



DARTMOUTH PUBLIC SCHOOLS

8 Bush Street, Dartmouth, MA 02748

Phone: 508-997-3391 Fax: 508-991-4184 Website: dartmouthps.schoolfusion.us

New Student Registration Form

PLEASE PRINT: AS IT APPEARS ON BIRTH CERTIFICATE

STUDENT NAME: <i>Legal Last Name</i>		<i>Legal First Name</i>	School _____	Grade: _____
		<i>Legal Middle Name</i> <input type="checkbox"/> Check if none		
BIRTHDATE (Month/Day/Year)	GENDER	BIRTHPLACE: <i>City</i>	<i>State</i>	<i>Country</i>
		In USA less than 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> Country?		

PRIMARY CONTACTS	STUDENT LIVES WITH	(Parent/Guardian where student resides)		PHONE	Home - _____			
	<input type="checkbox"/> Both parents <input type="checkbox"/> Mother only <input type="checkbox"/> Father only <input type="checkbox"/> Grandparents <input type="checkbox"/> Mother/Stepmother <input type="checkbox"/> Father/Stepfather <input type="checkbox"/> Guardian <input type="checkbox"/> Foster parent <input type="checkbox"/> Agency <input type="checkbox"/> Self <input type="checkbox"/> Ward of state <input type="checkbox"/> Other _____	<i>LAST NAME:</i>			PHONE	Work - _____		
		<i>FIRST NAME:</i>				Cell - _____		
		(Parent/Guardian where student resides)		<i>LAST NAME:</i>		PHONE	Home - _____	
		<i>FIRST NAME:</i>		Work - _____				
ADDRESS		<i>Apt #</i>	<i>City</i>	<i>State</i>	<i>Zip</i>			
MAILING ADDRESS (if different from above)		<i>Apt #</i>	<i>P.O. Box</i>	<i>City</i>	<i>State</i>	<i>Zip</i>		

e-MAIL ADDRESS(ES) – If you would like to make your e-mail address(es) available to teachers and administrators please write it (them) here:

SECONDARY HOUSEHOLD	RELATIONSHIP	<i>LAST NAME:</i>		PHONE	Home - _____		
	<input type="checkbox"/> Both parents <input type="checkbox"/> Mother only <input type="checkbox"/> Father only <input type="checkbox"/> Grandparents <input type="checkbox"/> Mother/Stepfather <input type="checkbox"/> Father/Stepmother <input type="checkbox"/> Guardian <input type="checkbox"/> Foster parent <input type="checkbox"/> Agency <input type="checkbox"/> Ward of state <input type="checkbox"/> Other _____	<i>FIRST NAME:</i>			PHONE	Work - _____	
		MAILING ADDRESS				<i>Apt #/P.O. Box</i>	<i>City</i>
		ADDITIONAL MAILINGS REQUESTED		<input type="checkbox"/> Yes <input type="checkbox"/> No		Cell - _____	

IS THERE A JOINT-CUSTODY OR PARENTING DOCUMENT IN EFFECT? Yes No (If yes, document must be on file with the school for enforcement)

Who has legal custody of this child? (*Last, First, Middle Initial*) _____ Relationship to Child _____

IS THERE A RESTRAINING ORDER IN EFFECT? Yes No (If yes, document must be on file with the school for enforcement)

Restraining order is against: Mother Father Other _____

SCHOOL PREVIOUSLY ATTENDED	SCHOOL DISTRICT PREVIOUSLY ATTENDED	PREVIOUS SCHOOL LOCATION (City and State)
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HAS THIS STUDENT EVER ATTENDED DARTMOUTH PUBLIC SCHOOLS? Yes No IF YES, NAME OF SCHOOL ATTENDED: _____

IS EITHER PARENT/GUARDIAN ON MILITARY ACTIVE DUTY?? Yes No Date: _____

HAS THIS STUDENT EVER BEEN SUSPENDED OR EXPELLED FOR A WEAPONS VIOLATION? Yes No Date: _____

HAS THIS STUDENT EVER BEEN CHARGED OR CONVICTED OF A FELONY UNDER MASS. GEN. LAWS CHAPTER 71, SECTION 37h 1/2? Yes No Date: _____

IS THIS CHILD CURRENTLY ENROLLED IN A SPECIAL ED PROGRAM? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of most recent IEP _____	HAS THIS CHILD EVER BEEN RETAINED?
HAS THIS CHILD EVER PARTICIPATED IN: <input type="checkbox"/> Title I Reading <input type="checkbox"/> Title I Math <input type="checkbox"/> Counseling <input type="checkbox"/> ELL Program <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech/Language Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> 504 Plan (Date of most recent plan _____) <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, at what grade level(s) _____
PLEASE PROVIDE A COPY OF YOUR CHILDS MOST RECENT IEP/504 PLAN. <input type="checkbox"/> Received	

The Dartmouth Public Schools is an affirmative action employer, ensuring that its programs and facilities are accessible to the public. We do not discriminate on the basis of race, creed, color, age, sex, gender identity, national origin, disability or sexual orientation.

PLEASE LIST OTHER SCHOOL AGED CHILDREN RESIDING AT THE ABOVE ADDRESS		Date of Birth	School	Current Grade
Last Name	First Name			

SPECIAL INSTRUCTIONS REGARDING RELIGIOUS BELIEFS (Please provide information to the school in writing)

ETHNICITY <input type="checkbox"/> Check if Hispanic/Latino	RACE (Check all that apply) <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Island	PRIMARY LANGUAGE SPOKEN AT HOME <input type="checkbox"/> English <input type="checkbox"/> Portuguese <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	U.S. CITIZEN <input type="checkbox"/> Yes <input type="checkbox"/> No
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ADDITIONAL CONTACTS: When injury, illness or other non-emergency situations occur involving your child, we want to be able to quickly reach families or other responsible adults. In the event that we cannot reach a parent/guardian, please list a person(s) you trust who are available during the day to provide care for your child.

ADDITIONAL CONTACTS	1st Contact (Other than parent/guardian)	FIRST NAME:	RELATIONSHIP TO CHILD <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor <input type="checkbox"/> Other _____	PHONE	Home -
		LAST NAME:			Work -
		ADDRESS: Street City State Zip			Cell -
	2nd Contact (Other than parent/guardian)	FIRST NAME:	RELATIONSHIP TO CHILD <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor <input type="checkbox"/> Other _____	PHONE	Home -
		LAST NAME:			Work -
		ADDRESS: Street City State Zip			Cell -
	3rd Contact (Other than parent/guardian)	FIRST NAME:	RELATIONSHIP TO CHILD <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor <input type="checkbox"/> Other _____	PHONE	Home -
LAST NAME:		Work -			
ADDRESS: Street City State Zip		Cell -			

STUDENT RELEASE AUTHORIZATION: In the event that the school is unable to contact the parent/guardian, I authorize that my child may be released to the person(s) listed above.

Legal Parent/Guardian Signature _____ Date _____

VERIFICATION OF INFORMATION: I understand that pursuant to Massachusetts General Law Chapter 76 Section 1 and Dartmouth School Committee Policy, students who actually reside in the Town of Dartmouth may attend Dartmouth Schools. I understand that this certification will be relied upon by the Dartmouth Public Schools for the purpose of determining the eligibility to attend Dartmouth Public Schools on the basis of residency. Under the penalties of perjury, I verify that the information on this form is true and accurate as of this date. I understand that I can and will upon request, substantiate all statements made on this application and that such statements are true, accurate, and complete and are made in good faith. I further understand that falsification of information to achieve enrollment or assignment may be cause for revocation of the student's enrollment or assignment to a school in the Dartmouth Public Schools.

Legal Parent/Guardian Signature _____ Date _____

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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.

School _____

Student Information	
First Name _____	Middle Name _____
Last Name _____	
Gender F <input type="checkbox"/> M <input type="checkbox"/>	
Country of Birth _____	Date of Birth (mm/dd/yyyy) _____
Date first enrolled in ANY U.S. school (mm/dd/yyyy) _____	
School Information	
Start Date in New School (mm/dd/yyyy) _____ / _____ /20_____	Name of Former School and Town _____
Current Grade _____	
Questions for Parents/Guardians	
What is the native language(s) of each parent/guardian? (circle one) _____ (mother / father / guardian) _____ (mother / father / guardian)	Which language(s) are spoken with your child? (include relatives - <i>grandparents, uncles, aunts, etc.</i> - and caregivers) _____ 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?
Which other languages does your child know? (circle all that apply) _____ speak / read / write _____ speak / read / write	Which languages does your child use? (circle one) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always
Will you require written information from school in a language other than English? Y <input type="checkbox"/> N <input type="checkbox"/>	Will you require an interpreter/translator when you are at the school? Y <input type="checkbox"/> N <input type="checkbox"/>
Parent/Guardian Signature: X _____	Date: _____

To Be Completed by ELE Staff:

_____ Proficiency Testing/Records Review
_____ Intake Test Score
_____ Level

Need ELE Services: ___ Yes ___ No

ELE Staff Initials: _____ Date _____



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SCHOOL BUS INFORMATION

Dear Parent(s)/Guardian(s):

Please fill out the following to provide us with information to help us formulate our bus lists for the school year.

If this information should change at any time, it is most important that you notify the secretary of your child's school as soon as possible.

We will only bus to one location.

Date: _____

Please circle your school: Cushman DeMello Potter Quinn DMS DHS

Student Name: _____

Student Address: _____

ARRIVAL:

My child will be picked up:

- Neighborhood Bus Stop Mon. _____ Tues. _____ Wed. _____ Thurs. _____ Fri. _____
- I will Drop Off Mon. _____ Tues. _____ Wed. _____ Thurs. _____ Fri. _____
- Daycare Mon. _____ Tues. _____ Wed. _____ Thurs. _____ Fri. _____

Daycare Name: _____

Daycare Address: _____

Daycare Phone Number: _____

DISMISSAL:

My child will be dropped off:

- Neighborhood Bus Stop Mon. _____ Tues. _____ Wed. _____ Thurs. _____ Fri. _____
- I will Pick Up Mon. _____ Tues. _____ Wed. _____ Thurs. _____ Fri. _____
- Daycare Mon. _____ Tues. _____ Wed. _____ Thurs. _____ Fri. _____

Daycare Name: _____

Daycare Address: _____

Daycare Phone Number: _____



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RESIDENCY AFFIDAVIT – LANDLORD/SHARED TENANCIES

Any applicant seeking to have their child(ren) attend the Dartmouth Public Schools who cannot produce a property deed or lease must have the owner or lessee of the property where the applicant lives complete and sign this legal affidavit. It is the responsibility of the applicant (not the person who completes this affidavit) to attach a record of recent rent payment, *unless this affidavit affirms in #3 below that the tenancy does not require rent payment.*

My name is _____, and I hereby depose and certify as follows:
(Please complete all three items and sign below).

1. I am the owner/property manager of the property located at _____ in Dartmouth.

2. _____, who is the parent/legal guardian of _____, leases/rents this property as their principal residence as a tenancy at-will, from month to month.

3. **CHECK ONE:**

_____ I have received within the last thirty (30) days rental payment for the lease/rent of said premises.

_____ I hereby state that the above named party resides with me at the address above with no rental payment and no utility bills.

As the owner/property manager, I understand that this affidavit will be relied upon by the Dartmouth Public Schools for the purpose of determining the above student's eligibility to attend the Dartmouth Public Schools on the basis of residency. If said student is enrolled in the Dartmouth Public Schools based upon information contained in this affidavit and it is subsequently determined that the student does not actually reside in Dartmouth, I/we understand that the student's enrollment in the Dartmouth Public Schools will be promptly terminated and I/we will be jointly liable to the Dartmouth Public Schools for the student's tuition for the duration of the student's attendance in the Dartmouth Public Schools.

Signed under the pains and penalties of perjury this _____ day of _____, 20_____.

Signature: _____

Print Name: _____

Print Address (including City, State, Zip): _____

COMMONWEALTH OF MASSACHUSETTS

BRISTOL, ss.

Date _____

On this _____ day of _____, 20____ before me, the undersigned Notary Public, personally appeared _____ (name of document signer), proved to me through satisfactory evidence of identification, which was _____, to be the person whose name is signed on the preceding or attached document, and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of his/her knowledge and belief.

Notary Public
My Commission Expires: _____

Note: The information contained in this legal affidavit is subject to verification by a residency investigator.



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It is the Dartmouth Public Schools' goal to preserve the limited classroom space for Dartmouth residents, by safeguarding the credibility of the residency requirements set forth by the Dartmouth School Committee to avoid educating students not actually residing in Dartmouth.

Before your child/ren is invited to attend the Dartmouth Public Schools, he/she must live with his/her parent(s) or legal guardian(s) in Dartmouth. Guardianship consists of a legal document from a court or other legal agencies.

- Registrations will not be accepted unless a valid Massachusetts Driver's License or a Massachusetts ID issued by the Registry of Motor Vehicles with your current address has been provided along with three (3) forms of proof of residency listed below:

One form from each column specifying the parent/guardian's residency/address must be provided

(For Column A, if the family is currently living with a family member or a friend, a Landlord Affidavit must be completed and copy of their deed or mortgage statement must be provided)

Column A	Column B	Column C
<ul style="list-style-type: none"> <input type="checkbox"/> Copy of Quitclaim Deed if you do not have a mortgage <input type="checkbox"/> Copy of mortgage statement AND recent receipt <input type="checkbox"/> Copy of Lease Agreement (including BHA & HUD leases) AND a recent rent receipt <input type="checkbox"/> Legal affidavit from landlord affirming tenancy AND recent rent receipt <input type="checkbox"/> Purchase and Sales Agreement <input type="checkbox"/> Placement Letter 	<p>A utility bill or utility new service work order dated within the past 60 days:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Gas Bill <input type="checkbox"/> Oil Bill <input type="checkbox"/> Electric Bill <input type="checkbox"/> Home Telephone Bill <input type="checkbox"/> Cable Bill <input type="checkbox"/> Water Bill <input type="checkbox"/> N/A <p><i>*Cell phone bill is NOT Acceptable</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Current Vehicle Registration/Insurance <p>Dated within the Past Year:</p> <ul style="list-style-type: none"> <input type="checkbox"/> W2 Form <input type="checkbox"/> Vehicle Excise Tax Bill <input type="checkbox"/> Property Tax Bill <p>Dated within the 60 Days:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Letter from Approved Govt. Agency <input type="checkbox"/> Payroll Stub <input type="checkbox"/> Bank or Credit Card Statement <input type="checkbox"/> N/A

Important Required Documents

- A full copy of your child/ren birth certificate(s) is required. (Not an abstract)
- Copy of most recent Physical (within 1 year)
- A copy of your child/ren immunizations.
- Custody Agreement

Important Notes

- If a Family is sharing housing with an individual or family and does NOT pay rent. Information in the name of that person/family must also be submitted.
- If necessary, in order to preserve the credibility of the residency requirements, site visits will be conducted by the Attendance Officer.
- If your residency changes within the school year, you **must** provide that information to the school in order for your child/ren's records to be properly transferred to the new school in a timely manner.
- This residency policy does NOT apply to children who qualify under the McKinney-Vento Homeless Education Assistance Act.



THIS FORM MUST BE FULLY EXECUTED PRIOR TO PARTICIPATION - In the case of a student who transfers into your school after the start of that practice season, this form can NOT render approval. You must request a waiver & include Form 200.

TRANSFER RULE ~ FORM 200

A. The Receiving School Principal completes this section and then forwards to the Sending School Principal.

1. Receiving Principal _____ School _____ Phone _____
School Fax: _____
2. Student's Name _____ Grade _____ Date of enrollment _____
Student's Address _____ Date of Birth _____
3. The student wishes to participate in the following sports:
Fall: _____ Winter: _____ Spring: _____
4. Student's reason for transfer: _____

B. The sending School Principal & Athletic Director complete this section & returns to Receiving School Principal.

1. Sending Principal _____ School _____ Phone _____
2. List ALL athletic participation since first entering grade 9 (include level of play, e.g.: F, JV, V, AAU, etc. & school)

	Grade 9 yr:	Grade 10 yr:	Grade 11 yr:	Grade 12 yr:
Fall:				
School				
Winter:				
School				
Spring:				
School				

3. The Sending School Principal and Athletic Director certify the following by initialing each (*complete section 3a-e OR check off box next to section 4*):
 - a. To our knowledge recruitment, was not involved in any way: _____
 - b. At the time of transfer, the student was in good standing: _____
 - c. The student would be academically eligible at our school: _____
 - d. We have no knowledge that the transfer was related to athletics which would cause our objection to eligibility: _____
 - e. The transfer student would be eligible at our school to participate in athletics: _____
 - f. Comments: _____
4. (*Please DO NOT check this box if you completed #3 above*). We support the MIAA Transfer Rule 57.1: A student who transfers from any school to an MIAA member high school is ineligible to participate in any interscholastic athletic contest at any level for a period of one year in all sports in which that student *participated at the varsity level or its equivalent* during the one year period immediately preceding the transfer.
5. Has this student had any Chemical Health Violations since the beginning of the Fall Practice Season?
No ___ Yes ___ If yes, please list if penalty: has been served or needs to be served (circle one)
6. Sending School A.D.'s signature: _____ Date _____
7. Sending School Principal's signature: _____ Date _____

C. APPROVED (may only be approved when B,3 a through e – ALL have been initialed)

1. The Receiving School Principal certifies (ref. B,3, a-f) Transfer Rule eligibility on: ____/____/____
2. The student also is eligible under all other MIAA and local eligibility standards: ____yes ____no
3. Receiving School Principal's signature: _____ Date: _____
4. Receiving School A.D.'s signature: _____ Date _____

D. DENIED (must be denied if B,3 a through e – one or more NOT initialed – OR if box next to number 4 is checked)

1. The Receiving School Principal does not certify (ref. B,3, a-e) Transfer Rule eligibility: ____/____/____
2. Receiving School Principal's signature: _____ Date: _____
3. Receiving School A.D.'s signature: _____ Date _____

DO NOT RETURN THIS FORM TO THE MIAA(unless applying for a waiver) PLEASE RETAIN AT THE RECEIVING SCHOOL.



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Massachusetts School Immunization Requirements

	Child Care/Preschool ¹	Kindergarten	Grades 1-6	Grades 7-12	College ²
Hepatitis B³	3 doses	3 doses	3 doses	3 doses	3 doses for all health science students and fulltime undergraduate and graduate students
DTaP/DTP/DT/Td/Tdap⁴	>4 doses DTaP/DTP	5 doses DTaP/DTP	≥4 doses DTaP/DTP or ≥3 doses Td	4 doses DTaP/DTP or ≥3 doses Td; plus 1 dose Tdap (See Phase-In Schedule)	All health science students and full-time freshmen-seniors: 1 dose Tdap Full-time graduates: 1 dose Td (See Phase-In Schedule)
Polio⁵	≥ 3 doses	4 doses	> 3 doses	≥ 3 doses	N/A
Hib⁶	1 to 4 doses ⁶	N/A	N/A	N/A	N/A
MMR⁷	1 dose	2 doses	Grade 1-3: 2 doses Grades 4-6: 2 doses measles, 1 mumps, 1 rubella (See Phase-In Schedule)	Grades 7-10: 2 doses Grades 11-12: 2 doses measles, 1 mumps, 1 rubella (See Phase-In Schedule)	All health science students and full-time freshmen-seniors: 2 doses Full-time graduates: 2 doses measles, 1 mumps, 1 rubella (See Phase-In Schedule)
Varicella⁸	1 dose	2 doses	Grade 1-3: 2 doses Grades 4-6: 1 dose (See Phase-In Schedule)	Grades 7-10: 2 doses Grades 11-12: 1 dose (See Phase-In Schedule)	All health science students and full-time freshmen-seniors: 2 doses (See Phase-In Schedule)
Meningococcal^{9,10}	N/A	N/A	N/A ¹⁰	1 dose for new full-time residential students ⁹	1 dose for full-time residential students ⁹

N/A = no vaccine requirement for the grades indicated.

- These requirements also apply to all new "enters."
- If a child has turned 4 years old by the registration date, he or she must have received the Pre-K/K immunizations. However, if the child is only 3 years old at the time of registration, he or she is NOT expected to have received the 4 year old immunizations.
- We strongly recommend that your child have a Tuberculosis Risk Assessment, physical examination, lead test date results and vision and hearing testing done on the child's 5th birthday.

Phase-In Schedule for MMR, Varicella, and Tdap Vaccines 2014-2017

	2015	2016	2017
2MMR And 2 Varicella	K-4 and 7-11 College: full-time freshmen-graduates; all health science	K-5 and 7-12 College: full-time freshmen-graduates; all health science	K-12 College: full-time Freshmen-graduates; All health science
Tdap	Grades 7-11 College: full-time Freshmen-graduates; all health science	Grades 7-12 College: full-time Freshmen-graduates; all health science	Grades 7-12 College: full-time Freshmen-graduates; all health science

¹ Child Care/Preschool: Minimum requirements by 24 months; immunize younger children according to their age.

² College: Requirements apply to: 1) all full-time undergraduate and graduate students; 2) all full-time and part-time health science students; and 3) any full-time or part-time student attending any post-secondary institution while on a student or other visa, including foreign students attending or visiting classes as part of a formal academic visitation or exchange program.

³ Hepatitis B: 3 doses required for child care attendance and preschool entry, kindergarten-12th grade, and college (see footnote 2 above). Laboratory proof of immunity is acceptable.

⁴ DTaP/DTP/DT/Td/Tdap: ≥4 doses required for child care attendance and preschool entry; 5 doses of DTaP/DTP required for school entry unless the 4th dose is given ≥ the 4th birthday. DT is only acceptable with a letter stating a medical contraindication to DTaP/DTP. One dose of Tdap is required for all students entering grade 7-10, full-time college freshmen-seniors and all health science students. If it has been <5 years since the last dose of DTaP/DTP/DT/Td, Tdap is not required but is recommended regardless of the interval since the last tetanus-containing vaccine. See Phase-In Schedule below.

⁵ Polio: ≥ 3 doses required for child care attendance and entry into preschool. 4 doses required for school entry, unless the 3rd dose is given on or after the 4th birthday, and ≥ 6 months following the 4th birth and ≥ 6 months following the previous dose. If 4 doses are administered before age 4 years, a 5th dose is recommended at age 4-6 years.

⁶ Hib: Required for child care attendance and preschool entry. The number of doses is determined by vaccine product and age the series begins.

⁷ MMR: 1 dose of MMR is required for child care attendance and preschool entry; 2 doses are required for kindergarten-grade 3, grade 7-10, college freshmen-seniors and all health science students. Laboratory proof of immunity is acceptable. For college students, except health science students, birth before 1957 in the U.S. is also acceptable. See Phase-In Schedule below.

⁸ Varicella: 1 dose required for child care attendance and preschool entry; 2 doses required for kindergarten-grade 3, grade 7-10, and college freshmen-seniors and all health science students, unless they have a reliable history of chickenpox. A reliable history includes a diagnosis of chickenpox, or interpretation of parent/guardian description of chickenpox, by a physician, nurse practitioner, physician assistant or designee; or 2) laboratory proof of immunity. Birth before 1980 in U.S. is acceptable for college students, except health science students. See Phase-In Schedule below.

⁹ Meningococcal: 1 dose MCV4, or a dose of MPSV4 in the last 5 years, is required for 1) newly enrolled full-time students attending a secondary school and grades 9-12 (in ungraded classrooms, those with students ≥ 13 years) who will live in a dormitory or comparable congregate living arrangement approved program at a post-secondary institution (e.g., college) who will live in a dormitory or comparable congregate living arrangement approved by the institution.

Students may decline the vaccine after they have read and signed the MDPH Meningococcal Information and Waiver Form provided by their institution. These requirements apply to newly-enrolled full-time residential students, regardless of grade and year of study.

¹⁰ At residential schools with lower grades: The requirements apply to residential students in grades pre-K through 8 only if the school combines these grades in the same school with students in grades 9-12.



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Release/ Request of Information

Student: _____ Date of Birth: _____

Parent/ Guardian Name(s): _____

I hereby authorize the personnel of:

To release any and all information to:

This information is needed for the purposes of:

I understand that this request is subject to revocation at any time upon written request.
Otherwise this consent will expire one year from the date of signature.

Parent/Guardian Signature: _____ Date: _____



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Student's Name: _____

Grade: _____

Music Selection: (please pick one)

____ Chorus

____ Band

____ Orchestra (strings)

____ General Music (music appreciation not application)

World Language Selection (for 7th and 8th only) (please pick one)

____ Portuguese

____ Spanish

Parent's Signature: _____

Today's Date: _____

Dartmouth Health Questionnaire

Student's Name: _____ DOB: _____ Grade: _____

Parent/Guardian: _____ Telephone: _____

Address: _____

The list below is designed in part to help identify those issues which may have an effect upon your child in the classroom setting and for his/her well being in the school. All of the information provided may be shared at the nurse's discretion with the appropriate faculty and staff to ensure student safety.

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Food _____	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury
<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems/Murmurs
<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Insect Bites	<input type="checkbox"/>	<input type="checkbox"/>	Immune Problems
<input type="checkbox"/>	<input type="checkbox"/>	Epipen Kit	<input type="checkbox"/>	<input type="checkbox"/>	Medications _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds (frequent)
<input type="checkbox"/>	<input type="checkbox"/>	Inhaler _____	<input type="checkbox"/>	<input type="checkbox"/>	Physical Limitations _____
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Ear or Throat Infections
<input type="checkbox"/>	<input type="checkbox"/>	Bone, Joint, Muscle Problem	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problem
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid
<input type="checkbox"/>	<input type="checkbox"/>	Communicable Disease	<input type="checkbox"/>	<input type="checkbox"/>	Visual Problem
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Glasses/Contacts
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Recent Illness, Accident or Operation _____
<input type="checkbox"/>	<input type="checkbox"/>	Dietary Restrictions	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Headaches (frequent)	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems

Please be specific if you have answered yes to any of the above. Also, if you would like to add any additional information regarding your child's physical and/or emotional well-being to the school nurse's attention or school physician's attention, please do so at the space provided below. Please schedule an appointment with your child's school nurse prior to the beginning of the school year if he/she has health concerns. Thank you.

Physician's Name: _____ Telephone: _____

Dentist's Name: _____ Telephone: _____

Parent/Guardian's Signature: _____ Date: _____

The Dartmouth Public Schools is an affirmative action employer, ensuring that its programs and facilities are accessible to the public. We do not discriminate on the basis of race, creed, color, age, sex, gender identity, national origin, disability or sexual orientation

MASSACHUSETTS SCHOOL HEALTH RECORD

School Name _____ Year of Graduation _____
 Female Male Primary Language Spoken (home) _____
 Last First Middle DOB / / Place of Birth _____
 Street _____ City/Town, State, Zip Code _____

Contact Information

(1) Parent/Guardian: _____
 Name & Mailing Address if different: _____

(2) Parent/Guardian: _____
 Name & Mailing Address if different: _____

Phone Numbers _____
 Home _____
 Work _____
 Cell _____
 FAX _____

Emergency Contact Information
 (1) Emergency Contact Name & Phone Number: _____
 (2) Emergency Contact Name & Phone Number: _____

Primary Care Provider Name: _____
 Phone Number: _____
 Dental Care Provider Name: _____
 Phone Number: _____

Health Insurance: _____
 Allergies: _____

Primary Custody (if not joint) _____

School District	Year	Grade	Age	Growth			Vision				Hearing			Postural				
				Ht.	Wt.	BMI	Preschool-Certificate		Right Eye		Left Eye		Right Ear		Left Ear			
							Pass	Refer	Pass	Refer	Pass	Refer	Pass		Refer	Pass	Refer	
		Pre K																
		K																
		1																
		2																
		3																
		4																
		5																
		6																
		7																
		8																
		9																
		10																
		11																
		12																

Special Testing Lead Date / / _____ Tuberculin 1. Date of PPD / / _____; result _____ mm; 2. Date of PPD / / _____; result _____
 Low risk (no PPD done)

- *School District on Waiver in accordance with MGL c71,s57 indicated by * in 'Grade' column.
- Immunizations: Please attach complete Massachusetts Immunization Certificate/record
- Due to software differences, this form may be used as a template for other formats. (All information on this form must be included.)

Parents: Please complete this section only.

School Use Only