Putney Central School- Registration Form

WINDHAM SOUTHEAST SCHOOL DISTRICT

Student Information

Name: _____ Entering Grade: _____
Last First Middle

Gender:_____ Assigned Gender at birth: M / F

Date of Birth: _____/_____/ _____ Age Sept. 1 this year: _____ yrs _____ mo. Town of Residence:_____

Home Phone # _____Cell Phone # _____

Residential Address:_____

Mailing Address (if different) _____

Who has Legal Custody (circle) Both Parents Mother Father DCF Guardian or Other

Please Circle: Mother Father Step Other_____

Name:_____

Address:_____

Mailing Addr. (if different): _____

Town/State of Residency:_____

Phone #_____Landline/Mobile
(circle one)

Phone #_____Landline/Mobile
(circle one)

E-mail: _____

Place of Employment: _____Work Phone#_____

Please Circle: Mother Father Step Other_____

Name:_____

Address:_____

Mailing Addr. (if different): _____

Town/State of Residency:_____

Phone #_____Landline/Mobile
(circle one)

Phone #_____Landline/Mobile
(circle one)

E-mail: _____

Place of Employment: _____Work Phone #_____

Emergency Contact #1

Name:_____

Relationship:_____

Address:_____

Phone #_____Landline/Mobile
(circle one)

Emergency Contact #2

Name:_____

Relationship:_____

Address:_____

Phone #_____Landline/Mobile
(circle one)

Ethnicity Information *(for federal use)* Please Circle All That Apply.

Hispanic or Latino White Black American Indian Asian Native Hawaiian or other Pacific Islander

Others Living in the Home

Name _____ Relationship_____ D.O.B. ___/___/_____

Name _____ Relationship_____ D.O.B. ___/___/_____

Name _____ Relationship_____ D.O.B. ___/___/_____

Name _____ Relationship_____ D.O.B. ___/___/_____

Educational History

School Last Attended: _____ Grade Last Enrolled: _____

School Address: _____ Phone number: _____

Other Schools Attended (including preschool programs and dates):_____

Legal Information

Are there any legal constraints on Custodial Rights? YES / NO *Note: Copies of court documentation related to custody and legal constraints/rights must be submitted to the school office prior to the start of the school year.*

Are there any legal constraints on school visitation rights? YES / NO *Note: Copies of court documentation related to custody and legal constraints/rights must be submitted to the school office prior to the start of the school year.*

Is the student in DCF Custody? YES / NO

Has the student received services through Title I or 504? YES / NO

Does the student have a current Individual Education Plan (IEP) for Special Education? YES / NO

Emergency Contact Information

Emergency Contact 1 (other than parents)	Name:_____ Relation: _____	Phone 1 _____ Phone 2 _____
Emergency Contact 2 (other than parents)	Name:_____ Relation: _____	Phone 1 _____ Phone 2 _____

Immunizations Current: YES / NO ***Note: Immunization record must be provided before the start of school.***

If no, please explain: _____

AFTER SCHOOL TRANSPORTATION HOME PLAN

Will your child

- ❑ Walk home independently
- ❑ Be picked up
- ❑ Bus. If so contact, F.M.Kuzmeskus Transportation for bus stop locations, times, and policies. 802-490-2817
- ❑ Other

FOR OFFICE USE ONLY

If entering Kindergarten, date of birth verified:	YES / NO
Custodial rights and/or visitation court documentation verified if necessary:	YES / NO
Primary Home Language Survey Completed?	YES / NO
Is the student in DCF custody YES / NO If Yes, complete FORM DCF-1	YES / NO
Updated immunization record verified:	YES / NO
IEP copy requested to be sent to Special Ed Office	YES /NO /NA
Residency Verified	YES/NO

PUTNEY CENTRAL SCHOOL
Windham Southeast Supervisory Union 2024-2025 Annual Health Form

Student Name:	**DOB**:	Grade:	Teacher:

Emergency Contact Information

Parent/Guardian #1: email:	Home Phone: Cell Phone:	Place of Employment: Work Phone:
Parent/Guardian #2: email:	Home Phone: Cell Phone:	Place of Employment: Work Phone:
Emergency Contact#1: **Emergency Contact #2**:	Relationship: Relationship:	Phone: Phone:

Medical Information and Health Questions

List and describe any **HEALTH PROBLEMS, ILLNESS, DISABILITY** (seizures, ADD, ADHD, anxiety, cardiac, concussions) the school should be aware of:

ALLERGIES (food, venom, medications, seasonal) and symptoms. If you child has food allergies, please list specific food restrictions:	**ASTHMA**	Y	N
	Has a doctor, nurse, or other health professional EVER said that you child has ASTHMA?		
	If YES, does your child STILL have ASTHMA?		
	If YES, does your child have an up-to-date VT Asthma Action Plan?		
	Will your child require the use of an inhaler during school?		
	Will your child need to take medication during school hours? If yes, medication name:		

Please list any **MEDICATIONS** your child takes regularly:_____

		Yes	No
Doctor/Nurse Practitioner:	Well Child Exam within the last year?		
Dentist:	Appointment within the last year?		

OTHER Medical Providers(ie: Therapist, eye doctor, audiologist, neurologist:_____

	Yes	No
Does your child have Health Insurance? For information on Vermont Insurance (vermonthealthconnect.gov or 1-855-899-9600)		

Please review the list below and please place a check next to the over the counter medications that you approve for administration to your child while at school (as needed):

__Tylenol (Acetaminophen)___Motrin/Advil (Ibuprofen) ___Benadryl (diphenhydramine)__Sunscreen___Insect Repellant

SIGNATURES NEEDED-Please Sign Both

In Case of Emergency: In case of accident or acute illness I request that the school contact me. In an emergency, emergency personnel can be contacted. If the school is unable to reach me, I hereby authorize the school to call the health care provider indicated and to follow his/her instructions. If it is impossible to contact the provider, the school may make whatever arrangements necessary.

Signature:_____Date:_____

Release of Information: I give permission for school nurse to send/ receive confidential medical information to ALL my child's Health Care Providers

Signature:_____Date:_____