

Cohasset Public Schools  
New Student Registration Form

Joseph Osgood Elementary     Deer Hill Elementary     Cohasset Middle High School

SASID Number: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Name: \_\_\_\_\_  
  (Last name)                              (First Name)                              (Middle Name)

Date of Birth: \_\_\_\_\_ Birth Place: \_\_\_\_\_ Sex:  M  F  N

Street Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Ethnicity (select only one):

Are you Hispanic or Latino?

No, not Hispanic or Latino

Yes, Hispanic or Latino

Race (you may select one or more races):

White

Black or African American

American Indian or Alaska Native

Asian

Native Hawaiian or Other Pacific Islander

Family Information:

Parent/Guardian 1 Name: \_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Parent/Guardian 2 Name: \_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

May the student be dismissed to either parent/guardian? \_\_\_ yes \_\_\_ no

May school record information be provided to either parent/guardian? \_\_\_ yes \_\_\_ no

If no to above statements, has documentation been provided? \_\_\_ yes \_\_\_ no

Siblings Names and Ages: \_\_\_\_\_

Is there any language other than English spoken in the home? \_\_\_\_\_

School Information:

Cohasset Public Schools Entry Date: \_\_\_\_\_ Entering Grade: \_\_\_\_\_

Has the student ever been enrolled in a Massachusetts Public School: \_\_\_ yes \_\_\_ no

If yes, please answer below

Previous School Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Do we have permission to contact school: \_\_\_ Yes \_\_\_ No

Prior to age six (6) Please mark the circle which best describes your child's previous experience in school

- No formal early childhood program experience
- Family Support: Coordinated Family and Community Engagement (CFCE)
- Family Support: Parent Child Home Program (PCHP)
- Family Support: Both CFCE & PCHP
- Formal: Licensed Family Child Care Provider < 20 hours per week
- Formal: Licensed Family Child Care Provider => 20 hours per week
- Formal: Center Based Program < 20 hours per week
- Formal: Center Based Program => 20 hours per week
- Formal: Both Family Child Care Provider and Center Based Program < 20 hours per week
- Formal: Both Family Child Care Provider and Center Based Program => 20 hours per week

Has your student received any of the following services? (Please mark all the apply)

- |                                      |                                    |                                 |
|--------------------------------------|------------------------------------|---------------------------------|
| ___ Special Education                | ___ Title 1                        | ___ Individual Health Care Plan |
| ___ Occupational Therapy             | ___ Physical Therapy               | ___ Speech Language             |
| ___ Counseling                       | ___ Section 504 Accommodation Plan |                                 |
| ___ English Language Learner Program | ___ Other (please describe below)  |                                 |

Is there any additional information you would like the school to know about your student?

---

---

---

---

---

---

Member of Military Family?

No, not a member of a military family

Yes, child of active duty member

Yes, child of members of veterans who are medically discharged or retired for 1 year

Yes, child of member who died on active duty

Homeless?  yes  no

Has student been expelled or disciplined?  yes  no

Will transportation be requested?  yes  no

Can information be shared with a third party?  yes  no

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Please provide at the time of enrollment the students original birth certificate.***

\_\_\_\_\_, in the year \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

**Proof of Residency (1 from each category, 3 different documents)**

Category 1	Category 2	Category 3
~ Mortgage Statement ~ Deed ~ Purchase and Sales Agreement ~ Property tax bill ~ Lease and record of most recent rent payment. You must submit both of these documents.	~ Utility bill/ work order within the past 60 days: ~ Gas bill ~ Oil bill ~ Electric bill ~ Cable bill	~ MA driver's license, ~ Passport ~ State issued ID card

# Cohasset PUBLIC SCHOOLS

## HEALTH REGISTRATION FORM

Dear Parent,

Please complete this form and return to your designated school.

Student Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 (Last, First, Middle)                      Male     Female     Email: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Please answer the following questions. Allergies \_\_\_\_\_

1. Is your child **CURRENTLY** being treated for any of the following? Please circle "Y" for Yes or "N" for No and provide details where indicated.

Arthritis or joint disease	Y	N	Heart Disease	Y	N
Asthma	Y	N	Kidney disease	Y	N
Blood disorder	Y	N	Food allergy	Y	N
Celiac disease	Y	N	Medication allergy	Y	N
Compromised immune system	Y	N	Bee sting allergy	Y	N
Concussion/head injury	Y	N	Seizures	Y	N
Diabetes	Y	N	Behavioral or social/emotional regulation issues	Y	N
Lyme disease	Y	N	Fracture or sprain injuries	Y	N
Cystic Fibrosis	Y	N	Other _____ Explain below.	Y	N

Please explain any "Yes" answers to above and provide more detailed information and dates.

2. Does your child take any medications\* now?  Yes  No      Medication: \_\_\_\_\_  
 \*If a student requires medication at school, a physician's order is needed.

3. Does your child require an EPIPEN\*?  Yes  No  
 \*If yes, written physician's orders and the EPIPEN must be provided before the child may start school.

4. Check off the following health concerns that pertain to the student.

Eyes:	Glasses:	Y	N	Other (continued):		
	For Distance or Near	D	N	Headaches	Y	N
	Lazy eye	Y	N	Lungs	Y	N
Ears:	Frequent infections	Y	N	Skin	Y	N
	Tubes	Y	N	Bowel problem	Y	N
	Hearing difficulty	Y	N	Phobias	Y	N
Other:	Nosebleeds	Y	N	Dental	Y	N
	Eating	Y	N	Bedwetting	Y	N
	Sleeping	Y	N	ADD/ADHD	Y	N

Please explain above health concern: \_\_\_\_\_

I give the school nurse permission to share the above confidential health information with his/her teacher, specialists, principal and assistant principal on an as needed basis.  Yes  No

Parent Signature/Date: \_\_\_\_\_

# MASSACHUSETTS SCHOOL HEALTH RECORD

## Health Care Provider's Examination

Name \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_  
 Medical History \_\_\_\_\_

**Pertinent Family History**

**Current Health Issues**

Y  N  Allergies: Please list: Medications \_\_\_\_\_ Food \_\_\_\_\_ Other \_\_\_\_\_  
 History of Anaphylaxis to \_\_\_\_\_ Epi-Pen®:  Yes  No  
 Asthma: Asthma Action Plan  Yes  No (Please attach)  
 Diabetes:  Type I  Type II  
 Seizure disorder: \_\_\_\_\_  
 Other (Please specify) \_\_\_\_\_

**Current Medications (if relevant to the student's health and safety)** Please circle those administered in school; a separate medication order form is needed for each medication administered in school.

**Physical Examination**

Date of Examination: \_\_\_\_\_  
 Hgt: \_\_\_\_\_ (\_\_\_\_%) Wgt: \_\_\_\_\_ (\_\_\_\_%) BMI: \_\_\_\_\_ (\_\_\_\_%) BP: \_\_\_\_\_  
 (Check = Normal / If abnormal, please describe.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

**Screening:** (Pass) (Fail)      (Pass) (Fail)      (Pass) (Fail)  
 Vision: Right Eye        Hearing: Right Ear        Postural Screening:    
 Left Eye        Left Ear        (Scoliosis/Kyphosis/Lordosis)  
 Stereopsis

**Laboratory Results:**  Lead \_\_\_\_\_ Date \_\_\_\_\_  Other \_\_\_\_\_

The entire examination was normal:

**Targeted TB Skin Testing:**  Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):  
 TB Test Type:  TST  IGRA Date: \_\_\_\_\_ Result:  Positive  Negative  Indeterminate/Borderline  
 Referred for evaluation to: \_\_\_\_\_ Date: \_\_\_\_\_  Low risk (no TB test done)

This student has the following problems that may impact his/her educational experience:  
 Vision  Hearing  Speech/Language  Fine/Gross Motor Deficit  
 Emotional/Social  Behavior  Other

**Comments/Recommendations:**

Y  N This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions: \_\_\_\_\_

Y  N Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.

Signature of Examiner Circle: MD, DO, NP, PA Date \_\_\_\_\_

Please print name of Examiner. \_\_\_\_\_

Group Practice \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Please attach additional information as needed for the health and safety of the student.

MDPH 04/13/17

# CERTIFICATE OF IMMUNIZATION

Name: \_\_\_\_\_ Date of Birth:    /    /    Sex:    M    F

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine	Date	Vaccine Type	Vaccine	Date	Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		Measles, Mumps, Rubella (e.g., MMR, MMRV)	1	
	2			2	
	3		Varicella (Var, MMRV)	1	
	4			2	
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1		Meningococcal Quadrivalent MenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4)	1	
	2			2	
	3		Meningococcal Serogroup B (Men B) MenB-FHbp MenB-4C	1	
	4			2	
	5			3	
	6		Seasonal Influenza Inactivated IIV4, IIV4-ID, IIV3, IIV3- ID, IIV3-HD, RIV3-IM, ccIIV3-IM	1	
	7			2	
	8			3	
Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP- IPV/Hib, Hib-MenCY)	1		Live Attenuated LAIV, LAIV4 (quadrivalent)	4	
	2			5	
	3			6	
	4			7	
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP- IPV)	1		2009 H1N1 Influenza Inactivated or Live	1	
	2			2	
	3		Pneumococcal Polysaccharide (PPSV23)	1	
	4			2	
	5		Hepatitis A (HepA, HepA-HepB)	1	
		2			
Pneumococcal Conjugate (PCV13, PCV7)	1		Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	
	2			2	
	3			3	
	4				
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		Zoster (shingles)	1	
	2		Other:	1	
	3			2	

Please see next page ➡

# CERTIFICATE OF IMMUNIZATION (continued)

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

\* Must also check Chickenpox History box.

Chickenpox History	
<input type="checkbox"/>	Check the box if this person has a physician-certified reliable history of chickenpox.
Reliable history may be based on:	
<ul style="list-style-type: none"> <li>• physician interpretation of parent/guardian description of chickenpox</li> <li>• physical diagnosis of chickenpox, or</li> <li>• serologic proof of immunity</li> </ul>	

*I certify that this immunization information was transferred from the above-named individual's medical records.*

**Doctor or nurse's name (please print):** \_\_\_\_\_ **Date:**    /    /  
**Signature:** \_\_\_\_\_  
**Facility name:** \_\_\_\_\_



# COHASSET CONFIDENTIAL HEALTH FORM

STUDENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ GRADE: \_\_\_\_\_

PLEASE COMPLETE THE FOLLOWING QUESTIONS, EXPLAINING ANY "YES" RESPONSES.

1. Do you have any concerns about your child's physical health? \_\_\_ YES \_\_\_ NO
2. Has your child been diagnosed with a chronic illness? \_\_\_ YES \_\_\_ NO
3. Does your child have any allergies? \_\_\_ YES \_\_\_ NO Epipen required? \_\_\_ YES \_\_\_ NO
4. Does your child have any problems with vision or hearing? \_\_\_ YES \_\_\_ NO
5. Any major hospitalizations, operations, illnesses or injuries? \_\_\_ YES \_\_\_ NO
6. Does your child have a medical issue that will impact their attendance/performance at school?  
\_\_\_ YES \_\_\_ NO IF YES, PLEASE PROVIDE MEDICAL DOCUMENTATION.

Additional Information:

PLEASE LIST ANY MEDICATIONS THAT YOUR CHILD IS CURRENTLY TAKING AT HOME AND THE REASON THE MEDICATION HAS BEEN PRESCRIBED. IF IT IS NECESSARY TO ADMINISTER MEDICATION DURING THE SCHOOL DAY PLEASE CONTACT THE SCHOOL NURSE.

MEDICATION	REASON
1. _____	_____
2. _____	_____
3. _____	_____

PHYSICIAN'S NAME \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

USE A SECOND PAGE IF ADDITIONAL SPACE IS NEEDED

### PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATION IN SCHOOL

If your child demonstrates the medical need, while in school, for any over-the-counter medication listed below, a parent/guardian signature is required. PLEASE CIRCLE the medications you give the nurse permission to administer. The appropriate dose would be given according to your child's age and weight.

MEDICATION ALLERGY? \_\_\_ YES \_\_\_ NO NAME OF MEDICATION: \_\_\_\_\_

Acetaminophen (Tylenol) every 4 hours as needed

Ibuprophen (Motrin) every 6 hours as needed

Benadryl every 6 hours as needed (allergic reaction)

Tums tablets

Antibiotic ointment

Calamine product to skin rash as needed

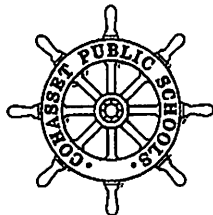
Vaseline topically as needed

NONE OF THE ABOVE

PARENT / GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

THIS FORM IS TO BE COMPLETED YEARLY AND RETURNED TO THE NURSE'S OFFICE.

Patrick E. Sullivan, Ed.D.  
Superintendent of Schools  
781-383-6111



Leslie A. Scollins, Ed.D.  
Assistant Superintendent  
781-383-4210

Michael C. MacMillan  
Director of Finance & Operations  
781-383-6108

Mary E. Buchanan  
Director of Student Services  
781-383-6104

## Cohasset Public Schools

Administration Office • 143 Pond Street • Cohasset, MA 02025  
www.cohassetk12.org • Facsimile: 781-383-6507

I, \_\_\_\_\_ the parent/legal guardian of \_\_\_\_\_ hereby authorize  
the Cohasset Public Schools and it's personal to:

Check the applicable section(s):

- Both release information to and accept information from the Agency/individual listed below;
- Only accept information from the Agency/Individual listed below;
- Only release information to the Agency/individual listed below;
- Fax information to the Agency/Individual listed below, according to the following provision:

By requesting to have records faxed to a location that is not my home, I understand that the records might be seen by/disclosed by a third party who has no right to view the records; I hereby consent to such disclosure.

Name of the Agency/Individual: \_\_\_\_\_

Contact Information of Agency/Individual: \_\_\_\_\_

I allow the following information to be released:

- Academic Transcript
- Health Record
- Special Education Evaluations
  - Psychological  Educational/Achievement
  - Related Services  Other: \_\_\_\_\_
- Individualized Education Program (IEP)
- Special Education Progress Reports
- Social Work/Adjustment Counselor Records
- Guidance Reports
- Discipline Record
- Attendance Record
- Standardized Testing Results (including MCAS)
- Verbal information regarding any of the above designated items

Student Date of Birth: \_\_\_\_\_

Student Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Relationship to Student: \_\_\_\_\_

## Cohasset Public Schools: Home Language Survey

State and federal law require that *all* schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. If a language other than English is spoken in the home, the District is required to do further assessment of your child. Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

### Student Information

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_ Gender F  M   
 Country of Birth \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_\_ Date first enrolled in ANY U.S. school (mm/dd/yyyy) \_\_\_\_\_

### School Information

Start Date in New School \_\_\_\_\_ / \_\_\_\_\_ / 20\_\_\_\_ Name of Former School and Town \_\_\_\_\_ Current Grade \_\_\_\_\_  
 (mm/dd/yyyy)

### Questions for Parents/Guardians

What is the native language(s) of each parent/guardian? (circle one)  _____ (mother /father /guardian) _____ (mother/ father / guardian)	Which language(s) are spoken with your child? (include relatives -grandparents, uncles, aunts, etc. - and caregivers)  _____ seldom / sometimes /often /always _____ seldom / sometimes /often /always
What language did your child first understand and speak?	Which language do you use most with your child?
Which other languages does your child know? (circle all that apply)  _____ speak / read / write _____ speak / read / write	Which languages does your child use? (circle one)  _____ seldom /sometimes /often /always _____ seldom /sometimes/often/always
Will you require written information from school in your native language?  Y <input type="checkbox"/> N <input type="checkbox"/>	Will you require an interpreter/translator at Parent-Teacher meetings?  Y <input type="checkbox"/> N <input type="checkbox"/>
Parent/Guardian Signature:  X _____	_____ / _____ / 20____ Today's Date (mm/dd/yyyy)

To be completed by District English Language Learner Coordinator before placement:

Date of School Enrollment _____ / _____ / _____	Student's First Name _____ Student's Family Name _____	Age Birth Date Grade _____ / _____ / _____
Number of Years Student has been in the USA: _____	Relationship of Person Completing Home Language Survey: <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Guardian <input type="radio"/> Other Recommendation: <input type="radio"/> Proficiency Testing/Records Review <input type="radio"/> No ELL Program	Signature of ELL Coordinator:  _____

# COHASSET PUBLIC SCHOOLS DISCIPLINE RELEASE FORM

Sending school \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Student Name \_\_\_\_\_

Under the Education Report Act, Section 37:37L of Chapter 71, we are requesting information relative to discipline. Please respond to the following questions:

\_\_\_\_\_ The above named student had no issues relative to discipline as defined by Section 37:37L of Chapter 71.

\_\_\_\_\_ The above named student has issues relative to discipline as defined by Section 37:37L of Chapter 71. A copy of this discipline record is included with this form.

Signature of Preparer \_\_\_\_\_ Position: \_\_\_\_\_

### Education Reform Act of 1993

Section 37, Section 37L of said chapter 71 of the General Laws, as appearing in the 1990 Official Edition, is hereby amended by adding the following:

"A student transferring into a local school system must provide the new school system with a complete school record of entering student. Said record shall include, but not be limited to, any incident reports in which such student was charged with any suspended act."

**EMERGENCY INFORMATION SHEET**

Dear Parent/Guardian:

The information you will provide below is very important to us. It will be used to contact you in the case of an emergency and to support ongoing communication between school and home.

Grade: \_\_\_\_\_

Student Name (full name as it appears on birth certificate)

\_\_\_\_\_

(Last Name)	(First Name)	(Middle Name)
-------------	--------------	---------------

Address: \_\_\_\_\_

(Number)	(Street)	(Apt #)
----------	----------	---------

City/State/Zip: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_

Gender: \_\_\_M\_\_\_ F \_\_\_N\_\_\_      Date of Birth: \_\_\_\_\_      City of Birth: \_\_\_\_\_

Parent(s)/Guardian(s) Name: \_\_\_\_\_

<b>Parent 1/Guardian 1</b>	<b>Parent 2/Guardian 2</b>
Name: _____	Name: _____
Work #: _____	Work #: _____
Cell #: _____	Cell #: _____
Email: _____	Email: _____

List two Emergency Contacts who will assume temporary care of student if parent cannot be reached.

<b>Emergency Contact 1</b>	<b>Emergency Contact 2</b>
Name: _____	Name: _____
Primary Phone #: _____	Primary Phone #: _____

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Cohasset Public Schools  
Residency Statement

I/We, the parent(s)/legal guardian(s) of \_\_\_\_\_ (student name), hereby certify as follows:

1. I/We wish to enroll the above named student in the Cohasset Public Schools. I/We understand that pursuant to Massachusetts law and Cohasset Public School protocol, students who actually reside in the Town of Cohasset may attend the Cohasset Public Schools. Students who do not actually reside in the Town of Cohasset may not attend the Cohasset Public School without the permission of the Cohasset School Committee.

2. I/We hereby certify that effective \_\_\_\_\_ (date), the above named student will be residing at the following address in Cohasset, Massachusetts with:  
Parent/Guardians:

\_\_\_\_\_  
Address:

\_\_\_\_\_  
Phone Number:

3. I/We acknowledge that I am/we are required to notify the Cohasset Public Schools or the above named student's school, in writing, of any change in the student's address within five (5) calendar days of such change of address.

4. I/We understand this Residency Statement will be relied upon by the Cohasset Public Schools for the purpose of determining the above student's eligibility to attend the Cohasset Public Schools on the basis of residency. If the said student is enrolled in the Cohasset Public Schools based upon the information provided and it is subsequently determined that the student does not actually reside in Cohasset, I/we will be jointly and severely liable to the Cohasset Public Schools for the student's tuition for the full academic year(s).

5. I/We understand that all applicants must reside in the Town of Cohasset (Massachusetts General Laws, Chapter 76, section 5: Every person shall have the right to attend the public schools of the town where he/she actually resides, subject to the following section. No School Committee is required to enroll a person who does not actually reside in the town unless said enrollment is authorized by the law or by the School Committee. Any person who violates or assists in the violation of this provision may be required to remit full restitution to the town of the improperly-attended public schools. No person shall be excluded from or discriminated against in admission to a public school of any town, or in obtaining the advantages, privileges, and courses of student of such public school on account of race, color, sex, religion, national origin, or sexual orientation. Amended by st. 1971, c.622, c.1; st. 1973, c.925, s.9A; st. 1993, c. 282; st. 2004, c. 352, s. 33).

Signed under the pains and penalties of perjury on this \_\_\_\_\_ day of