

CARVER PUBLIC SCHOOLS STUDENT REGISTRATION FORM

STUDENT INFORMATION

Student's Name _____ Sex M F
First Middle Last
Date of Birth

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 Place of Birth _____
(Town or city, state, country)
Address #1 _____ Phone (Home) _____
Mailing Address (if different) _____ Phone (Cell) _____
Address #2 _____
Social Security #

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 E-mail: _____

FAMILY BACKGROUND

Parent 1/Guardian _____ Occupation _____
Employer _____ Work phone # _____
Parent 2/Guardian _____ Occupation _____
Employer _____ Work phone # _____
Student resides with _____ May child be dismissed to either parent? Yes No
Due to divorce or any other reason, has a court order been written granting custody of your child? If yes, please complete the following:
♦ Is custody temporary or permanent? _____
♦ Date of order? _____ Date of expiration? _____ An official court order has been brought to school
♦ Name of person granted custody _____ Child of military family?
Are there any legal issues or dismissal restrictions that the school should be aware of? Yes No
Siblings (Name/Grade) _____
Language spoken at home (if other than English) _____
Ethnicity (Race) African American Asian Caucasian Hispanic Native American Other
If Foster Child, Name of Social Worker _____
Agency _____ Phone # _____ Medicaid: Yes No

SCHOOL INFORMATION

School Last Attended _____ Grade _____
Address _____ Current 504 Plan? Yes No
Has student ever received SPECIAL EDUCATION SERVICES? Yes No When _____
Has student ever received TITLE 1 SERVICES? Yes No When _____
Has student ever attended CARVER PUBLIC SCHOOLS? Yes No When _____

PARENT/GUARDIAN SIGNATURE: _____

FOR OFFICE USE ONLY

Grade _____ YOG _____ ID # _____ LASID _____ SASID _____
School _____ Date Attendance Starts _____ Entry Code _____ Bus # _____
Homeroom _____ Counselor _____ Verification of Student's Identity: Certified Birth Certificate (must be attached)
Verification of Residence: Driver's Rent Tax Utility Lease Court Other

PARENT QUESTIONNAIRE

Child's Name _____

Does your child display any special interest/talents – music, art, performing for others, leading other children, engaging in physical activities, etc.? _____

Does he/she prefer to play alone or with others? _____

How old are his/her favorite playmates? _____

Has your child had any special testing – educational, speech and language, psychological, neurological, etc.? _____ Yes _____ No

What kind of testing? _____

When: _____ Where: _____

Results: _____

Have there been any significant experiences in your child's life – moves, deaths, separations, etc.? _____

Do you have any questions or concerns about any of the areas listed below?

YES

NO

Behavior Management
Crying or Irritability
Fears
Tantrums
Sibling Relationships
Peer Relationships
General Development
Speech and Language

Please explain _____

#

Ruby C. Maestas
Principal

Carver Elementary School

85 Main Street, Carver, MA 02330

www.carver.org

(508) 866-6210-6220

Tanya Dawson
Associate Principal

Paula S. Foley
Associate Principal

Michelle Taylor
Director of Literacy, K-12



MILITARY FAMILY STATUS

In May 2012, as part of the VALOR Act, Massachusetts became a member of the Interstate Compact on Educational Opportunity for Military Children. The Compact aims to make the transition to a new school easier for military children in areas such as enrollment, assessment, graduation, etc. The provisions of the Compact also apply to students whose Parent/Guardian is currently deployed, or who was discharged from active duty due to a disability or passed away while on active duty within the past year.

Please fill in the form below if any of the following statements are true.

=====

There is a Parent or Guardian in the student's household who:
(Please check the box that applies)

Is a member of the uniformed services or National Guard and Reserve on full-time active duty orders.

Is currently deployed.

Is a veteran who retired within the past year.

Was medically discharged within the past year.

Died while serving our country within the past year.

Other: _____

Date of discharge, retirement, death, deployment, military transfer, etc. _____

Student Name: _____ Name of Service Member: _____

Name of Person completing this form: _____ Date: _____

For more information, please visit: www.mic3.net



MEDICAL INFORMATION RELEASE FORM

(Please fill out a separate form for each child)



There are medical considerations that staff members need to be made aware of in order to assure every child's safety, well being and continued academic success (i.e., physical restrictions, vision or hearing problems, allergies, etc.).

Please check one of the following statements:

_____ I do give permission for medical information pertaining to _____ to be shared with school personnel as necessary. (child's name)

_____ I do not give permission for medical information pertaining to _____ to be shared with school personnel. (child's name)

COMMENTS:

Signature of parent/guardian _____

Date _____

**CARVER PUBLIC SCHOOLS
HOME LANGUAGE SURVEY**

DATE: _____

STUDENT NAME: _____ **AGE:** _____ **BIRTHDATE:** _____ **GRADE:** _____

Dear Parents and Guardians:

In order to help your child succeed in school, we ask that you please answer the following questions for each child in your family. Your answers will help us in creating the best possible educational program for your child.

1. What language did your child first understand or speak? _____

2. What language do you use most often when speaking with your child at home? _____

3. What language does your child use most often when speaking with you at home? _____

4. What language does your child use most often when speaking with other family members? _____

5. What language does your child use most often when speaking with friends? _____

6. What language(s) does your child read? _____

7. What language(s) does your child write? _____

8. At what age did your child start attending school? _____

9. Has your child attended school every year since that age? Yes No

If no, please explain: _____

10. Would you prefer oral and written communication from the school in: English Native Language

Signature of Parent/Guardian

Relationship of person completing survey: Mother Father Guardian Other _____

Number of years student in USA: _____

To be completed by ELL Program staff before placement:

Recommendation:

- Proficiency Testing/Records Review
- No ELL Services

Signature of ELL Staff

cc: Principal
ELL Services Coordinator
Guidance Counselor

CARVER PUBLIC SCHOOLS – TRANSPORTATION DEPARTMENT

RETURN TO CHILD'S HOMEROOM TEACHER BY June 1, 2018

or mail to 3 Carver Square Blvd., Carver, MA 02330

TRANSPORTATION BUS REQUEST FORM – 2018/2019

*****PLEASE FILL OUT ONLY IF DIFFERENT FROM PAST YEAR****

___ YES, I am requesting a ride to & from school for a student(s) in Grades **K-12**

Print student name (s) please print clearly

Grade Level for 2018/2019

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Pick up/Drop off address if different than home address.

Please remember students can only be assigned *ONE* bus in the AM & *ONE* in the PM

AM: _____

PM: _____

___ NO, I am NOT requesting a ride to & from school for a student(s) in Grades **K-12**

Print student name (s) please print clearly

Grade Level for 2018/2019

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Parent/Guardian Name _____ Date _____
Please print clearly

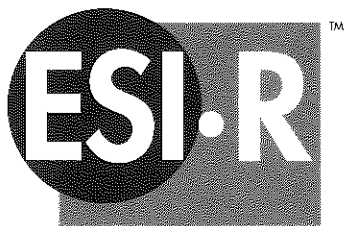
Home Address _____

Telephone Number: _____

This form may be downloaded from www.carver.org under Transportation Forms.

Office use only:

Date received _____ # of student's _____ BUS ROUTE NUMBER _____



Early Screening Inventory-RevisedTM Meisels et al.

Parent Questionnaire

Date _____

CHILD INFORMATION

NAME _____ Male Female

HOME ADDRESS Street _____ Apt _____

City _____ State _____ Zip _____

Phone (_____) _____ Date of Birth _____

Who is completing this Parent Questionnaire? Mother Father Other Relative (specify) _____
 Guardian Caregiver Other (specify) _____

FAMILY

Mother

NAME _____

HOME ADDRESS Street _____ Apt _____

same as child's City _____ State _____ Zip _____

Phone (_____) _____ Date of Birth _____

EDUCATION Highest Grade Completed _____

OCCUPATION (be specific) _____

Father

NAME _____

HOME ADDRESS Street _____ Apt _____

same as child's City _____ State _____ Zip _____

Phone (_____) _____ Date of Birth _____

EDUCATION Highest Grade Completed _____

OCCUPATION (be specific) _____

Other Family Information

With whom has the child lived for most of the past year? Mother Father Both Guardian
 Other (specify) _____

Other children in the family -How many older? _____ How many younger? _____

Other people living in the household _____

What language(s) are spoken at home? English Other (specify) _____

PRESCHOOL/CHILD CARE HISTORY

Has your child attended preschool/child care before? Yes No

If yes, for how long? 6 months 1 year 2 years more than 2 years

Name of child's present or most recent school _____

MEDICAL HISTORY**Birth**

Were there any significant problems during pregnancy? Yes No

If yes, please explain:

Was your child more than 3 weeks premature? Yes No

If yes, how many weeks premature? _____

Baby's birth weight _____

Did the baby stay in the hospital longer than the mother? Yes No

If yes, please explain:

At the time of birth, did the baby — have seizures? Yes No

turn blue? Yes No

Child's Health Since Birth**EYES**

Has your child ever had trouble seeing? Yes No

Does your child hold books and objects close to his or her face? Yes No

Have your child's eyes ever looked crossed? Yes No

Have you ever suspected that your child has vision problems? Yes No

If yes, please explain:

EARS

Has your child had frequent ear infections? Yes No

Has your child ever had trouble hearing? Yes No

Have you ever suspected that your child has hearing problems? Yes No

If yes, please explain:

COORDINATION

Has your child ever had trouble walking, climbing, reaching, Yes No

holding on to things?

If yes, please explain:

MEDICAL HISTORY continued

**Child's Health
Since Birth** continued

Has your child ever had any significant injuries or hospitalizations? Yes No

If yes, please explain:

Does your child have allergies? Yes No

If yes, please describe:

Is your child presently on any medications? Yes No

If yes, please describe:

Please describe any other health concerns:

CHILD'S DEVELOPMENT

Can your child — feed him or herself using a spoon and/or a fork? Yes No

wash and dry his or her own hands? Yes No

help with dressing or dress with little assistance? Yes No

stay with a babysitter? Yes No

speak so that he or she can be understood by others? Yes No

express his or her thoughts and needs easily? Yes No

Do you have any concerns about your child's appetite or willingness to try different foods? Yes No

If yes, please explain:

Do you have any concerns about your child's sleeping patterns (going to bed with difficulty or waking often during the night)? Yes No

If yes, please explain:

Is your child — highly active? Yes No

very quiet? Yes No

Is your child — toilet trained during the day? Yes No

in need of help with toileting? Yes No

Does your child — play with blocks, boxes, cups, or other construction toys without help? Yes No

use crayons and/or markers to scribble or draw? Yes No

listen to stories being read? Yes No

turn pages of a book and look at pictures? Yes No

recall stories or events? Yes No

enjoy playing alone or with imaginary friends? Yes No

talk with your friends/relatives who come to visit? Yes No

follow simple, age-appropriate directions? Yes No

What are your child's favorite activities?

Does your child have opportunities to play with other children? Yes No

How many hours a day does your child spend watching TV? _____

Does he or she sit very close to the TV? Yes No

Does he or she turn up the volume very high? Yes No

Are there other things you would like to tell us about your child?

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Carver Elementary School

*85 Main Street, Carver, MA 02330
(508) 866-6210/6220*

Dear Parent/Guardian:

During the Kindergarten Registration/Screening, I will be conducting a vision and hearing screening on each child. I have enclosed a sheet with the letters of the alphabet that I would like you to review with your child before your appointment.

If you have any questions, please call me at (508) 866-6215. Thank you for your cooperation.

Sincerely,

Vira Berkobein
School Nurse

O H E
V T

These are the letters that your child will need to recognize for the vision screening. Please review these letters with your child prior to your scheduled appointment.

**HEALTH QUESTIONNAIRE
CARVER PUBLIC SCHOOLS**

In order to complete our records, we would appreciate the following information:

Name of child _____ M ___ F ___
Town and State of Birth _____ Date of Birth _____
Present Address _____ Phone Number _____
Child resides with _____
Parent 1/Guardian _____ Parent 2/Guardian _____
Parents' Marital Status:
____ Married ____ Widow(er) ____ Divorced ____ Separated ____ Single
Primary Home Language _____
Child's Doctor _____ Dentist _____

In emergency, please notify (Name, address & phone number) _____

MEDICAL HISTORY

Premature Birth? Yes ___ No ___ Tonsillectomy? Yes ___ No ___
Any History of a Heart Murmur? _____ If so, are activities restricted? _____
Does child wear glasses? Yes ___ No ___
Eye Doctor's Name _____ Date of last visit _____
Does child have any visual problems? Yes ___ No ___
Nature of problem _____
Does child have any ear trouble? Yes ___ No ___
Hearing Problems? Yes ___ No ___
Has child had any operations? Yes ___ No ___ Doctor/Year _____
Nature of operation _____
Serious illness or hospitalization? Yes ___ No ___
If yes, please explain _____
Allergic to any foods, insect bites or other substances? Yes ___ No ___
If allergic reactions, is medication required? Yes ___ No ___
Is Epi-Pen required? Yes ___ No ___
Is child taking medication at the present time? Yes ___ No ___
If yes, what? _____

Has child had any of the following? Give dates, if known.

Chicken pox _____	Pneumonia _____	Scarlet Fever _____
Convulsions _____	Hepatitis _____	Diabetes _____
Asthma _____	Whooping Cough _____	Kidney Disease _____
Epilepsy _____	Rheumatic Fever _____	Fractures _____
Strep throat _____	Mononucleosis _____	

Where did child last attend school? _____

Is child capable of carrying a full program of school work, including gymnastics and athletics?

Yes _____ No _____

Names of other children in the family

Date of Birth

When did the child last see the doctor? _____

Reason (illness, routine check-up, etc.) _____

Parent/Guardian Signature _____ Date _____