



## Kindergarten Registration Information 2011

Dear Parent/Guardian,

Welcome! It is our understanding that you are the parent/guardian of a prospective kindergarten pupil. Please read this list of frequently asked question, it will assist you through the registration process.

### IS MY CHILD ELIGIBLE FOR KINDERGARTEN?

- Connecticut law requires public schools to be open to all children who reach the age of 5 on or before the first of January of any school year. [C.G.S.\* Sec. 10-15c]. **In order for your child to be eligible for kindergarten, he/she must be born on or before January 1, 2007**

### DOES MY CHILD NEED A PHYSICAL EXAMINATION?

- Your child will need a physical examination. A physical performed after September 1, 2010 is acceptable. Please bring the State of Connecticut Department of Education, Health Assessment Record with you to the doctor and return completed form to school with your application. **This form must be received and reviewed prior to the first day of school.**

### WHAT DOCUMENTS DO I NEED TO BRING TO REGISTRATION?

- Child's full size Birth Certificate (**child must be five on or before 1/1/12**)
- Picture I.D. of Parent (Drivers License, Non-Driver Photo I.D., Valid Passport with photo)
- Two proofs of Residency (Notarized Lease Agreement, Mortgage Note, Mortgage Deed, **and** 2011 Voter Registration Card, Tax Bill, Current Utility Bill- UI, Gas, Home Telephone, Water). **Cell Phone Bills are not accepted.**
- Child' Immunization Record (Completed Health Assessment Record)

### IS THERE AN ORIENTATION FOR NEW KINDERGARTEN STUDENTS?

- The parents and students will be given an opportunity to visit the kindergarten before the start of the new school year. Our Kinderprep program will be offered in the summer. Details will be available at a later date.

### WHERE CAN I OBTAIN REGISTRATION FORMS?

- The registration forms can be obtained at any one of our elementary schools and on The Hamden Public Schools' website [www.hamden.org](http://www.hamden.org).

### WHEN AND WHERE IS REGISTRATION?

- Parents may obtain and submit registration information at their child's designated elementary school. Registration times and dates are as follows.

<ul style="list-style-type: none"><li>○ Friday, March 25<sup>th</sup>, 1:30-2:30 PM</li><li>○ Monday, March 28<sup>th</sup>, 1:30 PM – 3:00 PM</li><li>○ Tuesday, March 29<sup>th</sup>, 1:30 PM – 3:00 PM</li></ul>
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- Please do not bring your child as a special visit will be scheduled for kindergarten orientation at a later date. Registration will take approximately a half hour. If you are not sure, which school your child will be attending, please call Central Office (203) 407-2000 or an elementary school in your neighborhood and give your address. The school will use the district street directory to verify the correct school.

### WHAT FORMS DO I NEED TO COMPLETE?

- The following forms must be completed for kindergarten registration. You may use this checklist to help you keep track of all of the registration requirements.

- |   |
|---|
| <ol style="list-style-type: none"><li>1. <input type="checkbox"/> Registration Form: To be filled out by parent/guardian</li><li>2. <input type="checkbox"/> Emergency Form: To be filled out by parent/guardian</li><li>3. <input type="checkbox"/> Home Language Survey: To be filled out by parent/guardian</li><li>4. <input type="checkbox"/> Hamden Public Schools Internet Use Policy Form: To be filled out by parent/guardian</li><li>5. <input type="checkbox"/> Permission to Photograph/Videotape Form: To be filled out by parent/guardian</li><li>6. <input type="checkbox"/> Pre School Observation Form: To be filled out by Preschool/Child Care Provider</li><li>7. <input type="checkbox"/> Health History Form: To be filled out by parent/guardian</li><li>8. <input type="checkbox"/> Residency Affidavit: To be filled out by parent/guardian</li><li>9. <input type="checkbox"/> State of Connecticut Department of Education Health Assessment Form: To be filled out by physician</li></ol> |
|---|

We look forward to welcoming you and your family to the Hamden Public Schools' community. It is our belief all students will thrive in and be prepared for an ever-changing world when students, families, teachers, and the community form respectful relationships and strong, active partnerships. If you have any questions, please feel free to contact me.

Sincerely,

Director of Elementary Education  
Hamden Public Schools



Hamden Public Schools
Elementary Registration Card
2011-2012

Revised 2/1/11

Student's Name: My child likes to be called: Grade:

Date of Birth: Gender: Male Female United States Citizen? Yes No

Current Address: (Include Apartment/Floor)

Student Lives With: Mother Father Stepmother Stepfather Other (Please Specify):

Ethnicity: Is the student Hispanic/Latino? Yes No
Is the student from one or more races using the following? (choose all that apply): White, Asian, American Indian or Alaskan Native, Black or African American, Native Hawaiian or Other Pacific Islander

Mother/Guardian Name: United States Citizen? Yes No

Address (if different): Employer:

Contact Information: Home Phone: Cell/Pager: Work Phone: Email:

Father/Guardian Name: United States Citizen: Yes No

Address (if different): Employer:

Contact Information: Home Phone: Cell/Pager: Work Phone: Email:

Student's Place of Birth (City and State): Former Address (if applicable):

School Last Attended: City and State:

Grade(s) Attended: Dates Attended:

Pre-Kinderqarten Information: Did your child attend Pre-School/Daycare? Yes No

If yes, school attended: City and State:

How many years or months did your child attend Pre-School/Daycare?

How many days a week did your child attend Pre-School/Daycare? full day(s) or part day(s).

How many hours a weed did your child attend Pre-School/Daycare? hours per week

Assessment of Dominant Language:

- 1. In what language do you speak to your child in the home?
2. In what language does your child respond to you in the home?
3. What language did your child first learn?
4. How long have you lived in this country?
5. Has your child been exposed to English? Yes No If yes, how long?

Signature of Parent/Guardian

Date



**Hamden Public Schools  
Elementary Emergency Information  
2011-2012  
Important Please Print**

<b>For Office Use Only</b>
<input type="checkbox"/> Legal Restrictions on the release of child to non-custodial parent
<input type="checkbox"/> Child has a medical condition

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Primary Phone Number:

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Primary Email:

Current Address: \_\_\_\_\_  
(Include Apartment/Floor)

Student Lives With:  Mother  Father  Stepmother  Stepfather  Other (Please Specify): \_\_\_\_\_

Name of Custodial Parent(s)/Guardian(s): \_\_\_\_\_

In case of illness or accident it is vital that our office have a telephone number available where you can be contacted during the day. **PLEASE NOTIFY US OF ANY CHANGES DURING THE YEAR.**

Mother/Guardian Name: \_\_\_\_\_

Address (if different): \_\_\_\_\_ Employer: \_\_\_\_\_

<b>Contact Information:</b>
Home Phone: _____ Cell/Pager: _____ Work Phone: _____ Email: _____

Father/Guardian Name: \_\_\_\_\_

Address (if different): \_\_\_\_\_ Employer: \_\_\_\_\_

<b>Contact Information:</b>
Home Phone: _____ Cell/Pager: _____ Work Phone: _____ Email: _____

List two people that we may contact during the school day and to whom your child may be released to if you cannot be reached. The two people listed below will be authorized to pick-up your child. You may add more names to the reverse side of the page.

Name: _____ Relationship to Student: _____
Address: _____ Town: _____ Zip Code: _____
Home Phone: _____ Cell/Pager: _____ Work Phone: _____ Email: _____

Name: _____ Relationship to Student: _____
Address: _____ Town: _____ Zip Code: _____
Home Phone: _____ Cell/Pager: _____ Work Phone: _____ Email: _____

**Are there any legal restrictions on the release of your child or his/her records to non-custodial parent?**  
 Yes  No **If yes, please specify and provide documentation to the principal.**

In case of accident or illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible to contact the physician, the school may make whatever arrangements necessary.

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital of Preference: \_\_\_\_\_

Is there any medical problem that we should be alerted to? \_\_\_\_\_



# Home Language Survey

Student's Name: \_\_\_\_\_ Hamden School: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Grade Level in Previous School: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Country of Birth: \_\_\_\_\_  Male  Female

1. Language(s) you speak to your child: \_\_\_\_\_

2. Language(s) your child speaks to you: \_\_\_\_\_

3. Language your child learned first: \_\_\_\_\_

4. How long have you lived in the United States? \_\_\_\_\_

5. Name and phone number of English speaking contact if needed

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

6. Put an "X" on the grades your child attended in United States schools

None	1	2	3	4	5	6	7	8	9	10	11	12
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7. a. Date your child entered the U.S.: \_\_\_\_\_ b. Date your child entered U.S. schools: \_\_\_\_\_

8. Was your child in a bilingual or ESL/ESOL program?  Yes  No

If yes, Date completed: \_\_\_\_\_  Not completed  Not sure

School where services were offered: \_\_\_\_\_  
(school)

Address: \_\_\_\_\_  
(street) (town/city) (state) (zip)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### For School Use Only

State and federal guidelines state that all English language learners must be identified and assessed annually. Families can decide on participating only after the student is assessed. Students that opt out do not receive services, but must be assessed annually. It is imperative that we have this information as complete and correct as possible. ELL's receive support accommodations on CMT's and CAPT, and have rigid exiting criteria.

If 2 answers to 1,2, and 3 are not English, the child needs screening.

If the answer to 7a is less than three years, the child needs screening.

If the answer to a past bilingual or ESL/ESOL program is not completed, the family doesn't know, isn't sure, or the records aren't clear, the child needs screening.

Exchange students are not considered for identifying ELL's

If it is indicated that screening is needed, please notify the ESOL coordinator, William Thomas, at he the time of the initial registration by scanning this page and emailing it or sending a fax to 407-2058 and an email. Copy sent to:

\_\_\_\_\_ Date: \_\_\_\_\_



## HAMDEN PUBLIC SCHOOLS INTERNET USE AGREEMENT

1. Students and/or parents may never share passwords or accounts. Users have full responsibility for the use of their account. All violations of this policy that can be traced to an individual account name will be treated as the sole responsibility of the owner of the account.
2. Users may never use the Network for any activities that are considered illegal pursuant to state or federal law. Illegal activities may include, but are not limited to, the following conduct:
  - a. Tampering with computer hardware or software, unauthorized entry into computers, or vandalism or destruction of computer files.
  - b. Fraudulent copying, communications or modification of original, authored materials.
  - c. Using the network to harass or disparage others based on their race, national origin, sex, sexual orientation, age, disability, or religious or political beliefs.
  - d. Violations of copyright rules regarding software, information, and attributions of authorship. For this reason, commercial software may not be installed on the system without express permission of the system administrator.
  - e. Deliberate attempts to degrade or disrupt system performance of the Network or any other computer system or network on the Internet. Such conduct may include, but is not limited to, the development of programs that harass other users or infiltrate a computer system and/or damage the software components of a computer system, and use of the network to intentionally obtain or modify files, passwords or data belonging to other users.
  - f. Hate mail, threats, harassment, and other similar communication via the Network.
3. The Network will not be used to transmit or obtain obscene or pornographic material. There is to be no display or transmission of sexually explicit images, messages, or cartoons, or any transmission or use of E-mail communications that contain ethnic slurs or racial epithets.
4. Loading or use of unauthorized games and programs is prohibited.
5. Do not post communications to a public forum without the prior consent of the author of the communication. However, messages posted in a public forum such as newsgroups may be copied in subsequent communications, so long as proper attribution is given.
6. Use appropriate language. Profanity or obscenity will not be tolerated on the network. All network users should use language appropriate to school situations as indicated by district and school codes of conduct.
7. Avoid offensive or inflammatory speech. Network users must respect the rights of others both in the local community and in the Internet at large. Personal attacks are an unacceptable use of the Network.
8. Do not assume a false name or communicate on the Network using another person's name or password.
9. Behave in an exemplary manner on "virtual" field trips. When "visiting" locations on the Internet, or using video conferencing or screen sharing communications tools, network users must conduct themselves as representatives of both their school and the community.
10. Use of the Network for non-school purposes is prohibited.
11. Do not reveal personal information about yourself or others, including home address, telephone numbers, social security number or credit card number.

### **Student**

I understand and will abide by the above Internet Use Agreement. I further understand that any violation of the regulations above is unethical and may constitute a criminal offense. Should I commit any violation, my access privileges may be revoked, school disciplinary action, and/or appropriate legal action may be taken.

Student Name (please print): \_\_\_\_\_

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

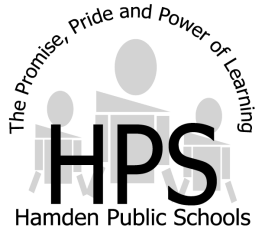
School : \_\_\_\_\_ Grade \_\_\_\_\_

### **Parent or Guardian**

As the parent or guardian of this student, I have read the Internet Use Agreement. I understand that this access is designed for educational purposes. However, I also recognize it is impossible for Hamden Public Schools to restrict access to all controversial materials and I will not hold the school system responsible for materials students may acquire on the network. I hereby give permission for my child to access the Internet to issue an account if necessary and to certify that the information on this form is correct.

Parent/Guardian Name (please print) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



Hamden Public Schools  
Permission to Photograph/Video Tape

In connection with the educational programs in our school building, opportunities may occur to photograph or videotape your child. These photographs and/or videos may be used in the school or PTA newsletters, school web sites, yearbooks, bulletin boards, in local or regional newspapers, on television, to train staff members, or as part of a public performance.

In order to grant the school district permission to photograph and/or videotape your child parents/guardians of all students must complete and return the form below.

I hereby give permission for my child \_\_\_\_\_ to be photographed, videotaped, audio-taped, named on radio, named or shown on television, named or pictured in a newspaper, and/or appear in a public performance (which may be photographed or videotaped).

\_\_\_\_\_  
Parent/Guardian Name (please print)

\_\_\_\_\_  
Parent Guardian Signature

\_\_\_\_\_  
Date

Please not: As per the Hamden Public Schools Web Site Policy (6141.311), no personal information and/or identification of any student (other than first name, and last initial) may be contained in a school web site, whether in conjunction with published photograph or not.



## Observation Sheet from Former Preschool/Child Care Provider

Dear Parent/Guardian,

The information we are seeking will assist your child's kindergarten teacher in planning appropriate learning and social activities. Please sign below and give this form to your child's Preschool/Child Care Provider to complete and return to the Hamden Public Schools.

I give permission for \_\_\_\_\_ to share this information with the Hamden Public Schools.  
(Name of Preschool/Child Care Provider)

Name of Student: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Parent's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please circle school child will be attending:

Bear Path 10 Kirk Road Hamden, CT 06514	Church Street 95 Church Street Hamden, CT 06514	Dunbar Hill 315 Lane Street Hamden, CT 06514	Helen Street 285 Helen Street Hamden, CT 06514	Ridge Hill 120 Carew Road Hamden, CT 06517	Shepherd Glen Skiff Street Ext. Hamden, CT 06514	Spring Glen School 1908 Whitney Ave Hamden, CT 06514	West Woods 350 W. Todd St. Hamden, CT 06518
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Preschool/Child Care Provider \_\_\_\_\_ Phone Number: \_\_\_\_\_

Child attended the Preschool/Child Care for \_\_\_\_ years and \_\_\_\_ months. Child attended \_\_\_\_ hour x \_\_\_\_ days/week.

Teacher's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Teacher: Place an  next to those skills/behaviors that the child displays on a consistent basis.**

**Reading Readiness:**

- Identifies own first name  points to pictures when asked about the characters or objects in the book
- Identifies upper case letters of the alphabet  Identifies lower case letters of the alphabet
- Tracks text during a read aloud  Writes own first name  Answers questions about stories
- Tells about the events of his/her day  Engages in conversation  Retells stories  Knows Alphabet

**Language Skills:**  English dominant language  Fluent in language other than English

**Listening Skills/Social Emotional Development:**

- Socializes/Plays with other children  Shares with others  Expresses self verbally
- Takes turns  Seeks adult assistance when needed  Maintains self-control
- Appropriate response to authority  Transitions easily  Adjusts to new situations easily
- Listens quietly  Follows simple directions  Knows first and last name  Knows body parts
- Responsible for material  Cleans up after play  Cleans up after snack  Cares for own toilet needs

**Colors, Shapes, Numbers:**

- Recognizes basic colors  Identifies numbers to 10  Recognizes circle, square, triangle, rectangle
- Counts objects to 10

**Motor Skills:**

- Is able to complete simple puzzles  Is able to cut with scissors  Is able to control pencil and crayon
- Is able to draw some recognizable objects  Is able to build with blocks

**Child's favorite things:**

Food:	Toys:	Activity:

Child is good at: \_\_\_\_\_

Child likes to: \_\_\_\_\_

Child doesn't like to: \_\_\_\_\_

**Note to Preschool/Child Care Provider: Please return this form directly to the school circled above by June 1st**



Hamden Public Schools  
Hamden School Health Services  
Health History Questionnaire

Dear Parent/Guardian,

Please fill out the following health history information if your child is a new entrant to Hamden elementary schools and return to the school nurse. If this is part of the kindergarten packet, please bring the completed form to the school nurse when your register for school along with your child's Immunization records.

**1. Identifying Information**

Student's Name: \_\_\_\_\_ Entering Grade: \_\_\_\_\_ Email: \_\_\_\_\_

Current Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
(Include Apartment/Floor)

Date of Birth: \_\_\_\_\_ Birth Place: \_\_\_\_\_ Gender:  Male  Female

Parent/Guardian Name(s): \_\_\_\_\_

Last School Attended: \_\_\_\_\_

**2. Early Health and Developmental History**

Birth Weight: \_\_\_\_\_

Please note any complications of pregnancy, labor or delivery, such as illness, infection, long labor, prematurity, etc.: \_\_\_\_\_

Have you or your primary health care provider identified any developmental problems or concerns?

Yes  No

If yes, please explain: \_\_\_\_\_

**3. Medical Information**

Primary Health Care Provider's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last physical exam \_\_\_\_\_

Findings: \_\_\_\_\_

Is your child on regular medication?  Yes  No If yes, please name and explain:

Does your child occasionally need medication for any reason?  Yes  No If yes, please name and explain:

Does your child have an allergy to:

- |             |                              |                             |   |
|-------------|------------------------------|-----------------------------|---|
| Food        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> If yes, explain: _____ |
| Insects     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> If yes, explain: _____ |
| Medication  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> If yes, explain: _____ |
| Environment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> If yes, explain: _____ |
| Latex       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> If yes, explain: _____ |
| Other       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> If yes, explain: _____ |

#### **4. Review of Systems**

If your child has/had any of the following within the past 12 months please check and briefly describe.

Head:  None/No incidents  Loss of Consciousness  Pain

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Eyes:  None/No incidents  Squinting  Tearing  Cross Eyes  Loss/Impaired Sight

---

Ears:  None/No incidents  Excess Wax  Frequent Infections  PE Tubes  Loss/Impaired Hearing

---

Nose:  None/No incidents  Frequent Colds  Nose Bleeds  Allergies (explain type)

---

Throat:  None/No incidents  Frequent Infections  Strep Throat  Difficulty Swallowing

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Mouth & Teeth:  None/No incidents  Toothaches  Cavities  Sourness of the Mouth  Speech Problems

---

Lungs:  None/No incidents  Difficulty Breathing  Wheezing  Persistent Cough  Asthma  Infections  
(Bronchitis/Pneumonia)

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Heart:  None/No incidents  Murmur  Chest Pains  Tires Easily  Shortness of Breath  
 High Blood Pressure  Elevated Heart Rate

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Stomach & Bowels:  None/No incidents  Vomiting  Diarrhea  Constipation  Frequent Stomachaches

---

Bladder & Kidneys:  None/No incidents  Painful Urination  Infections  Bed Wetting

---

Bones & Muscles:  None/No incidents  Joint Pain  Joint Swelling  Limp  Knee Pain

---

Growth:  None/No incidents  Overweight  Underweight  Anemia (low red blood cells)  Too short  Too Tall

---

Skin & Lymph:  None/No incidents  Rashes  Hives  Infections  Swollen Glands  Bruise Easily  Eczema

---

Hospitalization (explain): \_\_\_\_\_

Serious Injury/Accident (explain): \_\_\_\_\_

Surgery (explain): \_\_\_\_\_

**5. Current Behavior and Development**

Activities of daily living: Please briefly describe:

Usual sleep pattern (include any problem): \_\_\_\_\_

Usual eating pattern (include any dietary limitations): \_\_\_\_\_

Elimination Pattern (indicate any problem with urination or bowel movement): \_\_\_\_\_

Exercise Habits: \_\_\_\_\_

**Behaviors** Please check and explain as appropriate. My child...

- is overly active  Yes  No  Sometimes: \_\_\_\_\_
- is easily distracted  Yes  No  Sometimes: \_\_\_\_\_
- is very quiet  Yes  No  Sometimes: \_\_\_\_\_
- has unusual fears  Yes  No  Sometimes: \_\_\_\_\_
- has temper tantrums  Yes  No  Sometimes: \_\_\_\_\_
- plays regularly with other children  Yes  No  Sometimes: \_\_\_\_\_
- can cooperate with other children  Yes  No  Sometimes: \_\_\_\_\_

**Skills** Can your child use...

- pencils?  Yes  No
- crayons?  Yes  No
- scissors?  Yes  No

**Language**

- Can strangers easily understand your child's speech?  Yes  No
- Is your child under care for speech?  Yes  No
- What languages are spoken at home? \_\_\_\_\_

**6. Family Information**

Has your family had any recent significant changes? (death, divorce, move)  
If yes, please explain:

Does any immediate family member or relative have any significant medical problem(s)?  
If yes, please explain:

Please give the following information for other children in your family:

Name	Age	Gender	Any Health Problems?	School (if still in school)

Medical Insurance: \_\_\_\_\_



**8. School Adjustment**

How do you think your child will react on the first day of school? \_\_\_\_\_

Is there anything we can do or should know that might help your child in adjusting positively in school?

What does your child enjoy? \_\_\_\_\_

Please list your child's interests: \_\_\_\_\_

What does your child dislike? \_\_\_\_\_

Thank you for your time and assistance. This information will help me to provide appropriate health care for your child in the school setting. Please keep me updated about any future changes in your child's health status.

I can be reached at: \_\_\_\_\_

Sincerely,

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Date

The above information is accurate to the best of my knowledge.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



6. If I move outside of Hamden, or the Student(s) no longer reside(s) with me at my Hamden residence, I agree to so inform the Hamden Public Schools immediately.
7. I understand and hereby acknowledge that the statements herein are true and that I may be subject to civil and criminal penalties if I have knowingly provided inaccurate information.
8. If it is determined that the Student(s) is/are not legally residing in Hamden and/or is/are not legally entitled to school accommodation in Hamden, I acknowledge and understand that the Hamden Board of Education may assess me tuition for the period of time that the Student(s) was/were not legally entitled to attend Hamden Public Schools. I hereby agree to waive any defenses or claims I may have in any administrative, legal or other proceeding brought by the Hamden Public Schools to collect tuition for the period of time that the Student(s) illegally attended Hamden Public Schools.

Dated: \_\_\_\_\_, Connecticut

\_\_\_\_\_ 201\_\_

By: \_\_\_\_\_

This document must be witnessed and signed by another person over the age of 18:

\_\_\_\_\_  
Witness



## **Hamden Public School Health Services Health Assessment and Immunization Information**

Dear Parents/Guardian,

State Law in Connecticut requires that every student entering a school system in the State must meet certain health requirements before s/he is allowed to begin school. These requirements are implemented to protect the health of students in our schools.

These requirements include a health assessment and immunizations before entry into school as described below.

1. Health Assessment: Includes a physical examination with height, weight, blood pressure, pulse, and hematocrit or hemoglobin; vision, hearing, speech, scoliosis, and gross dental screening; health and developmental history; and updating of immunizations.

- A. The medical evaluation must be recorded on the Connecticut State Department of Education, Health Assessment Record (HAR-3) to be acceptable. Page one must be completed and signed by the parent/guardian, page two and three must be completed and signed by the Primary Health Care Provider.
- B. **For any student first entering a school in Connecticut**, any health assessment completed in the United States within twelve months prior to the student's date of entry into school in Hamden is acceptable
- C. **For any student transferring from another school in Connecticut**, documentation that the state-mandated health assessments were accomplished as required (on entry, in 6<sup>th</sup> or 7<sup>th</sup> grade and in 10<sup>th</sup> or 11<sup>th</sup> grade, depending on the student's grade level), and documentation of any significant findings will suffice to meet entry requirements into Hamden Public Schools. Adequate documentation is the student's health record form from the former school system, including all previously completed state health assessment forms.
- D. **Any student entering from Asia, Africa, Latin America or any high risk area** is required to get a PPD or show proof of having received one with the date and results.
- E. A more recent health assessment that indicated in (B) or (C) above may be required of any entering student if the School Medical Advisor determines it necessary for the protection of the student or others in school.

### **No student will be allowed to enter school until the requirements are met.**

Students who are not adequately immunized may enter once they provide documentation of having received a dose of each required vaccine for which that student is lacking in the month prior to first attendance; and, continues on the recommended schedule with intent to continue the series as required.

The only valid proof of immunizations is the signature of a primary health care provider or department of health, stating what immunizations were given and the date on which they were administered. Exemptions for mandated immunizations for medical or religious reasons are valid only with appropriate documentation. Forms are available from the school nurse and on the Connecticut State Department of Education Website (<http://www.sde.ct.gov>).

Please call the schools nurse if you have any questions. If school is not in session, please call Hamden School Health Services, (203) 407-2220.

Thank you for your cooperation.



# State of Connecticut Department of Education

## Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

*Please print*

Student Name (Last, First, Middle)	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	<input type="checkbox"/> Black, not of Hispanic origin
Primary Care Provider	<input type="checkbox"/> American Indian/ Alaskan Native	<input type="checkbox"/> White, not of Hispanic origin
		<input type="checkbox"/> Asian/Pacific Islander
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N	If your child does not have health insurance, call <b>1-877-CT-HUSKY</b>	
Does your child have dental insurance? Y N		

\* If applicable

### Part I — To be completed by parent/guardian.

**Please answer these health history questions about your child before the physical examination.**

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
<b>Family History</b>						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)						Diabetes	Y	N
Any immediate family members have high cholesterol						ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

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Is there anything you want to discuss with the school nurse? Y N If yes, explain:

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Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian

Date

**Part II — Medical Evaluation**

**Health Care Provider must complete and sign the medical evaluation and physical examination**

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Date of Exam \_\_\_\_\_

I have reviewed the health history information provided in Part I of this form

**Physical Exam**

**Note:** \*Mandated Screening/Test to be completed by provider under Connecticut State Law

\*Height \_\_\_\_\_ in. / \_\_\_\_\_ % \*Weight \_\_\_\_\_ lbs. / \_\_\_\_\_ % BMI \_\_\_\_\_ / \_\_\_\_\_ % Pulse \_\_\_\_\_ \*Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

**Screenings**

*Vision Screening			*Auditory Screening			Lead:	Date
Type:	<u>Right</u>	<u>Left</u>	Type:	<u>Right</u>	<u>Left</u>		
With glasses	20/	20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Pass			
Without glasses	20/	20/	<input type="checkbox"/> Fail	<input type="checkbox"/> Fail			
<input type="checkbox"/> Referral made			<input type="checkbox"/> Referral made			*HCT/HGB:	
						Other:	

**TB:** High-risk group?  No  Yes PPD date read: \_\_\_\_\_ Results: \_\_\_\_\_ Treatment: \_\_\_\_\_

**\*IMMUNIZATIONS**

Up to Date or  Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

**\*Chronic Disease Assessment:**

**Asthma**  No  Yes:  Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent  Exercise induced  
 If yes, please provide a copy of the **Asthma Action Plan** to School

**Anaphylaxis**  No  Yes:  Food  Insects  Latex  Unknown source

**Allergies** If yes, please provide a copy of the **Emergency Allergy Plan** to School

History of Anaphylaxis  No  Yes Epi Pen required  No  Yes

**Diabetes**  No  Yes:  Type I  Type II **Other Chronic Disease:** \_\_\_\_\_

**Seizures**  No  Yes, type: \_\_\_\_\_

This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.  
 Explain: \_\_\_\_\_

Daily Medications (specify): \_\_\_\_\_

This student may:  participate fully in the school program  
 participate in the school program with the following restriction/adaptation: \_\_\_\_\_

This student may:  participate fully in athletic activities and competitive sports  
 participate in athletic activities and competitive sports with the following restriction/adaptation: \_\_\_\_\_

Yes  No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.

Is this the student's medical home?  Yes  No  I would like to discuss information in this report with the school nurse.

Signature of health care provider MD / DO / APRN / PA \_\_\_\_\_ Date Signed \_\_\_\_\_ Printed/Stamped **Provider** Name and Phone Number \_\_\_\_\_

# Immunization Record

**To the Health Care Provider: Please complete and initial below.**

Vaccine (Month/Day/Year) Note: \*Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap						
IPV/OPV	*	*	*			
MMR						
Measles	*	*				
Mumps	*					
Rubella	*					
HIB	*				Students under age 5	
Hep A						
Hep B	*	*	*			
Varicella	*					
PCV					Pneumococcal conjugate vaccine	
Meningococcal						
HPV						
Flu						
Other						

Disease Hx \_\_\_\_\_  
of above (Specify) (Date) (Confirmed by)

### Exemption

Religious \_\_\_\_\_ Medical: Permanent \_\_\_\_\_ Temporary \_\_\_\_\_ Date \_\_\_\_\_  
Recertify Date \_\_\_\_\_ Recertify Date \_\_\_\_\_ Recertify Date \_\_\_\_\_

### Immunization Requirements for Newly Enrolled Students at Connecticut Schools

- KINDERGARTEN** DTaP: At least 4 doses. The last dose must be given on or after 4th birthday  
Polio: At least 3 doses. The last dose must be given on or after 4th birthday  
MMR: 1 dose on or after the 1st birthday  
*Measles*: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose  
Hib: Children less than 5 yrs of age need 1 dose at 12 months or older Children 5 and older do not need proof of Hib vaccination  
Hep B: 3 doses  
Varicella: 1 dose on or after the 1st birthday or verification of disease
- GRADES 1-6** DTaP/Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday  
Students who start the series at age 7 or older only need a total of 3 doses  
Polio: At least 3 doses. The last dose must be given on or after 4th birthday  
MMR: 1 dose on or after the 1st birthday  
*Measles*: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose  
Hep B: 3 doses  
Varicella: 1 dose on or after the 1st birthday or verification of disease
- GRADES 7-12** Td/Tdap: At least 3 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses  
Polio: At least 3 doses. The last dose must be given on or after 4th birthday  
MMR: 1 dose on or after the 1st birthday  
*Measles*: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose  
Hep B: 3 doses  
Varicella: 1 dose on or after first birthday or verification of disease:  
**VARICELLA VACCINE**: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart  
**VERIFICATION OF DISEASE**: Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history

Initial/Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed/Stamped <i>Provider</i> Name and Phone Number
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