Andover School District

35 SCHOOL ROAD
ANDOVER, CT 06232
TEL. (860) 742-7339
FAX (860) 742-8288
www.andoverelementaryct.org

Valerie E. Bruneau
Superintendent

John P. Briody
Principal/Director of Curriculum

Holly L. Maiorano
Director of Special Education

Welcome to Andover Elementary School.

Dear Parent(s) or Guardian(s) of Students Entering Kindergarten – Grade 6:

Enclosed you will find:

Registration Form
Certification of Residence
Transportation Request
Records Request Form
Blue State of CT Health Assessment Record (Kindergarten only)

Please return the above forms at your earliest convenience.

A copy of your child's birth certificate is also required.

Birth certificate, affidavit of residence, current physical form and immunization record are required for your child to attend school.

If you have any questions, please do not hesitate to contact Rosemary Crandall at (860) 742-7339.

Thank you very much.

ANDOVER SCHOOL DISTRICT

School Registration Form - Grades PK through 6

TO BE FILLED OUT BY PARENTS, GUARDIANS OR PERSONS WITH WHOM THE STUDENT LEGALLY RESIDES. PLEASE PRINT AND FILL OUT FORM COMPLETELY.

LEGAL NAME OF STUDENT		
LAST:	**FIRST:**	**MIDDLE:**
STREET ADDRESS:	**CITY:**	
STATE:	**ZIP CODE:**	**P.O. BOX:**
BIRTHPLACE (CITY AND STATE):		**BIRTH DATE:**
GENDER: M or F or N (Non-binary)		**AGE:**

Homeless: ☐ **Not Homeless** ☐ **Shelter** ☐ **Doubled Up** ☐ **Unsheltered** ☐ **Hotel/Motel**
Immigrant Status: Y or **N** _____(Defined as children who are ages 3 – 21; not born in any state, the District of Columbia or 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.)
Military Family: Y or **N** _____(If child's parent or guardian is a member of the Armed Forces on **active duty** or serves on **full-time National Guard duty**.)
Migrant: Y or N _____ A child whose parent is a migratory agricultural worker and has moved in the past 36 mos.

DATE OF REGISTRATION:	**STARTING DATE:**	**GRADE ENTERING:**
Transferring from (Name of School or Pre-School):		
Address of School:		**Years Attended:**
Is this an Accredited Pre-School? YES_____ or NO_____		
If student has repeated a grade, please indicate which grade.		

PARENT(S) / LEGAL GUARDIAN(S) WITH WHOM STUDENT LEGALLY RESIDES			
Family Status: Married ☐ Divorced ☐ Remarried ☐ Single ☐ Separated ☐			
NAME:		**RELATIONSHIP TO STUDENT:**	
HOME PHONE:	**CELL PHONE:**	**E- MAIL:**	
EMPLOYER:		**WORK PHONE:**	**EXT:**
NAME:		**RELATIONSHIP TO STUDENT:**	
HOME PHONE:	**CELL PHONE:**	**E-MAIL:**	
EMPLOYER:		**WORK PHONE:**	**EXT:**

OTHER LEGAL GUARDIAN (TYPE)	FULL:	VISITATION:	OTHER:
NAME:	**RELATIONSHIP TO STUDENT:**		
HOME PHONE:	**CELL PHONE:**	**E-MAIL:**	
EMPLOYER:	**WORK PHONE:**		

LANGUAGE SURVEY
1. What is the primary language spoken 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 that the student first acquired?_____

OTHER OCCUPANTS IN THE HOME	
Names: (Grandparents, etc.)	
Other minor children in the family: (Names and Birth Dates)	
Child's Name:	**Birth Date:**
(Optional) Child is: Natural ☐ Foster ☐ Adopted ☐ Relative ☐	

If there is any other information you feel would be helpful to the school, please indicate below:

_____

_____

Please answer both of the following sections per the Connecticut State Department of Education.

ETHNIC BACKGROUND		
Check the Appropriate Box	**YES**	**NO**
Hispanic or Latino – see description below		

RACIAL BACKGROUND		
Check the appropriate box for EACH category below.	**YES**	**NO**
American Indian or Alaskan Native		
Asian		
Black or African American		
Native Hawaiian or Other Pacific Islander		
White		

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

American Indian or Alaskan Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American: A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander: a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa

The Andover board of Education prohibits harassment and discrimination in educational programs, services, or employment on the basis of race, color, religious creed, age, national origin, sexual orientation, or past or present physical or mental disability in accordance with Titles VI, VII of the Civil rights Act of 1964, Title XI of the Educational Amendments Act of 1973, Section 504 Rehabilitation Act of 1973, The Americans with Disabilities Act of 1991, and Appropriate State Laws.

Please check if you would like information regarding any of the following assistance programs:			
☐ Literacy / Adult Education	☐ Town Social Services	☐ Mental Health Support	
Would you like a copy of the Andover Human Resources Guide?		☐ Yes	☐ No

PARENT SIGNATURE:_____ **DATE:**_____

Rev. 1/28/19 / rhc

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CERTIFICATION OF RESIDENCE

NEW ENROLLEE/STUDENT TRANSFER/CHANGE OF ADDRESS

All students attending Andover Elementary School must be town residents unless specifically permitted to attend by the Board of Education. Any out-of-district student seeking admission on a tuition basis must be approved by the Board of Education and pay the actual per-pupil rate.

Students may not enroll in Andover Elementary School unless and until they are actually residing in Andover. For new housing, a Certificate of Occupancy with the residency date must be presented to the Superintendent of Schools for students to enroll. For existing housing in Andover, two of the following three items must be presented to the school office:

____ 1. Rental / Lease Agreement or mortgage papers with the name and address of the new resident,
____ 2. Driver's license with name and Andover address,
____ 3. A utility bill or other business correspondence with the name and Andover address.

The building administration may require additional residence verification if necessary. Students who move during the school year must withdraw from Andover Elementary School or pay the appropriate out -of-district tuition.

Non-residents whose children are enrolled in Andover Elementary School without prior permission from the Superintendent will be assessed tuition for the time children were in attendance in Andover.

Parent/Legal Guardian Statement

I (print name) _____ the parent or legal guardian of student(s) _____/_____ Grade(s) _____
(Andover Address)_____
certify that the above named student actually lives at the above address.
The telephone number at the same address is _____; the emergency telephone number is _____. The Owner/Landlord name is _____ and telephone number is_____.

The information and documentation provided are accurate. I authorize representatives of Andover Elementary School to verify this information, and I understand falsification of any information or documents required for this verification will result in revocation of registration for the student, and may lead to liability for tuition and to criminal penalties for fraud.

Parent/Guardian Signature:_____Date: _____

Administrator's Signature:_____Date:_____

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TRANSPORTATION REQUEST

Dear Parents,

We are in the process of setting up bus routes for next year. Please complete the following form and return it to the school as soon as possible. Students must ride the same bus each morning or each afternoon. If your child goes to daycare, they must ride the same bus every day. For further clarification, please do not hesitate to contact the school. Thank you very much for your cooperation.

Date: _____

Name of Student(s): _____

Resident Address: _____

Phone Number(s): _____

****

Student should be **PICKED UP** for transportation to school from:

_____Home _____Daycare

Name of Daycare Provider: _____

Address: _____

Telephone: _____

****

Student should be **DROPPED OFF** at the end of the day at:

_____Home _____Daycare

Name of Daycare Provider: _____

Address: _____

Telephone: _____

****

My child will attend **COOL**: _____Mornings _____Afternoons

ANDOVER ELEMENTARY SCHOOL
35 SCHOOL ROAD
ANDOVER, CT 06232
(860) 742-7339
(860) 742-8288 fax

PERMISSION TO SEND/RECEIVE STUDENT RECORDS AND FOR VERBAL COMMUNICATION

I give permission for _____
(Name of School)
_____ to:
(School Address)

_____ send records _____ receive original records _____ give verbal information

As checked below:

Student's Name _____ **Grade/Class** _____

_____ Transcript of grades/courses (Academic Records)
_____ Standardized Test Results
_____ CMT or CAPT Test Results (for students entering from Connecticut schools)
_____ Health Record
_____ Psychological Evaluation(s)
_____ Social Work and/or Guidance Records
_____ Speech/Language
_____ Individual Education Plan(s) (from years _____)
_____ Planning and Placement Team (PPT)/Special Education records
_____ Other (Specify) _____

_____ _____
Signature of Parent/Guardian **Date**

Communication (written and/or verbal) between:

_____ and _____

_____ _____

_____ _____

Revised: 4/27/15

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 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

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 ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
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 1 — 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 2 — Medical Evaluation

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 1 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**			***Auditory Screening**			History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	Date
Type:	Right	Left	Type:	Right	Left		
With glasses	20/	20/		❑ Pass	❑ Pass	***HCT/HGB:**	
Without glasses	20/	20/		❑ Fail	❑ Fail	***Speech** (school entry only)	
❑ Referral made			❑ Referral made			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

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No

Risk Assessment	**Describe Risk Factors**	
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other _____

Recommendation(s) by health care provider: _____

_____

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

_____

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

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 7/2018

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 7th-12th grade	
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	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
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:** _____

Renew Date: _____ _____ _____ _____

Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.
Medical exemptions that are temporary in nature must be renewed annually.

Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 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, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an 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 nationwide 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