Kindergarten Registration Requirements:

Your child needs to be five (5) before September 1st, 2023.

- 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
(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 ___________________________ Mother's D.O.B. ______________ Work Phone ____________________  

Address (If different) ________________________________________________________ Address (If different) ________________________________________________________  

Father Last ___________________________ First ___________________________ Father’s D.O.B. ______________ Work 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 __________________________

IBP (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>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date of Birth: Place of Birth:

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) 745-5575 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.)

   

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**Signature of Parent or Guardian**

**Print Parent/Guardian Name**

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**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:

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

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

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

Oral Interview Necessary: □ YES □ NO

Date of Individual Interview: ____________

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:

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

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: ____________

Name of the Language Screening Assessment: ____________

Score achieved: ____________

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

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.rde.r.i.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.
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 300.165 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, this 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:

<table>
<thead>
<tr>
<th><strong>ALLERGIES:</strong> Please check and list name of allergens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food: ___________________</td>
</tr>
<tr>
<td>Medication Allergy: ___________</td>
</tr>
<tr>
<td>Insect: ___________________</td>
</tr>
<tr>
<td>Environmental: ___________</td>
</tr>
</tbody>
</table>

- Are you child experienced any of these allergic symptoms? 
  - Rash  O Swelling  O Hives  O Trouble Breathing  O Vomiting  O Diarrhea  O Local Reaction _____________________________
  - Has 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>O Triggers: ___________________</td>
</tr>
<tr>
<td>O Needs Inhaler at School Yes ___ No ___</td>
</tr>
<tr>
<td>O Frequent colds  O Nasal bleed  O Frequent Strep Throat  O Bronchitis  O Pneumonia  O Other: ____________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>BLOOD DISORDERS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>O Sickle cell disease  O Anemia  O Hemophilia  O Other blood disorder/condition: _____________________________</td>
</tr>
<tr>
<td>O Precautions/Restrictions: _____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>EMOTIONAL/BEHAVIORAL CONCERNS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>O ADHD: ___________________</td>
</tr>
<tr>
<td>O Other Diagnoses: ___________________</td>
</tr>
<tr>
<td>O Treatment/Medication: _____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CONGENITAL DISORDERS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>O Cystic Fibrosis  O Spina Bifida  O Other: _____________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DENTAL CONCERNS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>O Multiple cavities/fillings  O History of tooth injury: _____________________________</td>
</tr>
<tr>
<td>O Wears braces/corrective device: _____________________________</td>
</tr>
<tr>
<td>O Other dental concerns: _____________________________</td>
</tr>
</tbody>
</table>

**DIGESTIVE/ELIMINATION**

- Frequent stomachaches _____________________________
- Constipation  O Diarrhea  O Bladder/Bowel control problems _____________________________
- Other concerns/conditions: _____________________________

**HEART CONDITION:**

- Type: _____________________________
- Physical Restrictions: _____________________________
- Other Precautions: _____________________________

**EARSING DIFFICULTIES:**

- Hearing loss, type: _____________________________
- Frequent ear infections _____________________________
- Ear tubes Presently In: _____________________________
- Right ear  O Left ear _____________________________
- History of ear tubes (removed): _____________________________
- Right ear  O Left ear _____________________________
- Assistive hearing device: _____________________________
- Classroom accommodations: _____________________________
- Special seating: _____________________________
- Other: _____________________________

**HOSPITALIZATION:**

- Reason: _____________________________ Date: _____________________________
- Treatment: _____________________________

**INJURIES REQUIRING MEDICAL TREATMENT:**

- Type of injury: _____________________________ Date: _____________________________
- Treatment: _____________________________

**KNEE/LEG/MUSCULAR CONDITIONS and MOBILITY NEEDS:**

- Muscular Dystrophy _____________________________
- Other Muscular/Skeletal conditions: _____________________________
- Wears/uses orthopedic device: _____________________________
- Needs wheelchair _____________________________
- Classroom accommodations: _____________________________

**NEUROLOGICAL CONDITIONS:**

- Frequent headaches  O Migraines: _____________________________
- Cerebral Palsy  O Other neurological condition: _____________________________

**SEIZURE CONDITIONS:**

- Grand mal  O Absence (petit mal)  O 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  O Strabismus (cross eye) _____________________________
- Wears: glasses  O contacts _____________________________
- Date of last eye exam: _____________________________

*All medications given at school require a signed physician's order and parental/guardian permission. Please inquire with school nurse.*

O Other medical conditions or limitations not listed above: _____________________________

**Parent/Guardian Signature:** _____________________________ Date: _____________________________

**10/25/18**
STATE OF RHODE ISLAND
SCHOOL PHYSICAL FORM

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).

<table>
<thead>
<tr>
<th>Student Name: Last</th>
<th>First</th>
<th>Middle</th>
<th>Date of Birth</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: Street</td>
<td>Apt #</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>IMMUNIZATIONS</th>
<th>Please enter dates in MM/DD/YYYY format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td></td>
</tr>
<tr>
<td>Diphtheria-Tetanus-Pertussis</td>
<td></td>
</tr>
<tr>
<td>DTaP &lt; 7 years</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate PCV</td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
</tr>
<tr>
<td>Haemophilus Influenzae Type B</td>
<td></td>
</tr>
<tr>
<td>Hib</td>
<td></td>
</tr>
<tr>
<td>Measles-Mumps-Rubella MMR</td>
<td></td>
</tr>
</tbody>
</table>
| Varicella                     | Student has history of varicella disease | Yes
| Tetanus-Diphtheria-Pertussis     |                                        |
| TdIP/dT > 7 years               |                                        |
| Rotavirus                      |                                        |
| Hepatitis A                    |                                        |
| Meningococcal                  |                                        |
| HPV                           |                                        |
| Influenza                      |                                        |

Medical Exemption:

- Hep B
- DTaP
- PCV
- Polio
- Hib
- MMR
- Varicella
- TdIP/dT
- 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:

1. ASTHMA: No Yes If yes, complete an Asthma Action Plan (www.health ri.gov/publications/adoptionplans/2012Asthma.pdf)
2. 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 ri.gov/document.doc?id=214)
3. DIABETES: No Yes If yes, complete a Physicians Order Form For Students With Diabetes (www.health ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf)
4. 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 No

SCOLIOSIS SCREENING
Yes No

VISION SCREENING (Children entering Kindergarten)
- Passed Screening
- Screened & referred for comprehensive exam
- Referred for comprehensive exam, but not screened

TUBERCULOSIS (If required by school district)
Date of TB test:

HEALTH CARE PROVIDER SIGNATURE:

PRINT NAME: 

DATE: 6-2016