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, Annemarie Gorman at 203-938-2508 Ext. 1513, or agorman@er9.org.*

All other inquiries, please feel free to contact me.

Thank you.

Sincerely,

Jean Talamelli
Counseling Office Coordinator
203-938-2508 Ext. 1518
jtalamelli@er9.org

100 Black Rock Turnpike, Redding, Connecticut 06896
Phone: (203) 938-2508; Fax: (203) 938-2959

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

[1]Section 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 form 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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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 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	❑ Black, not of Hispanic origin
Primary Care Provider	❑ American Indian/ Alaskan Native	❑ White, not of Hispanic origin
	❑ Hispanic/Latino	❑ Asian/Pacific Islander
		❑ Other
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

HAR-3 REV. 7/2018

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**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
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

HAR-3 REV. 7/2018

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