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)  
☐ Updated Physical Form  
☐ 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 (last 30 days)</td>
</tr>
<tr>
<td>Current Lease</td>
<td>Gas/Electric/Cable/Cell Phone</td>
<td>Bank Statement (last 30 days)</td>
</tr>
<tr>
<td>Section 8 Agreement</td>
<td>Student Loan</td>
<td>W-2/Tax Return (past year)</td>
</tr>
<tr>
<td>Legal affidavit from landlord</td>
<td>Credit Card Statement</td>
<td>Property/Vehicle Tax</td>
</tr>
<tr>
<td>affirming tenancy</td>
<td>State Assistance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ex. WIC/Unemployment</td>
<td></td>
</tr>
</tbody>
</table>
EAST PROVIDENCE SCHOOL DEPARTMENT
PUPIL REGISTRATION FORM

(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: Last: ____________ First: ____________ Middle: ____________ Mother's D.O.B. ____________ Work Phone: ____________________________

Address (If different): ____________________________ Cell Phone: ____________________________

Father: Last: ____________ First: ____________ 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, Cuben, 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**

<table>
<thead>
<tr>
<th>Student Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

---


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
   ____________________________
   Print Parent/Guardian Name
   ____________________________
   Month: Day: Year:
   Date

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:
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: ____________________________


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

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

Release/Request of Records

Student: ____________________________  Date of Birth:__________
Address: ____________________________  East Providence, RI 02914
School: ____________________________  

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

Agency/School: ____________________________
Attention: ____________________________  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  ☐ Parental 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  
1998 Pawtucket Avenue  
East Providence, RI 02914  
(401) 270-8276  
(401) 919-5912 Fax

OR  ☐  

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

<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 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:

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 ___
- 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.

- 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 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: ____________________

EUROLOGICAL CONDITIONS:
- Frequent headaches □ Migraines
- Cerebral Palsy □ Other neurological condition: ____________________

EPILEPSY 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: ____________

10/25/18