Carl Allgrove Elementary School

Robert McGrath, Principal

Welcome to East Granby Public Schools
www.eastgranby.k12.ct.us

Registration Information for Grades K-2

Welcome to Allgrove School! All of the forms in our registration packet can be completed in your web browser, saved, and printed for submission. All completed registration forms may also be emailed to registration@eastgranby.k12.ct.us. We recommend typing in the fillable forms to ensure the accuracy of the information submitted. Please increase the point size of the type so that it is legible. We look forward to meeting you and your child(ren) in the very near future.

If you have any questions regarding registration, please feel free to email us or leave a message at 860-653-2505. Please complete the following fillable forms included in this registration packet:

- Allgrove Registration Form
- Public School Information System Form
- Release of Information
- Dominant Language Form
- Emergency Form
- Bus Transportation Form
- State of Connecticut Health Assessment Record

In order to complete the registration process, you will need to appear in person with the following documentation:

<u>Original Birth Certificate</u>

- We will take a copy for our records.

<u>Proof of Residency:</u>

- If you own your home, we will verify through the Town Assessor's Office
- Copy of a Utility Bill
- Copy of the Sales Agreement if purchasing home and scheduled closing date. (If requesting to start school prior to closing date, written request must be submitted and approved by our Superintendent, Melissa Bavaro – mbavaro@eastgranby.k12.ct.us)
- If you are renting, a copy of your current lease agreement with lessee and lessor signatures.
- If residing with family and do not have a lease, a Proof of Residency, Policy 5118, APR#1 must be completed and Notarized.

We look forward to having you become a member of our Allgrove Community!

bmcgrath@eastgranby.k12.ct.us

33 Turkey Hills Road • East Granby, CT 06026 •860-653-2505 • Fax 860-413-9080

EAST GRANBY PUBLIC SCHOOLS

- ❒ Uses an Inhaler
- ❒ Needs EpiPen for: __________
- ❒ Daily Meds: _______________

Please note we must have all medication present on the day of Orientation.

- ❒ Birth Certificate Received
- ❒ Proof of Residency

East Granby, Connecticut

GRADES K – 2 REGISTRATION FORM

Student/Parent Information:

❒ Male
❒ Female

______________________ __________ ____________ ____________________

Student's Name Grade Birth Date Birth Place

Address: ______________________________ ❒ Own ❒ Rent **Phone #:**_______________

*If you are not currently occupying this East Granby residence, give current residence. Written permission must be obtained from the Superintendent of Schools if your current residence is not East Granby.

____

Child Resides with: ❒ Mother ❒ Father ❒ Both Parents
❒ Grandparent ❒ Legal Guardian ❒ Other ______________________

Email Address: ______________________________

Full Name of Siblings in Family:

Name: ______________________________ Year of Birth: __________ Grade: ________

Name: ______________________________ Year of Birth: __________ Grade: ________

Name: ______________________________ Year of Birth: __________ Grade: ________

Mother's Name or Guardian: ____________________________ Home Phone:_____________
Home Address: ____________________________________ Cell Phone: _____________
Employer: ____________________________________ Work Phone: ____________

Father's Name or Guardian: ____________________________ Home Phone:_____________
Home Address: ____________________________________ Cell Phone: _____________
Employer: ____________________________________ Work Phone: ____________

Guardian: ____________________________ Home Phone:_____________
Home Address: ____________________________________ Cell Phone: _____________
Employer: ____________________________________ Work Phone: ____________

Student Education Information:

Has your child previously attended preschool? ❒ Yes ❒ No

If yes: Name of School:______________________________ Address:________________ # of Yrs _____

Has your child ever been referred for Special Education Services? ❒ Yes ❒ No

Has your child ever received Special Education Services? (ie. Speech, Birth to 3, etc.) ❒ Yes ❒ No
Town where services were received: __________________________ Provider: _________________________

Please Check:

❒ If there is any information about your child's health or personality which you think the teacher should know, please explain on the back of this form or arrange to have a conference with the teacher.

Signature of Parent (Guardian)______________________________________ Date:_________________ **Rev. 1/19**

East Granby Public Schools
Student Information Request Form

Student's Last Name	**Student's First Name**	**Student's Middle Name**
Street Address	**City, State, Zip**	**Home Phone**

Gender *(M, F, Non-binary)*	**Birthdate** *(MM-DD-YYYY)*	**Name of Last School Attended**	**City and State of Last School Attended**

Place of Birth: *Please list City, State and Country*	**Year of Immigration** *(complete if child was not born in USA)*	**Number of School Years Completed in USA** *(complete if child was not born in USA)*
Date of Enrollment	**Anticipated Year of Graduation**	**Grade**
(Parent 1) **Name**	*(Parent 1)* **Street Address**	*(Parent 1)* **City, State, Zip**
(Parent 1) **Occupation**	*(Parent 1)* **Employer**	*(Parent 1)* **Home Phone**
(Parent 1) **Work Phone**	*(Parent 1)* **Cell Phone**	*(Parent 1)* **Email**
(Parent 2) **Name**	*(Parent 2)* **Street Address**	*(Parent 2)* **City, State, Zip**
(Parent 2) **Occupation**	*(Parent 2)* **Employer**	*(Parent 2)* **Home Phone**
(Parent 2) **Work Phone**	*(Parent 2)* **Cell Phone**	*(Parent 2)* **Email**
Military Family – the child's parent or guardian is a member of the Armed Forces on active duty or serves on full-time National Guard duty.	**Military Family?** - ***YOU MUST CHOOSE ONE*** ☐ **YES** ☐ **NO**	**Immigrant?** - ***YOU MUST CHOOSE ONE*** ☐ **YES** ☐ **NO**

Race/Ethnicity: **IS YOUR CHILD HISPANIC OR LATINO? –*YOU MUST CHOOSE ONE***

☐ **YES** ☐ **NO**

Race/Ethnicity: (*Check all that apply*)-- **YOU MUST CHOOSE AT LEAST ONE**

☐ **American Indian or Alaska Native** ☐ **Asian**
☐ **Black or African American** ☐ **Native Hawaiian or Other Pacific Islander** ☐ **White**

What is the dominant language at home? *(If other than English)*	**Eligible for free/reduced price for milk and lunches?** *(Yes or No) Please call 860-653-6486 for details.*
Transfer Students Only-School Name (Transferring From)	**School Address and Phone (Transferring From)**

Revised—Nov, 2019

EAST GRANBY PUBLIC SCHOOLS

East Granby, Connecticut

RELEASE OF INFORMATION

Name of Student: ______________________________ Date of Birth: _____________

Phone # where parent can be reached after moving:_________________

❒ I give permission for the East Granby Public Schools to receive the records indicated below from:

Name of school the student attends:

____

Name of School Address/Zip Code Phone #

❒ I give permission for the East Granby Public Schools to release the records indicated below to:

____

Name of School Address Zip Code

These records are for the purpose of educational planning and programming.

IMPORTANT: Please check items you wish to be received or released:

❒ Health Record
❒ Grades
❒ Achievement Scores
❒ Behavorial Check Lists
❒ Anecdotal Information
❒ Verbal Communication
❒ Psychological Record
❒ Social Work Record
❒ Speech/Language Evaluation Report
❒ I.Q. Scores
❒ Special Education Evaluation Report
❒ Other: _______________________
❒ PPT Records (Notice of Meeting, Notice of Evaluation, Case Summaries, Referral, etc.)

NOTE: This confidential information is being sent on the condition that no other party should have access to it without written consent of parent/guardian, or the student, if he/she is 18 years of age or a graduate.

I understand that I may review the materials checked on this release form before they are transmitted. I understand that one week from the date of this release, the above materials will be forwarded as requested.

_______________________________________ ____________________

Parent/Guardian Signature Date

Please return this form and all records/correspondence to:

Allgrove School
33 Turkey Hills Road
East Granby, CT 06026
Fax (860) 413-9080
Attn: School Secretary

Rev. 1/17/19

EAST GRANBY PUBLIC SCHOOLS

DOMINANT LANGUAGE

Parent Questionnaire for Preliminary Assessment of Dominant Language
(Step 1)

Date:_________________

Dear Parent / Guardian:

Connecticut State Law requires that each school district conduct a preliminary assessment of the dominant language of each student in its public schools. This assessment is made in order to ascertain the need to provide a required bilingual education program for students who are limited English proficient.

Please complete the following form and return it to the office.

Thank you for your cooperation.

Student's Name: ____________________________________

Grade: _______________

Where was your child born? ____

What language did your child first learn to speak?
____

What is the primary language spoken by you or other persons in your home?
____

What is the primary language spoken by your child when he/she is at home?
____

____ ______________________
Parent's Signature Date

Rev. 2/27/02

Grade ____________
Teacher ____________
Bus No. ____________

EMERGENCY INFORMATION FORM

(Please Print)

For Office Use

☐ Allergies __________
☐ EMCP
☐ Known Services

Student Name: ______________________________ **Birthdate:** ____________
Last Middle First

Address: ______________________________
Street Town

____
State Zip Parent Email Address

Mother's Name: ______________________________ **Home:** ____________
(Parent 1) Last First **Cell:** ____________
______________________________ **Work :** ____________
Address

Employer: ______________________________

Father's Name: ______________________________ **Home:** ____________
(Parent 2) Last First **Cell:** ____________
______________________________ **Work:** ____________
Address

Employer: ______________________________

List three neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

Name: ____________ **Address:** ____________ **Phone:** ____________
Cell: ____________

Name: ____________ **Address:** ____________ **Phone:** ____________
Cell: ____________

Name: ____________ **Address:** ____________ **Phone:** ____________
Cell: ____________

In case of accident or serious 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 this physician, the school may make whatever arrangements seem necessary.

____
Signature of Parent/Guardian Date

Remarks: ______________________________
Allergies: ______________________________
Other Conditions: ______________________________

Local Physician's Name: ____________ **Address:** ____________
Office Number: ____________ **Other Number:** ____________
Hospital Preference: ____________ **Does your child have health insurance?** ☐ **Yes** ☐ **No**

Transportation Request Form

IMPORTANT: *To plan for next year's transportation, we are asking for parents/guardians to complete a transportation form for **each** student.* ***Please complete in full and return to your child's school office.*** ***If we do not receive a completed form, your child will be assigned the bus route for your home address of record****. If, over the course of the summer, your transportation needs change, please notify the school office IN WRITING two weeks prior to the start of school. Thank you for your continued support in making transportation safe for our students.*

Student Name:	2024-2025 Grade Level:
Home Address:	
My child will travel to school:	
☐ **By bus** ☐ **By parent drop-off**	
I request that my child be picked up by the bus from:	
Address:	Home Daycare Alternate location
Phone:	
If alternate location: please print name / contact number and signature of receiving adult at above address:	
Name: Best Contact Number:	
Signature of receiving adult:	
☐ **Daily** ….**OR**	Only on the following days: (please circle) **M T W TH F**
My child will travel from school:	
☐ **By bus** from school	
Address:	Home Daycare Alternate location
Phone:	
If alternate location: please print name/contact number and signature of receiving adult at above address:	
Name: Best Contact Number:	
Signature of receiving adult:	
☐ **Daily** **OR**	Only on the following days: (please circle) **M T W TH F**

For Allgrove School and Seymour School Students ONLY

☐ I will **PICK UP** my child from school ☐ I have made arrangements to have my child picked up from school by: ____________________ ____________________(Phone#)____________	
☐ **Daily** **OR**	Only on the following days: (please circle) **M T W TH F**

AND/OR

☐ My child attends the YMCA Afterschool Program Reminder: Your child must be **enrolled** in the YMCA and on their list.	
☐ **Daily** **OR**	Only on the following days: (please circle) **M T W TH F**

Required for all requests

Parent Name (Print):	Contact Number:
Parent Signature:	Date:

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 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

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, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base 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	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part 1 — 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
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	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.

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

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

To be maintained in the student's Cumulative School Health Record

Part 2 — 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 1 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** ❑ No spinal abnormality	❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made	
Genitalia/ hernia					
Skin					

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
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 Allergies ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source
*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

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination Completed by: ❑ Dentist	**Visual Screening** Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	**Normal** ❑ Yes ❑ Abnormal (Describe) ______________________ ______________________ ______________________ ______________________ ______________________	**Referral Made:** ❑ Yes ❑ No
Risk Assessment	**Describe Risk Factors**		
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other ____________________		❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other ____________________

Recommendation(s) by health care provider: ____

____

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

____

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

Student Name: ______________________________ **Birth Date:** ________________ HAR-3 REV. 1/2022

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	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above ______________________ (Specify) ______________________ (Date) ______________________ (Confirmed by)

Religious Exemption: ________

Religious exemptions must meet the criteria established in Public Act 21-6: https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf.

Medical Exemption: ______________

Must have signed and completed medical exemption form attached. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

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