

# Auburn Village School Student Information and Emergency Dismissal Form

## Student Information

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Grade Level: \_\_\_\_\_ Sex (circle): Male / Female Primary Phone: \_\_\_\_\_ Primary Email: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Siblings at Auburn Village School:

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Name: \_\_\_\_\_ Grade: \_\_\_\_\_

## Transportation

Bus #: \_\_\_\_\_ Commuter: Yes / No Notes: \_\_\_\_\_

## Parent / Guardian Information

Parent/Guardian 1: \_\_\_\_\_ Relationship to Child: Mother / Father / Legal Guardian

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address (If different): \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Parent/Guardian 2: \_\_\_\_\_ Relationship to Child: Mother / Father / Legal Guardian

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address (If different): \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Custody

Student lives with

(circle all that apply): Both Parents / Mother / Father / Mother + Other / Father + Other / Guardian(s) / Other Family / Multiple Homes / Other

Are there any legal restrictions or custody issues we should be aware of: Yes / No

**Please provide all legal documentation or court papers to the Main Office. We can not be responsible for materials we have not seen.**

## Emergency Information

Contact 1: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_

Contact 2: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_

Contact 3: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_

Contact 4: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_

## Emergency Dismissal

**In case of an emergency dismissal: 1. Your child may be dismissed home on the bus, 2. To a neighbor on the bus, or 3. Bused to an evacuation site to be picked up by you. Note: All children second grade or lower without siblings will automatically be bused to an evacuation site. Parents will then be notified by phone where to pick up their children.**

Please circle one of the following: To Home / To Neighbor / To Evacuation Site Bus #: \_\_\_\_\_

Neighbor Name: \_\_\_\_\_ Address of Neighbor (if applies): \_\_\_\_\_

## Other Information

Ethnicity (Please check all that apply):

\_\_\_ White/Caucasian \_\_\_ Hispanic \_\_\_ American Indian/Alaskan Native \_\_\_ Native Hawaiiin/Pacific Islander

\_\_\_ Black/African American \_\_\_ Asian

Is a language other than English spoken in the home: Yes / No If so, what language: \_\_\_\_\_

Does your child have an Individual Education Plan (IEP) or 504 Plan (circle all that apply): IEP / 504 / None

Does one or more parent or guardian of this child currently serve full time in the regular military? Yes / No

Does one or more parent or guardian of this child currently serve full time in the National Guard? Yes / No

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**My signature indicates that the above information is correct.**

# Home Language Survey

School: \_\_\_\_\_ District: \_\_\_\_\_ Date: \_\_\_\_\_

## Student Information:

| First Name       | Middle                | 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

## SPECIAL LEARNING NEEDS

To help us identify children with possible special learning needs, please fill in the information on the form below at the time of registration.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

1) Has your child ever been enrolled in a special education class?

Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, please answer the following questions:

What was the name of the program? \_\_\_\_\_

Was your child in special education at the time he/she transferred to this school?

Yes \_\_\_\_\_ No \_\_\_\_\_

How many hours did your child spend per day in a special education program?

Hours/Day \_\_\_\_\_

Did your child have an Individualized Educational Program?

Yes \_\_\_\_\_ No \_\_\_\_\_

At the most recent annual review, what was the recommendation for program placement? \_\_\_\_\_

\_\_\_\_\_

2) Has your child ever received additional help such as instruction by a reading specialist, Title One tutor, or speech/language specialist?

Yes \_\_\_\_\_ No \_\_\_\_\_

Please describe: \_\_\_\_\_

\_\_\_\_\_

3) Was your child on a 504 Plan? Yes \_\_\_\_\_ No \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# 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  |
| 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 Orthopedic/Bone/Muscle Problems                          |
| 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/Bladder 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                |   |

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

**OVER**

Has your child had a professional eye exam? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last exam \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Does he/she wear glasses? \_\_\_\_\_ All the time? \_\_\_\_\_

Any other problems with vision? \_\_\_\_\_

Has your child had any hearing problems? \_\_\_\_\_

Has he/she had frequent ear infections? \_\_\_\_\_

Has he/she seen an ear specialist? \_\_\_\_\_

Name of specialist: \_\_\_\_\_ Address: \_\_\_\_\_

Ear tubes: Yes \_\_\_\_\_ No \_\_\_\_\_ Are they still in place? \_\_\_\_\_

Does your child take any regular medication, including over the counter medications? \_\_\_\_\_

Please list medications: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Please use this area for additional comments or call the School Nurse at 483-2769 ext. 1010 Thank you

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**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 (Tdap)** \_\_\_\_\_ **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 send 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: \_\_\_\_\_

**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

Topical medications for first aid

- Calamine/Caladryl lotion
- Hydrocortisone cream
- Antibiotic ointment (such as Bacitracin)
- Sting-kill insect bite swabs (Benzocaine 6%)
- Bactine and Burngel

Other (parents must supply): \_\_\_\_\_

Reason for use: \_\_\_\_\_

Thank you for your cooperation,  
Jennifer Bernier, 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  
AUBURN, NEW HAMPSHIRE 03032**

School personnel at Auburn Village School would like permission to contact your child's kindergarten/day care center in order to obtain additional information about your child to plan his/her education program. Please check the appropriate line.

I authorize \_\_\_\_\_  
(kindergarten/day care center)  
\_\_\_\_\_  
(street)  
\_\_\_\_\_  
(town) (state) (zip code)

to release any pertinent information about my child.

I do not give my permission for the release of information.

My child did not attend kindergarten/day care center.

Name of child: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: (603) \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date





# 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**  
William J. Rearick

**Assistant Superintendent**  
Marge Polak

**Business Administrator**  
Amy Ransom

**AUBURN VILLAGE SCHOOL**  
11 Eaton Hill Road  
Auburn, NH 03032  
Telephone 603-483-2769  
www.auburn.sau15.net

**Principal**  
Lori Collins

**Assistant Principal**  
Lindsay Murray

**Director of Student Services**  
Deena Jensen

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