East Providence School Department  
1998 Pawtucket Avenue - Door 2  
East Providence, RI 02914  
401-270-8276  
Fax: 401-919-5912  
Email: mrodrigues@epschoolsri.com

Requirements for School Registration

☐ Birth Certificate  
☐ Health Records (Proof of Immunizations and Date of Last Physical)  
☐ Prior School Transcripts - Report Card - IEP - 504  
☐ Three Forms of Proof of Residency and Driver’s License

1. Lease/Mortgage Statement  
2. Utility Bill  
3. Pay Stub/Bank Statement

Proof of Residency Procedure

All students requiring educational or related services through the City of East Providence must first prove legal residence in the City. Students include all school age children attending district public schools, as well as children attending private and/or parochial school, or being home school, and requesting services, such as but not limited to transportation, special education and related services, books etc.

Only a parent and/or legal guardian can register, change the address, and prove residency.

Three (3) such forms to prove residency are required. One item from each column below needs to be selected and presented at the time of registration, or change of address occurs. They must be in the name of the student’s parent/guardian.

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
<th>Column C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Recent Mortgage Statement</td>
<td>Most Recent Utility Bill</td>
<td>Payroll Stub</td>
</tr>
<tr>
<td>Current Lease</td>
<td>Gas/Electric/Cable.Cell Phone</td>
<td>(last 30 days)</td>
</tr>
<tr>
<td>Section 8 Agreement</td>
<td>Student Loan</td>
<td>Bank Statement (last 30 days)</td>
</tr>
<tr>
<td>Legal affidavit from landlord</td>
<td>Credit Card Statement</td>
<td>W-2/Tax Return (past year)</td>
</tr>
<tr>
<td>affirming tenancy</td>
<td>State Assistance</td>
<td>Property/Vehicle Tax</td>
</tr>
<tr>
<td></td>
<td>Ex. WIC/Unemployment</td>
<td></td>
</tr>
</tbody>
</table>
EAST PROVIDENCE SCHOOL DEPARTMENT
PUPIL REGISTRATION FORM

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:

Parent email address: ____________________________ (required as primary mode of communication.)

Name of Student ____________________________

Date of Birth ____________________________ City/State of Birth ____________________________ Sex ______

Student Address ____________________________ Zip Code ______ Primary Phone ______

Mother ____________________________ Mother's D.O.B. ______ Work Phone ______

Last Name ____________________________ First Name ______ Address (If different) ____________________________ Cell Phone ______

Father ____________________________ Father's D.O.B. ______ Work Phone ______

Last Name ____________________________ First Name ______ 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 ☐ Malaysian ☐ 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:__________
Home Language Survey (HLS)

To be completed by Parent or Guardian

Student Name:

<table>
<thead>
<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
</table>

Date of Birth: Place of Birth:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

Parent or Guardian Relationship to student:
- [ ] Mother
- [ ] Father
- [ ] Other

Home Language Code:

Language Background
(Please check all that apply)

1. What is the primary language used in the home, regardless of the language spoken by the student?
   - [ ] English
   - [ ] Other
   Specify

2. What is the language most often spoken by the student?
   - [ ] English
   - [ ] Other
   Specify

3. What is the language that the student first acquired?
   - [ ] English
   - [ ] Other
   Specify

4. What language(s) does your child understand?
   - [ ] English
   - [ ] Other
   Specify

5. What language(s) does your child speak?
   - [ ] English
   - [ ] Other
   Specify
   - [ ] Does not speak

6. What language(s) does your child read?
   - [ ] English
   - [ ] Other
   Specify
   - [ ] Does not read

7. What language(s) does your child write?
   - [ ] English
   - [ ] Other
   Specify
   - [ ] Does not write

1 Required by Rhode Island law (R.I.G.L. § 16-54-2) and the Equal Educational Opportunity Act (20 U.S.C. §1705ff).
2 Families are not required to provide the place of birth, but providing the information can help LEAs to better prepare to be culturally responsive.
**Family Interview – Educational History**

1. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe.
   - Yes*  
   - No  
   - Not sure
   *If yes, please explain:

How severe do you think these difficulties are?  
- Minor  
- Somewhat severe  
- Very severe

2a. Has your child ever been referred for a special education evaluation in the past?  
- No  
- Yes*
   *If referred for an evaluation, has your child been identified?  
- No  
- Yes*
   *If referred for an evaluation, and identified has your child ever received any special education services in the past?
- No  
- Yes – Type of services received:

2b. Age at which services received (Please check all that apply):
- Birth to 3 years (Early Intervention)  
- 3 to 5 years (Special Education)  
- 6 years or older (Special Education)

2c. Does your child have an Individualized Education Program (IEP), or 504 plan?  
- No  
- Yes

3. In which language do you prefer to receive oral communications from the school or district?
- English  
- Other
   Specify

4. In which language do you prefer to receive written communications from the school or district?
- English  
- Other
   Specify

5. Indicate date first enrolled in ANY U.S. school  
   (mm/dd/yyyy)

Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

---

**Signature of Parent or Guardian**

______

Month:  
Day:  
Year:

**Date**

---

**Print Parent/Guardian Name**

---

**OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLS**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position:</th>
</tr>
</thead>
</table>

**IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:**

**NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLS AND CONDUCTING INDIVIDUAL INTERVIEW**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position:</th>
</tr>
</thead>
</table>

**IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:**

**NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING THE LANGUAGE SCREENING ASSESSMENT**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position:</th>
</tr>
</thead>
</table>

**IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:**

**NAME/POSITION OF QUALIFIED PERSONNEL REPORTING THE LANGUAGE SCREENING SCORES**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position:</th>
</tr>
</thead>
</table>

**Date of Screener:**  
Month:  
Day:  
Year:  
Name of the Language Screening Assessment:  
Score achieved:

Proficiency Level Achieved:  
Entering 1 / Beginning 2 / Developing 3 / Expanding 4 / Bridging 5 / Reaching 6

**FOR STUDENTS WITH AN IEP OR 504 PLAN, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED:**

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Telephone (401) 222-4600  Fax (401) 222-5178  TTY (800) 745-5555  Voice (800) 745-6575  Website: www.ride.ri.gov

The R.I. Board of Education does not discriminate on the basis of age, sex, sexual orientation, gender identity/expression, race, color, religion, national origin, or disability.
Student: ___________________________ Date of Birth: ________________
Address: __________________________________________________________
School: ___________________________________________________________

The East Providence School Department is authorized to request _____ /send_____ information to/from written and or verbal.

Agency/School: ____________________________________________________
Attention: _________________________________________________________
Street: __________________ City: _______ State/Zip: ________________

<table>
<thead>
<tr>
<th>CHECK ALL WHICH APPLY:</th>
<th>Physical Therapy Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Behavior Report</td>
<td>Psychiatric Evaluation</td>
</tr>
<tr>
<td>Attendance Report</td>
<td>Psycho-Education Evaluation</td>
</tr>
<tr>
<td>Behavior Report</td>
<td>Psychological Evaluation</td>
</tr>
<tr>
<td>Classroom Observation</td>
<td>Release Form</td>
</tr>
<tr>
<td>Clinical Psychological Evaluation</td>
<td>Report Card</td>
</tr>
<tr>
<td>Educational Evaluation</td>
<td>School Immunizations</td>
</tr>
<tr>
<td>Evaluation Team Report</td>
<td>Social History</td>
</tr>
<tr>
<td>Functional Behavior Assessment</td>
<td>Speech/Language Evaluation</td>
</tr>
<tr>
<td>Medical Hospital Reports</td>
<td>Suspension Data</td>
</tr>
<tr>
<td>IEP (Individual Education Program)</td>
<td>Transcript from Middle School</td>
</tr>
<tr>
<td>Language Deficiency Test</td>
<td>Transcript from High School</td>
</tr>
<tr>
<td>LD Documentation Report</td>
<td>504 Plan</td>
</tr>
<tr>
<td>Manifestation Determination</td>
<td>Other</td>
</tr>
<tr>
<td>Neurological Evaluation</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy Evaluation</td>
<td></td>
</tr>
</tbody>
</table>

Reason for Request: □ To plan for educational needs □ Evaluation Team Request
□ Student moving out of East Providence □ Parental Request

(1) Information released or obtained will not be given, sold, or transferred to any person or organization
without written consent of the parent/guardian/educational advocate.

(2) The Parent has the right to revoke this authorization at any time.

(3) Authorization will expire in one year.

Signature: ___________________________ Date: ________________
□ Parent □ Guardian □ Educational Advocate

Send to:
□ East Providence School Department OR □
1998 Pawtucket Avenue
East Providence, RI 02914
(401) 270-8269
(401) 919-5912 Fax

EP Representative requesting information: _______________________________________
Location of person requesting information: ______________________________________

Parental permission is no longer required when records are requested by authorized school personnel. (Family Educational Rights and Privacy Act, Final Rule on Educational Records, Federal Registrar, Vol: 41, #118, pg 24676).
Effective October 9, 2013 Rhode Island Model Form: Parental Consent to Access Public Benefits

PARENT/GUARDIAN CONSENT TO ACCESS MEDICAID FUNDS

<table>
<thead>
<tr>
<th>Student's Name</th>
<th>Birth Date (DOB)</th>
<th>Grade</th>
<th>Today's Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian Name</td>
<td>Parent/Guardian Address</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 that 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 process 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 voluntary 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: ____________________________
### 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.

<table>
<thead>
<tr>
<th>Name of Child</th>
<th>Date of Birth</th>
<th>Male</th>
<th>Female</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Physician Name</th>
<th>Physician Number</th>
<th>Dentist Name</th>
<th>Name of prior school, if any</th>
<th>City/Town, State</th>
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#### HEALTH CONCERNS/HEALTH HISTORY

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

**ALLERGIES:** Please check and list name of allergens:
- [ ] Food: __________________
- [ ] Medication Allergy: __________________
- [ ] Insect: __________________
- [ ] Environmental: __________________

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

- [ ] An EpiPen prescribed for school? Yes _No_ (If No, please specify): __________________
- [ ] Other medicines prescribed: __________________
  - [ ] My child follows a ‘special diet’: __________________
  - [ ] My child requires allergy exposure precautions in the classroom/cafeteria: ____________

**ASTHMA/RESPIRATORY CONDITIONS:**
- [ ] Triggers: __________________
- [ ] Needs Inhaler at School Yes _No_ (If No, please specify): __________________
- [ ] Frequent colds
- [ ] Nosebleeds
- [ ] Frequent Strep Throat
- [ ] Bronchitis
- [ ] Pneumonia
- [ ] Other: __________________

**BLOOD DISORDERS:**
- [ ] Sickle cell disease
- [ ] Anemia
- [ ] Hemophilia
- [ ] Other blood disorders/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: __________________
  - [ ] Parental/guardian permission: __________________
- [ ] Taken at school: __________________

**Other medical conditions or limitations not listed above:** __________________

### DIGESTIVE/ELIMINATION
- [ ] Frequent stomachaches
- [ ] Constipation
- [ ] Diarrhea
- [ ] Bladder/Bowel control problems
- [ ] Other concerns/conditions: __________________

### HEART 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 devices: __________________
- [ ] Classroom accommodations: __________________
- [ ] Special seating: __________________
- [ ] Other: __________________

### HOSPITALIZATION
- [ ] Reason: __________________
- [ ] Date: __________________
- [ ] Treatment: __________________

### INJURIES REQUIRING MEDICAL TREATMENT
- [ ] Type of injury: __________________
- [ ] Date: __________________
- [ ] Treatment: __________________

### KINESTHETIC/MUSCULAR CONDITIONS and MOBILITY NEEDS
- [ ] Muscular Dystrophy
- [ ] Other Muscular/Skeletal conditions: __________________
- [ ] Wears/takes 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: __________________

### 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: __________________

**Parent/Guardian Signature:** __________________

**Date:** __________________