Early Learning Program Registration For Washington Elementary School

2024-2025

Child must be 3 years old before September 30, 2024 to participate in Washington Elementary School's Early Learning Program

Please supply a copy of your child's **BIRTH CERTIFICATE**, **PROOF OF RESIDENCY, IMMUNIZATION RECORD**, and **most recent PHYSICAL EXAM** along with this registration packet

Information Sheet

Student ____

Pregnancy and Delivery (full term, complications, etc.)

____

____

Developmental Milestones

Age child was toilet trained _____________

Age first used single words _______________________

Age started walking _____________________________

History of ear infection or other medical concerns ___________________________

What type of activities does your child enjoy?

____

Does your child have any unusual eating or sleeping habits? _________________________

____

Please provide any additional information that you would like to share about your child.

____

____

____

Parent Signature ____________________________

A birth certificate, immunization record, a **medical record indicating a current physical examination, and proof of residency** will be required for registration and attendance in the program.

Washington School District

Student Registration Information - *Please complete/verify and return to school office.*				
Last Name		**Middle Name**	**First Name**	
Grade	**Gender**	**Date of Birth**	**City/State of Birth**	**Bus #**

Is the student's Ethnicity Hispanic or Latino? Yes ☐ No ☐

Student's Ethnicity (Please circle all that apply):
White ☐ Asian ☐ American Indian or Alaskan Native ☐ Black or African American ☐
Native Hawaiian or Other Pacific Islander ☐

Primary Language Spoken at Home:
List all languages spoken at home:

Does your child speak a language other than English? Yes ☐ No ☐

Other siblings (Name & age or grade level):

Student Physical Address:

Street

City **State** **Zip Code**

Student Mailing Address (if different from above):

Street

City **State** **Zip Code**

Living Situation: Permanent ☐ Temporary ☐
Are you in transition? Yes ☐ No ☐
If yes, circle one : living with family ☐ living with friends ☐ other (please explain): ☐

Parent/Guardian with whom student resides	
Parent/Guardian Name(s)	**Relationship**
Email Address	**Phone Numbers** (please note type; ex. home, Dad cell, Mom work)

Other Parent/Guardian – Will receive information on student unless otherwise stated by a court.	
Other Parent/Guardian Name(s)	**Relationship**
Address (if different than student)	**Phone Numbers** (please note type; ex. home, cell, work)
Email Address	**Permission to Pick-up student:** Yes ☐ No ☐

Are there any court orders or legal documentation pertaining to this student's custody, guardianship or safety? Yes☐ No ☐ If so, legal documentation must be provided.		
Additional Information		
Previously attended school(s) or pre-school other than Washington Elementary School:		
Emergency Contact Information - In the event that the parents are unable to be reached, please list the names of 3 adults who will assume responsibility for your child and are able to be reached during school hours.		
Emergency Contact Name	**Home/Cell Phone**	**Relationship**
Emergency Contact Name	**Home/Cell Phone**	**Relationship**
Emergency Contact Name	**Home/Cell Phone**	**Relationship**

I, (print parent/legal guardian name)______________________________ have reviewed the information entered on this registration form and acknowledge that the information is accurate.

Signature of Parent/Legal Guardian:____ Date:__________

In case of an accident or other emergency, **every effort will be made to contact the parents/guardians**. In the event parents cannot be contacted in a **reasonable amount of time**, or the injury would require **immediate** medical attention, we would like permission to take the necessary steps to initiate treatment.

I hereby authorize school personnel to administer first aid and if necessary call the Rescue Squad for medical treatment and/or transport to a hospital.

Hospital Preferred________________________________

Washington, New Hampshire the __________day of ____________________________20________

____
Signature of Parent/Guardian

Note: If there is any change in the information given, it is important to notify the school office immediately. Thank You!

EMERGENCY INFORMATION FOR HEALTH OFFICE USE		
Last Name:	**Middle Name:**	**First Name:**
Grade	**Homeroom/Advisory**	**Date of Birth**

Emergency Contact Information - In the event that the parents are unable to be reached, please list the names of 3 adults who will assume responsibility for your child and are able to be reached during school hours.

Emergency Contact Name	Home/Cell Phone	Relationship
Emergency Contact Name	Home/Cell Phone	Relationship
Emergency Contact Name	Home/Cell Phone	Relationship

HEALTH OFFICE INFORMATION

Family Doctor's Name:	Phone:
Dentist's Name:	Phone:
Specialist's Name:	Phone:

Does your child have health insurance? Yes   No

Please list **all** medical concerns and allergies (including reactions) that health office staff needs to be aware of – as medical conditions change, please update this information with the health office staff.

____
____
____
___

List **all** medications that your child takes at home and at school (in case of emergencies, it is important to have this information available for rescue and hospital personnel). Please include medication(s) name, dosage and times of day taken. Please list even if condition/medication has been listed in previous years.

____
____
____
___
____
_

Before any medication can be given at school/school functions, a MEDICATION ADMINISTRATION FORM must be filled out by the child's physician and signed by a parent/guardian. All prescription medications need a physician's signature as well as written instructions given to Health Office staff, who may prepare meds for field trips, etc. Medications should NEVER be brought to school by a child.

In case of an accident/incident or other health emergency, every effort will be made to contact the parent/guardian. In the event that parent/guardians cannot be contacted in a reasonable amount of time, or the injury requires immediate medical attention, we would like permission to take the necessary steps to initiate treatment.

I hereby authorize the District, or its agent, to administer first aid and to refer for medical treatment, including transport to a medical facility, as may be reasonably required under the circumstances.

Signature of Parent/Legal Guardian**____** ***Date*****__________**

Student's Name: ____ Grade: __________________

Please answer BOTH part A and B.

Part A. **Is this student Hispanic/Latino?** (Choose only one)

- ☐ **No, not Hispanic/Latino**
- ☐ **Yes, Hispanic/Latino** (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)

The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your student's (or your) race to be.

Part B. **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 people 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)
- ☐ **White** (A person having origins in any of the original people of Europe, the Middle East, or North Africa)
- ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Island)

Parent/Guardian Signature: _________________________________ Date: _____________

Procedure for Medical Records
Washington Elementary School

1) All students entering school for the first time must provide a birth certificate, proof of immunizations, and a copy of his/her physical. A sample form is included in this packet. A physical must be conducted within one year prior to entry into school.

2) All records regarding the student's health will be reviewed at regular intervals by the school nurse.

3) Any medication, prescription or over the counter, that a child takes in school will be kept in a locked drawer or cabinet and must have a **medication administration form** with it. The form must be filled out and **signed by a parent or guardian**. Any medication prescribed by a physician must have the **physician's signature** with dosage and time to be given at school on the form or copy of the prescription stapled to the form. **All medications need to be delivered to the school by an adult.**

4) All medication administered in school must be in the **original containers** and must have the child's name, medication and dose on the bottle.

5) Sending a child to public school implies that all routine screening (vision, hearing, height and weight) will be conducted on the child. Any parent who wishes to have screening conducted by their family physician needs to inform the school of this intention at the beginning of the school year.

6) If a child fails a school screening, the parent/guardian will be informed and requested to take their child for further testing. Please do this as soon as possible and notify the school of the date of the child's appointment.

Standard Pediatric Health Form

Washington Elementary School

Name: ____________________________ DOB: ________________________

Address:__________________________ Phone: ______________________

Immunizations

Immunizations	Date	Date	Date	Date	Date	Date
DTaP						
Polio						
MMR						
HIB						
Hep B						
Varicella						
Other						

Health History

Allergies: __________________________

Medications: ______________________

____

____

Other: _________________________

____

____

____

Physical Exam

Date of Exam: ____________________

Height: _______________ Weight: _____________ Blood Pressure: ___________

Vision: R: 20/_______ L: 20/_______ Pulse: _____________

EENT _____________________________

____

Thyroid & Lymph Nodes: ________

Heart: ____________________

Lungs: ____________________

Abdomen: __________________

GU: _______________________

Orthopedic

Scoliosis: ______________________

Other: __________________

Nervous System

Seizures: ________________

Other: __________________

Comments:____

____

I hereby certify that this child has received the above immunizations and a complete medical examination in accordance with New Hampshire school laws.

Physician's Signature: ____________________________________ Date: ______________

A copy of the child's most recent physical that includes all above information dated within the last year is acceptable in lieu of this form.

Medical Form

Child's Name ______________________________ Date of Birth________________

Parents ___________________________________ Home Phone ________________

Physician __________________________________ Phone # _____________________

Dentist ____________________________________ Phone # _____________________

Does your child have any of the following medical conditions?

Asthma Y/N Frequent Ear Infections Y/N

Seizures Y/N Cystic Fibrosis Y/N

Diabetes Y/N Congenital Heart Condition Y/N_______________

Does your child have any known allergies: ____________________________________

Does your child have any allergy or reaction to bee stings or insect bites: Y/N

If yes, does he or she have medication for it? Y/N________________________

Does your child have any problem with bladder or bowel control, day or night? Y/N

____

Has your child ever been hospitalized, had surgery, or had any major illness or injury of which we should be aware? Y/N______________________________________

Is your child currently on any type of medication? Y/N_________________________

Does your child have any special medical needs that will need to be provided for in the school setting? Y/N____

Pre-school Students 3-5 Years Old
New Hampshire Immunization Requirements 2022-2023

Refer to page 2 for minimum ages and intervals

DIPTHERIA, TETANUS, PERTUSSIS (DTaP/DTP/DT)

3-5 years	Four doses. The 3rd and 4th dose must be separated by at least 6 months.

POLIO

3-5 years	Three doses. Any OPV dose(s) given on or after April 1, 2016 does not count toward the polio vaccine requirement and the series must be completed with IPV.

MEASLES, MUMPS, and RUBELLA (MMR)

3-5 years	One dose. This dose must be administered on or after age 12 months.

HAEMOPHILUS INFLUENZAE TYPE B (Hib)

3-5 years	One dose on or after 15 months of age OR Four doses with the last dose administered on or after 12 months of age OR **see catch-up schedule below*** Hib is not required for children $\geq$ 5 years of age.

HEPATITIS B

3-5 years	Three doses given at acceptable intervals. See attached schedule (page 2)

VARICELLA (CHICKEN POX)

3-5 years	One dose. This dose must be administered on or after age 12 months. OR laboratory confirmation of chicken pox disease.

*Hib catch-up vaccination schedule:

- If unvaccinated at 15-59 months: 1 dose needed.
- If dose 1 given before 12 months and dose 2 before 15 months, 3rd and final doses must be 8 weeks after dose 2.
- If dose 1 given at 7-11 months, dose 2 must be at least 4 weeks later and 3rd and final dose given at 12-15 months or 8 weeks after dose 2 (whichever is later).
- If dose 1 given at 12-14 months, 2nd and final dose must be at least 8 weeks after dose 1.
- If **PedvaxHIB** brand used, call NHIP for recommended schedule and requirements for dosing.

SAU #34 – Hillsboro, Deering, Windsor, Washington

62 Wolf Way, Washington, NH 03280

AUTHORIZATION FOR THE RELEASE OF EDUCATIONAL, HEALTH AND MEDICAL INFORMATION

This authorization pertains to the protected health information and educational information regarding:

______________________________________ ______________________________

Student/Patient Name **Date of Birth**

This authorization allows WSD to (check all that apply):

☐ Provide verbal and written information to the individual or entity named below.

☐ Obtain verbal and written information from the individual or entity named below.

WSD Contact Information:

Name: ***Secretary, Nurse, and/or Principal/Washington Elementary School***

Address: ***62 Wolf Way, Washington, NH 03280***

Phone: ***Phone: 603-495-3463***

Physician's Office Contact Information:

Name: ____

Address: ____

Phone: ______________________ **Fax:** ______________________

Type(s)of Information to be disclosed:

Immunizations Records, Most Recent Physical

Purpose(s)of Disclosure:

Required school documentation

Information will be released only with a valid signature below. This authorization will expire 1 year from the signature date, unless otherwise specified. I understand that I can cancel this authorization at any time. Cancellations of authorization do not apply to information that has already been released while this authorization was valid. I understand that WSD cannot guarantee the confidentiality of released information because the recipient may not be subject to federal laws governing the privacy of medical, health and educational information.

____ ____________

Signature of Parent or Legal Guardian **Date**