



## Kindergarten Registration Requirements



- ✓ Parent/Guardian must register child
- ✓ Birth Certificate
- ✓ Health Records (Proof of Immunizations)
- ✓ Updated Physical Form
- ✓ 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**

<i>For Office Use Only</i>	<i>For Office Use Only</i>	<i>For Office Use Only</i>
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 \_\_\_\_\_ *Last* \_\_\_\_\_ *First* \_\_\_\_\_ *Middle* \_\_\_\_\_ Sex \_\_\_\_\_

Student Address \_\_\_\_\_ Zip \_\_\_\_\_ Primary Phone \_\_\_\_\_

Mother \_\_\_\_\_ *Street No. and Name* \_\_\_\_\_ Mother's D.O.B. \_\_\_\_\_ Work Phone \_\_\_\_\_

Address (If different) \_\_\_\_\_ *Last* \_\_\_\_\_ *First* \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father \_\_\_\_\_ *Last* \_\_\_\_\_ *First* \_\_\_\_\_ Father's D.O.B. \_\_\_\_\_ Work Phone \_\_\_\_\_

Address (If different) \_\_\_\_\_ *Last* \_\_\_\_\_ *First* \_\_\_\_\_ 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: \_\_\_\_\_

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)

To be completed by Parent or Guardian

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<sup>1</sup>.

Thank you for your collaboration.

Student Name:		
First	Middle	Last
Date of Birth:		Place of Birth <sup>2</sup> :
Month	Day	Year
Parent or Guardian Relationship to student:		
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____		
Home Language Code:		

Language Background		
<i>(Please check all that apply)</i>		
1. What is the primary language used in the home, regardless of the language spoken by the student?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <i>Specify</i>
2. What is the language most often spoken by the student?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <i>Specify</i>
3. What is the language that the student first acquired?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <i>Specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <i>Specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <i>Specify</i> <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <i>Specify</i> <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <i>Specify</i> <input type="checkbox"/> Does not write

<sup>1</sup> Required by Rhode Island Law (R.I.G.L. § 16-54-2) and the Equal Educational Opportunity Act (20 U.S.C. §1703(f))

<sup>2</sup> 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: \_\_\_\_\_

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 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.

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:

<p><b>ALLERGIES:</b> Please check and list name of allergen/s  <input type="checkbox"/> Food: _____ <input type="checkbox"/> Medication Allergy: _____  <input type="checkbox"/> Insect: _____ <input type="checkbox"/> Environmental: _____</p> <p>Has your child experienced any of these allergic symptoms? :  <input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Hives <input type="checkbox"/> Trouble Breathing  <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Local Reaction                  Is an Epipen prescribed for school? ___ Yes ___ No  <input type="checkbox"/> Other medicines prescribed: _____  <input type="checkbox"/> My child follows a special diet: _____  <input type="checkbox"/> My child requires allergy exposure precautions in the classroom/cafeteria: <input type="checkbox"/> Peanut/Nut Free Classroom/Table <input type="checkbox"/> Other _____</p> <p><b>ASTHMA/ RESPIRATORY CONDITIONS:</b>  <input type="checkbox"/> Triggers: _____  <input type="checkbox"/> Needs Inhaler at School <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Frequent colds <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Frequent Strep Throat  <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other: _____</p> <p><b>BLOOD DISORDERS:</b>  <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Anemia <input type="checkbox"/> Hemophilia  <input type="checkbox"/> Other blood disorder/condition: _____  <input type="checkbox"/> Precautions/Restrictions: _____</p> <p><b>EMOTIONAL/BEHAVIORAL CONCERNS:</b>  <input type="checkbox"/> ADHD  <input type="checkbox"/> Other Diagnosis: _____  <input type="checkbox"/> Treatment/Medication: _____</p> <p><b>CONGENITAL DISORDERS:</b>  <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Other: _____</p> <p><b>DENTAL CONCERNS:</b>  <input type="checkbox"/> Multiple cavities/fillings  <input type="checkbox"/> History of tooth Injury: _____  <input type="checkbox"/> Wears braces/corrective device: _____  <input type="checkbox"/> Other dental concerns: _____</p> <p><b>DIABETES</b>  <input type="checkbox"/> Type I <input type="checkbox"/> Type II  <input type="checkbox"/> Needs medication at school: _____  <input type="checkbox"/> Needs blood sugar monitoring at school: _____</p> <p><input type="checkbox"/> <b>MEDICATIONS:</b>                  Taken at home: _____                  _____                  _____                  Taken at school: _____                  _____                  _____</p> <p>***All medications given at school require a signed physician's order and parental/guardian permission. Please inquire with school nurse.</p>	<p><b>DIGESTIVE/ELIMINATION</b>  <input type="checkbox"/> Frequent stomachaches  <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bladder/Bowel control problems  <input type="checkbox"/> Other concerns/conditions _____</p> <p><b>HEART CONDITION:</b>  <input type="checkbox"/> Type: _____  <input type="checkbox"/> Physical Restrictions: _____  <input type="checkbox"/> Other Precautions: _____</p> <p><b>HEARING DIFFICULTIES:</b>  <input type="checkbox"/> Hearing loss, type: _____  <input type="checkbox"/> Frequent ear infections  <input type="checkbox"/> Ear tubes, Presently In <input type="checkbox"/> Right ear/ <input type="checkbox"/> Left ear  <input type="checkbox"/> History of ear tubes (removed) <input type="checkbox"/> Right ear/ <input type="checkbox"/> Left ear  <input type="checkbox"/> Assistive hearing device: _____  <input type="checkbox"/> Classroom accommodations: _____  <input type="checkbox"/> Special seating _____ <input type="checkbox"/> Other: _____</p> <p><b>HOSPITALIZATION:</b>  <input type="checkbox"/> Reason: _____ Date: _____  <input type="checkbox"/> Treatment: _____</p> <p><b>INJURIES REQUIRING MEDICAL TREATMENT:</b>  <input type="checkbox"/> Type of Injury: _____ Date: _____  <input type="checkbox"/> Treatment: _____</p> <p><b>SKELETAL/MUSCULAR CONDITIONS and MOBILITY NEEDS:</b>  <input type="checkbox"/> Muscular Dystrophy  <input type="checkbox"/> Other Muscular/Skeletal conditions: _____  <input type="checkbox"/> Wears/uses orthopedic device: _____  <input type="checkbox"/> Needs wheelchair  <input type="checkbox"/> Classroom accommodations: _____</p> <p><b>NEUROLOGICAL CONDITIONS:</b>  <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Migraines  <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Other neurological condition: _____</p> <p><b>SEIZURE CONDITIONS:</b>  <input type="checkbox"/> Grand mal <input type="checkbox"/> Absence (petit mal) <input type="checkbox"/> Complex  <input type="checkbox"/> Frequency of seizures: _____  <input type="checkbox"/> Date of last seizure: _____  <input type="checkbox"/> Medication at school: _____</p> <p><b>SURGERIES:</b>  <input type="checkbox"/> History of surgery: Date: _____ Type: _____  <input type="checkbox"/> Other: _____</p> <p><b>VISION PROBLEMS:</b>  <input type="checkbox"/> Difficulty seeing: ___ far ___ close  <input type="checkbox"/> Lazy eye <input type="checkbox"/> Strabismus (cross eye)  <input type="checkbox"/> Wears: ___ glasses ___ contacts  <input type="checkbox"/> Date of last eye exam: _____</p>
<p><input type="checkbox"/> Other medical conditions or limitations not listed above: _____</p>	

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Name & Address:

Grade: \_\_\_\_\_



### STATE OF RHODE ISLAND SCHOOL PHYSICAL FORM

Health Care Provider Name and Address:

Phone: \_\_\_\_\_

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex
Address: Street	Apt #	City	State	Zip Code
			Home Phone	

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS	Please enter dates in MM/DD/YYYY format			
Hepatitis B				
Diphtheria-Tetanus-Pertussis DTaP < 7 years				
Pneumococcal Conjugate PCV				
Polio				
Haemophilus Influenzae Type B Hib				
Measles-Mumps-Rubella MMR				
Varicella			<input type="checkbox"/> Student has history of varicella disease	
Tetanus-Diphtheria-Pertussis Tdap/Td > 7 years				
Rotavirus				
Hepatitis A				
Meningococcal				
HPV				
Influenza				

Medical Exemption:

- Hep B  
  DTaP  
  PCV  
  Polio  
  Hib  
  MMR  
  Varicella  
  Td/Tdap  
  Rotavirus  
  Hep A  
  Mening  
  HPV  
  Influenza

#### PHYSICAL EXAMINATION

Date of PE \_\_\_\_/\_\_\_\_/\_\_\_\_      Height \_\_\_\_\_      Weight \_\_\_\_\_      BP \_\_\_\_\_

PLEASE NOTE ANY HEALTH PROBLEM, CHRONIC HEALTH CONDITION OR DISABILITY THAT MAY AFFECT BEHAVIOR OR HEALTH AT SCHOOL:

- ASTHMA: No  Yes  If yes, complete an *Asthma Action Plan* ( [www.health.ri.gov/publications/actionplans/2012Asthma.pdf](http://www.health.ri.gov/publications/actionplans/2012Asthma.pdf) )
- ALLERGIES: No  Yes  (Please explain) \_\_\_\_\_ EPINEPHRINE AUTO-INJECTOR REQUIRED: No  Yes   
If student has a severe allergy (food, insect, other) complete a *Food Allergy & Anaphylaxis Emergency Care Plan* ( [www.foodallergy.org/document.doc?id=234](http://www.foodallergy.org/document.doc?id=234) )
- DIABETES: No  Yes  If yes, complete a *Physicians Order Form For Students With Diabetes* ( [www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf](http://www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf) )
- OTHER: \_\_\_\_\_

Treatment Plan: \_\_\_\_\_

RESTRICTIONS: Can participate in physical education/sports: Fully  With limitation  \_\_\_\_\_

MEDICATION (REQUIRED AT SCHOOL): No  Yes  (Please list) \_\_\_\_\_

Other medication(s) that may affect behavior or health at school: \_\_\_\_\_

LEAD SCREENING (Required for children < 6 years old) Student is in compliance with lead screening requirements: Yes <input type="checkbox"/> No <input type="checkbox"/>	SCOLIOSIS SCREENING Yes <input type="checkbox"/> No <input type="checkbox"/>	VISION SCREENING (Children entering Kindergarten) <input type="checkbox"/> Passed Screening <input type="checkbox"/> Screened & referred for comprehensive exam <input type="checkbox"/> Referred for comprehensive exam, but not screened
TUBERCULOSIS (If required by school district) Date of TB test: _____		Screening / Referral Date: _____      Comprehensive Exam Date: _____

HEALTH CARE PROVIDER SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_