

**PAUL SCHOOL**  
**REGISTRATION FORM**  
**- NEW STUDENTS -**

Student's Full Name: \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Gender:  M  F Grade Level: \_\_\_\_\_

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

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

Parent's Marital Status:  Married  Single  Divorced  Separated

Student lives with:  Both Parents  Mother  Father  Other (specify)

Are there any court ordered custody agreements?  Yes  No

Who has court ordered *residential responsibility* of the children? \_\_\_\_\_

Are there any current court orders limiting the rights of the non-custodial parent to access your child, and/or your child's school records?  Yes  No (If Yes, please provide copies as soon as possible)

Father/Guardian: \_\_\_\_\_ Mother/Guardian: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Work/Day Phone: \_\_\_\_\_ Work/Day Phone: \_\_\_\_\_

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

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

Does the student have siblings in the same school district? (If yes, please list names and ages):

\_\_\_\_\_  
\_\_\_\_\_

Does your child receive any special services?  IEP  Speech  Health Services  
 OT/PT  Title I  Counseling  504 Plan

If yes, please describe: \_\_\_\_\_

Previous school attended (if any): \_\_\_\_\_ Grade \_\_\_\_\_

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

# **PAUL SCHOOL**

## **REGISTRATION REQUIREMENTS FORM**

**Proof of Immunization** – Minimum requirements, State of New Hampshire

*DTP/DT/DTaP/Td/Tdap:*

<7 years old: Four or five doses, last dose after age 4

>7 years old: Three or four doses with last dose after age 4

11 years and older and 5 years since last tetanus - Tdap or (Td)

*POLIO*

Grades K-12: Three doses with last dose after age 4 of all IPV or OPV, or four doses of combination of IPV and OPV

*MEASLES-MUMPS-RUBELLA*

All students: Two doses of MMR

*HEPATITIS B*

All students – Three doses

*VARICELLA (Chicken Pox)*

Grades K-2: Two doses of vaccine or laboratory confirmation of immunity

Grade 3: Two doses of vaccine or history of disease

Grades 4-5: One dose of vaccine or a history of the disease

Grades 6-8: Two doses of vaccine or a history of the disease

\*All above immunizations need to be given at acceptable intervals according to State law.

**Physical Exam** - By your medical provider within the last 12 months for kindergarten or a previous school health record showing evidence of a physical exam.

**Copy of Birth Certificate** - May be included in transferred student record. Child must be 5 years old on or before September 30<sup>th</sup> to enter kindergarten.

**Proof of Residency** – Complete enclosed form and submit proper documentation.

# Wakefield Public School District FAMILY RESIDENCY FORM

**SAU #101**

## STUDENT INFORMATION (list all children living in the home under the age of 21):

Student Name	Date of Birth	Grade	School Attending		
_____	_____	_____	<input type="checkbox"/> Paul School	<input type="checkbox"/> Spaulding	<input type="checkbox"/> Kingswood
_____	_____	_____	<input type="checkbox"/> Paul School	<input type="checkbox"/> Spaulding	<input type="checkbox"/> Kingswood
_____	_____	_____	<input type="checkbox"/> Paul School	<input type="checkbox"/> Spaulding	<input type="checkbox"/> Kingswood
_____	_____	_____	<input type="checkbox"/> Paul School	<input type="checkbox"/> Spaulding	<input type="checkbox"/> Kingswood

\* If Spaulding has been selected, Wakefield will provide them with proper Proof of Residency, if it has been provided to us.

## CONTACT INFORMATION

Mother/Guardian:

Father/Guardian:

\_\_\_\_\_  
Last First

\_\_\_\_\_  
Last First

## ADDRESS INFORMATION (of parent with residential responsibility)

Who has residential responsibility of the child(ren)?  Both Parents  Mother  Father

PRIMARY (PHYSICAL) ADDRESS AT WHICH CHILD(REN) RESIDE:

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

MAILING ADDRESS (if different from primary):

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

Where is your child/family currently living? (Please check the appropriate box)

- Single family residence in Wakefield (house, apt., condo, etc.)
- Temporary residence while building or looking for a home
- Doubled-Up (sharing housing with another family due to economic hardship)
- In a shelter or transitional housing program
- Unsheltered (car/campsite)
- Motel/Hotel  Foster Home  Other \_\_\_\_\_

In order to satisfy the districts annual residency requirements, the parent, guardian or court appointed legal guardian must provide photocopies of one (1) of the following items printed with the physical address as proof of residency:

- \* Property Tax Statement
- \* Rental/Lease Agreement
- \* Other \_\_\_\_\_
- \* Notorized Residency Statement (Doublers)
- \* Utility Bill (electric, propane, gas, cable)

I hereby certify that all the information provided on this form is true and complete to the best of my knowledge.

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

# PAUL SCHOOL

## EMERGENCY INFORMATION FORM

Student's Full Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

○ Contact 1 (*parent/guardian*): \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone Type: \_\_\_\_\_

○ Contact 2: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone Type: \_\_\_\_\_

○ Contact 3: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone Type: \_\_\_\_\_

Siblings also attending Paul School: \_\_\_\_\_

Child Care Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_

### MEDICAL INFORMATION

Family Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Does the student have any medical conditions that should be noted?  Yes  No

Explain \_\_\_\_\_

1. Is the student taking any medications regularly?  Yes  No

2. Had any diseases, accidents, tests or immunizations during the past year?  Yes  No

3. Presently on any medication, or health concerns - allergies, physical limitations, illnesses?  Yes  No

4. Do you have any concerns for your child's vision or hearing?  Yes  No

5. If you answered "yes" to questions 1-4 please explain: \_\_\_\_\_

Do you grant permission to share medical information regarding the student with appropriate staff members on a need to know basis?  Yes  No

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me or the person whose names I have given, I hereby authorize the school to make any arrangements that seem necessary, including taking my child to the hospital or outpatient department for treatment.

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

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

# PAUL SCHOOL

## MEDICATION AND TREATMENT FORM

Dear Parent/Guardian,

In order to provide more comprehensive health services to your child, we would like to be able to use a limited amount of over-the-counter medications. To do this, we need permission from you.

**Student's Full Name:** \_\_\_\_\_

- I **GIVE PERMISSION** to the nurse, or nurse designee, to apply over-the-counter topical medication to my child. This may include Bacitracin, Neosporin ointment, Hydrocortisone cream, 1%, topical antiseptics such as Anbesol, Caladryl Calagel, and Aloe-Vera gel.

**PLEASE CHECK ALL THAT APPLY:**

- Acetaminophen (Tylenol) for pain/headache/fever as directed on label
  - Ibuprofen (Advil, Motrin) for pain/headache/fever as directed on label
  - Calcium Carbonate antacid(Tums) for indigestion as directed on label
  - Cough drops - **provided by parents in original container** given as directed on label
  - Diphenhydramine (Benadryl) for allergy reactions as directed on label
- I **DO NOT** give permission to have my child receive topical treatment at school.

You may withdraw permission for the above treatments at any time. Please notify our School Nurse to do so.

I authorize the school to assist my child in taking medication and agree that we will not hold liable any member of the school staff or administration who is directed by us, and the school administration, to assist my child in taking the above medication.

Sincerely,

Lisa A.Wunderlich RN, BSN

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Parent/Guardian (PRINT)*

\_\_\_\_\_  
*Date*

**PAUL SCHOOL**  
**SCHOOL HEALTH SERVICES FORM**  
*(To be completed by physician)*

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

Medical Exam:      Height: \_\_\_\_\_ Weight: \_\_\_\_\_

General Condition: \_\_\_\_\_ Nose/Throat: \_\_\_\_\_

General Nutrition: \_\_\_\_\_ Teeth/Gums: \_\_\_\_\_

Posture: \_\_\_\_\_ Orthopedic: \_\_\_\_\_

Ears/Hearing: \_\_\_\_\_ Eyes/Vision: \_\_\_\_\_

Skin: \_\_\_\_\_ Glands: \_\_\_\_\_

Lungs: \_\_\_\_\_ Heart/Pulse: \_\_\_\_\_

Murmurs: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Abdomen: \_\_\_\_\_ Nervous System: \_\_\_\_\_

Emotional Status: \_\_\_\_\_ Urine/Genitalia: \_\_\_\_\_

HGB/HCT: \_\_\_\_\_ Speech: \_\_\_\_\_

Is this student currently under medical care?    Yes    No    If so, for what reason? \_\_\_\_\_

Is this student currently taking medication?    Yes    No    If so, what medication & how often?  
\_\_\_\_\_  
\_\_\_\_\_

Does this student have any physical disability?    Please specify: \_\_\_\_\_

Does this student have any limitations of restrictions to full participation in school activities including physical education?    Yes    No    Please specify: \_\_\_\_\_

Physician's Recommendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please attach an immunization record to this form. List any additional immunizations given at the time of the exam if not included on the attached form.  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*Physician's Signature*

\_\_\_\_\_  
*Date*

# PAUL SCHOOL

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last) (First) (Middle)

## ETHNICITY

Dear Parents,

Under State law, we are required to ask you about the ethnicity and race of your child. Please check the following description which best describes how you would define your child:

**Please select one or more of the following:**

- American Indian/Alaska Native
- Asian
- Black
- Native Hawaiian or Pacific Islander
- White
- Hispanic/Latino

## HOME LANGUAGE SURVEY

Please list all languages spoken in your home: \_\_\_\_\_

What language did your child first learn to speak?  English  Other: \_\_\_\_\_

➤ **If ENGLISH is the only language spoken in your home, DO NOT PROCEED FURTHER:**

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? \_\_\_\_\_

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

# PAUL SCHOOL

## SCHOOL MESSENGER CALL SYSTEM

This form is used by our electronic notification system for delays, cancelations and/or notifications. When we cancel school or have a delay, calls are generally made as early as 5:00AM. Please do not put anyone's phone number on here without prior permission first. The system will not generate phone calls to numbers with extensions. PLEASE PRINT CLEARLY

Student's Full Name: \_\_\_\_\_

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

1. Primary Number \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Type \_\_\_\_\_

2. Secondary Number \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Type \_\_\_\_\_

3. Alternate Number \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Type \_\_\_\_\_

4. Alternate Number \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Type \_\_\_\_\_

Email Address \_\_\_\_\_ Relationship \_\_\_\_\_

Email Address \_\_\_\_\_ Relationship \_\_\_\_\_

Would you like to use the above email addresses as a source to receive school information, such as the Wakefield Weekly, upcoming events, lunch menu's, etc.

No, I will access information on our school website



# **PAUL SCHOOL**

## **PHOTO RELEASE FORM**

As a parent or guardian of \_\_\_\_\_, I hereby consent to the use of photographs/videotape or publication of my child's name during the course of the school year for publicity, promotional and/or educational purposes (including publications, presentation or broadcast via newspaper, internet or other media sources). I do this with full knowledge of consent and waive all claims for compensation for use, or for damages.

- YES, I give consent for Paul School to photograph my child and/or print their name, for school purposes and/or at school events**
  
- NO, I do not authorize Paul School to photograph or use my child's name for any event, including yearbook and honor roll recognition**

---

*Student's Name*

---

*Date*

---

*Parent/Guardian Signature*

---

*Date*

# PAUL SCHOOL

## FIELD TRIP RELEASE FORM - BLANK APPROVAL

On occasion, classes may visit the Gafney Library, Police and Fire Station, Town Hall or may explore the woods around the Paul School. Rather than send a permission slip home each time we walk downtown, we ask that you sign this permission slip granting your approval for your son/daughter to join us when we go to the center of Sanbornville. Prior to each trip, we will send home a notice explaining the purpose for the trip, but you will not be asked to sign one each time. You will be asked to sign a permission slip for any trip other than to the center of Sanbornville.

<b>Student:</b>	<b>Home Phone:</b>	<b>DOB:</b>
<b>Parent's Name:</b>		<b>Daytime Phone:</b>
<b>Medical Information</b>		
Does the participant have any of the following? (If yes, explain below. Use back if necessary)		
<input type="checkbox"/> Special Diet	<input type="checkbox"/> Chronic/Recurring Illness	<input type="checkbox"/> Surgery or serious illness in past year
<input type="checkbox"/> Allergies	<input type="checkbox"/> Medication	<input type="checkbox"/> Physical condition that limits activity

In consideration of permission granted my son/daughter by the Wakefield School District to participate in the aforementioned activity, I hereby release and discharge the Wakefield School District, its successors or assigns, for all personal injuries, known or unknown, and injuries to property, caused by, or arising out of the above named activities.

I am aware the participation in this program may present strain on my child's body, or its parts and therefore I represent to the school district that to the best of my knowledge my child is in proper physical condition to allow him/her to participate and that I assume the risk of participating.

I understand that in case of injury or illness, I will be notified. If it is impossible to contact me and it is an emergency, I hereby give permission to the attending physician to treat, hospitalize, administer anesthesia or to order injections or surgery for the safety of my child.

If my child is already taking medication, I will be responsible for administration of medication or will instruct the teacher, as needed, in administration of the medication.

I, the undersigned, have read this release and understand all of its terms. I execute it voluntarily and with full knowledge of its significance. I have executed this release on the date indicated next to my name.

\_\_\_\_\_

*Parent/Guardian Signature*

\_\_\_\_\_

*Date*

# PAUL SCHOOL TRANSPORTATION REGISTRATION AND RENEWAL FORM



Date: \_\_\_\_\_  New Student  Change of Address  Renewal

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First) (Middle)

Parent/Guardian: \_\_\_\_\_ Street Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Town: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Zip Code: \_\_\_\_\_

1. Will the student use the school bus as their primary transportation to and from school?  Yes  No  
If NO, how will your child be transported?  Car  Walk  Other (please specify) \_\_\_\_\_  
\_\_\_\_\_

2. Please indicate if the student will be picked-up or dropped-off at a different location other than the assigned bus stop on a frequent basis. (daycare, babysitter, work, etc.) \_\_\_\_\_  
\_\_\_\_\_

3. List ALL REGISTERED STUDENTS in your household (each student must have his/her own form)  
Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Policy EEA, states, in part, that students in grades K-2 will not be let off the bus without a parent or designee at the bus stop, without prior written parent authorization, provided to the school office.

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

### \*\*\* FOR TRANSPORTATION DEPARTMENT USE ONLY \*\*\*

Bus Number: \_\_\_\_\_ Bus Color: \_\_\_\_\_ Driver Notified:  Yes  No Date: \_\_\_\_\_

Addition to Existing Stop  New Stop  New Location: \_\_\_\_\_

Parents and school have been notified of stop time and location:  Yes  No

Pick-Up Location: \_\_\_\_\_ Pick-Up Time: \_\_\_\_\_

Drop-Off Location: \_\_\_\_\_ Drop-Off Time: \_\_\_\_\_

Processed by: \_\_\_\_\_ Date: \_\_\_\_\_

# PAUL SCHOOL

## NOTICE TO STUDENTS AND PARENTS REGARDING THE USE OF AUDIO/VIDEO RECORDERS ON SCHOOL BUSES

The Wakefield School District has installed audio/video recording equipment on all school buses to monitor school transportation and will be audio/videotaping bus routes during the school year.

Tapes may be reviewed at any time by the transportation coordinator, principal and assistant principal, or superintendent. Evidence of student misconduct will be documented. Students found to be in violation of any law, school or bus rule, will be notified and disciplinary action will be initiated under the guidelines contained in the district's discipline procedures.

Audio/videotapes will be treated as protected student records under the Family Educational Rights and Privacy Act.

The following guidelines will apply (per RSA 570 A:2):

1. Tapes will remain in the custody of the Wakefield School District for up to 10 school days.
2. Parents of students who wish to view an audio/videotape in response to disciplinary action taken against a student, may request such access under the district's approved disciplinary procedures. Only the portion of the audio/video pertaining to the student's infraction may be viewed.
3. Persons unrelated to a disciplinary incident will not be permitted to listen to/view

-----

### ACKNOWLEDGMENT

I understand and acknowledge the district's procedure concerning the use of audio/video recorders on school buses. I also understand that my child, \_\_\_\_\_, will be held accountable for his/her conduct on district transportation and for the consequences outlined in the district's discipline procedures for district approved student transportation.

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

# PAUL SCHOOL

60 Taylor Way  
Sanbornville, NH 03872  
P: (603) 522-8891  
F: (603) 522-6143



Jerry Gregoire, Principal  
James Lampron, Assistant Principal

## **AUTHORIZATION TO RELEASE RECORDS**

Name and Address of School Last Attended:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

The student's listed below have enrolled in the Wakefield School District, SAU 101. Please forward all records, including grades and medical information. **Prior to mailing, please FAX any Special Education files (IEP/504)** to the above fax number ATTN: Main Office, and mail to the above address ATTN: Main Office.

Student Name	Date of Birth	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*