

AUBURN SCHOOL - ENROLLMENT PACKET

Student Name: _____

PARENT CHECKLIST:

REQUIRED DOCUMENTS

- Picture ID of Parent / Guardian _____
- Birth Certificate _____
- Immunization / Health Records _____
- Court Order / Custody Agreement _____

Proof of Residency: Parent or Guardian must provide two (2) current documents as proof of residence. Acceptable Documentation – reflecting name and physical street address (not Post Office Box) – Includes, but is not limited to:

Purchase and Sale Agreement, Property Tax Assessment, Lease Agreement, Mortgage Statement, Utility Bill, Welfare Card, Court Order

The completed registration forms and all required papers listed below should be returned to the school as soon as possible. No child will be enrolled in school without the return of these mandatory documents:

- Registration Form
- Special Learning Needs
- Home Language Survey
- Annual Health Information Sheet
- Student Health History
- Release of Records

Auburn Village School

Student Information

Student Name _____
Address _____
City, State, Zip _____
Home Phone _____
Student Lives With _____ (Parents-Mother-Father-Grandparent-Other)
Marital Status _____ (Married, Living Together, Separated, Re-Married, Divorced, Single, Other)
Court Orders Filed _____

Student ID _____
Grade _____
Homeroom _____
Bus No. (AM/PM) _____

Date of Birth _____
Place of Birth _____
Primary Emergency Phone _____
Gender _____
Language Spoken in the home other than English _____

Is this student Hispanic/Latino? ___ Yes, Hispanic/Latino ___ No, Hispanic/Latino
What is the student's race? ___ American Indian or Alaska Native ___ Asian ___ Black or African American ___ White
(Check one or more) ___ Native Hawaiian or Other Pacific Islander Note: Ethnicity and Race information is required by the NH Dept. of Education

Mother/Legal Guardian

Relationship _____

Legal Guardian Custodial Parent Receives Separate Mailing

Home Phone _____

Same as Student

Address (if different than student) _____ City, State, Zip _____

Cell Phone _____

Mailing Address (if different) _____ City, State, Zip _____

Business Phone _____

Business Name _____

Email _____

Father/Legal Guardian

Relationship _____

Legal Guardian Custodial Parent Receives Separate Mailing

Home Phone _____

Same as Student

Address (if different than student) _____ City, State, Zip _____

Cell Phone _____

Mailing Address (if different) _____ City, State, Zip _____

Business Phone _____

Business Name _____

Email _____

Emergency Contact Information

Please list four other adults who would be available to assume temporary care of your child if you are not available.

1 First Name, Last Name _____ Relationship _____
Daytime Phone Number 1 _____ Daytime Phone Number 2 _____ Address _____ City, State, Zip _____

2 First Name, Last Name _____ Relationship _____
Daytime Phone Number 1 _____ Daytime Phone Number 2 _____ Address _____ City, State, Zip _____

3 First Name, Last Name _____ Relationship _____
Daytime Phone Number 1 _____ Daytime Phone Number 2 _____ Address _____ City, State, Zip _____

4 First Name, Last Name _____ Relationship _____
Daytime Phone Number 1 _____ Daytime Phone Number 2 _____ Address _____ City, State, Zip _____

Childcare Provider _____ Phone _____

Physician _____ Phone _____

Hospital of Choice _____ Phone _____

Allergies/Physical Disabilities _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements necessary.

Parent or Guardian Signature _____

Date _____

Home Language Survey

School: _____ District: _____ Date: _____

Student Information:

First Name _____ Last Name _____ Date of Birth _____ Gender _____

Country of Birth _____ Date of entry in U.S. _____ Date first enrolled in U.S. School _____ Grade _____

Family Information:

Name of parent/legal guardian _____ Address _____

Phone Number _____ Please translate school notices in (Language) _____

Questions for Parents/Guardians:

Please list all languages spoken in your home: _____

Which Language did your child first hear or speak? _____

If English is the only language listed, stop here. If another language is listed, please answer the rest of the questions:

Which language(s) do you speak to your child? _____

Which language(s) does your child speak at home with adults? _____

Which language(s) does your child speak at home with other children? _____

For Parents and Guardians: If a language other than English is listed above, an ESOL teacher will test your child to find out if he or she can speak, understand, read, and write well in English. The results will be sent to you within 30 days. Based on the results of the test, your child may be eligible to enroll in an English language (ESOL) class at school. Parents/guardians may accept or decline ESOL program services for their child.

Instructions for survey administrator:

Please provide an interpreter when necessary.

If responses indicate a language other than English, please contact the ESOL teacher and provide her/him with a copy of this survey. Date of referral to ESOL teacher: _____

File original Home Language Survey in student's cumulative folder.

**AUBURN VILLAGE SCHOOL
HEALTH SERVICES
ANNUAL HEALTH INFORMATION UPDATE**

Your child's health and safety is of utmost concern to the school staff. It is essential that the school nurse be notified when a child is diagnosed with an allergy or other medical condition or begins taking medication at home. Please call the school nurse whenever you have a concern or new information relative to your child's health and safety.

Student's Name _____ **Birth Date** _____ **Grade/Teacher** _____

Allergies (to food, insect stings, meds, etc) _____
Reaction/symptoms _____

Medical concerns, please check any that apply:

Asthma _____ Diabetes _____ Seizures _____ Head injury _____ Heart Condition _____

Urinary or Kidney condition _____ Skin problems _____ Depression _____ Anxiety _____

Attention Deficit Disorder (ADD/ADHD) _____ Frequent headaches _____ Other _____

Frequent ear infections _____ Hearing problems _____ Vision problems _____

Bowel problems _____ Frequent stomachaches _____ Frequent nosebleeds _____

Has your child had any illness or injury over the summer? _____

Indicate the dates of any immunizations your child has had **during the past year**.

Tetanus (Td) _____ **MMR** _____ **Hepatitis B** _____ **Varicella (Chickenpox)** _____

Please follow-up with written documentation from your provider.

Have there been any changes in your family and/or problems you wish to share with the school? Feel free to call or a confidential note. _____

Explain any physical limitations or disability your child has and any modification or restriction necessary to accommodate your child's health or safety. _____

Medical aids: _____ glasses/contacts _____ hearing aids _____ crutches _____ braces _____ wheelchair
_____ other If other, please explain: _____

Medications: please contact school nurse to make arrangements for medications in school.

At school: _____ dosage _____ time _____ reason _____

_____ dosage _____ time _____ reason _____

At home: _____ dosage _____ time _____ reason _____

_____ dosage _____ time _____ reason _____

Physician's Name _____ Tel # _____

I understand that there may be times the nurse may need to speak with our physician.

I would like more information about low cost health insurance for my child.

Parent/Guardian signature _____ Date _____

PLEASE COMPLETE THE OPPOSITE SIDE

Auburn Village School
Parental Permission Form for Over-the-Counter Medications

Dear Parent/Guardian:

The New Hampshire School Nurse is a Registered Nurse who manages School Health Services to facilitate and strengthen the educational process for all students within the school setting. Although not encouraged, I realize that Over-The Counter (OTC) medications are sometimes appropriate and, in fact, necessary. Under the NH Department of Education administrative rule, Ed 311.02, parents may give written permission for a child to receive short-term OTC medication at school. **A new form must be completed each year.**

The decision to administer such medication/treatment is that of the School Nurse. Please understand that these will only be administered to relieve symptoms of occasional pain and/or discomfort and should not be used as a substitute for chronic health problems or to keep an ill child in school.

If your child seems to need any of these medications more often than occasionally or I have concerns regarding the use of any of these medications, I may request that you have a health care provider's evaluation and authorization to continue giving the medication. You may be asked to provide a supply for your child as well; all medications must be delivered to school by an adult in the original container. Any medication left at the end of the year will be disposed of within one week of the end of school.

Below is a list of over-the-counter items available in the Health Office. Any other item must be supplied by the parent (original container, delivered by an adult). **Please check those items that you authorize your child to receive:**

Oral medications

- Acetaminophen (generic Tylenol), **tablets** dosage by age/weight
- Ibuprofen (generic Advil/Motrin) **tablets** dosage by age/weight
- Benadryl elixir/tablets, dosage by age/weight for significant allergy
- Antacid tablets (chewable)
- Chloraseptic type spray for minor sore throat
- Cough Drops

Other (parents must supply): _____

Reason for use: _____

For your information, the following topical medications are used for first aid: Please indicate if not allowed by crossing off

Calamine/Caladryl lotion
Hydrocortisone cream
Antibiotic ointment (such as Bacitracin)
Sting-kill insect bite swabs (Benzocaine 6%)
Bactine, Burnigel,
Sunscreen, Insect repellent

Thank you for your cooperation

Ellen Warecki, MS APRN

School Nurse

Child's Name _____ Grade _____

- My child has no known allergies.
- My child is allergic to: _____

Signature _____ Date _____
(parent/guardian)

Print Name: _____ Relationship: _____

PLEASE TURN OVER AND COMPLETE THE BACK OF THIS FORM



Auburn Village School

Student Health History

Please complete and return to the School Nurse to assist us in meeting your child's needs.

Student's Name: _____ Birth date: _____

Sex: M F Entering Grade: _____ Parent's names: _____

Primary Health Care Provider: _____

Dentist: _____

Please circle the appropriate number if any of the following conditions apply to your child and give a brief explanation in the space provided below. If needed, additional information may be given on the reverse side.

- | | |
|---|---|
| 01 Allergy-Bee Sting (Requires medication) | 25 Hemophilia |
| 02 Allergy-Food (Restrictions, Treatment?) | 26 Hyperactivity (Requires Medication) |
| 03 Allergy-Medication (list below) | 27 Kidney Disease |
| 04 Allergy-Pollen/Dust/Hayfever | 28 Medication Prescribed |
| 05 Allergy-Unknown Cause | 29 Menstrual Cramps (Severe) |
| 06 Anemia | 30 Migraine Headaches |
| 07 Arthritis (Rheumatoid) | 31 Muscular Dystrophy |
| 08 Asthma-Mild | 32 Nosebleeds (Frequent) |
| 09 Asthma-Requires Medication | 33 Osgood-Schlatter Disease |
| 10 Birth Defect (Chromosomal Disorder) | 34 Physical Activity Limitation (Requires Physician's Note) |
| 11 Blood Disorder | 35 Rheumatic Fever History |
| 12 Blood/Blood Products (Religious Exclusion) | 36 Scoliosis |
| 13 Bowel Problems | 37 Sickle Cell Anemia |
| 14 Cancer/Leukemia | 38 Speech Problem |
| 15 Cerebral Palsy | 39 Surgery |
| 16 Color Blindness | 40 Tuberculosis |
| 17 Cystic Fibrosis | 41 Other |
| 18 Diabetes | 42 No Known Health Problems |
| 19 Eating Disorder/Under/Overweight | |
| 20 Endocrine Disorder | |
| 21 Epilepsy/Seizures | |
| 22 Eczema/Persistent rash | |
| 23 Growth Disorder | |
| 24 Heart Disease/Defect/Murmur | |

Has your child had the chickenpox? Yes _____ No _____ If yes, please give date _____

OVER



Auburn School District

AUTHORIZATION TO RELEASE STUDENT RECORDS

AUBURN SCHOOL BOARD
School Administrative Unit No. 15
90 Farmer Road
Hooksett, NH 03106
Telephone 603-622-3731

Superintendent
Charles P. Littlefield, Ed.D.

Assistant Superintendent
Marge Polak

Business Administrator
Karen F. Lessard

AUBURN VILLAGE SCHOOL
11 Eaton Hill Road
Auburn, NH 03032
Telephone 603-483-2769
www.auburnvillageschool.com

Principal
Lori Collins

Assistant Principal
Michel O'Rourke

Director of Student Services
Anne McSweeney

Date: _____

Previous school: _____

Previous school's address: _____

_____, born on _____
Student Name D. O. B.

has enrolled in our school. He/She is enrolled in grade _____, effective _____.

Please send a copy of all records, including transcripts of grades, attendance, health records, test results, special education information, and all pertinent information concerning this student.

Thank you for your cooperation.

Respectfully,

Lori Collins
Principal

I hereby authorize the _____ School to release all educational records pertaining to my child to the Auburn Village School.

Parent/Guardian Signature

Date