Haverhill Public Schools

FAMILY RESOURCE CENTER
REGISTRATION DEPARTMENT
45 FOUNTAIN STREET, HAVERHILL MA 01830
EMAIL: REGISTRATION@HAVERHILL-PS.ORG
TEL: 978-420-1951 / FAX: 978-469-8730

Welcome to the Haverhill Public Schools. Please use this packet to begin registration for your child. Ask our registration staff for assistance and if you need translation. To successfully enroll your child for school, **ALL** required documents must be submitted with the application. Missing documents will delay enrollment.

REQUIRED DOCUMENTATION FOR ALL NEW STUDENTS:

- ❑ This Complete Student Registration Packet
- ❑ Proof of Haverhill Residency (See examples below):
  - ❑ Lease or Mortgage Statement
  - ❑ Recent Utility Bill (within 60 days)
  - ❑ Valid Photo Identification
- ❑ Up to date Immunizations
- ❑ Recent Physical Examination
- ❑ Child's Birth Certificate or Valid Passport
- ❑ Any Legal Paperwork Pertaining to Child (custody, court orders, etc.)
- ❑ Copy of **IEP** if student receives services under a Special Education Program
- ❑ Copy of **504** Plan if student receives services under Section 504
- ❑ Report Card or Transcript, if transferring from another school

REGISTRATIONS WILL NOT BE COMPLETE AND STUDENTS WILL NOT BE ABLE TO START SCHOOL UNTIL ALL THE REQUIRED DOCUMENTS ARE PROVIDED

EXAMPLES OF VALID PROOF OF RESIDENCY

Column A	Column B	Column C
Evidence of Residency	Evidence of Occupancy	Evidence of Identification
❑ Recent mortgage payment receipt and/or property tax bill ❑ Copy of Lease Agreement ❑ Recent Rental Payment Receipt ❑ Notarized Landlord Affidavit ❑ Section 8 Agreement	A recent utility bill dated within the last 60 days showing a Haverhill address: ❑ Gas, Oil, Electric ❑ Home Telephone (not cell) ❑ Cable or Excise Bill ❑ Lease agreement stating Landlord is paying the utilities	❑ Valid Driver's License ❑ Valid MA ID Card ❑ Passport

Students considered homeless under the McKinney-Vento Act have the right to enroll immediately upon registration. Please contact our Homeless Liaison, at 978-420-1967 or 978-420-1974 with any questions or for assistance.

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STUDENT REGISTRATION FORM

STUDENT INFORMATION

SCHOOL YEAR: _____ **GRADE REGISTERING FOR:** _____

STUDENT'S FULL NAME

_____

FIRST NAME MIDDLE NAME LAST NAME

DATE OF BIRTH (MONTH/DAY/ YEAR): _____ **GENDER:** ❑ Female ❑ Male ❑ Non-Binary

ETHNICITY: ❑ Black or African American ❑ White ❑ Native Hawaiian or Other Pacific Islander ❑ American Indian or Alaska Native ❑ Asian

RACE: ❑ Hispanic/Latino ❑ Not Hispanic/Latino

COUNTRY OF BIRTH: _____ **CITY AND STATE OF BIRTH:** _____

IS STUDENT A MEMBER OF A MILITARY FAMILY? ❑ YES ❑ NO

HAS THE STUDENT ATTENDED HAVERHILL PUBLIC SCHOOL BEFORE? ❑ YES ❑ NO

EARLY CHILDHOOD EXPERIENCE

DID STUDENT EVER ATTEND A FORMAL PRESCHOOL OR OTHER EARLY CHILDHOOD EDUCATION PROGRAM? ❑ YES ❑ NO

❑ More than 20 hours per week
❑ Less than 20 hours per week
❑ Licensed family childcare provider
❑ Center based program (childcare center, Head Start, or public preschool program)
❑ Family support program such as:
  ❑ PCHP (Parent Child Home Program)
  ❑ CFCE (Coordinated Family and Community Engagement)

HOME ADDRESS

STREET ADDRESS: _____ **BLDG./ APT #**_____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

MAILING ADDRESS *(IF DIFFERENT THAN HOME ADDRESS)*

STREET ADDRESS: _____ **BLDG./ APT #**_____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PREVIOUS SCHOOL INFORMATION *(IF TRANSFERRING FROM ANOTHER SCHOOL DISTRICT)*

SCHOOL DISTRICT: _____

SCHOOL NAME: _____

CITY, STATE, ZIP CODE: _____

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STUDENT REGISTRATION FORM

WHO DOES THE STUDENT LIVE WITH: ❑ BOTH PARENTS ❑ MOTHER ❑ FATHER ❑ LEGAL GUARDIAN

Parents are responsible for providing and alerting school staff of any court documentation that affects custodial rights to student records, visitation, etc. Copies of these documents must be provided to the school at time of enrollment. Legal Guardian is defined as "Parent(s), guardian(s), or person(s) assigned by the court."

ARE THERE ANY CURRENT RESTRAINING ORDERS OR COMMUNICATION RESTRICTIONS RELATED TO THE ABOVE STUDENT? (Please Explain)

_____

PARENT / GUARDIAN INFORMATION

RELATIONSHIP TO STUDENT: _____

FIRST NAME: _____ **LAST NAME:** _____

HOME ADDRESS *(IF DIFFERENT FROM STUDENT)*: _____

HOME PHONE: _____ **CELL PHONE:** _____

WORK PHONE: _____

EMAIL: _____

PARENT / GUARDIAN INFORMATION

RELATIONSHIP TO STUDENT: _____

FIRST NAME: _____ **LAST NAME:** _____

HOME ADDRESS *(IF DIFFERENT FROM STUDENT)*: _____

HOME PHONE: _____ **CELL PHONE:** _____

WORK PHONE: _____

EMAIL: _____

OTHER SIBLINGS OF HOUSEHOLD

NAME: _____ **RELATIONSHIP**: _____ **DOB**: _____

NAME: _____ **RELATIONSHIP**: _____ **DOB**: _____

NAME: _____ **RELATIONSHIP**: _____ **DOB**: _____

NAME: _____ **RELATIONSHIP**: _____ **DOB**: _____

ALERT CONTACT INFORMATION

Provide the phone numbers and emails where you would like to be contacted in the event of an emergency and receive No School, "Snow Day" Notifications and School Announcements

PHONE 1: _____ **PHONE 2:** _____

EMAIL 1: _____ **EMAIL 2:** _____

❑ Check here to receive communications in your native language

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STUDENT REGISTRATION FORM

SPECIAL EDUCATION SERVICES:

An **Individualized Education Plan (IEP)** provides special education and related services to a student who is identified as having a disability that negatively affects their ability to receive academic instruction.

A **504 Accommodation Plan** is guided by the Americans with Disabilities Act (ADA) to ensure that a student with a disability has access to accommodations that improve academic functioning.

IS THE STUDENT ON AN INDIVIDUAL EDUCATION PLAN (IEP)? ❑ YES ❑ NO

IS THE STUDENT ON A 504 ACCOMMODATION PLAN? ❑ YES ❑ NO

ENGLISH LANGUAGE SERVICES

DOES THE STUDENT RECEIVE ENGLISH LANGUAGE SERVICES? ❑ YES ❑ NO

IF YES, DESCRIBE THE SERVICES: _____

IS A LANGUAGE OTHER THAN ENGLISH SPOKEN IN THE STUDENT'S HOME? ❑ YES ❑ NO

WHAT IS THE PRIMARY LANGUAGE SPOKEN IN THE HOME? _____

❑ Check here to receive communications in your native language

EMERGENCY CONTACTS

Emergency contacts should be **different** from the parent/guardian information

❑ Check here to provide permission for emergency contacts to pick up student (must be 18y or older)

EMERGENCY CONTACT 1 (Different from the parent/guardian)

RELATIONSHIP TO STUDENT: _____

FIRST NAME: _____ **LAST NAME:** _____

CELL PHONE: _____ **WORK PHONE:** _____

EMAIL: _____

EMERGENCY CONTACT 2 (Different from the parent/guardian)

RELATIONSHIP TO STUDENT: _____

FIRST NAME: _____ **LAST NAME:** _____

CELL PHONE: _____ **WORK PHONE:** _____

EMAIL: _____

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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

_____ GENDER: ❑F ❑M
FIRST NAME MIDDLE NAME LAST NAME

_____ _____ _____
COUNTRY OF BIRTH DATE OF BIRTH (MM/DD/YYYY) DATE FIRST ENROLLED IN ANY U.S. SCHOOL (MM/DD/YYYY)

SCHOOL INFORMATION

_____ _____ _____
START DATE IN NEW SCHOOL (MM/DD/YYYY) NAME OF FORMER SCHOOL AND TOWN CURRENT GRADE

QUESTIONS FOR PARENTS/GUARDIANS

What is the primary language used in the home, regardless of the language spoken by the student?
_____

What language did your child first understand and speak?
_____

How many years has the student been in US Schools?
(Not including Pre-Kindergarten)
_____

Will you require written information from the school in your native language? ❑Yes ❑No
If yes, what language? _____

What language(s) are spoken with your child?
(Include relatives, grandparents, uncles, aunts and caregivers)

_____ ❑Seldom ❑Sometimes ❑Often ❑Always
_____ ❑Seldom ❑Sometimes ❑Often ❑Always

Which language do you use most with your child?
_____

Which Languages does your child use?

_____ ❑Seldom ❑Sometimes ❑Often ❑Always
_____ ❑Seldom ❑Sometimes ❑Often ❑Always

Will you require an interpreter/translator at Parent/Teacher meetings? ❑Yes ❑No
If yes, what language? _____

Parent/Guardian Signature: _____ **Today's Date:** _____

FOR SCHOOL USE ONLY

DATE OF ENROLLMENT:	ASSESSMENT:	
1st Year in US Schools? ❑Yes ❑No If No, Transferring from? _____ _____ Parent Phone Number:	**PK: Pre-IPT Oral** A-B-C-D-E **K: WIDA Model** First Semester (LS): Second Semester (LSRW): **Grades 1 -12: WIDA Screener** Overall Composite: **EL** **NOT EL**	**School Placement and Level:** **Programming and Assessment Notes (including domain scores)**

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AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE THE FOLLOWING SCHOOL (ENTER Name, Address and Phone Number of Previous School):

_____

_____

TO RELEASE COPIES OF THE FOLLOWING INFORMATION:

- All Official Transcripts and Report Cards
- MCAS and Other State Testing Reports
- Individual Education Plans, IEP, and any other Special education documents
- 504 Accommodation Plans
- English Language Testing and Progress Reports
- Health Records Including all Immunizations
- Attendance History
- Discipline Records

_____	_____	_____
STUDENT NAME	DATE OF BIRTH	GRADE AND SCHOOL ENTERING
_____	_____	_____
STUDENT NAME	DATE OF BIRTH	GRADE AND SCHOOL ENTERING
_____	_____	_____
STUDENT NAME	DATE OF BIRTH	GRADE AND SCHOOL ENTERING

_____	_____	_____
PRINT PARENT /GUARDIAN NAME	PHONE NUMBER	HAVERHILL ADDRESS

_____	_____
SIGNATURE OF PARENT OR STUDENTS (IF OVER 18 YEARS OF AGE)	DATE

❑ **SEND K-8 RECORDS TO:**
Attendance Department
Haverhill Public Schools
45 Fountain Street
Haverhill, MA 01830
Tel: 978-374-3439
Fax: 978-373-3815
Scan/Email: smoccio@haverhill-ps.org

❑ **SEND HIGH SCHOOL RECORDS TO:**
High School Guidance Department
Haverhill High School
137 Monument Street
Haverhill, MA 01832
Tel: 978-374-5700 ext. 1134
Fax: 978-372-7419
Scan/Email: mgravel@haverhill-ps.org

FOR HAVERHILL REGISTRATION STAFF ONLY:

Did student ever attend HPS? ❑YES ❑NO
Month/Year Discharged: _____
Date Release Sent: _____
Initial: _____
Date 2nd Request Made: _____
Initial: _____

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INITIAL / ANNUAL UPDATE HEALTH FORM

☐ New Student ☐ Established Student School Year: _____

Student Name: _____ Sex: _____ Date of Birth: _____

Parent/Guardian Name: _____ Phone: _____

School: _____ Grade: _____

HEALTH/MEDICAL CONDITIONS/DIAGNOSES: CHECK HERE IF ☐ **NONE** OR CHECK ALL THAT APPLY BELOW:

☐ Allergies ☐Seasonal ☐Bees ☐Food ☐Latex ☐Medication ☐Lactose ☐Gluten List specific allergies/intolerances: _____ _____ _____	☐ Dental Problems *Specify:* _____	☐ Hearing Deficit ☐Left ☐ Right ☐Hearing Aids
	☐ Diabetes ☐Type I ☐Type II Insulin by ☐pump ☐injection	☐ Visual ☐Glasses ☐ Contacts ☐ Preferential Seating
	☐ Nose Bleeds	☐ Seizure Disorder *Specify*: _____
☐ Asthma (current or history) If yes, used asthma medication within past two years? ☐Yes ☐No (Describe) _____	☐ Postural (back) Problems *Specify:* _____	☐ Blood Disorder *Specify*: _____
	☐ Heart Condition *Specify:* _____	☐ Neurological Condition *Specify*: _____
☐ GI (Stomach/Intestinal) Problems *Specify:* _____	☐ Migraine Headaches	☐ Skin Condition: *Specify:*_____
	☐ Gynecological/Menstrual Issues	
☐ Urination Concerns	☐ Kidney Disease	☐ Other Physical/Developmental Conditions: *Specify:* _____ _____ _____
☐ Constipation or Encopresis	☐ Lyme Disease ☐Acute or ☐Chronic	
	☐ Ear Infections/Tubes	
☐ ADHD	☐ Depression	☐ Other Diagnoses: _____ _____ _____ _____
☐ Anxiety (GAD, School Phobia, etc.)	☐ Eating Disorder	
☐ Autism Spectrum Disorder	☐ PTSD/Trauma History	

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INITIAL / ANNUAL UPDATE HEALTH FORM

Student Name: _____ Date of Birth: _____

Will your child need to take medication at school? Ex: Epi-Pen, Albuterol inhaler? ❑ YES ❑ NO

Have you traveled outside of the U.S. in the past 12 months? ❑ YES ❑ NO

If yes, where and for how long? _____

Primary Care Doctor Name: _____ Phone: _____

Primary Care Dentist Name: _____ Phone: _____

Do you have Health Insurance: ❑ YES ❑ NO

Health Insurance Provider: _____

Subscriber Name: _____

Health Insurance #: _____

Do you need help obtaining health insurance for your family? ❑ YES ❑ NO

PERMISSIONS

I give the school nurse permission to administer the following over the counter medication in accordance with the established protocols.

❑ **Ibuprofen/Advil/Motrin** ❑**Tylenol/Acetaminophen** ❑ **First Aid Topicals** ❑ **Benadryl**
❑ **Tums** (Tums will be administered only to students age 12 or older).

I understand alcohol based hand sanitizer is being offered in school per CDC recommendation. I do NOT want my child to use school provided alcohol based hand sanitizer. Check here: ❑

In case of an emergency, the school nurse will attempt to contact the parent/guardian. In the event that we are unable to contact you, your child will be transported by ambulance to the nearest hospital accompanied by a responsible adult.

In compliance with state and federal law relevant to student records, the school nurse may share information relevant to my child's health conditions(s) and medication with authorized school personnel when that information is required to meet my child's health and safety needs.

❑ I agree to allow Haverhill Public School Nurses to share information about my child in order to access the Vaccine for Children program at the Haverhill Department of Public Health should vaccines be required prior to school entry. This may include demographic information such as my child's name, date of birth, address, parent or guardian phone number, email, and a list of vaccines needed.

Parent/Guardian Signature: _____ Date: _____

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AUTHORIZATION FORM

Student's Name (First, Middle, Last): _____

Parent/Guardian's Name: _____

FREEDOM OF INFORMATION ACT

The Freedom of Information Act states that school rosters or directories with addresses of students and/or parents are public documents as described in that act. Anyone seeking this information must do so in writing and must be specific concerning what roster or directory they are looking for. The school system must annually provide parents the opportunity to remove their child's information from a directory or roster that could be made public if requested by a third party.

Please Check One of the Options Below:

☐ **YES,** I authorize my son/daughter's information be released to any written request by a third party.

☐ **NO**, I do not authorize my son/daughter's information be released and request it be removed from any roster/directory that is requested by a third party.

Parent/Guardian Signature: _____ Date: _____

INTERNET ACCESS

Haverhill Public Schools offers full internet access. The benefit of being connected to the internet is that it expands our students' access to resources, including original source material from all over the world. It brings information, data, images, and computer soil ware from around the globe almost instantaneously to the classroom.

While the benefits of the internet are enormous, parents need to be aware that the internet is an open system, which contains pockets of material that many people might find offensive. We cannot absolutely guarantee that your son or daughter will not encounter text, pictures, or references that are objectionable, but we can assure you that your son or daughter will only access Internet resources while under the supervision of a professional staff member. In addition, the District is in full compliance of the Children's Internet Protection Act (CIPA) and has taken technology protection measures that block and/or filter inappropriate material.

We ask for your assistance in developing responsible attitudes and reinforcing appropriate behaviors on the internet. I understand and will abide by the terms and conditions for internet access in the Haverhill Public School System. I further understand that any violation of the regulations is unethical and may constitute a criminal offense. Should I commit any violation, my access privileges may be revoked and school disciplinary action may be taken.

As the Parent or Guardian I have read the terms and conditions for internet access in the Haverhill Public School System. I understand that this access is designed for educational purposes and the School System has taken reasonable precautions to prevent access of inappropriate material. However, I also recognize that it is impossible to prevent access to all inappropriate materials and I will therefore not hold the Haverhill Public School System responsible for materials viewed, acquired, or communicated on the internet or private accounts accessed. I understand that if my son/daughter should commit any violation, his/her access privileges may be revoked and school disciplinary action may be taken.

Parent/Guardian Signature: _____ Date: _____

Massachusetts Parental Notice for One Time Consent to Allow the School District To Access MassHealth (Medicaid) Benefits

School District Name and Code: Haverhill Public Schools 01280000

School/District Contact:

Dear Parent/Guardian:

The purpose of this letter is to ask for your permission (also known as consent) to share information about your child with MassHealth. Local communities in Massachusetts have been approved to receive partial reimbursement from MassHealth for the costs of certain health-related services provided by the district to your child (or children). In order for your community to get back some of the money spent on services, the school district needs to share with MassHealth the following types of information about your child: name; date of birth; gender; type of services provided, when, and by whom; and MassHealth ID.

With your permission, the school district will be able to seek partial reimbursement for services provided by MassHealth, including, among others, a hearing test or eye exam; a school physical; occupational or speech or physical therapy; some school nurse visits; and counseling services with the school social worker or psychologist. Each year, the district will provide you with notification regarding your permission; you do not need to sign a form every year.

The school district cannot share with MassHealth information about your child without your permission. As you consider giving permission, please be advised of the following:

1. The school district cannot require you to sign up for MassHealth in order for your child to receive the health-related and/or special education services to which your child is entitled.

2. The school district cannot require you to pay anything towards the cost of your child's health-related and/or special education services. This means that the school district cannot require you to pay a co-pay or deductible so that it can charge MassHealth for services provided. The school district can agree to pay the co-pay or deductible if any such cost is expected.

3. If you give the school district permission to share information with and request reimbursement from MassHealth:
   a. This will not affect your child's available lifetime coverage or other MassHealth benefit; nor will it in any way limit your own family's use of MassHealth benefits outside of school.
   b. Your permission will not affect your child's special education services or IEP rights in any way, if your child is eligible to receive them.
   c. Your permission will not lead to any changes in your child's MassHealth rights; and
   d. Your permission will not lead to any risk of losing eligibility for other Medicaid or MassHealth funded programs.

4. If you give permission, you have the right to change your mind and withdraw your permission at any time.

5. If you withdraw your permission or refuse to allow the school district to share your child's records and information with MassHealth for the purpose of seeking reimbursement for the cost of services, the school district will continue to be responsible for providing your child with the services, at no cost to you.

I have read the notice and understand it. Any questions I had were answered. I give permission to the school district to share with MassHealth records and information concerning my child(ren) and their health-related services, as necessary. I understand that this will help our community seek partial reimbursement of MassHealth covered services.

Parent/Guardian Signature: _____ Date: _____

Child's Name:	**Date of Birth:**	**SASID # (for district to add):**
Child's Name:	**Date of Birth:**	**SASID # (for district to add):**
Child's Name:	**Date of Birth:**	**SASID # (for district to add):**

Add more children