AMESBURY PUBLIC SCHOOLS
Where children come first!

Jordan Shay Lower Elementary School
P: 978-388-3659 / F: 978-388-4479

Amesbury Middle School
P: 978-388-0515 / F: 978-388-1626

Cashman Elementary School
P: 978-388-4407 / F: 978-388-4479

Amesbury Innovation High School
P: 978-388-8037 / F: 978-388-8073

Amesbury High School
P: 978-388-4800 / F: 978-388-3393

Parent/Guardian Checklist for Registering a new Student

****Please return all paperwork to the Central Registrar:
Julie Hartshorn/Julie.Hartshorn@amesburyma.org
Amesbury High School / 5 Highland St.****

Student Name: _____

Date of Birth: _____ **Grade:** _____ **School Year:** _____

❒ Completed Registration Packet

❒ Proof of Parent/Guardian identity - Valid Driver's License/Real ID/Photo ID Card/Passport
Proof of custody may be necessary - Legal guardianship requires additional documentation from a court or agency

❒ Original Birth Certificate - the original certificate will NOT be retained by the district

❒ Medical Records - including proof of up to date immunizations and a recent physical examination

❒ Proof of Residency (see below for accepted documents which must be pre-printed with the parent/guardian's name and address)

You must provide **ONE** of the following to prove residency:	You must **ALSO** provide **TWO** of the following to prove occupancy:
❒ Property Deed or Current Mortgage Payment or Property Tax Bill ❒ Fully signed and executed Purchase and Sale Agreement (occupancy date must fall within 30 days of enrollment) ❒ Notarized letter from builder or realtor ❒ Fully signed and executed Lease/Rental Agreement	❒ Landline telephone bill dated within last 60 days ❒ Gas/Oil bill dated within last 60 days ❒ Electric bill dated within last 60 days ❒ Cable/Internet bill dated within last 60 days ❒ Water bill ❒ Bank statement dated within the last 60 days ❒ Voter Registration Record from Town Hall ❒ Payroll stub dated within last 30 days

Student Data

Student's Legal First Name:_____

Preferred First Name:_____

Legal Middle Name:_____

Legal Last Name:_____

Street Address:_____

City:_____ State:_____

School Last Attended: _____ City/State:_____

Date of Birth:_____

Grade:_____

Gender:_____

Preferred Pronouns:_____

City/State/Country of **Birth**:

_____

Who has legal custody of this student? ❒Both Parents ❒Mother ❒Father ❒ Guardian ❒Other(please explain):

Who does the student live with? ❒ Both Parents ❒ Mother ❒ Father ❒ Legal Guardian

Siblings Name(s)/D.O.B:

Special Services:

Is the student currently accessing the curriculum with the assistance of any of the following?

❒ Individualized Education Plan (IEP) ❒ 504 Plan ❒ English Language Services ❒ Title 1 ❒ Other _____ ❒None

Ethnicity & Race:

Ethnic Background: ❒ No, not Hispanic or Latino ❒ Yes, Hispanic or Latino: a person of Cuban, Mexican, Chicano, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race

Race (you may select one or more races):

❒ White: a person having origins in any of the original peoples of Europe, the Middle East, or North Africa

❒ Black or African American: a person having origins in any of the black racial groups of Africa

❒ American Indian or Alaska Native: a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment

❒ Asian: a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, Chna, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam

❒ Native Hawaiian or other Pacific Islanders: a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

Parent/Guardian Information:

Parent/Guardian #1:

Name:_____

Address:_____

Relationship:_____

Primary Phone:_____

Email:_____

Parent/Guardian #2:

Name:_____

Address:_____

Relationship:_____

Primary Phone:_____

Email:_____

The answers you provide to the following questions help us to determine if you or your family may be eligible for supplemental services and/or immediate enrollment

Where is the student currently living?: (Please check **ONE**)

❒ In permanent housing ❒ In a shelter ❒ With another family or person (sometimes referred to as "doubled-up") ❒ In a hotel/motel ❒ In a car, park, bus, train, or campsite ❒ Other temporary living situation (please describe):_____

Military Family Status - Students who are children of:

❒ Active duty members of the uniformed services, National Guard and Reserve on active duty orders

❒ Members or veterans who are medically discharged or retired within one year

❒ Members who die on active duty

In the past 3 years, have you or someone you lived with:

A. **Moved from one city or country to another city?**
   ❒ Yes ❒ No

B. **Worked or looked for work in any of the following areas? Please check if yes:**

❒Fish/Shellfish Processing ❒ Farm Work (including tobacco)

❒Vegetable/Fruit/Meat Processing ❒Dairy Industry ❒Plant Nursery

Parent/Guardian Signature:_____ Date:_____

Emergency Contact Information

Student Name:_____
(First) (Middle) (Last)

Date of Birth:_____

Who has legal custody of this student? ❒Both Parents ❒Mother ❒Father ❒Other (please explain):_____

CONTACT 1:	**CONTACT 2:**
Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City/Town:_____ Zip_____	City/Town:_____ Zip_____
Home Phone:_____ Work:_____	Home Phone:_____ Work:_____
Cell:_____	Cell:_____
Primary Email:_____	Primary Email:_____
Does this contact live with the student? ❒Yes ❒No	Does this contact live with the student? ❒Yes ❒No
This contact may pick up the student ❒Yes ❒No	This contact may pick up the student ❒Yes ❒No

In the event contacts #1 and #2 cannot be reached please list an additional 2 contacts below:

CONTACT 3:	**CONTACT 4:**
Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City/Town:_____ Zip_____	City/Town:_____ Zip_____
Home Phone:_____ Work:_____	Home Phone:_____ Work:_____
Cell:_____	Cell:_____
Does this contact live with the student? ❒Yes ❒No	Does this contact live with the student? ❒Yes ❒No
This contact may pick up the student ❒Yes ❒No	This contact may pick up the student ❒Yes ❒No

Parent/Guardian Signature:_____ Date:_____

Home Language Survey

Massachusetts Department of Elementary and Secondary Education regulations require that *all* schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. If a language other than English is spoken in the home, the District is required to do further assessment of your child. Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

Student Information

First Name	Middle Name	Last Name
Country of Birth	**Date of Birth**	**Date first enrolled in ANY US school**
	(mm/dd/yyyy)	(mm/dd/yyyy)

School Information

Start Date in New School	Name of Former School and Town	Current Grade
(mm/dd/yyyy)		

Questions for Parents/Guardians

What is the primary language used in the home, regardless of the language spoken by the student?	Which language(s) are spoken with your child? (include relatives and caregivers - grandparents, uncles, aunts, etc.) seldom / sometimes / often / always seldom / sometimes / often / always
What language did your child first understand and speak?	Which language do you use most with your child?
How many years has the student been in U.S. Schools? (not including pre-kindergarten)	Which language(s) does your child use? seldom / sometimes / often / always
Will you require written information from school in your native language? If yes, what language?	Will you require an interpreter/translator at Parent-Teacher meetings? If yes, what language?

Parent/Guardian Signature _____ **Today's Date** _____

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Request for Student Records

Student Name: _____ **Date of Birth:** _____

Requesting Records From: _____
(School Name) **(School District)**

The above student has enrolled in the Amesbury Public School district. Please send the following educational records:

❒Cumulative Records
❒Attendance records
❒Disciplinary records
❒Health records
❒Special Education Records including IEP, Evaluation Reports, and Progress Reports (if applicable)
❒504 Plan (if applicable)

For High School Students please also include the following additional records:

❒High School Transcript including a list of all subjects, final grades, and credits (please include any unfinished quarter/semester grades)
❒ MCAS Results
❒ School Profile

Authorization to Release Student's Records

I have enrolled my child, _____, in the Amesbury Public School district and authorize you to release all school and health records to them.

_____ _____
Signature of Parent/Guardian **Date**

_____ **Relationship to child** _____
Parent/Guardian Name (please print)

Email Records to the Central Registrar:	**Fax Records to:**	**Mail Records to:**
Julie.Hartshorn@amesburyma.org	(978)388-7224	Amesbury Public Schools / Student Services 5 Highland Street / Amesbury, MA 01913

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Information about the use of your child's photograph

We are very proud of the accomplishments that our students make and we enjoy sharing that news with the community. There may be times throughout the school year when photos are taken and shared online, with the newspaper or published on our website.

__ONLY__ fill out this form if you __DO NOT__ want your child's photo to be used online or shared with the newspaper

---

I __DO NOT__ want my child's name/photo to be published in the paper or online. I understand that the only exception will be for the yearbook.

Child's Name:_____ Grade:_____ DOB:_____

Parent/Guardian's Name (please print):_____

Parent/Guardian's Signature:_____ Date:_____

For office use only: Teacher: _____

Amesbury Public Schools - Student Health Information

DIRECTIONS: Parent/Guardian, please complete all areas (print), check appropriate boxes, sign, and date

Student's Legal Name: Last:	First:	Middle: Grade:
Student's Address:	City:	State:
Does Student live with parent? ❒Yes ❒No If no, provide name/relationship of guardian:_____	Student's Home Phone:	Date of Birth:
Is child covered by: ❒ Private health insurance ❒ Medicaid ❒None **(please contact school nurse for information about state sponsored health plans for uninsured children)**	Sex: ❒ Male ❒Female	Siblings name(s) & grade(s) attending APS:

Contact & Emergency Information

	Home Phone	Work Phone	Cell Phone	Authorized Pickup	Legal Custody
Parent/Guardian #1 Name: Email:				❒Yes ❒No	❒Yes ❒No
Parent/Guardian #2 Name: Email:				❒Yes ❒No	❒Yes ❒No
Emergency Contact Name: (If Parent/Guardian cannot be reached)				❒Yes ❒No	❒Yes ❒No

Medication Permissions

Over the Counter Medications

The following **over the counter medications** have been approved for use by our school physician: Tylenol, Ibuprofen, Cetirizine/Loratadine, Bacitracin Ointment, Caladryl Lotion, Topical Lidocaine, Antacid Tablets, Contact Solution, and Benadryl.

I give the school nurse permission to administer the above medications after assessment ❒Yes ❒No

KI (Potassium Iodide)

In the event of a **nuclear emergency**, my child may receive Potassium Iodide **(see reverse for more information)**

❒Yes ❒No

Medical Information

Medications needed during the school day must have a written physician's order, written parent/guardian permission and must be supplied in the original pharmacy container.

List any medications taken on a regular basis:

_____

_____

_____

_____

Physician diagnosed allergies:

Foods:_____

Medicines:_____

Bee/Insect:_____

Describe reaction:_____

Does child require life saving medications? ❒Yes ❒No

If so, which medication(s)?_____

*** If prescribed please provide school nurse with an EpiPen***

Check all that apply:
❒Asthma ❒Diabetes ❒ Seizures ❒ Physical Disability:_____

Hearing Problems: ❒None ❒Left Ear ❒Right Ear ❒Hearing Aid

Vision Problems: ❒None ❒ Wears Glasses ❒Wears Contacts

Last Physical Exam?_____(please provide copy)

Student's Physician:_____

Does your child: ❒drink city water ❒ receive fluoride

Student's Dentist:_____Last Exam:_____

Military Service

Is anyone in the student's immediate family actively involved in military service? ❒Yes Relation:_____ ❒No

Consent

I give the school nurse permission to share information relevant to my child's health condition with appropriate school personnel if needed for my child's health, safety, and educational needs. In the event my child requires emergency medical treatment, I give permission to exchange information with emergency medical personnel and the receiving hospital, including person to contact information and my child's physician for the purpose of referral, diagnosis and treatment.

Parent/Guardian Name (print):_____Parent/Guardian Signature:_____Date:_____

Potassium Iodide (KI) Information

The Amesbury School District, in cooperation with the Massachusetts Department of Public Health (MA/DPH) has decided, with parent permission, to make Potassium Iodide (KI) available to students and staff prior to evacuation to our designated host facility which is Methuen High School. The school committee has given approval for this distribution. Participation of students in the distribution is VOLUNTARY. Student participation will require parental/guardian signature on the consent form following this notice.

This consent is reviewed annually. If you have any questions, please contact this office, the school nurse in your building and/or call the MA/DPH at (617)242-3035. We strongly urge you to read all emergency public information found at www.mass.gov (search for Potassium Iodide) or call the Massachusetts Emergency Management Association (MEMA) at (800)982-6846.

Reason for taking Potassium Iodide: In case of an accident at a nuclear power plant or what is known as a radiological emergency, radioactive iodine will be released into the air. The material may be inhaled or ingested and enter the thyroid gland where it can cause cancer and/or disease. Children and infants are the most vulnerable to this occurrence. When taken by pill, Potassium Iodide (KI) floods the thyroid with non-radioactive iodine and prevents the thyroid from absorbing the radioactive material. KI needs to be taken before or shortly after exposure to radiation. KI works only to prevent the thyroid from absorbing radioactive iodine.	**Risk of Taking Potassium Iodide:** Taking KI is safe for most people. KI **should not** be taken if someone: • Is allergic to Iodine • Has Graves Disease • Has Thyroid Illness • Takes Thyroid medication
Potential Side Effects of Potassium Iodide: It is possible to experience any or all of the following side effects when taking KI: • Upset stomach • Rash • Allergic Reaction	**Administration of Potassium Iodide:** **KI will only be given:** • In case of radiological emergency • If it is recommended by public health officials • If a parent/guardian signs the consent form

Student Health History Form

To Parent/Guardian,

To better serve your child and provide them with the best educational experience, we request that you complete a detailed health assessment so we can address your child's needs in the classroom. Information will only be shared with school personnel who have a legitimate educational interest in the information.

This is a general assessment so we can better understand your child. Should your child require medications, or other special health treatments or procedures, additional paperwork will need to be completed. Please complete this form and contact your school nurse as needed.

PLEASE PRINT CLEARLY

Born: **Male** ☐ **Female** ☐

Student Name (Last, First, Middle) _____ **Birth Date** (Month/Day/Year) _____

School (Circle One):

SES | CES | AMS | AHS | AIHS

Grade _____

Primary Care Provider Name _____ **Clinic Name** _____ **MD Phone #** _____

Does your child have health insurance?	Yes	No	If you answered "No" to either of these questions, please contact the nurse for further assistance.
Does your child have dental insurance?	Yes	No	

Please answer these health history questions about your child to the best of your ability.

Seasonal allergies	Yes	No	Immunity Problems	Yes	No	Is your child toilet trained?	Yes	No
Allergies to food	Yes	No	"Mono" (past 1 year)	Yes	No	Has only 1 kidney or testicle	Yes	No
Allergies to medication(s)	Yes	No	Chest pain	Yes	No	Sickle Cell Disease	Yes	No
Allergy to bee / insect stings	Yes	No	Heart (Cardiac) history/problems	Yes	No	Any problems with vision	Yes	No
Anaphylaxis	Yes	No	High / Low blood pressure	Yes	No	Limited physical activity	Yes	No
Any other allergies	Yes	No	Fainting or blacking out	Yes	No	Problems running	Yes	No
Concussion(s) / Head injury	Yes	No	Bleeding more than expected	Yes	No	Uses contacts or glasses	Yes	No
Headaches	Yes	No	Asthma treatment (past 3 years)	Yes	No	Any problems hearing	Yes	No
Migraines	Yes	No	Any smoking	Yes	No	Any problems with speech	Yes	No
Traumatic brain injury	Yes	No	Problems breathing or coughing	Yes	No	Birth Defects	Yes	No
Seizure treatment (past 2 years)	Yes	No	Dental braces, caps, or bridges	Yes	No	Concerns with sleeping habits	Yes	No
Musculoskeletal problems (including cerebral palsy)	Yes	No	Does your child require a special diet?	Yes	No	Mental health/behavioral concerns (i.e., depression)	Yes	No
Any broken bones or dislocations	Yes	No	Bowel problems	Yes	No	ADHD / ADD	Yes	No
Any muscle or joint injuries	Yes	No	Stomach problems	Yes	No	Lead Poisoning	Yes	No
Any neck or back injuries	Yes	No	Excessive weight gain/loss	Yes	No	Surgeries	Yes	No
Any daily medications	Yes	No	Bladder problems	Yes	No	Any other health concerns	Yes	No
Diabetes	Yes	No	Any hospitalizations, or had any operations, procedures, or special tests?				Yes	No

If you **answered "Yes"** to any of the above questions, please further explain your answers here: _____

_____

_____

All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.

Does your child take ANY medications? Please list name(s) of medication(s): _____

Please list any **medications** your child will need to take **during** school hours: _____

_____

Will your child require any emergency medication (e.g. epinephrine auto-injectors, inhalers, glucagon, diastat, etc.) to be administered in school? _____

Does your child require any special health treatments or procedures (e.g. tube feeding or catheterization)? Yes No

If "Yes," please contact the school nurse for a meeting (contact info below).

Would you like to request a meeting with your school nurse to discuss your child's needs? Yes No

By signing below I agree that the above information in regards to my child have been answered to the best of my ability.
Should there be any changes to my child's health status, I acknowledge that it is my responsibility to notify the nurse as soon as possible.

Print: _____ Sign: _____ Date: _____

Name of Parent/Guardian | Signature of Parent/Guardian | Today's Date

PERMISSION TO EXCHANGE INFORMATION

I, _____, authorize and request my child's primary care provider to exchange
Name of Parent/Guardian

information about my child's health and development with Amesbury Public Schools. The information may be provided by phone, fax, mail, or in person. I understand that the disclosed information will be considered confidential and will be used for the health and educational benefit of my child and family. Except as needed to comply with federal and state regulations, it will not be re-disclosed to any other person, school, or agency without my consent. I understand that this form will expire in one year unless I choose to cancel my permission in writing before that time.

Name of School requesting information		Signature of Parent/Guardian	Date / /
School Mailing Address	, Amesbury, MA 01913	Signature of Witness	Date / /
School Telephone Number	School Fax Number	Signature of School Nurse	Date

School Mailing Addresses / School Nurse Contact info:

Jordan Shay Memorial Lower Elementary School (SMS): 193R Lions Mouth Rd; **School Phone:** 978-388-3659 **Fax:** 978-388-4479
School Nurse: Nicole Quadros, BSN, RN **Email:** Nicole.Quadros@amesburyma.org

Cashman Elementary School (CES): 193 Lions Mouth Rd; **School Phone:** 978-388-4407 **Fax:** 978-388-4479
School Nurse: Kieran Ford, RN **Email:** kieran.ford@amesburyma.org

Amesbury Middle School (AMS): 220 Main St; **School Phone:** 978-388-0515 **Fax:** 978-388-1626
School Nurse: Jody Omohundro, BSN, RN, NCSN **Email:** Jody.Omohundro@amesburyma.org

Amesbury High School (AHS): 5 Highland St; **School Phone:** 978-388-4800 **Fax:** 978-388-4919
School Nurse: Michelle Parsons, BSN, RN **Email:** Michelle.Parsons@amesburyma.org

Amesbury Innovation High School (AIHS): 71 Friend St **School Phone:** 978-388-8037 **Fax:** 978-388-8073
School Lead Nurse: Kristin Tierney, FNP-C, NCSN **Email:** Kristin.Tierney@amesburyma.org

Do NOT fill out the following 2 pages UNLESS you CANNOT provide the 3 documents to prove residency/occupancy

AMESBURY PUBLIC SCHOOLS

ELIZABETH MCANDREWS
SUPERINTENDENT OF SCHOOLS

LYNN CATARIUS
DIRECTOR OF STUDENT SERVICES

JOAN LIPORTO
DIRECTOR OF FINANCE AND OPERATIONS

LYN JACQUES
DIRECTOR OF TEACHING & Learning

5 Highland Street
Amesbury, MA 01913
Tel : 978-388-0507
Fax : 978-388-7224

PROOF OF RESIDENCY
Property Owner Information

Three forms of identification are required from the parent/guardian to verify residency. **These two pages need to be completed and notarized ONLY IF the parent can't produce the three required forms.**

Today's Date:	**Student's Full Name:**	**Parent(s)/Guardian(s) Name(s):**
Current Address:	**Current Telephone Number:**	**Date Student will Enter School:**
Property Owner:	**Address of Property Owner:**	**Telephone Number of Property Owner:**

The undersigned do hereby certify that_____is living in Amesbury, Massachusetts and that all records relating to the enrollment of _____ into Amesbury Public Schools are true. Any falsification of this information will subject me, as parent or guardian, to full tuition payment for the number of days he/she was not a legal resident of the City of Amesbury as well as the removal of the student from Amesbury Public Schools.

_____ _____

Parent Signature **Property Owner's Signature**

The following documentation must be provided along with this form:

- ❒ Copy of property owner's current real estate tax bill
- ❒ Copy of current utility bill with either the lessor or lessee's name (due within 30 days of actual residence)
- ❒ Proof of identification of property owner: Driver's License/Passport, etc.

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5 Highland Street
Amesbury, MA 01913
Tel : 978-388-0507
Fax : 978-388-7224

PROOF OF RESIDENCY
Affidavit of Residency

I Certify that:

Name of Parent(s)/Legal Guardian(s):_____

Name(s) of Child(ren):_____

Reside at:_____

In the Amesbury Public School District, as of_____
(Date)

Property Owner or Lessor Signature:_____

(Relationship to Parent(s)/Guardian(s)):_____

***Parent/Guardian Signature:**_____

_____

Commonwealth of Massachusetts / County of Essex

Subscribed and sworn to me, a Notary Public, in and for said County and State,

this_____**day of**_____**, 20**_____**.**

Notary Public
Signature:_____

Printed Name of Notary:_____

My Commission expires:_____

***My signature confirms that the information above and supporting documentation I have provided the School District to prove residency are true. I understand that fraudulent claims constitute perjury, punishable by law, and can also result in the expulsion of the student from school and immediate demand for tuition by the School district.**