John R. Briggs
ELEMENTARY SCHOOL
96 Williams Road
Ashburnham, MA 01430
WE GROW AND LEARN TOGETHER

Nathaniel North, Principal
Telephone: 978-827-5750
Fax: 978-827-1411
Jennifer Lilley, Assistant Principal

When registering your child/children you must have the following documents:

_____ birth certificate

_____ registration form

_____ school emergency form (2 side

_____ proof of residency (four documents required)

_____ current immunization

_____ current physical

_____ home language survey

If you are transferring from another school or district you must also complete a record release form.

Ashburnham-Westminster Regional School District's Policy of non-discrimination will extend to students, staff, the general public and individuals with whom it does business; and will apply to race, color, national background, religion, sex, disability, economic status, political party, age, handicap, sexual orientation, homelessness and other human differences.

Ashburnham - Westminster Regional School District
Students New/Returning to the School District Registration Form

☐ New
☐ Returning

Must be completed with all required documentation attached by ALL REGISTRANTS prior to enrollment.

School:
☐ Oakmont Regional High School ☐ Overlook Middle School ☐ Westminster Elementary School
☐ John R. Briggs Elementary School ☐ Meetinghouse Elementary School

Student: _____ _____ _____
Last Name First Name Middle Name

Address: _____ _____
Street / Apt./PO Box Town Zip Code Home Phone #

Gender: ☐ Male ☐ Female **Grade/YOG:** ____/____ **Soc. Sec. #:** _____

Date of Birth: ____ ____ ____ _____ _____ _____
Month Day Year **Birth City** **Birth State** **Birth Country**

- Is your child a U.S. citizen? ☐ Yes ☐ No
  If not, alien registration #: _____ ☐ Permanent Visa ☐ Temporary Visa

Ethnicity: (Check all that apply) ☐ Hispanic or Latino ☐ Not Hispanic, Not Latino
Race: ☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Asian
Primary Language: ☐ English, Other: _____ (First language learned by student)

For School Use Only
MA Dept. of Education race and ethnicity code (two-digit) ____

Special Education:
- Does your child currently have an IEP? ☐ Yes ☐ No (If yes, a copy must be received by the school prior to enrollment)
- Has your child previously received special education services? ☐ Yes ☐ No Grade terminated _____
- What special education services did your child receive in their previous school district?
  ☐ Speech/Language ☐ Occupational Therapy ☐ Physical Therapy ☐ Academic ☐ Other _____

Medical Concerns/Allergies: _____
Previous School Attended: _____
School Address: _____ **School Telephone #:** _____

Student lives with: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Other _____

Parent/Guardian Name:	_____	Parent/Guardian Name:	_____
Relationship to Child:	_____	Relationship to Child:	_____
Home address:	_____	Home address:	_____
Home Telephone #	_____	Home Telephone #	_____
Cell Phone #	_____	Cell Phone #	_____
Bus. Telephone #	_____	Bus. Telephone #	_____
E-mail address:	_____	E-mail address:	_____

Required documentation MUST accompany this form. Enrollment cannot take place until the following is verified.:
1. Birth Certificate AND Immunization documentation AND
2. Documentation as defined on Establishing Residency Guide for Parents/Guardians form OR
3. Completed Guidelines for Non-Residents Planning to Move into the District Form

My signature signifies that the information on this form is accurate under the penalty of perjury. I understand that the Ashburnham-Westminster School District reserves the right to make any additional inquiries requiring the student's record and residency status.

Parent/guardian: _____ Date: _____

Student Emergency and Health Record

Please complete both sides and return to the School Nurse

School Use Only
Bus:
Hr:
Team:

School: ☐ Oakmont Regional High School ☐ Overlook Middle School ☐ John R. Briggs Elementary ☐ Meetinghouse Elementary School ☐ Westminster Elementary School

Student _____ DOB: _____ Birthplace: _____

SS # _____ GRADE/YOG ____ / ____ Guidance Counselor _____ Gender _____

Lives with: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Other _____

Primary Language: (First language learned by student) ☐ English ☐ Other _____ Family serving in the military ☐ Yes ☐ No

Home Address _____
Street City State Zip

Phone #'s _____
Home Mother Cell Father Cell

Email Address _____

Help us save paper & postage
EMAIL Preferred- Check One: ☐ Yes ☐ No

2nd Parent/Home Address (if different)

Home Address _____
Street City State Zip Email address

Phone #'s _____
Home Cell Work

Any legal restrictions for student release? ☐ No ☐ Yes _____
(If yes please specify & provide supporting legal documentation to the Principal)

Employment

Mother _____ Father _____

Employer _____ Employer _____

Work # _____ Ext _____ Work # _____ Ext _____

Siblings

Name					
Age					
School					

Emergency Contacts (local contacts to be notified in case of emergency or illness, when you are unable to be reached) Your child will only be released to the care of those listed below

Contact #1 Name _____ Relationship _____

Street City State Zip Email address

Home Phone Cell Phone Work Phone Other

Contact #2 Name _____ Relationship _____

Street City State Zip Email address.

Home Phone Cell Phone Work Phone Other

Contact #3 Name _____ Relationship _____

Street City State Zip Email address

Home Phone Cell Phone Work Phone Other

Day Care Provider (Children cannot be bussed to different locations such as: two days at one place and three days at another)

Name _____ Relationship _____

Street City State Zip Email address

Home Phone Cell Phone Work Phone Other

NOTIFICATION REGARDING STUDENT IDENTIFICATION – Throughout the year, faculty, staff & administration attempt to acknowledge & celebrate the achievements, work and contributions of students and community members. We do this through the display of work, verbal recognition, and various printed, electronic and recorded photographic mediums.

PLEASE CHECK ☐ Publish (Includes Newspaper & Internet) ☐ Do Not Publish (Includes Newspaper & Internet) ☐ Do Not Publish to Military

Parent/Guardian Signature: _____ Date: _____

Our School Physician, Dr. Lisa Rembetsy-Brown, has agreed to grant her permission for the administration of *Acetaminophen, Ibuprofen and Tums* in the school at the discretion of the School Nurse, with written permission on file in our Health Office. If you choose to give permission, please complete the form below.

MEDICATION PERMISSION FORM (check yes or no for each medication listed below)

Yes ☐ No ☐ I give permission to the School Nurse to administer Acetaminophen (Tylenol) 240-650 mg per weight guidelines by mouth as needed.
Yes ☐ No ☐ I give permission to the School Nurse to administer Ibuprofen (Advil) 200-400 mg per weight guidelines by mouth as needed.
Yes ☐ No ☐ I give permission to the School Nurse to administer Tums (or generic equivalent) 1-2 tablets as needed for heartburn or upset stomach.

Parent/Guardian Signature: _____ Date: _____

HEALTH HISTORY: LIFE THREATENING ALLERGIES: Please indicate if your child has a ***physician verified*** allergy to any of the following. If yes, please provide official documentation by your child's physician and an Emergency Care Plan to the School Nurse at the beginning of the school year. Written prescriptions are required for all Epi Pens, Benadryl and inhalers.

Bee Stings ☐ Peanuts/Nuts ☐ Latex ☐ Medication _____ Other Food _____

Describe ~~your child's~~ allergic reaction: _____ ~~Emergency Care Plan~~ _____

Is Epi Pen Required? Yes ☐ No ☐
Has Epi Pen ever been used? Yes ☐ No ☐
Does your child carry his/her own Epi Pen? Yes ☐ No ☐

Is Benadryl required? Yes ☐ No ☐
Has Benadryl ever been used? Yes ☐ No ☐
Asthma inhaler? Yes ☐ No ☐

OTHER ALLERGIES (please list):
Medications _____ Lactose Intolerant _____ Seasonal _____
Environmental _____ Other _____
Describe reaction _____ Medication used for symptoms _____

ILLNESS/CHRONIC CONDITIONS (Indicate if your child has experienced any of the following and explain below)

Asthma	☐	Anxiety	☐	Attention Deficit	☐	Concussion	☐	Date	
Depression	☐	Diabetes	☐	Fainting	☐	Heart Condition	☐		
Hearing Deficit	☐	Hospitalization	☐	Migraines	☐	Recent Surgeries	☐	Date	
Injuries	☐	Scoliosis	☐	Other					

Please explain condition: _____

HEALTH CARE: Does your child have health insurance? Yes ☐ No ☐ Mass Health? Yes ☐ No ☐ No Insurance? Yes ☐ No ☐
(If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the School Nurse for more information about these programs. All communications will be confidential.

Name of Health Insurance Company _____ Policy # _____

Physician _____
Name Street Address Town Zip Telephone

Scoliosis (postural) screening is done in grades 5-9. If you DO NOT wish your child to participate in this screening please sign here

_____

Vision: Eye Glasses: Yes ☐ No ☐ Contact Lenses: Yes ☐ No ☐ Date of last eye exam _____

Sports: Do you know of any reason your child should not participate in sports/fitness? Please explain _____

_____

(Note: A physical exam is required for students entering grades K, 3, 6 and 9 as well as annually for school sports at the middle and high school level)

MEDICATIONS: Please list prescribed and over the counter medications your child takes. Include herbal treatments.

Name of Medication & Dose	Reason	Home	School

Statement: *"In the event of an accident or serious illness, I request that the school contact me. If the school is unable to reach me, I hereby authorize the school to contact the physician or dentist listed on this form and to follow his/her instructions. If the physician or dentist is unable to be reached, the school may make whatever arrangements are necessary. I give permission to the School Nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to the school nurse to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment, as well as obtaining current immunization and physical exam status."*

Parent/Guardian Signature: _____ Date: _____

Early Childhood Education Experience Survey

Please check next to the option that best describes your child's preschool experience in the school year prior to entering Kindergarten. Select one option only, and indicate hours where applicable. Thank you!

Name of child:_____ Date of Birth:_____

☐ My child did not have any formal early childhood program experience

☐ My child did not have formal early childhood program experience but participated in Coordinated Family and Community Engagement (CFCE) services.

☐ My child did not have formal early childhood program experience but participated in Parent Child Home Program (PCHP) services.

☐ My child did not have formal early childhood program experience but participated in **BOTH** Coordinated Family and Community Engagement (CFCE) **AND** Parent Child Home Program (PCHP) services.

☐ My child attended a Licensed Family Child Care Provider **(indicate hours below)**

___ for less than 20 hours per week

___ for 20+ hours per week

☐ My child attended a Center Based Program **(indicate hours below)**

___ for less than 20 hours per week

___ for 20+ hours per week

☐ My child attended **BOTH** a Licensed Family Child Care Provider **AND** a Center Based Program **(indicate hours below)**

___ for less than 20 hours per week

___ for 20+ hours per week

ASHBURNHAM-WESTMINSTER REGIONAL SCHOOL DISTRICT
DEPARTMENT OF ENGLISH LANGUAGE LEARNERS
Kathy Veroude, Director of Pupil Personnel Services and ELL
11 Oakmont Drive, Ashburnham, MA 01430
Tel. (978) 827-3062
Fax (978) 827-3140
Email: kveroude@ awrsd.org

Home Language Survey

Massachusetts Department of Elementary and Secondary Education regulations 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

_____ F ☐ ☐
M
First Name | Middle Name | Last Name | Gender

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

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)

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ASHBURNHAM-WESTMINSTER REGIONAL SCHOOL DISTRICT
Office of the Superintendent

11 Oakmont Drive 978-827-1434
Ashburnham, MA 01430 fax 978-827-5969

Establishing Residency Guide for Parents/Guardians

Please return with registration paperwork.

Please take note: If a student is moving into the district they will have to complete the Guidelines for Non-Residents Planning to Move into the District Form.

A determination that a student is ineligible to attend the Ashburnham-Westminster Regional School District due to a failure to reside in the Towns of Ashburnham or Westminster will result in dismissal from the School District.

In order to register a child for school, all applicants must submit documents from each of the following columns.

Column A (1 doc)	Column B (1 doc)	Column C (2 docs)
☐ Copy of Deed OR record of most recent mortgage payment.	A utility bill or work order dated within the past 60 days, including:	☐ Valid MA driver's license
☐ Copy of Lease AND copy of most recent rent payment.	☐ Gas Bill	☐ Current vehicle registration
☐ Legal affidavit from landlord affirming tenancy AND record of recent rent payment.	☐ Oil Bill	☐ Valid MA Photo ID
☐ Section 8 agreement	☐ Electric Bill	☐ Valid Passport
	☐ Home Telephone Bill	OR one of the following dated within the past year:
	☐ Cable Bill	☐ W-2 form
		☐ Excise tax bill

Divorced Parent/Guardian Custodial Information: Divorced parents and legal guardians must present a copy of an Order of the Probate Court designating current physical custody of the student.

AFFIDAVIT FOR ASHBURNHAM/WESTMINSTER RESIDENCY

DATE_____

Student Name_____MALE___FEMALE___

Ashburnham/Westminster address_____Since_____

Parent's/Legal Guardian's name_____

Parent's/Legal Guardian's address_____

The Ashburnham-Westminster Regional School District reserves the right to make any additional inquiries regarding the incoming student's residency status.

_____ Date_____
Parent/Guardian Signature

**My signature signifies that the information on this form is accurate and true under penalty of perjury.*

Enrollment cannot take place until residency is verified.

My Child as a Learner

Please describe your child in response to the questions below. The information you provide will help your child's teacher to know him/her better by the beginning of the first day they enter our school.

NAME OF STUDENT _____

My child learns best when _____

_____

_____

_____

My child is strong in _____

_____

_____

_____

An area my child needs (or may need) assistance _____

_____

_____

_____

If you wish to add more information about your child, please use the back of this form. Thank you very much for helping us to know your child better.

_____

Parent/Guardian

_____

Date

(Learner Form)

State Mandated Screenings

Provided in school

Screening	Grade
Scoliosis	5-9
Vision	K-5,7,9
Hearing	K-3,7,9
Height/Weight	1,4,7,9&10
BMI Calculations	1,4,7,9&10
SBIRT	7 & 9

Screenings are also provided as needed and upon request of parent/teacher during years not mandated.

Physical Exams are required in grades K, 3, 6, 9 and all new entrances and students playing sports. Because your family physician has a comprehensive knowledge of your child's health status, it is recommended that he/she perform the exam.

No child in Massachusetts should be without access to a primary healthcare provider. Massachusetts offers free or low cost health insurance for children up to the age of 19. For more information, contact your School Nurse.

School Nurses

- Jane Flis, RN BSN NCSN
  JRBriggs Elementary
  978-827-5750
  Fax: 978-827-5699
  jflis@awrsd.org

- Jessica Heffernan, RN BSN
  Westminster Elementary
  978-874-2043
  Fax: 978-874-0964
  jheffernan@awrsd.org

- Susan Lofquist, RN BSN NCSN
  Oakmont High School
  978-827-5907
  Fax: 978-827-5624
  slofquist@awrsd.org

- Marcia Sharkey, RN BS
  Meetinghouse School
  978-874-0163
  Fax: 978-874-0726
  msharkey@awrsd.org

- Nancy Taylor, RN BSN NCSN
  ESHS grant funded nurse
  for the district
  ntaylor@awrsd.org

- Heidi Williams, RN BSN
  Overlook Middle School
  978-827-1425
  Fax: 978-827-4986
  hwilliams@awrsd.org

Ashburnham-Westminster Regional School District

School Health Services...

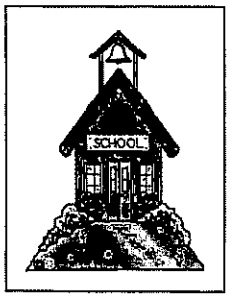
Linking the school to the home and community

Children...the world's most precious resource

"You cannot educate a child who is not healthy and you cannot keep a child healthy who is not educated."

Jocelyn Elders,
Former Surgeon General

School Health Services



Ashburnham-Westminster Regional School District Nurses are integral members of the educational team who assist children to develop their full potential. We do this by providing quality health services, teaching disease prevention strategies and through the promotion of healthy lifestyles.

"A child must be healthy to learn and a child must learn to be healthy..."
Massachusetts Department of Public Health

The Role of the School Nurse Includes:

- Providing acute and emergency care for students and staff
- Conducting mandated screenings
- Health counseling and education when needed
- Medication administration and assessment
- Planned care for those students with special needs
- Data evaluation in terms of immunizations and screenings
- Providing resources to access primary health care services
- Communicable disease control
- Promoting environmental health and safety
- Providing linkage to community resources

Medication Policy

- The A-W Regional School District Health Services Team encourages that medication be administered before and after school if possible.
- When medication is needed during school hours there must be a physician's order and a parental written permission with the medication or it cannot be given. Administration of narcotics during the school day is not recommended.
- Medication must be delivered to the school in a pharmacy or manufactured-labeled container by the parent, guardian or responsible adult. (Medications are not accepted in such things as plastic bags.) No child is permitted to bring medication to school.

- Please contact your school nurse for the proper forms which must accompany all medications.

Ashburnham-Westminster Regional School District
ESHS Nurse Coordinator Office
Meetinghouse School
8 South Street
Westminster, MA 01473
Telephone: 978-874-0163
Fax: 978-874-0726

When should your child stay home from school?

- If your child has a contagious illness such as strep throat, flu or chicken pox or has a suspicious rash
- If your child has a fever of 100 degrees or higher within the past 24 hours
- If your child is vomiting or has diarrhea within the past 24 hours
- If your child has red/pink eyes or has drainage from the eyes.
- If your child has head lice or nits
  Once treatment has been done child needs to be checked by school nurse before returning to school
- **If your child does not have proof of all required immunizations**

PLEASE NOTE:

- If your child will be absent, please call the school.
- If your child is out of school for an extended period of time and/or under the care of a physician, please notify the school nurse.
- It is very important that you maintain communication with your child's school nurse.

When it is necessary to excuse your child from Physical Education, written notification is required from both parent and physician. Written notification is also required to resume participation in Physical Education.

Dear Parents/Guardians:

Welcome to the John R. Briggs Elementary School. I look forward to having your child as a member of our school and to meeting any health care needs he/she may have.

The Ashburnham Westminster Regional School District requires a student to be seen by his/her health care provider and have a completed physical on file upon entry into **Kindergarten**, 3rd grade, 6th grade, and 9th grade. Physical exam forms are available at school and will be sent home as needed. Annual vision screening for grades K – 5, hearing screening for grades K – 3, BMI Screening in 1st and 4th grade, and Postural Screening in grade 5 are provided during the school year. You will be notified if any further evaluation is needed.

Our school district has a policy regarding administration of medications. NO medication, prescription or non-prescription will be administered to any student unless there is a physician's order and signed parent/guardian consent on file in the nurse's office. Medication order forms are available from the school nurse. Our school physician has written standing orders for the administration of Acetaminophen, Ibuprofen, and Tums. Please make sure you (parent/guardian) complete the back side of the emergency form and sign the portion of the form to allow the nurse to administer those medications if needed. Please note that all medications are to be brought to school by an adult. Students are not allowed to carry medication to and from school. Should your child ever require receiving a medication during the school day, please notify me and I will be happy to give you the appropriate forms.

Due to the increased prevalence of food allergies among school aged children, please check with your child's teacher when sending snacks into the classroom for special celebrations. If your child has a food allergy of any type, please inform us immediately. If there is a specific food allergy in your child's classroom, a detailed letter will go home the first days of school this fall. Also, please be aware of the AWRSD's Wellness Policy when planning your child's snack and items for celebrations i.e., healthy, low-fat, low-sugar, etc.

Thank you for your prompt attention to any health care matters that may arise. Please remember to keep all phone numbers current so that you may be reached when your child is ill. I look forward to working with your child as he/she begins his/her school experience in Kindergarten. If I can be of any assistance or you have any questions or concerns, please call me at 978-827-5750, press #5 for nurse.

Sincerely,

Jane Flis, RN, NCSN
School Nurse

MEDICAL QUESTIONNAIRE

DATE/TIME OF DEVELOPMENTAL SCREENING (office use only) _____

STUDENT'S NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY# _____

PARENTS'/GUARDIANS' NAMES
(first and last names please)

ADDRESS _____ 1. _____

PHONE NUMBER _____ 2. _____

PHYSICAL EXAM DATE _____ PHYSICIAN'S NAME _____

IMMUNIZATION CERTIFICATE _____ ADDRESS _____

PHONE# _____

1. WERE THERE ANY COMPLICATIONS OR PROBLEMS WITH THIS PREGNANCY OR DELIVERY? _____

2. ACCIDENTS OR HEAD INJURIES? (EXPLAIN) ? _____

3. OPERATIONS? _____

4. ASTHMA? _____

5. ALLERGIES? _____

6. BONE OR JOINT DISEASE OR INJURY? _____

7. COMMUNICABLE DISEASES? (SPECIFY)? _____

8. CONVULSIONS OR SEIZURES? _____

9. DIABETES? _____

10. DENTAL PROBLEMS? _____

11. EAR INFECTIONS/HEARING PROBLEMS? _____

12. HEADACHES? _____

13. HEART PROBLEMS? _____

14. HOSPITALIZATIONS? _____

15. VISION PROBLEMS/GLASSES? _____

16. ATTENTION DEFICIT? _____

17. OTHER HEALTH PROBLEMS OR HANDICAPPING CONDITIONS? _____

18. MEDICATIONS? _____
(medications can be given at school without a written order from your M.D.)

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:** _____

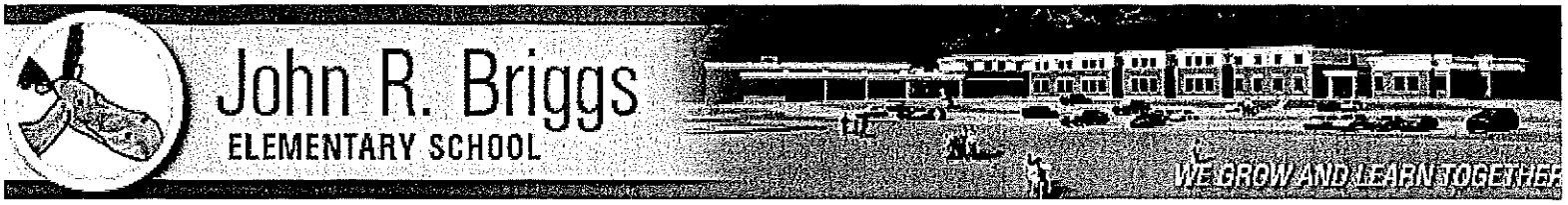
☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.**

_____ _____
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 08/15/13*



Welcome to John R. Briggs Elementary School!

I would like to make you aware of specific requirements that are mandated by Massachusetts State Law for Kindergarten entry.

Documentation by your physician is needed for the following:

1. Completed current (done within the past 12 months) **Physical Exam** form including **vision screening with stereopsis.**

2. **Immunizations:**

Hepatitis B	3 doses
DTaP	5 doses (4 doses is acceptable if the 4th dose was given on or after 4th birthday and at least 6 months after the previous dose)
IPV/OPV (Polio)	4 doses (4th dose must be given on or after 4th birthday and at least 6 months after the previous dose) 3 doses are acceptable if 3rd dose is given on or after 4th birthday and at least 6 months after the previous dose
MMR	2 doses (1st dose on or after 1st Birthday)
Varicella	2 doses (1st dose on or after 1st Birthday) or documentation of the disease (Chickenpox)

3. **Lead Test** certificate (or the date and result filled in on the physical exam form)

Also required is a copy of your child's **Birth Certificate.**

Please present/fax the above items to the John R. Brigg's Health office as soon as possible. Your child will not be able to start school without this information on file.

Nurse Fax # 978-827-5699

If you have any questions, please feel free to call me @ 978- 827-5750 X5

Thank you for your cooperation.

Mrs. Jane Flis, RN, NCSN

CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth:** / / **Sex:** M F

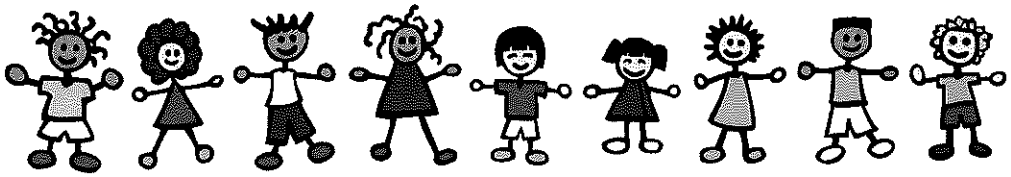
Please indicate vaccine type (e.g., DTaP-Hib, etc.)

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 Live Attenuated LAIV, LAIV4 (quadrivalent)	1		
	7				2		
	8				3		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1				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		
Pneumococcal Conjugate (PCV13, PCV7)	1				2		
	2			**Human Papillomavirus** (9vHPV, 4vHPV, 2vHPV)	1		
	3				2		
	4				3		
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1			**Zoster** (shingles)	1		
	2			**Other:**	1		
	3				2		

Please see next page ➡

Ashburnham-Westminster
Extended Day Program

Do you need childcare for your kindergarten child? Whether it's full-time, part-time or just occasional need? We have openings!



BEFORE SCHOOL (6:30 a.m. – 8:25 a.m.)
AFTER SCHOOL (2:55 p.m. – 6:00 p.m.)
EARLY RELEASE (12:00 p.m.) & FULL DAYS
Some VACATION WEEKS & Summer Program ☺

* Flexible scheduling * Flexible payment plans *

Students are offered a variety of developmentally appropriate activities, games and crafts. They are also given the opportunity to build social skills and self-confidence through play.

We have an open enrollment policy– at anytime throughout the school year if you find you need our services, just give us a call 978-827-4701, email us or stop by our office!

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Mark Brillon
Program Director
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