Kindergarten Registration Requirements:

Your child needs to be five (5) before September 1st, 2022

- Birth Certificate
- Health Records
  1. Proof of Immunizations
  2. Date of Last Physical
- Three Forms of Proof of Residency & Driver’s License
  1. Lease/Mortgage Statement
  2. Utility Bill
  3. Pay Stub/Bank Statement
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 ______ Primary Phone ______

Mother _______________________________________ Mother’s D.O.B. ___________ Work Phone _____________
Address (If different) ___________________________ Cell Phone _____________

Father _______________________________________ Father’s D.O.B. ___________ Work Phone _____________
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: ________________________________

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

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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.)

   ____________________________
   ____________________________
   ____________________________

   **Signature of Parent or Guardian**

   **Month:**  
   **Day:**  
   **Year:**  
   **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:
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 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 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
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:

<table>
<thead>
<tr>
<th><strong>ALLERGIES:</strong> Please check and list name of allergen(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Food: ___________________________ ☐ Medication Allergy: ______________</td>
</tr>
<tr>
<td>☐ Insect: ___________________________ ☐ Environmental: ______________</td>
</tr>
</tbody>
</table>

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 ___________________________

<table>
<thead>
<tr>
<th><strong>ASTHMA/RESPIRATORY CONDITIONS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Triggere: ________________</td>
</tr>
<tr>
<td>☐ Needs Inhaler at School: __ Yes __ No</td>
</tr>
<tr>
<td>☐ Frequent colds ☐ Nosebleeds ☐ Frequent Strep Throat</td>
</tr>
</tbody>
</table>
| ☐ Bronchitis ☐ Pneumonia ☐ Other: ___________________________

<table>
<thead>
<tr>
<th><strong>BLOOD DISORDERS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Sickle cell disease ☐ Anemia ☐ Hemophilia</td>
</tr>
</tbody>
</table>
| ☐ Other blood disorder/condition: ___________________________

<table>
<thead>
<tr>
<th><strong>EMOTIONAL/BEHAVIORAL CONCERNS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ADHD: ___________________________</td>
</tr>
<tr>
<td>☐ Other Diagnosis: ___________________________</td>
</tr>
<tr>
<td>☐ Treatment/Medication: ___________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CONGENITAL DISORDERS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Cystic Fibrosis ☐ Spina Bifida ☐ Other: ___________________________</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>DENTAL CONCERNS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Multiple cavities/ fillings</td>
</tr>
</tbody>
</table>
| ☐ History of tooth injury: ___________________________
| ☐ Wears braces/corrective device: ___________________________
| ☐ Other dental concerns: ___________________________

<table>
<thead>
<tr>
<th><strong>DIABETES:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Type I ☐ Type II</td>
</tr>
<tr>
<td>☐ Needs medication at school: ___________________________</td>
</tr>
</tbody>
</table>
| ☐ Needs blood sugar monitoring at school: ___________________________

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<thead>
<tr>
<th><strong>MEDICATIONS:</strong></th>
</tr>
</thead>
</table>

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.

☐ Other medical conditions or limitations not listed above: ___________________________

<table>
<thead>
<tr>
<th><strong>DIGESTIVE/ELIMINATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Frequent stomachaches</td>
</tr>
<tr>
<td>☐ Constipation ☐ Diarrhea ☐ Bladder/Bowel control problems</td>
</tr>
</tbody>
</table>
| ☐ Other concerns/conditions: ___________________________

<table>
<thead>
<tr>
<th><strong>HEART CONDITION:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Type: ________________</td>
</tr>
</tbody>
</table>
| ☐ Physical Restrictions: ___________________________
| ☐ Other Precautions: ___________________________

<table>
<thead>
<tr>
<th><strong>EARING DIFFICULTIES:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Hearing loss, type: ________________</td>
</tr>
<tr>
<td>☐ Frequent ear infections</td>
</tr>
<tr>
<td>☐ Ear tubes, Presently in: ☐ Right ear ☐ Left ear</td>
</tr>
<tr>
<td>☐ History of ear tubes (removed): ☐ Right ear ☐ Left ear</td>
</tr>
<tr>
<td>☐ Assistive hearing device: ___________________________</td>
</tr>
</tbody>
</table>
| ☐ Classroom accommodations: ___________________________
| ☐ Special seating ☐ Other: ___________________________

<table>
<thead>
<tr>
<th><strong>HOSPITALIZATION:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Reason: ___________________________ Date: ________________</td>
</tr>
</tbody>
</table>
| ☐ Treatment: ___________________________

<table>
<thead>
<tr>
<th><strong>INJURIES REQUIRING MEDICAL TREATMENT:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Type of Injury: ___________________________ Date: ________________</td>
</tr>
</tbody>
</table>
| ☐ Treatment: ___________________________

<table>
<thead>
<tr>
<th><strong>SKELETAL/MUSCULAR CONDITIONS and MOBILITY NEEDS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Muscular Dystrophy</td>
</tr>
</tbody>
</table>
| ☐ Other Muscular/Skeletal conditions: ___________________________
| ☐ Wears/uses orthopedic device: ___________________________
| ☐ Needs wheelchair |
| ☐ Classroom accommodations: ___________________________

<table>
<thead>
<tr>
<th><strong>NEUROLOGICAL CONDITIONS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Frequent headaches ☐ Migraines</td>
</tr>
</tbody>
</table>
| ☐ Cerebral Palsy ☐ Other neurological condition: ___________________________

<table>
<thead>
<tr>
<th><strong>SEIZURE CONDITIONS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Grand mal ☐ Absence (petit mal) ☐ Complex</td>
</tr>
<tr>
<td>☐ Frequency of seizures: ___________________________</td>
</tr>
<tr>
<td>☐ Date of last seizure: ___________________________</td>
</tr>
</tbody>
</table>
| ☐ Medication at school: ___________________________

<table>
<thead>
<tr>
<th><strong>SURGERIES:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ History of surgery: Date: __________ Type: __________</td>
</tr>
</tbody>
</table>
| ☐ Other: ___________________________

<table>
<thead>
<tr>
<th><strong>VISION PROBLEMS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Difficulty seeing: ☐ far ☐ close</td>
</tr>
<tr>
<td>☐ Lazy eye ☐ Strabismus (cross eye)</td>
</tr>
<tr>
<td>☐ Wears: ☐ glasses ☐ contacts</td>
</tr>
</tbody>
</table>
| ☐ Date of last eye exam: ___________________________

Parent/Guardian Signature: ___________________________ Date: ________________

10/25/18