

*Please complete this form in its entirety. It contains information that is required by the Commonwealth of Massachusetts.*

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last Name First Name Middle Name MONTH DAY YEAR

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Gender (circle one) M F Child's Grade Level at Time of Registration: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Country of Origin: \_\_\_\_\_  
CITY STATE

School/Preschool Attended Last Year: \_\_\_\_\_

Has your child ever received special education services?  Yes  No  
 If yes, has a copy of the IEP been provided?  Yes  No

**Child's Race & Ethnicity: Please check both Ethnicity and Race**

<b>Ethnicity: (Check One)</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	<b>Race: (check all that apply)</b> <input type="checkbox"/> African-American, <input type="checkbox"/> Asian, <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Eskimo, <input type="checkbox"/> Native American, <input type="checkbox"/> Pacific Islander
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**Family Information**

Mother's Name: \_\_\_\_\_ Address: (if different from above) \_\_\_\_\_

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

Mother's Place of Work: \_\_\_\_\_ Email: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Address (if different from above): \_\_\_\_\_

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

Father's Place of Work: \_\_\_\_\_ Email: \_\_\_\_\_

Guardian's Name: \_\_\_\_\_ Address (if different from above): \_\_\_\_\_

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

Guardian's Place of Work: \_\_\_\_\_ Email: \_\_\_\_\_

**(Legal documentation of guardianship is required for verification).**

**Marital Status of Parents:**     Married     Single     Divorced     Separated     Other \_\_\_\_\_

**Child lives with:**                 Both Parents     Mother     Father     Guardian     Other \_\_\_\_\_

Check here if there are any unique custody arrangements we should be aware of. Please provide appropriate documentation.



***In order to communicate with you concerning school-related enrichment opportunities, may we share your telephone number, mailing address and e-mail address with the following organization(s)?***

- your school's Parent Teacher Organization (PTO)  Gloucester Education Foundation  
 Gloucester Fisherman's Athletic Association (GFAA)

**IMPORTANT PERMISSION QUESTIONS:**

***Occasionally, your child's school or a photographer from the Gloucester Daily Times takes photographs of school events, including photographs of students. We would like your permission to use these photographs for either educational purposes or publicity.***

I give the Gloucester Public Schools, Gloucester Daily Times and the Cape Ann Beacon permission to take photographs of my child and use my child's name in press releases and news articles. OR

I give the Gloucester Public Schools, Gloucester Daily Times and the Cape Ann Beacon permission to take photographs of my child but not my child's name in press releases and news articles. OR

I do not give the Gloucester Public Schools, Gloucester Daily Times and the Cape Ann Beacon permission to take photographs of my child and use my child's name in press releases and news articles.

***Permission to use the internet on computers in the library or classroom. Internet access is filtered through a Child Internet Protection Act compliant device, and the schools use reasonable measures to preserve online safety. More information is contained in the District Acceptable Use Policy which is available at each school.***

I give permission for my child to use the internet on computers in the library or classroom.

I do not give permission for my child to use the internet on computers in the library or classroom.

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

**This section is for Kindergarten or Preschool only**

*The following are questions about your child's development and school experience:*

1. Has your child had pre-school experience?  Yes  No

Where? \_\_\_\_\_ For how long? \_\_\_\_  
Preschool Name Street Address City/Town

2. Has your child ever received early intervention services?  Yes  No

Where? \_\_\_\_\_ When? \_\_\_\_\_ Why? \_\_\_\_\_

3. Does your child have the opportunity to play with children of the same age? Yes No

4. Does your child spend a great deal of time with adults? Yes No

5. Do you feel your child may experience any separation problems? Yes No

6. Is this your family's first public school experience? Yes No

9. What is your child's favorite activity? \_\_\_\_\_

10. What is your child's least favorite activity? \_\_\_\_\_

11. What are your child's strengths? \_\_\_\_\_

12. Is your child able to sit and listen to a story being read? Yes No For how long? \_\_\_\_

13. Are there any issues that would impact your child's ability to learn?

14. Any concerns or comments you may have:

**FOR OFFICE USE ONLY**                      **DOCUMENT**                      **DATE REC'D**

Medical Record	
Immunizations	
Birth Certificate	
Dental Record	

Check off documents  
as they are received:

Child's home school district: \_\_\_\_\_

# Gloucester School District Home Language Survey

Dear Parent/Guardian,

In order to help your child succeed in school we ask that you please fill out the following form for EACH child that you are registering in the Gloucester School District. Your answers will help us to provide the best possible educational program for your child.

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

Current Grade \_\_\_\_\_ Country of Birth \_\_\_\_\_

Date of family's entry into the United States \_\_\_\_\_

What language did your child first understand or speak? \_\_\_\_\_

What language do you use most often when speaking to your child at home? \_\_\_\_\_

What language does your child use most often when speaking with you at home? \_\_\_\_\_

What language does your child speak most often when speaking with other family members? \_\_\_\_\_

What language does your child use most often when speaking to friends? \_\_\_\_\_

What languages does your child read? \_\_\_\_\_

What languages does your child write? \_\_\_\_\_

At what age did your child start attending school? \_\_\_\_\_

Has your child attended school every year since that age? \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, please explain:

Would you prefer oral and written communication from the school in English or in your home language? English \_\_\_\_\_

Home Language \_\_\_\_\_

Parent/Guardian Name (please print): \_\_\_\_\_

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

December 2016

- please complete both sides -

**The following are questions about your child's health:**

Child's Name \_\_\_\_\_

*Has your child ever had any of the following:*

	YES	NO		YES	NO
Allergies			Heart disease		
Asthma			Hernia		
Behavioral problems			Kidney disease		
Chicken pox			Measles/German measles		
Chronic or recurring illness			Pertussis (whooping cough)		
Congenital anomaly			Prolonged medication		
Convulsions/epilepsy			Serious accident/injury		
Diabetes			Speech difficulty		
Ear infections			Strep throat/tonsillitis		
Emotional problems			Surgery/hospitalization		
Hearing difficulty			Vision difficulty/wear glasses		

*If you answered yes to any of these, please explain:*

**Pre-Natal History:** *Were there any problems during pregnancy, birth or early infancy that you think is important to your child's growth and development? If yes, please explain:*

**Health History:** *Does your child have any health/medical problems that we should be aware of? If yes, please explain:*

*Is your child presently seeing a physician or specialist for any medical problems?*

*Do you have any concerns regarding your child's health, growth and/or development?*

*Do you have any concerns about your child's nutrition or eating habits?*

*Is there any further information you may wish to share with us about your child's health that may be helpful?*

**Does your child have Health Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_**

Does your child have Dental Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

Health Insurance Carrier \_\_\_\_\_  
Policy # \_\_\_\_\_

Dental Insurance Carrier \_\_\_\_\_  
Policy # \_\_\_\_\_

***If you have no health insurance, Massachusetts has plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the school nurse for more information about these programs. All Communication will be confidential.***

**In case of emergency, the school will attempt to contact parent/guardian before calling the student's primary care provider (physician). In the event that we are unable to contact you, your child will be transported by ambulance to Addison Gilbert Hospital Emergency Department accompanied by a staff member.**

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist Name \_\_\_\_\_ Phone \_\_\_\_\_

**Please list all medication that your child takes.**

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**Please check all that apply to your child:** Heart Condition \_\_\_\_\_ Diabetes \_\_\_\_\_ Asthma \_\_\_\_\_ ADD/ADHD \_\_\_\_\_  
Seizure Disorder \_\_\_\_\_ Migraines \_\_\_\_\_ Depression \_\_\_\_\_  
Other (specify) \_\_\_\_\_

Allergies (food, medication, environmental, insect) specify \_\_\_\_\_

Hearing Problems (specify) \_\_\_\_\_ Left Ear \_\_\_\_\_ Right Ear \_\_\_\_\_ Hearing Aides \_\_\_\_\_

Vision Problems (specify) \_\_\_\_\_ Eyeglasses \_\_\_\_\_ Contacts \_\_\_\_\_ Preferential Seating \_\_\_\_\_

**I give the school nurse permission to administer the following over the counter medications accordance with the established protocols. Tylenol will only be administered to children grades 4 and above. Advil will only be administered to children age 12 and over. Tums will be administered to high school students only.**

Advil \_\_\_\_\_ Anbesol \_\_\_\_\_ Benadryl \_\_\_\_\_ Insect Sting Relief \_\_\_\_\_ Tylenol \_\_\_\_\_ Tums \_\_\_\_\_

The following medication must be provided by the parent to be administered by the school nurse:  
Robitussin \_\_\_\_\_ Cepacol/throat lozenge/cough drop \_\_\_\_\_

**I give permission to the school nurse to share information relevant to my Child's health conditions with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care provider for the purpose of referral, diagnosis and treatment. I give Addison Gilbert Hospital permission to administer emergency care. Any such action will be taken in the best interest of my child and will be reported to me as soon as possible.**

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

***High School Only – Health Center Permission (check one)***

I give permission for my child to receive all services offered at the Student Health Center at Gloucester High School. OR

I give my permission for my child to receive all services offered at the Student Health Center at Gloucester High School EXCEPT for the provision/prescription of birth control.

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