East Providence School Department
1998 Pawtucket Avenue – Door 2
East Providence, RI 02914
401-270-8276
Fax: 401-919-5912

mrodrigues@epschoolsri.com

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

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)

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[1].

Thank you for your collaboration.

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

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:	

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:

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: _____

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: _____

▫ **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: _____

Parent/Guardian Signature:_____ Date: _____

10/25/18

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			☐ 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:

1. ASTHMA: No☐ Yes☐ If yes, complete an *Asthma Action Plan* (www.health.ri.gov/publications/actionplans/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.org/document.doc?id=234)

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)	SCOLIOSIS SCREENING	VISION SCREENING (Children entering Kindergarten)
Student is in compliance with lead screening requirements: Yes☐ No☐	Yes☐ No☐	☐ Passed Screening ☐ Screened & referred for comprehensive exam ☐ 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: _____

6-2016