



East Providence School Department
1998 Pawtucket Avenue - Door 2
East Providence, RI 02914
401-270-8276
Fax: 401-919-5912
Monica deSouza
Email: mdesouza@epschoolsri.com

Requirements for Registration

❖ 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.

| <u>Column A</u> | <u>Column B</u> | <u>Column C</u> |
|---|---|--------------------------------|
| Most Recent Mortgage Statement | Most Recent Utility Bill Gas/Electric/Cable/Cell Phone | Payroll Stub (last 30 days) |
| Current Lease | Student Loan | Bank Statement (last 30 days) |
| Section 8 Agreement | Credit Card Statement | W-2/Tax Return (past year) |
| Legal affidavit from landlord affirming tenancy | State Assistance Ex. WIC/Unemployment | Property Tax |

**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 _____ | 504 _____ | HLS 1-3 _____ |

(To be completed by parent/guardian)

STUDENT INFORMATION:

Parent email address: _____ (required as primary mode of communication.)

Name of Student _____

Date of Birth _____ *Last* City/State of Birth _____ *First* _____ *Middle* 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 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: _____

Previously attended East Providence Public Schools: ☐ Yes ☐ No *City* *State*

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: _____



Angélica Infante-Green
Commissioner

State of Rhode Island and Providence Plantations
DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Shepard Building
255 Westminster Street
Providence, Rhode Island 02903-3400

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 purposes¹.

Thank you for your collaboration.

| | | |
|--|--------|------------------------------------|
| Student Name: | | |
| First | Middle | Last |
| Date of Birth: | | Place of Birth²: |
| 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

(Please check all that apply)

| | | | |
|---|---|---|---------|
| 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 | _____ | Specify |
| 2. What is the language most often spoken by the student? | <input type="checkbox"/> English <input type="checkbox"/> Other | _____ | Specify |
| 3. What is the language that the student first acquired? | <input type="checkbox"/> English <input type="checkbox"/> Other | _____ | Specify |
| 4. What language(s) does your child understand? | <input type="checkbox"/> English <input type="checkbox"/> Other | _____ | Specify |
| 5. What language(s) does your child speak? | <input type="checkbox"/> English <input type="checkbox"/> Other | _____ <input type="checkbox"/> Does not speak | Specify |
| 6. What language(s) does your child read? | <input type="checkbox"/> English <input type="checkbox"/> Other | _____ <input type="checkbox"/> Does not read | Specify |
| 7. What language(s) does your child write? | <input type="checkbox"/> English <input type="checkbox"/> Other | _____ <input type="checkbox"/> Does not write | Specify |

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)745-6575 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:

Telephone (401)222-4600 Fax (401)222-6178 TTY (800)745-5555 Voice (800)745-6575 Website: www.ride.ri.gov

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

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 **OR** ☐ _____
1998 Pawtucket Avenue
East Providence, RI 02914
(401) 270-8276
(401) 919-5912 (fax)

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

| | | | |
|-----------------------------|--------------------------------|--------------|---------------------|
| <i>Student's Name</i> | <i>Birth Date (DOB)</i> | <i>Grade</i> | <i>Today's Date</i> |
| <i>Parent/Guardian Name</i> | <i>Parent/Guardian Address</i> | | |

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: _____ Phone Number: _____
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.

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:

1. ASTHMA: No ☐ Yes ☐ If yes, complete an [Asthma Action Plan](http://www.health.ri.gov/publications/actionplans/2012Asthma.pdf) (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](http://www.foodallergy.org/document.doc?id=234) (www.foodallergy.org/document.doc?id=234)
3. DIABETES: No ☐ Yes ☐ If yes, complete a [Physicians Order Form For Students With Diabetes](http://www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf) (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 <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 Screening / Referral Date: _____ Comprehensive Exam Date: _____ |
| TUBERCULOSIS (If required by school district) Date of TB test: _____ | | |

HEALTH CARE PROVIDER SIGNATURE: _____

DATE: _____

PRINT NAME: _____