EAST PROVIDENCE SCHOOL DEPARTMENT
East Providence, Rhode Island

PUPIL REGISTRATION FORM

For Office Use Only	*For Office Use Only*	*For Office Use Only*
Home School________________________	School ______________________ AT______ P_____	Entry Date:_________
GR ________ LOCAL ID#______________________	SASID # ______________________	
IEP______ Medical______ Transportation: Yes___ No___	Special Instructions:_________________________________	
	Accommodations:_________________________________	

(To be completed by parent/guardian)

STUDENT INFORMATION:

Name of Pupil ____
Last *First* *Middle*

Date of Birth ____________________ Place of Birth ____________________ Sex ___________

Pupil Address ________________________________ Zip__________ Home Phone ______________
Street No. and Name

Mother ________________________________ Mother's D.O.B.__________ Work Phone__________
Last *First*

Address **(If different)**________________________________ Cell Phone ______________

Father ________________________________ Father's D.O.B.__________ WorkPhone__________
Last *First*

Address **(If different)**________________________________ Cell Phone ______________

Legal Guardian____________________________ Guardian's D.O.B.__________ Work Phone__________
(Other than parent)

ETHNICITY/RACE:

Please indicate ethnicity/race below. This section must be completed per Federal Government regulations and reporting requirements. Ethnic and racial information is used for state and federal census reports only.

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

- ☐ **No, not Hispanic/Latino**
- ☐ **Yes, Hispanic/Latino** (A person of Cuban, Mexican, Puerto Rican, Cuban, 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 (or your) 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 peoples 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.)
- ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- ☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

EDUCATIONAL INFORMATION:

Child Outreach/Child Find Screening: ☐ Yes ☐ No If Yes, place/date________________________________

IEP (Special Needs): ☐ Yes ☐ No If Yes, ☐ Self Contained ☐ Resource

Sec 504 Plan: ☐ Yes ☐ No

Previous School: ________________________________ Last Date Attended: ____/____/____

Previous School Address:________________________________
City *State*

Previously attended East Providence Public Schools: ☐ Yes ☐ No

Other siblings in East Providence Schools: ☐ Yes ☐ No If Yes, Grade(s)/School(s) ________________

Family Doctor/Clinic: ________________________________

Current Medical Issues (Allergies, Migraines, etc.): ________________________________

____

IMPORTANT ACKNOWLEDGEMENT: **(Re: RI GENERAL LAWS Title 16, Chapter 64 Sections 1-8)**

By signing this form as parent/guardian or other person acting in "loco parentis" to the student being registered, I/we attest that all information supplied is true and accurate. I/we understand that submitting false or fraudulent residency information may require the payment to the East Providence School Department of tuition, to be calculated at the per pupil cost of education. **This provision is strictly enforced.**

Parent/Guardian Signature________________________________

Date of Registration: Month ____________ Day__________ Year ____________

School Registrar Signature________________________________

Release of Information

Should a question regarding the residency of those persons listed on school registration forms and/or affidavits arise, the East Providence School Department will conduct an investigation. By signing this form, I/we acknowledge that this form will authorize the agency/person from whom the information is sought, to release to the East Providence School Department, any all information regarding addresses listed with them, including addresses, dates of occupancy, a nd any other information available that will help establish residency of students enrolled in the East Providence School System.

I/we further understand that the use of this form will be limited to the request of information regarding residency only and all information obtained by the East Providence School Department will be kept confidential and used only in relation to such investigation and resulting proceedings conducted pursuant to Title 16 of the Rhode Island General laws.

Parent/Guardian:________________________ Date:__________

Parent/Guardian:________________________ Date:__________

Ken Wagner
Commissioner

RI Department of Education Home Language Survey

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

To be completed by parent or guardian:

Student Name:______________________________________

Registration Date:________________ Date of Birth:________________

DATE OF ENTRY IN THE UNITED STATES:________________

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

____

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

____

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

____

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

____

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

____

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

____

____
Signature of Parent or Guardian Date

____
Print Parent/Guardian Name

educational and safety purposes.

Name of Child ______________ Date of Birth__________ Male___ Female___ Grade: ____
Address ______________________________ Home Phone________________
Physician Name______________ Physician Number__________ Dentist Name ____________
Name of prior school, if any:__________________ City/Town, State:________________

HEALTH CONCERNS/HEALTH HISTORY

Please check any health concerns that apply and provide additional information on lines:

ALLERGIES: Please check and list name of allergen/s
- ◻ Food:____________ ◻ Medication Allergy:____________
- ◻ Insect:____________ ◻ Environmental:____________

Has your child experienced any of these allergic symptoms? :
- ◻ Rash ◻ Swelling ◻ Hives ◻ Trouble Breathing
- ◻ Vomiting ◻ Diarrhea ◻ Local Reaction

Is an Epipen prescribed for school? ___ Yes ___ No
- ◻ Other medicines prescribed: ____________
- ◻ My child follows a special diet :____________
- ◻ My child requires allergy exposure precautions in the classroom/cafeteria: ◻ Peanut/Nut Free Classroom/Table ◻ Other

ASTHMA/ RESPIRATORY CONDITIONS:
- ◻ Triggers:____________
- ◻ Needs Inhaler at School ◻ Yes ◻ No
- ◻ Frequent colds ◻ Nosebleeds ◻ Frequent Strep Throat
- ◻ Bronchitis ◻ Pneumonia ◻ Other:____________

BLOOD DISORDERS:
- ◻ Sickle cell disease ◻ Anemia ◻ Hemophilia
- ◻ Other blood disorder/condition: ____________
- ◻ Precautions/Restrictions:____________

EMOTIONAL/BEHAVIORAL CONCERNS:
- ◻ ADHD
- ◻ Other Diagnosis: ____________
- ◻ Treatment/Medication: ____________

CONGENITAL DISORDERS:
- ◻ Cystic Fibrosis ◻ Spina Bifida ◻ Other: ____________

DENTAL CONCERNS:
- ◻ Multiple cavities/fillings
- ◻ History of tooth injury: ____________
- ◻ Wears braces/corrective device: ____________
- ◻ Other dental concerns: ____________

DIABETES
- ◻ Type I ◻ Type II
- ◻ Needs medication at school: ____________
- ◻ Needs blood sugar monitoring at school: ____________

DIGESTIVE/ELIMINATION
- ◻ Frequent stomachaches
- ◻ Constipation ◻ Diarrhea ◻ Bladder/Bowel control problems
- ◻ Other concerns/conditions ____________

HEART CONDITION:
- ◻ Type: ____________
- ◻ Physical Restrictions: ____________
- ◻ Other Precautions: ____________

HEARING DIFFICULTIES:
- ◻ Hearing loss, type: ____________
- ◻ Frequent ear infections
- ◻ Ear tubes, Presently in ◻ Right ear/ ◻ Left ear
- ◻ History of ear tubes (removed) ◻ Right ear/ ◻ Left ear
- ◻ Assistive hearing device: ____________
- ◻ Classroom accommodations:
- ◻ Special seating__________ ◻ Other:__________

HOSPITALIZATION:
- ◻ Reason: ____________ Date: ____________
- ◻ Treatment: ____________

INJURIES REQUIRING MEDICAL TREATMENT:
- ◻ Type of Injury: ____________ Date:____________
- ◻ Treatment: ____________

SKELETAL/MUSCULAR CONDITIONS and MOBILITY NEEDS:
- ◻ Muscular Dystrophy
- ◻ Other Muscular/Skeletal conditions: ____________
- ◻ Wears/uses orthopedic device: ____________
- ◻ Needs wheelchair
- ◻ Classroom accommodations:____________

NEUROLOGICAL CONDITIONS:
- ◻ Frequent headaches ◻ Migraines
- ◻ Cerebral Palsy ◻ Other neurological condition: ____________

SEIZURE CONDITIONS:
- ◻ Grand mal ◻ Absence (petit mal) ◻ Complex
- ◻ Frequency of seizures:____________
- ◻ Date of last seizure: ____________
- ◻ Medication at school: ____________

◻ **MEDICATIONS:**

Taken at home: ______________________________

____

____

Taken at school: ______________________________

***All medications given at school require a signed physician's order and parental/guardian permission. Please inquire with school nurse.

SURGERIES:
- ◻ History of surgery; Date:________ Type:____________
- ◻ Other: ____________

VISION PROBLEMS:
- ◻ Difficulty seeing: ____far ____ close
- ◻ Lazy eye ◻ Strabismus (cross eye)
- ◻ Wears: __glasses __contacts
- ◻ Date of last eye exam: ____________

◻ Other medical conditions or limitations not listed above: ______________________________

Parent/Guardian Signature:______________________________ Date: ____________