

Joel Barlow High School

Serving the Towns of Easton and Redding, Connecticut

Dedicated to Academic Excellence and Moral Leadership

Gina M. Pin, Ed.D.
Assistant Superintendent, Head of School

Jennifer C. Desmarais
Assistant Principal

Michael Santangeli, Administrator
Athletics, Health and Physical Education

Julie A. McTague
Assistant Principal

Attached, please find a registration packet for your child. Fill out as much as possible prior to your scheduled meeting and bring any records that you may have from the previous school, including a copy of his/her birth certificate.

If you have not been cleared to register through our Central Office prior to receiving this packet, please call 203.261.2513.

*Please note that the blue Health Assessment Record MUST be completed, dated and signed by a physician prior to admission to Joel Barlow High School. Any questions regarding the Health Assessment Record should be directed to our school nurse, Annmarie Gorman @ ext 1513, or agorman@er9.org. All other inquiries, please feel free to contact me.

Thank you,

Deborah Farrell
Counseling Office Coordinator
ext. 1518
dfarrell@er9.org



Student ID _____

SASID _____

EASTON/REDDING/REGION 9 PUBLIC SCHOOLS
Easton - Redding, Connecticut

GRADE ENTERING _____

REGISTRATION CARD

DATE ENTERED _____

(Parents are responsible to inform the school of any change in information on this card.)

LEGAL NAME _____ M F
Last First Middle

HOME ADDRESS _____ Rent Own
Street Town Zip

MAILING ADDRESS _____
Street Town Zip

HOME TELEPHONE # _____

BIRTHDATE _____ BIRTHPLACE _____
Month Day Year

COPY OF PROOF OF RESIDENCY ON FILE LEGAL DOCUMENTATION OF BIRTH ON FILE
Documents reviewed _____

LIST ALL OTHER CHILDREN IN FAMILY

Full Name	Birthdate	Sex	Full Name	Birthdate	Sex
1. _____			4. _____		
2. _____			5. _____		
3. _____			6. _____		

SCHOOLS PREVIOUSLY ATTENDED

List most recent school first

City and State	Grade
_____	_____
_____	_____

Does your child have an existing: Individualized Education Program (IEP) or 504

The information below is required by the State of Connecticut Department of Education and U.S. Department of Education
DOMINANT LANGUAGE

1. What is the primary language used 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 the student first acquired? _____

Is the student a citizen of the United States? Yes No

Does your child meet all three criteria of the federal definition of an immigrant child/youth.¹ Yes No

- ¹Section 3201(5) of Title III of the ESEA defines immigrant children and youths as individuals who:
- are aged 3 through 21;
 - were not born in any State (defined as each of the 50 States, the District of Columbia, and 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.

U.S. DEPARTMENT OF EDUCATION RACE AND ETHNICITY INFORMATION

Is this child Hispanic/Latino? Yes No

- What is the child's race?
- American Indian or Alaskan Native Black or African American White
- Asian Native Hawaiian or Other Pacific Islander

MILITARY FAMILY STATUS:

- A child's parent or guardian is a member of the Armed Forces of the United States (Army, Navy, Air Force, Marine Corps and Coast Guard) on active duty or serves on full-time National Guard duty.
- Is your student a member of a Military Family as defined above? Yes No

A. Parent 1 _____
Last First Middle Occupation
 Parent 1's Address _____
Street Town State Zip Home Phone
 Parent 1's Employer _____
Company Address Business Phone Cell Phone
 Parent 1's e-mail address _____
 (Used for Listserv - electronic communications from the school and district office.)

B. Parent 2 _____
Last First Middle Occupation
 Parent 2's Address _____
Street Town State Zip Home Phone
 Parent 2's Employer _____
Company Address Business Phone Cell Phone
 Parent 2's e-mail address _____
 (Used for Listserv - electronic communications from the school and district office.)

C. Name of student's legal court-appointed guardian (if applicable):

_____ *Last First Middle Occupation*
 Guardian's Address _____
Street Town State Zip Home Phone
 Guardian's Employer _____
Company Address Business Phone Cell Phone
 Guardian's e-mail address _____
 (Used for Listserv - electronic communications from the school and district office.)

LEGAL GUARDIANSHIP DOCUMENTATION RECEIVED BY SCHOOL

D. If the student resides with someone other than mother, father or legal, court-appointed guardian, you must complete and have notarized the affidavits specified in policy #5118. Name of person with whom student resides:

_____ *Last First Middle Occupation*
 Address _____
Street Town State Zip Home Phone
 Employer _____
Company Address Business Phone Cell Phone
 E-mail address _____
 (Used for Listserv - electronic communications from the school and district office.)

AFFIDAVIT RECEIVED BY SCHOOL

E. Are parents divorced? Yes No
 If parents are divorced, list name(s) of person(s) having legal custody: _____
 Are parents separated? Yes No
 If parents are separated, list name(s) of person(s) with whom student is living: _____
 If parents are divorced or separated, list name of parent with NO Custodianship LIMITED Custodianship : _____
 1. Visit child at school? _____
 2. Remove child from school? _____
 3. Confer with child's teacher? _____
 4. Other (please specify) _____

LEGAL DOCUMENTATION MUST BE PROVIDED AND ON FILE AT THE SCHOOL. DOCUMENTATION RECEIVED BY SCHOOL

F. Is either parent deceased? Yes No Deceased parent's name: _____

G. I CERTIFY THAT THE INFORMATION PROVIDED ON THIS REGISTRATION CARD IS CORRECT AND ACCURATE.

_____ *Parent 1 or legal guardian's signature Date*
 _____ *Parent 2 or legal guardian's signature Date*
 _____ *Signature of staff member registering student Date*

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Julie A. McTague
Assistant Principal

Date: _____

Former School:

REQUEST FOR SCHOOL RECORDS

Please send to us the below noted records of:

Date of Birth: _____

- Cumulative Educational Records
- Transcript
- Medical/Health Records
- 8th Grade Mastery Test Results (9th graders only)
- Other

Parent/Guardian Signature: _____

THANK YOU FOR YOUR PROMPT ATTENTION TO THIS REQUEST

Lynne A. Bonavenia, Registrar x 1549
lbonavenia@er9.org

Region 9 Public School District

PowerSchool Parent Portal Acceptable Use Agreement

**Acceptable Use Agreement of Information Technology
Region 9 Public School District - Parent Acceptable Use Agreement**

The Region 9 School District is offering PowerSchool Parent Single Sign On Internet access for parent(s)/guardian(s) use to view their student's grades and attendance. Parents can create their own account for multiple students. To enter multiple email addresses for email alerts, please separate each address with a comma. This document contains the parent/guardian Acceptable Use Agreement for use of the Region 9 School District's PowerSchool Parent Portal.

System Security

- a. Parent(s)/Guardian(s) are responsible for their individual account and should take all reasonable precautions to prevent others from being able to use their account. Under no conditions should parent(s)/guardian(s) provide their password to another person.
- b. Parent(s)/Guardian(s) will immediately notify the PowerSchool Administrator if they have identified a possible security problem by emailing PowerSchool Support at powerschool@er9.org.

Parent or Guardian Section

I have read the above Region 9 District Acceptable Use Agreement. I understand passwords are an important aspect of computer security. If I feel my password has been compromised, I will email PowerSchool Support at powerschool@er9.org to obtain a new password.

.....

Student Name _____

Parent Signature _____ Date _____

Print Parent Name _____

Home Address _____ Phone _____



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 physi-

cian 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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)			
Parent/Guardian Name (Last, First, Middle)		Home Phone	Cell Phone
School/Grade	Race/Ethnicity		<input type="checkbox"/> Black, not of Hispanic origin
Primary Care Provider	<input type="checkbox"/> American Indian/ Alaskan Native		<input type="checkbox"/> White, not of Hispanic origin
	<input type="checkbox"/> Hispanic/Latino		<input type="checkbox"/> Asian/Pacific Islander
			<input type="checkbox"/> Other
Health Insurance Company/Number* or Medicaid/Number*			
Does your child have health insurance?		Y N	If your child does not have health insurance, call 1-877-CT-HUSKY
Does your child have dental insurance?		Y N	

* 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

Part 2 — Medical Evaluation

HAR-3 REV. 7/2018

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			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

Screenings

*Vision Screening	*Auditory Screening	History of Lead level ≥ 5µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes	Date
Type: Right Left	Type: Right Left		
With glasses 20/ 20/	<input type="checkbox"/> Pass <input type="checkbox"/> Pass	*HCT/HGB:	
Without glasses 20/ 20/	<input type="checkbox"/> Fail <input type="checkbox"/> Fail	*Speech (school entry only)	
<input type="checkbox"/> Referral made	<input type="checkbox"/> 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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination Completed by: <input type="checkbox"/> Dentist	Visual Screening Completed by: <input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> Dental Hygienist	Normal <input type="checkbox"/> Yes <input type="checkbox"/> Abnormal (Describe) _____ _____ _____ _____	Referral Made: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Risk Assessment <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	Describe Risk Factors <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____ </td> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____ </td> <td style="width: 34%; border: none;"></td> </tr> </table>			<input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____	<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	
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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 _____

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 the 1st 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 the 1st 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.