John Read Middle School

486 Redding Road
Redding, CT 06896-1901

Phone: (203) 938-2533
Fax: (203) 938-8667

Diane Martin, Principal
Darlene Wallin, Asst. Principal

www.johnreadps.org

Dear Parents and Guardians,

Welcome to the Redding Schools. I am certain you will find our schools to be some of the finest in Connecticut.

As a parent seeking enrollment for your child(ren) in our schools, you must be a Redding resident.

You will need to fill out an enrollment verification form and provide your proof of residency by suppling any **two (2)** of the following documents:

ONE DOCUMENT MUST BE A

- Recorded Deed
- *Current* Real Estate Tax Bill
- Field Property Card *from the Town Clerk's Office*
- Signed and Notarized Lease/Rental Agreement
- Signed and Notarized Affidavit *if living with family members*

AND ONE OF THE FOLLOWING:

- *Current* Utility Bill (gas, electric, propane or cable bill) with your name and address on it.
- Personal Property Tax Bill with your name and address on it.

Leaseholders and families enrolled with affidavits must update those documents yearly or as they expire.

If you are purchasing a home with pending occupancy or property in Redding to construct a permanent legal residence, you must contact Eileen Hepp at Central Office: 203-261-2513 to learn about the regulations to establish residency in these circumstances.

Thank you for your understanding in this matter and interest in our schools.

Sincerely,

Diane Martin
Principal

EASTON, REDDING, AND REGION 9 SCHOOL DISTRICTS

654 MOREHOUSE ROAD, P.O. BOX 500 EASTON, CONNECTICUT 06612
OFFICE (203) 261-2513 FAX (203) 261-4549
WEB SITE: WWW.ER9.ORG

ENROLLMENT APPROVAL FORM

DATE:_____ START DATE: _____

My legal residence is/will be _____
and I testify that we are/will be permanently residing at this address.

- If lease or rental property: a signed and notarized lease by both parties with begin and end dates is required and must be provided yearly. Dates_____
- If a month to month lease: a copy of the rent check must be sent to Central Office by the 12th of every month.

If separated or divorced the name, address and phone number of other parent/guardian and days, weeks or times children will be staying with them.

_____

_____

_____

I UNDERSTAND IT IS A VIOLATION OF CONNECTICUT CRIMINAL STATUTE, CGS 53A-157, TO MAKE A FALSE WRITTEN STATEMENT. THE POLICE DEPARTMENTS IN EASTON AND REDDING ASSIST THE BOARDS OF EDUCATION IN INVESTIGATIONS OF PUPIL RESIDENCY CLAIMS.

_____ _____
Printed Name Signature

_____ _____ _____
Home Phone Cell Phone Email Address

All children living in the household

Last Name	First Name	Sex	Date of Birth	School	Grade

PROOF OF RESIDENCY MUST BE PROVIDED BEFORE CHILDREN MAY BE REGISTERED IN SCHOOL

2 OF THE FOLLOWING DOCUMENTS MUST BE PROVIDED:

REQUIRED (1)

- ☐ Copy of Residence Purchase Agreement or Contract of Sale
- ☐ Copy of Signed and Notarized Lease/Rental Agreement with beginning and end dates included.
- ☐ Copy of Recent Deed with actual address noted.
- ☐ Copy of the Property Field Card from the Town Tax Assessors Office
- ☐ Current Real Estate Property Tax Bill with name and address
- ☐ Notarized affidavit and proof of residency from resident homeowner with whom parents and students reside. Student's parent must also provide proof of residency. (Pay stub, phone bill, insurance card, etc. w/name and address)

ADDITIONAL (1)

- ☐ Current Utility Bill with name and address. (Electric, Gas, Oil, Water, Cable.)
- ☐ Current Personal Property Tax Bill with name and address

- Families must inform the school district of a change of address and provide new proof of residency within 20 days of moving.
- Bus Changes and student records will not be updated without proper notification and documentation.

____ Registration Approved ___ Registration Denied - More Information Required

District/School Official _____ Date _____

Route to: School Registrar's

JBHS _____

RES _____ JRMS _____

SSES _____ HKMS _____

Laura Ponzio, Transportation _____ JBHS Guidance Department _____

EASTON, REDDING, AND REGION 9 SCHOOL DISTRICTS

654 MOREHOUSE ROAD, P.O. BOX 500 EASTON, CONNECTICUT 06612
OFFICE (203) 261-2513 FAX (203) 261-4549
WEB SITE: WWW.ER9.ORG

AFFIDAVIT FOR PURPOSES OF RESIDENCY

IT IS A VIOLATION OF CONNECTICUT CRIMINAL STATUTE, CGS 53A-157, TO MAKE A FALSE WRITTEN STATEMENT. THE POLICE DEPARTMENTS IN EASTON and REDDING ASSIST THE BOARDS OF EDUCATION IN INVESTIGATIONS OF PUPIL RESIDENCY CLAIMS. FRAUDULANT CLAIMS ARE SUBJECT TO PROSECUTION.

Students Parent/Guardian Names: (Please Print)_____

1. I currently reside with (*Homeowners Name*): _____

   Street Address _____

   In the Town of Easton or Redding, in the State of Connecticut.

2. I intend such residence* to be permanent.
3. I intend such residence to be provided without payment.
4. Such residence is being provided without payment.
5. Our residence is **NOT** for the sole purpose of obtaining school accommodations in the Easton/Redding/Region 9 School District.

***RESIDENCE shall refer to domicile, i.e. a person's true, fixed and permanent home or place of habitation, where he or she intends to reside permanently.**

_____
Student's Name(s), Grade(s), and School(s)

_____

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Resident Homeowner's Signature Date

THIS AFFIDAVIT MUST BE SIGNED AND NOTARIZED

STATE OF CONNECTICUT)
)ss:
COUNTY OF FAIRFIELD)

This affidavit is valid for 1 school year and must be resubmitted every year for children's enrollment in ER9 schools.

School Year _____

JOHN READ MIDDLE SCHOOL
NEW STUDENT INFORMATION FORM

Student's Legal Name: _____

Grade: _____ Date of Birth: _____ Gender: _____

Parent/Guardian: _____

_____

Current Address: _____

_____

Current Phone: _____

Current School: _____

New Address: _____

_____

New Phone: _____

DATE PACKET SENT: _____

INFO RECEIVED BY: _____

Student ID _____ SASID _____

EASTON/REDDING/REGION 9 PUBLIC SCHOOLS
Easton - Redding, Connecticut

GRADE ENTERING _____ **REGISTRATION CARD** DATE ENTERED _____

(Parents are responsible to inform the school of any change in information on this card.)

LEGAL NAME _____ ☐ M ☐ F
Last *First* *Middle*

HOME ADDRESS _____ ☐ Rent ☐ Own
Street *Town* *Zip*

MAILING ADDRESS _____
Street *Town* *Zip*

HOME TELEPHONE # _____

BIRTHDATE _____ BIRTHPLACE _____
Month *Day* *Year*

COPY OF PROOF OF RESIDENCY ON FILE ☐ **LEGAL DOCUMENTATION OF BIRTH ON FILE ☐**

Documents reviewed _____

LIST ALL OTHER CHILDREN IN FAMILY

Full Name	Birthdate	Sex	Full Name	Birthdate	Sex
1.			4.		
2.			5.		
3.			6.		

SCHOOLS PREVIOUSLY ATTENDED

List most recent school first	City and State	Grade

Does your child have an existing: ☐ **Individualized Education Program (IEP) or** ☐ **504**

The information below is required by the State of Connecticut Department of Education and U.S. Department of Education

DOMINANT LANGUAGE

1. What is the primary language used in the home, regardless of the language spoken by the student? _____
2. What is the language most often spoken by the student? _____
3. What is the language the student first acquired? _____

Is the student a citizen of the United States? ☐ Yes ☐ No

Does your child meet all three criteria of the federal definition of an immigrant child/youth.[1] ☐ Yes ☐ No

[1]Section 3201(5) of Title III of the ESEA defines immigrant children and youths as individuals who:
- are aged 3 through 21;
- were not born in any State (defined as each of the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico); and
- have not been attending one or more schools in any one or more States for more than 3 full academic years.

U.S. DEPARTMENT OF EDUCATION RACE AND ETHNICITY INFORMATION

Is this child Hispanic/Latino? ☐ Yes ☐ No

What is the child's race?

☐ American Indian or Alaskan Native ☐ Black or African American ☐ White

☐ Asian ☐ Native Hawaiian or Other Pacific Islander

MILITARY FAMILY STATUS:

- A child's parent or guardian is a member of the Armed Forces of the United States (Army, Navy, Air Force, Marine Corps and Coast Guard) on active duty or serves on full-time National Guard duty.

Is your student a member of a Military Family as defined above? ☐ Yes ☐ No

A. Parent 1 _____

Last *First* *Middle* *Occupation*

Parent 1's Address _____

Street *Town* *State* *Zip* *Home Phone*

Parent 1's Employer _____

Company *Address* *Business Phone* *Cell Phone*

Parent 1's e-mail address _____

(Used for Listserv - electronic communications from the school and district office.)

B. Parent 2 _____

Last *First* *Middle* *Occupation*

Parent 2's Address _____

Street *Town* *State* *Zip* *Home Phone*

Parent 2's Employer _____

Company *Address* *Business Phone* *Cell Phone*

Parent 2's e-mail address _____

(Used for Listserv - electronic communications from the school and district office.)

C. Name of student's legal court-appointed guardian (if applicable):

_____

Last *First* *Middle* *Occupation*

Guardian's Address _____

Street *Town* *State* *Zip* *Home Phone*

Guardian's Employer _____

Company *Address* *Business Phone* *Cell Phone*

Guardian's e-mail address _____

(Used for Listserv - electronic communications from the school and district office.)

LEGAL GUARDIANSHIP DOCUMENTATION RECEIVED BY SCHOOL ☐

D. If the student resides with someone other than mother, father or legal, court-appointed guardian, you must complete and have notarized the affidavits specified in policy #5118. Name of person with whom student resides:

_____

Last *First* *Middle* *Occupation*

Address _____

Street *Town* *State* *Zip* *Home Phone*

Employer _____

Company *Address* *Business Phone* *Cell Phone*

E-mail address _____

(Used for Listserv - electronic communications from the school and district office.)

AFFIDAVIT RECEIVED BY SCHOOL ☐

E. Are parents divorced? ☐ Yes ☐ No

If parents are divorced, list name(s) of person(s) having legal custody: _____

Are parents separated? ☐ Yes ☐ No

If parents are separated, list name(s) of person(s) with whom student is living: _____

If parents are divorced or separated, list name of parent with NO Custodianship ☐ LIMITED Custodianship ☐: _____

1. Visit child at school? _____
2. Remove child form school? _____
3. Confer with child's teacher? _____
4. Other (please specify) _____

LEGAL DOCUMENTATION MUST BE PROVIDED AND ON FILE AT THE SCHOOL. DOCUMENTATION RECEIVED BY SCHOOL ☐

F. Is either parent deceased? ☐ Yes ☐ No Deceased parent's name: _____

G. I CERTIFY THAT THE INFORMATION PROVIDED ON THIS REGISTRATION CARD IS CORRECT AND ACCURATE.

_____

Parent 1 or legal guardian's signature *Date*

_____

Parent 2 or legal guardian's signature *Date*

_____

Signature of staff member registering student *Date*

rev 10-19-17

SCHOOL RECORDS REQUEST FORM

Student Information				
1. Student's Legal Last Name		2. Student's Legal First Name	3. Middle Name	4. Generation
5. SASID	6. Local ID	7. Grade Level	8. Gender ☐ Male ☐ Female	9. Date of Birth / /

Section I. To the applicant's parent/guardian:

Please complete the top section of this form and deliver the entire form to the applicant's current school. John Read Middle School requires official records from the applicant's current school in order to complete the application process.

I, _____, hereby give permission to the registrar of
Name of Parent/Guardian

_____ _____
Name of Applicant's Current School *School's Full Address*

to send _____ 's school reports to John Read Middle School, where he/she
Full Name of Applicant

is applying to grade _____ .

Please include progress or grade reports, attendance records, health records, standardized test results, in-school support records, educational evaluations and IEPs (if applicable), and service plans.

_____ _____
Signature of Parent/Guardian *Date*

Section II. To the applicant's current school:

The student named above has applied to John Read Middle School. In order for us to complete the admissions process, we request a **copy** of the following information:

1. All of the student's progress or grade reports from your school plus any from other schools he/she has previously attended. **Please include progress reports for the current academic year.**
2. All testing results.
3. Any Health Records.
4. Any educational assessments and IEPs or 504 plan, if applicable.
5. Attendance Records
6. Disciplinary records, if any.

Request completed by:

_____ _____
Print Name Position

_____ _____
Signature Date

Please send the school records along with this form to:

John Read Middle School
Attn: Admissions
486 Redding Road
Redding, CT 06896
Phone: (203) 938-2533 Fax: (203) 938-8667

SPECIAL SERVICES DEPARTMENT
33 LONETOWN ROAD, REDDING, CT 06896
OFFICE (203) 938-9026 FAX (203) 938-0742

515 MOREHOUSE ROAD, EASTON, CT 06612
OFFICE (203) 459-9689 FAX (203) 261-7562

Tracy Edwards
Director of Special Services
Easton & Redding School Districts

Cindy Twiss
Interim Supervisor of Special Services
Easton & Redding School Districts

AUTHORIZATION FOR RELEASE OF INFORMATION

According to Public Law 94-142 and the statute of the State of Connecticut, written parental consent must be obtained before personally identifiable and/or confidential information on a student is disclosed to anyone other than the appropriate professional staff of the school district, or before the school district can obtain this information from another agency.

Please sign the form below, indicating your permission.

I hereby authorize _____ and _____
to exchange any and all information in the confidential records pertaining to my child,

_____

Address of school/agency/professional:

_____

_____

_____

Please initial documents you wish to be released:

_____ Psychological Reports
_____ Medical Reports
_____ Educational Evaluations
_____ Psychiatric Evaluations
_____ Speech/Hearing/Language Evaluations
_____ Individual Education Programs
_____ Speech Education Progress
_____ Home/School Correspondence
_____ Testing
_____ Other: _____

_____
Signature of Parent/Guardian

_____
Date

JOHN READ MIDDLE SCHOOL
World Language Selection

TO BE COMPLETED BY ALL NEW STUDENTS AND THEIR PARENTS

Student: _____
Last Name **First Name**

Please number in order of your choice (1, 2, 3):

_____ **Spanish Program** **Previous years in Spanish** _____

_____ **French Program** **Previous years in French** _____

_____ **Latin Program** **Previous years in Latin** _____

We will make every attempt to place a student in the world language of his/her choice. Although we do not anticipate class balance problems, understand that if a particular language is oversubscribed, we will place your child in their second or possibly third choice of language. **We place students on a first come, first serve basis.**

_____
Parent / Guardian Signature

_____
Date

_____
Date and Time Received by John Read Middle School

JOHN READ MIDDLE SCHOOL

NEW STUDENT
PEFORMING MUSIC GROUP APPLICATION FORM

NAME:_____ **DATE:**_____

____ I do NOT want to be scheduled for any performing music group.

_____ I want to be scheduled for the Chorus program.

_____ I want to be scheduled for the Band program.

Flute Oboe Clarinet Saxophone Trumpet Trombone Baritone French Horn Tuba Percussion

Please circle your instrument.

_____ I want to be scheduled for the yearlong String Orchestra program.

Violin Viola Cello String Bass

Please circle your instrument.

I understand that concert performance is considered a privilege that is earned by consistent participation and appropriate, respectful behavior. There are two concerts scheduled during the school year.

_____ _____

Student Signature *Date*

_____ _____

Parent Signature *Date*

ER9 Public School District

PowerSchool Parent Portal Acceptable Use Agreement

Acceptable Use Agreement of Information Technology
ER9 Public School District - Parent Acceptable Use Agreement

The ER9 School District is offering PowerSchool Parent Single Sign On Internet access for parent(s)/guardian(s) use to view their student's grades and attendance. Parents can create their own account for multiple students. To enter multiple email addresses for email alerts, please separate each address with a comma. This document contains the parent/guardian Acceptable Use Agreement for use of the ER9 School District's PowerSchool Parent Portal.

System Security

a. Parent(s)/Guardian(s) are responsible for their individual account and should take all reasonable precautions to prevent others from being able to use their account. Under no conditions should parent(s)/guardian(s) provide their password to another person.

b. Parent(s)/Guardian(s) will immediately notify the PowerSchool Administrator if they have identified a possible security problem by emailing PowerSchool Support at powerschool@er9.org.

Parent or Guardian Section

I have read the above ER9 District Acceptable Use Agreement. I understand passwords are an important aspect of computer security. If I feel my password has been compromised, I will email PowerSchool Support at powerschool@er9.org to obtain a new password.

.....

Student Name _____

Parent Signature _____ Date _____

Print Parent Name _____

Home Address _____ Phone _____

EMERGENCY INFORMATION
RETURN TO MAIN OFFICE AT JRMS

STUDENT	
RESIDENT ADDRESS	
MAIL ADDRESS	
CITY, STATE ZIP	
HOME PHONE	
BIRTHDATE	
GENDER	
STUDENT ID	

GRADE	
HOMEROOM	
RESIDES WITH:	
MOM	
DAD	
BOTH	
OTHER	

Parent/Guardian Information

	NAME	ADDRESS	CITY, STATE, ZIP	HOME PHONE	WORK #	ALT. #
Parent 1						
Parent 2						
Other1						
Other2						

STUDENT'S MOTHER'S MAIDEN NAME OR OTHER SECURE PASSWORD ON FILE:

Emergency Contact Information The individuals below have authorization to pick up my child in the event that I/we cannot not be reached at the numbers we have submitted to you.

CONTACT #1		HOME PHONE		CELL PHONE	
CONTACT #2		HOME PHONE		CELL PHONE	
CONTACT #3		HOME PHONE		CELL PHONE	
CONTACT #4		HOME PHONE		CELL PHONE	

Does your child have any health problems **NOW** about which the School Nurse should be informed, such as: asthma, diabetes, heart trouble, seizures, chronic disease, ADD/ADHD, physical disability, medication allergy, **LIFE THREATENING** food or bee sting allergy, etc.? _____
May we share this information with the appropriate school personnel? ___YES ___NO

PHYSICIAN'S NAME		PHONE	

Is your child covered by health insurance? ___YES ___NO

Emergency Medical Acknowledgement

Parent/Guardian will be notified in the event of an accident or injury. I understand the school will provide appropriate first aid and/or medical treatment for any injury or illness that my son/daughter may sustain or acquire. I further recognize that school personnel may be unable to reach me for consent for emergency medical care and I understand a 911 call may be made for emergency care, including hospital care, as may be deemed necessary under the existing circumstances. If my child needs to be sent to an emergency medical facility, I am responsible for all expenses.

I have verified that all information on this form is correct.

Parent/Guardian Signatures/Date **Parent/Guardian E-mail Addresses**

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	❑ Black, not of Hispanic origin
	❑ American Indian/ Alaskan Native	❑ White, not of Hispanic origin
Primary Care Provider	❑ Hispanic/Latino	❑ Asian/Pacific Islander
		❑ Other
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N Does your child have dental insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* If applicable

Part I — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part II — Medical Evaluation

HAR-3 REV. 4/2012

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____
Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 4/2012

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required for 7th grade entry	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			PK and K (born 1/1/2007 or later)	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			2 doses required for K & 7th grade as of 8/1/2011	
PCV	*				PK and K (born 1/1/2007 or later)	
Meningococcal	*				Required for 7th grade entry	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption

Religious ____ **Medical: Permanent** ____ **Temporary** ____ **Date** ____

Recertify Date _____ Recertify Date _____ Recertify Date _____

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN

- DTaP: At least 4 doses. The last dose must be given on or after 4th birthday.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 day apart – 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 5 years and older do not need proof of Hib vaccination).
- Pneumococcal: 1 dose on or after 1st birthday (born 1/1/2007 or later and less than 5 years old).
- Hep A: 2 doses given six months apart-1st dose on or after 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students enrolled before August 1, 2011, 1 dose given on or after 1st birthday; for students enrolled on or after August 1, 2011 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 1-6

- DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart- 1st dose on or after the 1st birthday.
- Hep B: 3 doses – the last dose on or after 24 weeks of age.
- Varicella: 1 dose on or after the 1st birthday or verification of disease*.

GRADE 7

- Tdap/Td: 1 dose of Tdap for students 11 yrs. or older enrolled in 7th grade who completed their primary DTaP series; For those students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are needed, one of which **must** be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Meningococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 8-12

- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine one of which should be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart- 1st dose on or after the 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart or verification of disease*.

* **Verification of disease:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nation-wide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

REDDING PUBLIC SCHOOLS
JOHN READ MIDDLE SCHOOL 2017-2018

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law 10-212a and Regulations 10-212a-1 through 10-212a9 require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse, physician's assistant, optometrist and, for athletic events only, a podiatrist) and parent/guardian written authorization, for school nurses, or in the absence of a nurse, other designated personnel to administer medication, including over-the-counter drugs. Medications must be in the original, properly labeled container and dispensed by a physician/pharmacist. Over-the-counter medications must be delivered in an unopened, properly labeled container. ALL medications must be delivered to school by a responsible adult.

Prescriber's Authorization

Name of Student: _____ Birthdate: _____ Grade: _____

Address: _____

Indication(s) for Medication: _____

Drug Name _____ Generic Name: _____ Dose: _____

Route: _____ Time of Administration: _____

Relevant Side Effects: ☐ None Expected ☐ Specify _____

ALLERGIES: ☐ No ☐ Yes (specify): _____

Medication shall be administered from: _____ to _____
(no more than 12 months) Month/Day/Year Month/Day/Year

Prescriber's Name/Title: _____

Phone: _____ Fax: _____

Address: _____

_____

Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. I understand that I must provide the school with no more than a 3 month supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: _____ **Date** _____

Parent's Home Phone #: _____ **Work #:** _____

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

For capable students with a chronic medical condition, self-administration of emergency and some other non-controlled medications may be authorized by the prescriber and parent/guardian. School nurse approval may be required according to CT State Regulations, Section 10-212a-4, and Board policy.

Prescriber's authorization for self administration: ☐ Yes ☐ No _____
Signature/Date

Parent/Guardian authorization for self administration: ☐ Yes ☐ No _____
Signature/Date

School Nurse approval for self administration: ☐ NR* ☐ Yes ☐ No _____
Signature/Date

*not required

REDDING PUBLIC SCHOOLS
JOHN READ MIDDLE SCHOOL 2017-2018
Health Office: 203-938-4892 (Ph.) 203-938-4841 (Fax)

PROCEDURE FOR REQUESTING MEDICATION ADMINISTRATION

If your child requires a prescription or over-the-counter medication during the school day or during intramural or interscholastic athletic events, you must follow the procedures required by Redding Public Schools, Connecticut General Statutes, Sec. 10-212a, and Connecticut Administrative Regulations, Sec. 10-212a-1 through 10-212a-9. These procedures promote safe practices for students and staff. Please read them carefully.

1. For each medication that must be administered daily or on an as-needed basis, the parent must obtain the written order of an authorized prescriber (physician, dentist, advanced practice registered nurse, physician assistant, optometrist and, for athletic events only, a podiatrist) using the *Authorization for the Administration of Medicine by School Personnel* form. A new order is required each year and, if so prescribed, may be effective from July 1st through June 30th of the given school year. A medical order dated July 1 of a year will cover summer programs *and* the upcoming school year.
2. The authorized prescriber must fill in the information requested on the form:
   a. Name of medication, the generic name of the medication, and strength of the medication;
   b. Indication(s) for the administration of this medication in school (condition, diagnosis);
   c. Amount (dosage) of the medication to be administered and route of administration
   d. Potential side effects of the medication;
   e. Time of day that the medication is to be administered; and frequency for PRN (as-needed) medications
   f. Duration of the order for administration of the medication (up to 12 months from July 1 through June 30th of the same school year).
   g. If applicable, authorization for self-administration in school.
3. A parent or guardian must sign the "Parent/Guardian Authorization" portion of the form and, if applicable, provide authorization for self-administration in school.
4. The medication must be packaged in the **ORIGINAL PHARMACY CONTAINER**, clearly labeled with the student's name, the authorized prescriber's name, and the prescription.
5. The medication and completed authorization form **must be delivered to the school nurse by a responsible adult.** (For students with a chronic medical condition who are prescribed emergency or some other non-controlled medications, once the nurse has reviewed the medical order, the student is responsible to carry the medication to/from school each day and maintain its safe control at all times.)
6. Self administration plans approved for the school day also extend to extra curricular activities and athletics.
7. Self administration of controlled medication is not permitted.
8. No more than a three (3) month supply may be stored at school. Unused medication will be destroyed if not picked up by a responsible adult by the end of the last day of school.

It may be helpful to take the *Authorization for the Administration of Medicine by School Personnel* form with you to your healthcare provider in case medication is prescribed for your child.

Thank you for your cooperation. Please contact the school nurse if you have any questions.

HEALTH REQUIREMENTS FOR ENTRY OF NEW STUDENTS TO JOHN READ MIDDLE SCHOOL

Health Assessment Form ("Blue Form" or "HAR-3")

A new student must have a physical exam within one year prior to entry. No student will be admitted without the completed Health Assessment Form in our possession. The physical may be performed by a MD, Physician's Assistant (PA), or Advanced Practice R.N. (APRN). The physical must include height, weight, blood pressure, Hct/Hgb, gross dental and posture assessments, vision and hearing screenings, immunization history, chronic disease assessment, and the signature and stamp of the examining physician.

TB Test

If coming from a high risk area (per MD on the Health Assessment Form), students must have a TB test done and read prior to entry.

Immunization Requirements

5th Grade

DTaP/Td: At least 4 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses.
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Hep B: 3 doses, last dose on or after 24 weeks of age
Varicella: 2 doses separated by at least 3 months-1 st dose on or after 1st birthday; or verification of disease
Hepatitis A: 2 doses given six calendar months apart, 1st dose on or after 1st birthday

6th Grade

DTaP/Td: At least 4 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses.
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Hep B: 3 doses, last dose on or after 24 weeks
Varicella: 2 doses separated by at least 3 months-1 st dose on or after 1st birthday; or verification of disease

7th and 8th Grade

Tdap/Td: 1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Meningococcal: 1 dose Hep B: 3 doses, last dose on or after 24 weeks of age
Varicella: 2 doses separated by at least 3 months-1 st dose on or after 1st birthday; or verification of disease

Health Record

If transferring from a school within CT, the original health folder must be sent to us.
If transferring from an out-of-state school, a copy of the health record must be sent to us.