of Home Owner) ***(Date)***

Subscribed and sworn to before me on this __________day of _____________, 20__.

____

(Notary Public)

My commission expires:_________________

Approved: Johnston School Committee
October 18, 2016

School Name & Address: Grade: ______________	 STATE OF RHODE ISLAND SCHOOL PHYSICAL FORM	Health Care Provider Name and Address: Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last		First	Middle	Date of Birth	Sex
Address: Street	Apt #	City	State	Zip Code	Home Phone

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS	Please enter dates in MM/DD/YYYY format				
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTaP < 7 years					
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella			☐ Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis Tdap/Td ≥ 7 years					
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					
Influenza					

Medical Exemption:

☐ Hep B ☐ DTaP ☐ PCV ☐ Polio ☐ Hib ☐ MMR ☐ Varicella ☐ Td/Tdap ☐ Rotavirus ☐ Hep A ☐ Mening ☐ HPV ☐ Influenza

PHYSICAL EXAMINATION

Date of PE ____/____/____ Height __________ Weight__________ BP___________

PLEASE NOTE ANY HEALTH PROBLEM, CHRONIC HEALTH CONDITION OR DISABILITY THAT MAY AFFECT BEHAVIOR OR HEALTH AT SCHOOL:

1. ASTHMA: No ☐ Yes ☐ If yes, complete an *Asthma Action Plan* (www.health.ri.gov/publications/actionplans/2012Asthma.pdf)

2. ALLERGIES: No ☐ Yes ☐ (Please explain) ________________________________EPINEPHRINE AUTO-INJECTOR REQUIRED: No ☐ Yes ☐

If student has a severe allergy (food, insect, other) complete a *Food Allergy& Anaphylaxis Emergency Care Plan* (www.foodallergy.org/document.doc?id=234)

3. DIABETES: No ☐ Yes ☐ If yes, complete a *Physicians Order Form For Students With Diabetes* (www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf)

4. OTHER: ____

Treatment Plan: ____

RESTRICTIONS: Can participate in physical education/sports: Fully☐ With limitation ☐ ______________________________________

MEDICATION (REQUIRED AT SCHOOL): No ☐ Yes ☐ (Please list) ____

Other medication(s) that may affect behavior or health at school: ____

LEAD SCREENING (Required for children < 6 years old) Student is in compliance with lead screening requirements: Yes ☐ No ☐	SCOLIOSIS SCREENING Yes ☐ No ☐		VISION SCREENING (Children entering Kindergarten) ☐Passed Screening ☐Screened & referred for comprehensive exam ☐Referred for comprehensive exam, but not screened
TUBERCULOSIS (If required by school district) Date of TB test:			Screening / Referral Date: Comprehensive Exam Date:

HEALTH CARE PROVIDER SIGNATURE: ____ DATE: ____________________

PRINT NAME: ____

JOHNSTON PUBLIC SCHOOLS
ADMINISTRATION OFFICE
10 MEMORIAL AVENUE
JOHNSTON, RHODE ISLAND 02919-3222

EARLY CHILDHOOD FIELD TRIP PERMISSION FORM

Date: ____

I______________________________give my permission for my child to go on a mini Field Trip (e.g., to Johnston
(PRINT PARENT NAME CLEARLY)
Memorial Park, or outside of the building on school grounds).

YES_____________ **NO** _____________

Parent Signature: ____

Student Name: ____

Revised: 1/2014
Revised: 4/2013