

Wachusett Regional School District

Holden, Paxton, Princeton, Rutland, Sterling

If you need this booklet translated, please contact the main office of your child's school.

Portuguese/Português

Se você necessitar este livreto traduzido, contate por favor o escritório principal da escola da sua criança.

Spanish/ Español

Si usted necesita este librete traducido, entre en contacto con por favor la oficina principal de la escuela de su niño.

French/ Français

Si vous avez besoin de ce livret traduit, entrez en contact avec svp le bureau principal de l'école de votre enfant.

German/ Deutsch

Wenn Sie diese übersetzte Broschüre benötigen, treten Sie bitte mit dem Hauptbüro der Schule Ihres Kindes in Verbindung.

Russian/Русско

Если вы этот переведенный буклет, то пожалуйста контактируйте главный офис школы вашего ребенка.

Korean/한국어

너가 번역되는 이 소책자를 필요로 하면, 너의 아이 학교의 본사를 접촉하십시오.

Chinese/汉语

如果您需要这本小册子被翻译，请与您的儿童的学校大会办公处联系。

Japanese/日本語

翻訳されるこの小冊子を必要とすればあなたの子供の学校の主要なオフィスに連絡하십시오。

Hindi/ihndi

Agar Aapka yah puistka ki Anavaaidt AavaSyakta ho tba kRpyaa Apnao bacciao ko ivaValaya ka mau#ya kayaa-laya sampk- kiryao .

Polish/Polski

Jeśli potrzebujesz tej broszury przetłumaczone, skontaktuj się z głównego urzędu Twoje dziecko w szkole.

Greek

Αν χρειάζεστε το φυλλάδιο αυτό μεταφράστηκε, παρακαλούμε επικοινωνήστε με την κύρια έδρα του σχολείου του παιδιού σας.

Italian/Italia

Se hai bisogno di questo opuscolo tradotto, si prega di contattare l'ufficio principale del vostro bambino scuola.

Arabic

المكتب الرئيسية من طفلك مدرسة. اتصل ب إن أنت تحتاج هذا كراس يترجم. رجاء

Albanian

Ne qofte se ju do te deshironit dokumentat te perkthyer ne gjuhen shqip. Ju mund ti kerkoni ne zyren qendrore te shkolles du eshte femija juaj.



Wachusett Regional School District
Holden, Paxton, Princeton, Rutland, Sterling

FOR IMMEDIATE RELEASE

**Wachusett Regional School District Kindergarten Registration
For the 2012-2013 School Year**

January 2012

Dear Parents/Guardians:

Kindergarten registration for the 2012-2013 school year has begun in the Wachusett Regional School District. Parents of children who will reach their fifth birthday **on or before August 31, 2012**, should contact the appropriate school **as soon as possible to arrange for a registration appointment**. There are no exceptions to the District's age policy.

Kindergarten registration materials are now available at the District website (www.wrsd.net). Parents who cannot access Kindergarten registration forms by visiting the District website may call the school where their child will enroll to request a packet of materials. Parents are **strongly encouraged** to complete the **entire** registration packet **prior to their appointment**. Please remember to bring completed forms to your appointment.

At the time of registration, parents are **required to bring their child's notarized birth certificate, an updated list of immunizations and proof of vision, hearing and lead screenings**. Please request these screenings at your child's **pre-enrollment physical**. The enclosed *Massachusetts School Health Record-Health Care Provider's Examination* form includes an area for physicians to record the results of vision, hearing and lead screening tests. Parents who have questions should call the main office of the appropriate school or the District's Central Office.

Please contact the school nurse if your child has specific medical conditions or concerns that may require a parent conference.

For your convenience, a listing of the schools in the Wachusett Regional School District is provided:

HOLDEN

Davis Hill School
508-829-1754

Dawson School
508-829-6828

Mayo School
508-829-3203

PAXTON

Paxton Center School
508-798-8576

PRINCETON

Thomas Prince School
978-464-2110

RUTLAND

Naquag Elementary School
508-886-2901

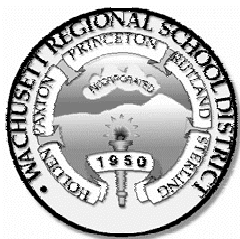
STERLING

Houghton Elementary School
978-422-2333

WRSD CENTRAL OFFICE

Jefferson School
508-829-1670x 237

Jefferson School
1745 Main Street, Jefferson, MA 01522
Telephone: (508) 829-1670 Facsimile: (508) 829-1680
www.wrsd.net



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Please bring the following completed documents with you when you bring your child to register for kindergarten:

- A completed Kindergarten Registration Form;
- A completed Home Language Survey;
- A completed Assignment to Kindergarten Sessions/Transportation Information Form;
- Completed Kindergarten Developmental History Form;
- A completed Massachusetts School Health Record Form (to be completed by student's physician), which includes:
 - Health Care Provider's Examination Form
 - Certificate of Immunization Form
For more information regarding immunizations, please visit
<http://www.mass.gov/dph/imm> or
<http://www.mass.gov/eohhs/docs/dph/regs/105cmr220.pdf>
- A copy of the student's Birth Certificate

At the time of registration, the Emergency Information Form will be completed.

January 31, 2008
January 2009
January 2010
January 8, 2011
January 18, 2012

**WACHUSETT REGIONAL SCHOOL DISTRICT
KINDERGARTEN REGISTRATION FORM
2012-2013 ACADEMIC YEAR**

The information requested below mirrors information managed by the District's Student Information System, and is used to generate state and federal demographic and statistical reports.

STUDENT INFORMATION

Student Last Name: _____

Student First Name: _____

Student Middle Name: _____

Preferred Name: _____

HOME ADDRESS

Street, Apt/Suite: _____

City, State, Zip _____

Home Phone

Date of Birth:

Birthplace

Grade

Federal Ethnicity and Race

Is the student Hispanic or Latino?

Yes

No

What is the student's race?

(A) Asian

(B) Black or African American

(I) American Indian or Alaska Native

(P) Native Hawaiian/Other Pacific Islander

(W) White

Previous School Attended:

Family Information:

Student Resides with: _____
(Parent(s), Guardian(s), Other)

Parent/Guardian: _____ Parent/Guardian: _____

Parent/Guardian Home Phone: _____ Parent/Guardian Home Phone: _____

Parent/Guardian Cell: _____ Parent/Guardian Cell: _____

Parent/Guardian Employer: _____ Parent/Guardian Employer: _____

Family Information, continued:

Parent/Guardian email: _____ Parent/Guardian email: _____

Step-parent (Last, First) _____ Step-parent (Last, First): _____

Step-parent Home Phone: _____ Step-parent Home Phone: _____

Step-parent Cell Phone: _____ Step-parent Cell Phone: _____

Step-parent Employer: _____ Step-parent Employer: _____

Step-parent's Work Phone: _____ Step-parent's Work Phone: _____

Step-parent's email: _____ Step-parent's email: _____

Other Guardian (Last, First) _____ Other Guardian (Last, First): _____

Other Guardian Home Phone: _____ Other Guardian Home Phone: _____

PowerSchool contact email (if more than one, separate by commas): _____

Additional Mailing Information:

Name: _____

Street, City, State, Zip: _____

Emergency Information

Emergency Contact 1: _____ Relationship: _____

Emergency Contact 1 Phone: _____ At: Work Home Cell

Emergency Contact 2: _____ Relationship: _____

Emergency Contact 2 Phone: _____ At: Work Home Cell

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Conditions: _____

ConnectEd Information (ConnectEd is an automated telephone notification system used by schools to contact parents in the event of inclement weather cancellations or delays, as well as important events happening in the school or District.)

ConnectEd Preferred Phone Number: _____

Additional Information:

Is the student a foster child under the Massachusetts Division of Social Services? Yes No

Is the student a "Ward of the Court?" Yes No

Signature of Parent/Guardian

Relationship to Student

Date

**WACHUSETT REGIONAL SCHOOL DISTRICT
HOME LANGUAGE SURVEY**

Massachusetts Department of Elementary and Secondary Education regulations require that *all* schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. If a language other than English is spoken in the home, the District is required to do further assessment of your child. Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

Student Information

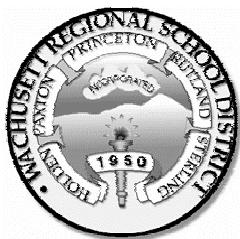
_____ F M
First Name **Middle Name** **Last Name** **Gender**
 _____ / _____ / _____
Country of Birth **Date of Birth (mm/dd/yyyy)** **Date FIRST enrolled in ANY U.S. school (mm/dd/yyyy)**

School Information

_____ / _____ /20 _____ _____
Start Date in New School (mm/dd/yyyy) **Name of Former School and Town** **Current Grade**

Questions for Parents/Guardians

<p>What is the native language(s) of each parent/guardian? (circle one)</p> <p>_____ (mother / father / guardian) _____ (mother / father / guardian)</p>	<p>Which language(s) are spoken with your child? (include relatives -<i>grandparents, uncles, aunts, etc.</i> - and caregivers)</p> <p>_____ seldom / sometimes / often / always _____ seldom / sometimes / often / always</p>
<p>What language did your child first understand and speak?</p>	<p>Which language do you use most with your child?</p>
<p>Which other languages does your child know? (circle all that apply)</p> <p>_____ speak / read / write _____ speak / read / write</p>	<p>Which languages does your child use? (circle one)</p> <p>_____ seldom / sometimes / often / always _____ seldom / sometimes / often / always</p>
<p>Will you require written information from school in your native language? <input type="checkbox"/> Y <input type="checkbox"/> N</p>	<p>Will you require an interpreter/translator at Parent-Teacher meetings? <input type="checkbox"/> Y <input type="checkbox"/> N</p>
<p>Parent/Guardian Signature: X</p>	<p>_____ / _____ /20 Today's Date: (mm/dd/yyyy)</p>



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Assignment to Kindergarten Sessions/Transportation Information

Children are assigned to sessions according to the neighborhood in which they reside.

For transportation purposes, please indicate where your child will be picked up or dropped off, if other than at home.

Child's Name _____

Babysitter/Childcare Name _____

Address _____

Telephone Number _____

Thank you for taking the time to supply us with this information. If there is any other information you feel the school should know, please note it at the bottom of this sheet.

January 31, 2008
January 18, 2012

**WACHUSETT REGIONAL SCHOOL DISTRICT
KINDERGARTEN DEVELOPMENTAL HISTORY**

Student's Name _____ Male Female

Home Address _____ Telephone No. _____

Birth Place _____ Birth Date _____

Do you feel that your child was delayed in any of the following:

Sitting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Toilet training	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Crawling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Feeding self	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Walking	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Premature birth	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Using simple words	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Normal delivery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Using full sentences	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments:	_____	

Has your child attended nursery school? Yes No Where? _____ For how long? _____

The following questions refer to problems in such areas as hearing, vision, speech, language, and physical, intellectual, social and emotional development.

Do you have any reason to suspect your child might be in need of any special services or considerations in his/her school setting or curriculum? Yes No If Yes, please explain: _____

Has your child ever been evaluated for any condition or problem which might have a bearing on school performance? Yes No If Yes, please explain: _____

Were the recommendations carried out? Yes No Please explain: _____

Would information regarding this evaluation and/or treatment be available for the appropriate school personnel?

Yes No

If Yes, please give name(s) and address(es) of person(s) or agency(ies) from whom this information may be obtained:

Is your child presently enrolled in any special school program? Yes No

If Yes, please explain: _____

What words best describes your child?

<input type="checkbox"/> shy	<input type="checkbox"/> self-confident	<input type="checkbox"/> cooperative
<input type="checkbox"/> happy	<input type="checkbox"/> jealous	<input type="checkbox"/> affectionate
<input type="checkbox"/> excitable	<input type="checkbox"/> nervous	<input type="checkbox"/> negative
<input type="checkbox"/> talkative	<input type="checkbox"/> other _____	

Which hand does your child prefer? right left

What words best describe your child's feelings about coming to school?

<input type="checkbox"/> enthusiastic	<input type="checkbox"/> eager	<input type="checkbox"/> fearful	<input type="checkbox"/> happy
<input type="checkbox"/> indifferent	<input type="checkbox"/> apprehensive	<input type="checkbox"/> other _____	

Is your child's speech easily understood by strangers? _____

Does he/she have a speech difficulty? _____

Does your child have any fears, such as:

<input type="checkbox"/> thunderstorms	<input type="checkbox"/> being alone
<input type="checkbox"/> the dark	<input type="checkbox"/> dogs or other animals
<input type="checkbox"/> noises	<input type="checkbox"/> other _____

Does your child have any special problems?

- | | | |
|---|---|--|
| <input type="checkbox"/> vision | <input type="checkbox"/> hearing | <input type="checkbox"/> eating |
| <input type="checkbox"/> nail-biting | <input type="checkbox"/> finger-sucking | <input type="checkbox"/> bed-wetting |
| <input type="checkbox"/> speech | <input type="checkbox"/> stubbornness | <input type="checkbox"/> temper-tantrums |
| <input type="checkbox"/> "accidents" in pants | <input type="checkbox"/> environmental allergies (pollen, etc.) | |
| <input type="checkbox"/> other If so, please list _____ | | |

Does your child have any physical condition that would prevent him/her from participating in an active kindergarten program?

Yes No If Yes, please explain: _____

Does your child play with:

- | | | |
|---|--|---|
| <input type="checkbox"/> brother/sister | <input type="checkbox"/> alone | <input type="checkbox"/> younger children |
| <input type="checkbox"/> older children | <input type="checkbox"/> neighborhood children | <input type="checkbox"/> one close friend |

Has your child had any of the following experiences?

- | | | |
|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> library | <input type="checkbox"/> public park | <input type="checkbox"/> beach |
| <input type="checkbox"/> airplane trip | <input type="checkbox"/> bus trip | <input type="checkbox"/> bank |
| <input type="checkbox"/> camping | <input type="checkbox"/> train trip | <input type="checkbox"/> other _____ |

Can your child:

- | | | |
|---|--|---|
| <input type="checkbox"/> zip | <input type="checkbox"/> button | |
| <input type="checkbox"/> snap | <input type="checkbox"/> dress self | <input type="checkbox"/> stay willingly with a relative |
| <input type="checkbox"/> tie shoes | <input type="checkbox"/> take care of toilet needs | <input type="checkbox"/> stay willingly with others |
| <input type="checkbox"/> stay willingly with a babysitter | | |

Does your child use at home:

- | | | |
|-----------------------------------|----------------------------------|--|
| <input type="checkbox"/> scissors | <input type="checkbox"/> crayons | <input type="checkbox"/> paste or glue |
| <input type="checkbox"/> puzzles | <input type="checkbox"/> pencils | <input type="checkbox"/> paint |
| <input type="checkbox"/> clay | <input type="checkbox"/> blocks | <input type="checkbox"/> books |

Previous School experiences:

- | | | |
|---|---|-------------------------------|
| <input type="checkbox"/> Head Start | <input type="checkbox"/> religious school | <input type="checkbox"/> None |
| <input type="checkbox"/> nursery school-where & for how long? _____ | | |

Please describe briefly your child's nursery/preschool experience: _____

May we have permission to contact your child's preschool? _____

Is your child able to:

- | | | |
|--|--|--|
| <input type="checkbox"/> identify colors | <input type="checkbox"/> print his/her name | <input type="checkbox"/> count to 10 |
| <input type="checkbox"/> count higher than 10 | <input type="checkbox"/> identify numbers 1-10 | <input type="checkbox"/> count objects to 10 |
| <input type="checkbox"/> identify numbers 10-20 | <input type="checkbox"/> identify alphabet letters | <input type="checkbox"/> count objects to 20 |
| <input type="checkbox"/> listen to and follow directions | <input type="checkbox"/> identify shapes | <input type="checkbox"/> pick up after him/herself |
| <input type="checkbox"/> complete tasks begun | <input type="checkbox"/> tell his/her full name | <input type="checkbox"/> tell his/her phone number |
| <input type="checkbox"/> occupy self with quiet play | <input type="checkbox"/> tell left from right | <input type="checkbox"/> sit and listen to a story |
| <input type="checkbox"/> tell his/her address | | |

Thank you for taking the time to supply us with this information. Your cooperation is appreciated. If there is any other information you feel the school should know, please note it at the bottom of this sheet.

Information supplied by:

Signature of Parent/Guardian	Relationship to Student	Date
DO NOT WRITE BELOW THIS LINE		

GRADE _____ BIRTH CERTIFICATE VERIFIED _____ NURSE INITIALS _____ DATE _____

**WACHUSETT REGIONAL SCHOOL DISTRICT
HEALTH HISTORY**

Student's Name _____ **Class** _____

Dear Parent/Guardian:

In order to provide better health services to your child, we ask that you complete the following health history. Please give dates if possible.

Date of last physical examination: _____ Physician's Name: _____

Date of last dental examination: _____ Dentist's Name: _____

Hearing/Vision Problems: _____ Hospitalizations: _____

Allergic reactions: _____ Operations: _____

Asthma Attacks: _____ Other respiratory: _____

Bone/Joint disease/injury: _____ Please give dates of Immunizations:

DPT: 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Communicable Diseases: _____ Oral Polio: 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Convulsions/seizures: _____ Hep B: 1 _____ 2 _____ 3 _____

Diabetes: _____ MMR: 1 _____ 2 _____

Dental Problems: _____ Hib: 1 _____ 2 _____ 3 _____ 4 _____

Ear Infections: _____ TB test: 1 _____ 2 _____

Throat Infections: _____ Lead Paint Test: 1 _____ 2 _____

Frequent headaches? _____

Results of examination by physician for:

Kidney problems: _____ Hearing: _____ Date: _____

Heart Problems/Murmur: _____ Vision: _____ Date: _____

Currently under treatment: _____

Does your child take medication for any reason? _____

NOTE: No medication can be given at school without written orders from your MD

Does your child have physical limitations that may require program modifications or restrictions? _____

Please add any other comments you would like to bring to the attention of the school nurse or physician:

Parent/Guardian signature: _____ Date: _____

Health Care Provider's Examination

Name _____ Male Female Date of Birth: _____

Medical History _____

Pertinent Family History

Current Health Issues

Y N
 Allergies: Please list: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen®: Yes No
 Asthma: Asthma Action Plan Yes No (Please attach)
 Diabetes: Type I Type II
 Seizure disorder: _____
 Other (Please specify) _____

Current Medications (if relevant to the student's health and safety) Please circle those administered in school; a separate medication order form is needed for each medication administered in school.

Physical Examination

Date of Examination: _____
Hgt: _____ (____%) Wgt: _____ (____%) BMI: _____ (____%) BP: _____
(Check = Normal / If abnormal, please describe.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

Screening

Vision:	Pass	Fail	Hearing:	Pass	Fail
Right Eye	<input type="checkbox"/>	<input type="checkbox"/>	Right Ear	<input type="checkbox"/>	<input type="checkbox"/>
Left Eye	<input type="checkbox"/>	<input type="checkbox"/>	Left Ear	<input type="checkbox"/>	<input type="checkbox"/>
Postural Screening (Scoliosis/Kyphosis/Lordosis):	<input type="checkbox"/>	<input type="checkbox"/>	Stereopsis	<input type="checkbox"/>	<input type="checkbox"/>

Laboratory Results:

Lead _____ Date _____

Other _____

The entire examination was normal:

Targeted TB Skin Testing: Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors): Date of PPD: ____; Results: ____mm.

Referred for evaluation to: _____ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> Other	

Comments/Recommendations:

Y N This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions: _____

Y N Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.

Printed Name of Examiner Signature of Examiner Circle: MD, DO, NP, PA Date

Group/Practice Telephone

Address City State Zip Code

Please attach additional information as needed for the health and safety of the student MDPH 01/25/07

**Massachusetts Department of Public Health
CERTIFICATE OF IMMUNIZATION**

Name: _____

Date of Birth: ____ / ____ / ____ Sex: Female male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP- HepB-IPV)	1		Haemophilus influenzae type b (e.g., Hib, HepB- Hib, DTaP-Hib)	1	
	2			2	
	3			3	
		4			
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		Measles, Mumps, Rubella (MMR)	1	
	2			2	
	3		Varicella (Var)	1	
	4			2	
	5		Hepatitis A (HepA)	1	
	6			2	
7					
Polio (e.g., IPV, DTaP-HepB-IPV)	1		Pneumococcal Polysaccharide (PPV23)	1	
	2			2	
	3		Influenza Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1		Other:	3	
	2				
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

* Must also check Chickenpox History box.

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox.
Reliable history may be based on: <ul style="list-style-type: none"> • physician interpretation of parent/guardian description of chickenpox • physical diagnosis of chickenpox, or • serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print) _____ Date: ____ / ____ / ____

Signature: _____

Facility/Practice Name: _____