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

Monica deSouza
mdesouza@epschoolsri.com

Kindergarten Registration Requirements:

Your child needs to be five (5) before September 1st, 2026.

- ☐ 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	*For Office Use Only*	*For Office Use Only*

Home School_____ School _____ AT_____ P_____ Entry Date _____

GR _____ LOCAL ID# _____ SASID # _____

IEP_____ 504 _____ HLS 1-3 _____

(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._____WorkPhone_____
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 the 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:_____
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 Tit le 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:

Family Housing Survey - REGISTRATION PACKET FORM

Please read the questions carefully and complete the document fully.

No student or family will be discriminated against based upon any of the information provided in this form. The information you provide is confidential. The answers you give will help us determine the services your student may be eligible to receive under the McKinney-Vento Homeless Assistance Act.

Student Information

Full Name: _____

Street Address _____ Apartment/Unit # _____

City: _____ State _____ Zip Code _____

School: _____ Grade: _____ Date of Birth _____ Gender _____

Phone: _____ Email: _____

Name of Parent/Legal Guardian: _____

Is the student living with a parent or legal guardian? ☐ Yes ☐ No

If not living with a parent or legal guardian, who is residing in the same location as the student?

_____

Housing

Are you experiencing any level of housing insecurity? ☐ Yes ☐ No

***if yes, the completion of an additional form will be required so that our McKinney Vento Liaison will contact you*

If yes, how would you describe your current housing status? Check all that apply:

☐ Doubled up: living with family or friends due to natural disaster, financial hardship, or loss of housing.

☐ Living in a shelter/transitional housing. Name of agency: _____

☐ Living in a hotel/motel due to lack of other suitable housing. Name of hotel/motel: _____

☐ Living on the street, in an abandoned building, in a car, campground, or other public place not intended for regular habitation.

Signature

I verify that the information provided above is true and correct. ☐ Yes Date: _____

Print Name _____ Relationship _____ Signature_____

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

Release/Request of Records

Student: _____ Date of Birth: _____

Address: _____ East Providence, RI 0291_____

School: _____ Grade _____

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

Agency/School: _____

Attention: _____

Street: _____ City: _____ State/Zip: _____

CHECK ALL WHICH APPLY:

Adaptive Behavior Report		Physical Therapy Evaluation	
Attendance Report		Psychiatric Evaluation	
Behavior Report		Psycho-Education Evaluation	
Classroom Observation		Psychological Evaluation	
Clinical Psychological Evaluation		Release Form	
Educational Evaluation		Report Card	
Evaluation Team Report		School Immunizations	
Functional Behavior Assessment		Social History	
Medical Hospital Reports		Speech/Language Evaluation	
IEP (Individual Education Program)		Suspension Data	
Language Deficiency Report		Transcript from Middle School	
LD Documentation Report		Transcript from High School	
Manifestation Determination		504 Plan	
Neurological Evaluation		Other	
Occupational Therapy Evaluation			

Reason for Request: ☐ To plan for educational needs ☐ Evaluation Team Request
☐ Student is 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

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
HEALTH HISTORY FORM

This information will become part of your child's educational record and may be shared with appropriate school personnel for educational and safety purposes

Demographic Information:

Student's Full Name: _____ Date of Birth: _____
Address: _____ PhoneNumber:_____
Parent/ Guardian Name: _____ Grade:_____
Physician Name: _____ Physician Telephone:_____
Physician Fax number: _____

Allergies:

Allergy Trigger	Name/Type Allergy	Reaction	Treatment
Animals			
Environmental			
Food			
Bees/Wasps			
Drugs			

Health History (Please check all conditions your child has or has had and explain below) Asthma Emotional Concerns Diabetes Hearing Difficulties Blood Disorders Congenital Disorders Digestive/Elimination Muscular Conditions Behavioral Concerns Dental Concerns Heart Condition Physical Limitations Neurological Conditions Seizure Conditions Vision Problems Daily Medications

Explain any check mark with age of onset and diagnosis:

_____
_____
_____
_____

List any other diagnosis, syndrome or limitations the student has or has had. (Provide, condition, treatment, etc): _____
_____
_____
_____

Parent/Guardian Signature:_____
Date:_____

Immunizations for Rhode Island Students

Required Immunizations

Kindergarten – requirements for entry		
Name of vaccine	**Diseases it protects against**	**Doses required**
DTaP	Diphtheria, tetanus, pertussis	5
Hepatitis B vaccine	Hepatitis B	3
MMR	Measles, mumps, rubella	2
Polio vaccine	Polio	4
Varicella vaccine	Varicella (chickenpox)	2 *

7th Grade – requirements for entry		
Name of vaccine	**Diseases it protects against**	**Doses required**
HPV vaccine	Human papillomavirus	1 **
Meningococcal conjugate	Meningitis	1
Tdap	Diphtheria, tetanus, pertussis	1

12th Grade – requirements for entry		
Name of vaccine	**Diseases it protects against**	**Doses required**
Meningococcal conjugate	Meningitis	1 (booster dose)

Recommended immunizations

- Flu: Everyone 6 months of age and older should be vaccinated against the flu every year.
- Hepatitis A: All children should be vaccinated against hepatitis A when they are 1 year old.

More information

More information about these requirements, see www.health.ri.gov/immunization/for/schools
If you have questions about the immunizations that students need, contact the Rhode Island Department of Health at 401-222-5960 / RI Relay 711.

---

* A signed note by a doctor stating that the child has had a history of chickenpox can meet the requirement for varicella immunizations.

** A 3-dose HPV immunization requirement is being phased in. For fall 2015, 1 dose will be required for 7th graders. For fall 2016, one dose will be required for 7th graders and 2 doses will be required for 8th graders. For fall 2017, 1 dose will be required for 7th graders, 2 doses will be required for 8th graders, and 3 doses will be required for 9th graders.

January, 2015

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)
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
Screening / Referral Date:
Comprehensive Exam Date:

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

HEALTH CARE PROVIDER SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____