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

- o No formal early childhood program experience
- o Family Support: Coordinated Family and Community Engagement (CFCE)
- o Family Support: Parent Child Home Program (PCHP)
- o Family Support: Both CFCE & PCHP
- o Formal: Licensed Family Child Care Provider < 20 hours per week
- o Formal: Licensed Family Child Care Provider => 20 hours per week
- o Formal: Center Based Program < 20 hours per week
- o Formal: Center Based Program => 20 hours per week
- o Formal: Both Family Child Care Provider and Center Based Program < 20 hours per week
- o 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
___ Occupational Therapy
___ Counseling
___ English Language Learner Program
___ Title 1
___ Physical Therapy
___ Section 504 Accommodation Plan
___ Other (please describe below)
___ Individual Health Care Plan
___ Speech Language

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.

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, c622, 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

_____, 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 <u>before</u> 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.)

☐ General _____ ☐ Lungs _____ ☐ Extremities _____

☐ Skin _____ ☐ Heart _____ ☐ Neurologic _____

☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____

☐ Dental/Oral _____ ☐ Genitalia _____

Screening:

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

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
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		
	2		
	3		
	4		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1		
	2		
	3		
	4		
	5		
	6		
	7		
	8		
Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1		
	2		
	3		
	4		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1		
	2		
	3		
	4		
	5		
Pneumococcal Conjugate (PCV13, PCV7)	1		
	2		
	3		
	4		
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2		
	3		

Vaccine		Date	Vaccine Type
Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
	2		
Varicella (Var, MMRV)	1		
	2		
Meningococcal Quadrivalent MenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2		
Meningococcal Serogroup B (Men B) MenB-FHbp MenB-4C	1		
	2		
	3		
Seasonal Influenza Inactivated IIV4, IIV4-ID, IIV3, IIV3-ID, IIV3-HD, RIV3-IM, ccIIV3-IM Live Attenuated LAIV, LAIV4 (quadrivalent)	1		
	2		
	3		
	4		
	5		
	6		
	7		
2009 H1N1 Influenza Inactivated or Live	1		
	2		
Pneumococcal Polysaccharide (PPSV23)	1		
	2		
Hepatitis A (HepA, HepA-HepB)	1		
	2		
Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1		
	2		
	3		
Zoster (shingles)	1		
Other:	1		
	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

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

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

Susan E. Owen
Director of Finance & Operations
781-383-6108

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

Barbara A. Cerwonka, M.Ed.
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 its personnel 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 _____ F ☐ M ☐ Gender

Country of Birth _____ Date of Birth (mm/dd/yyyy) ___/___/___ Date first enrolled in ANY U.S. school (mm/dd/yyyy) ___/___/___

School Information

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

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 ☐ N ☐	Will you require an interpreter/translator at Parent-Teacher meetings? Y ☐ N ☐
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: ◯ Mother ◯ Father ◯ Guardian ◯ Other Recommendation: ◯ Proficiency Testing/Records Review ◯ 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: _____

Parent 1/Guardian 1

Name: _____
Work #: _____
Cell #: _____
Email: _____

Parent 2/Guardian 2

Name: _____
Work #: _____
Cell #: _____
Email: _____

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

Emergency Contact 1

Name: _____

Primary Phone #: _____

Emergency Contact 2

Name: _____

Primary Phone #: _____

Parent/Guardian Signature: _____ Date: _____