EAST PROVIDENCE SCHOOL DEPARTMENT
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______		

(To be completed by parent/guardian)

STUDENT INFORMATION:

Name of Student ____
Last *First* *Middle*

Date of Birth ________________ City/State of Birth ________________ Sex __________

Student Address ________________________ Zip________ Primary 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.__________ Work Phone__________
Last *First*

Address **(If different)**________________________ Cell Phone________________

Legal Guardian________________________ Guardian's D.O.B.__________ Cell 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, or the Indian subcontinent including, for example, China, India, Japan, Korea, and Pakistan.) **If Southeast Asian check box below.**
  - ☐ **Bruneian** ☐ **Burmese** ☐ **Cambodian** ☐ **Filipino** ☐ **Hmong** ☐ **Indonesian**
  - ☐ **Laotian** ☐ **Malaysain** ☐ **Thai** ☐ **Timoran** ☐ **Singaporean** ☐ **Vietnamese**
- ☐ **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 ____________

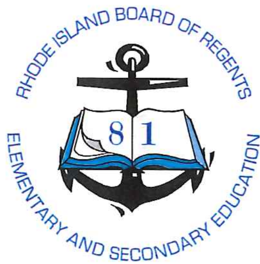
School Registrar Signature________________________________

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, and 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:__________



Ken Wagner
Commissioner

State of Rhode Island and Providence Plantations
DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
255 Westminster Street
Providence, Rhode Island 02903-3400

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

Telephone (401) 222-4600 **Fax** (401) 222-6178 **TTY** 800-745-5555 **Voice** 800-745-6575
www.ride.ri.gov

The RI Board of Regents does not discriminate on the basis of age, color, sex, sexual orientation, race, religion, national origin, or disability.

East Providence School Department

This information will become part of your child's educational record and may be shared with appropriate school personnel for 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:

\LLERGIES: Please check and list name of allergen/s
- ☐ Food:_______________ ☐ Medication Allergy:___________
- ☐ Insect: _______________ ☐ Environmental:____________

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

s 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: ____________

3LOOD 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: ___________

☐ 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.**

DIGESTIVE/ELIMINATION
- ☐ Frequent stomachaches
- ☐ Constipation ☐ Diarrhea ☐ Bladder/Bowel control problems
- ☐ Other concerns/conditions _______________

IEART CONDITION:
- ☐ Type: __________________________
- ☐ Physical Restrictions: ______________
- ☐ Other Precautions: _______________

EARING 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:_________

IOSPITALIZATION:
- ☐ Reason: _______________ Date: __________
- ☐ Treatment: ____________________________

NJURIES REQUIRING MEDICAL TREATMENT:
- ☐ Type of Injury: __________Date:__________
- ☐ Treatment: _________________________

KELETAL/MUSCULAR CONDITIONS and MOBILITY NEEDS:
- ☐ Muscular Dystrophy
- ☐ Other Muscular/Skeletal conditions: ____________
- ☐ Wears/uses orthopedic device: _______________
- ☐ Needs wheelchair
- ☐ Classroom accommodations:________________

IEUROLOGICAL CONDITIONS:
- ☐ Frequent headaches ☐ Migraines
- ☐ Cerebral Palsy ☐ Other neurological condition: __________

EIZURE CONDITIONS:
- ☐ Grand mal ☐ Absence (petit mal) ☐ Complex
- ☐ Frequency of seizures:_______________
- ☐ Date of last seizure: _______________
- ☐ Medication at school: _______________

URGERIES:
- ☐ History of surgery: Date:______ Type: __________
- ☐ Other: ___________________________

ISION 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:** ____________

10/25/18

PARENT/GUARDIAN CONSENT TO ACCESS MEDICAID FUNDS

Student's Name	*Birth Date (DOB)*	*Grade*	*Today's Date*
Parent/Guardian Name	*Parent/Guardian Address*		

Background:

The [East Providence School Department] provides special education and related services as a free and appropriate public education (FAPE), **at no cost to the parents,** in the least restrictive environment (LRE). The [East Providence School Department] can seek reimbursement through Medicaid for some special education services for students who are eligible for Medicaid benefits. Section 300.154 of the Rhode Island Board of Education's Regulations Governing the Education of Children with Disabilities Education requires that the [East Providence School Department] receive your **written informed consent** in order to seek Medicaid reimbursement for certain special education services.

Before you give or deny consent, please read the following:

Please check all of the following (this is informed consent):

☐ **I understand** that giving my consent to the district to access Medicaid reimbursement for services provided to my child **will not impact** my ability to access these services for my child outside the school setting.

☐ **I understand** this consent **does not include consent for assistive technology devices.** The district needs a **separate consent form** when accessing reimbursement for any assistive technology device.

☐ **I understand** that services in my child's IEP must be provided at **no cost** to me, whether or not I give consent to bill Medicaid. [If I refuse consent or if I revoke (withdraw) this consent, the school district is still responsible to provide special education and any related services identified for my child through the special education eligibility processes and these services will be provided at **no cost** to me. This includes no costs for co-pays, deductibles, loss of eligibility or impact on lifetime benefits.]

☐ **I understand that my consent is <u>voluntary</u>** and I may revoke (withdraw) my consent **in writing** at anytime after it is given. If I revoke (withdraw) my consent, the school department will no longer bill Medicaid from the date the written revocation (withdrawal) of consent is received by the district.

☐ **I understand** that the district follows both the Health Insurance Portability and Accountability Act (HIPAA – the federal health privacy act) and the Family Educational Rights and Privacy Act (FERPA – the federal education privacy act) requirements to protect my confidential information and that Medicaid funds received by the district directly support education in our district.

Permission given or denied (please check one):

☐ **I give permission** to the district to share information about my child with the state Medicaid Agency, its fiscal agent, and the district's Medicaid billing agent. The information shared may include my child's name, date of birth, address, primary special education disability, Medical Assistance Identification number (MID), and the type and amount of health services provided. Services may include personal care, assistive technology services, day program treatment, residential program treatment, child outreach screening, transportation, and services and/or evaluations provided by physical therapists, occupational therapists, speech, hearing and language therapists, licensed psychologists, social workers and nurses.

☐ **I do not give permission** to the district to share information about my child in order to seek Medicaid reimbursement for services provided to my child.

____

Parent/Guardian Signature *Date*