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.

Column A	Column B	Column C
Most Recent Mortgage Statement	Most Recent Utility Bill Gas/Electric/Cable/Cell Phone	Payroll Stub (last 30 days)
Current Lease	Student Loan	Bank Statement (last 30 days)
Section 8 Agreement	Credit Card Statement	W-2/Tax Return (past year)
Legal affidavit from landlord affirming tenancy	State Assistance Ex. WIC/Unemployment	Property/Vehicle Tax

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:

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

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:________

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

Angélica Infante-Green
Commissioner

Home Language Survey (HLS)

Dear Parent or Guardian,

The information requested on this form is necessary for the most appropriate school placement of your child, and will not be used for any other purposes[1].

Thank you for your collaboration.

To be completed by Parent or Guardian

Student Name:	
First *Middle* *Last*	
Date of Birth:	Place of Birth[2]:
Month *Day* *Year*	
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. §1703(f))*

[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.*

Last Updated: 4/30/2020

Telephone (401)222-4600 Fax (401)222-6178 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.

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 them.
   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.)

____

____

____ Month: Day: Year:
Signature of Parent or Guardian *Date*

____
Print Parent/Guardian Name

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLS		
Name:	Position:	
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:		
NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLS AND CONDUCTING INDIVIDUAL INTERVIEW		
Name:	Position:	
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:		
Oral Interview Necessary: ☐ YES ☐ NO	Date of Individual Interview: ____ *Month Day Year*	
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING THE LANGUAGE SCREENING ASSESSMENT		
Name:	Position:	
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:		
NAME/POSITION OF QUALIFIED PERSONNEL REPORTING THE LANGUAGE SCREENING SCORES		
Name:	Position:	
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:		

East Providence School Department
1998 Pawtucket Avenue
East Providence, RI 02914

Release/Request of Records

Student:______________________________ Date of Birth:__________
Address:______________________________ East Providence, RI 0291____
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:__________

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

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).

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

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:

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:__________

□ 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 ______________

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:__________

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:__________

10/25/18