BARNSTEAD SCHOOL DISTRICT

STUDENT ACTIVITIES EMERGENCY AUTHORIZATION FORM

20____ - 20____ SCHOOL YEAR

Student Name: _____ D.O.B: ___/___/___ Grade: _____ Homeroom: _____
(Last) (First) (MI)

Student Resides With: _____ Relationship to Student: _____

Address: _____ Home Phone: _____

Town: _____ State: NH Zip Code: _____ E-mail Address: _____

Mailing Address: _____ Town: _____ State: NH Zip Code: _____

Father's Name: _____ Cell #: _____ Employer: _____ Work Phone: _____

Mother's Name: _____ Cell #: _____ Employer: _____ Work Phone: _____

Are there any documents the school should have on file relating to the guardianship of your child and/or documents restricting a natural parent's access to school records? ❑ NO ❑ YES

If YES please explain and attach legal documentation: _____

Bus Route: (Circle One) Red Brown Blue Green Orange Purple Other: _____

IN CASE OF EMERGENCY OR ILLNESS

If Parent or Legal Guardian is not available, contact:

Name: _____ Relationship to Student: _____

Address: _____

Town: _____ Work Phone: _____ Home Phone: _____

Name: _____ Relationship to Student: _____

Address: _____

Town: _____ Work Phone: _____ Home Phone: _____

Daycare Provider Name: _____ Address: _____ Phone: _____ Cell: _____

MEDICAL INFORMATION

A. Allergies ❑ Yes ❑ No If Yes, please specify: _____

B. Student wears glasses? ❑ Yes ❑ No AND/OR Contacts? ❑ Yes ❑ No

C. Has your child received any Immunizations/Boosters during the past year? List Type & Date Received: _____

D. Date of most recent DPT (Diphtheria/Tetanus) Immunization or Booster*(mm/dd/yy):* _____

E. Medication(s) taken regularly? *(Please specify)*: _____

F. Other Medical Problems? *(Please specify)*: _____

For the health and safety of my child, I also give permission for the school nurse/health officer to share certain medical information about my child with the appropriate school personnel on a need-to-know basis only.

AUTHORIZATIONS

NEWS RELEASES:

I authorize the school to release my child's picture and/or video and name to publicize any activities and/or achievements. ❑ Yes ❑ No

MEDICAL RELEASE:

I authorize the school's representative(s) to transport, request and authorize treatment for my son/daughter in the event of an accidental injury/illness. I agree that I will not hold this person(s) liable while he/she is acting in accordance with these directions. ❑ Yes ❑ No

OTHER INFORMATION

If I call the school to make alternative arrangements for my child's dismissal, I will use the safety code word: _____

In the event that school closes early, the school WILL NOT call parents. My child will ride the bus home ❑

My child will go to the following location: _____

_____

The State Department of Education requires the following information. Please circle the code number of the group in which your child should be included:

1-American Indian/Alaskan Native 2-Asian 3-White and Hispanic 4-Black 5-White 6-Native Hawaiian or Other Pacific Islander

Primary Language spoken at home: ❑ English ❑ Spanish ❑ Other - Please specify: _____

SIGNATURE

Your signature on this form verifies that the above information is accurate and that you agree to the provisions indicated. Copy of this Authorization is of equal validity as original document.

Parent/Guardian Signature: _____ Date of Authorization: _____

NOTE TO PARENT/GUARDIAN: It is important that the parent/guardian notify the Principal AND School Nurse immediately of any modifications to the above Emergency Authorization form.

PUPIL REGISTRATION FORM

Student Information

Student Name:_____ GENDER M/F
LAST FIRST MIDDLE

Date of Birth_____ Place of Birth_____
YEAR DAY MONTH CITY STATE

ETHNICITY:

___American Indian ___African American ___Asian
___Hispanic ___White ___Native Hawaiian/Pacific Islander

Do you and your family share housing of others due to a loss of housing, economic hardship or a similar reason? Yes_____ No_____

SIBLINGS:

Name_____ Age_____ School_____
Name_____ Age_____ School_____
Name_____ Age_____ School_____
Name _____Age_____ School_____

Previous School Information

NAMES OF SCHOOLS PREVIOUSLY ATTENDED (begin with most recent)

School_____Town/State_____Grade/Last date attended_____
Previous Teacher Name_____
School_____Town/State_____Grade_____
School_____Town/State_____Grade_____
School_____Town/State_____Grade_____

Did your child receive Special Education Services___ or Title I tutoring____? If yes, please explain_____

Parent Information

NAME OF FATHER_____ EMPLOYER_____
ADDRESS_____TELEPHONE #_____
NAME OF MOTHER_____ EMPLOYER _____
ADDRESS_____TELEPHONE# _____
STEPPARENT(S) NAMES_____TELEPHONE#_____
STEPPARENT(S) NAMES_____TELEPHONE#_____

MY CHILD LIVES WITH: Both parents ____Mother/Guardian ____Father/Guardian____
1/2 time w/ Mom_____1/2 time w/ Dad____ Other_____

Are there any legal restrictions we should be aware of? ? Yes___ No_____
Please explain (confidential)_____
_____

BES Home Language Survey

School: Barnstead Elementary School **District: SAU #86** **Date:_____**

Student Information			
First name:	Last name:	Date of Birth:	Gender: ☐ female ☐ male
Country of Birth:	Date of entry in U.S.:	Date first enrolled in a U.S. school: Month_____ Year_____	Current grade:

Family Information	
Name of parent/legal guardian:	Phone number:
Address:	☐ Please translate school notices. Language_____

Questions for Parents/Guardians	Response
Please list all languages spoken in your home.	
Which language did your child first hear or speak?	
If English is the only language listed, stop here. If another language is listed, please answer the rest of the questions.	
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?	

For parents and guardians: If a language other than English is listed above, an ESOL teacher will test your child to find out if he or she can speak, understand, read, and write well in English. The results will be sent to you within 30 days. Based on the results of the test, your child may be eligible to enroll in an English language (ESOL) class at school. Parents/guardians may accept or decline ESOL program services for their child.

Instructions for survey administrator:

1. Please provide an interpreter when necessary.
2. If responses indicate a language other than English, please contact the ESOL teacher and provide her/him with a copy of this survey. Date of referral to ESOL teacher: _____
3. File original Home Language Survey in student's cumulative folder.

Barnstead School District
McKinney-Vento Eligibility Form

This form is intended to address the requirements of the McKinney-Vento Act (Title X, Part C of the No Child Left Behind Act). The questions below are to assist in determining if your student(s) meet the eligibility criteria for services provided under the McKinney-Vento Act. Please contact Sara Newell at 269-5161 ext 184 with questions regarding this form. Thank you!

1. **Is this student(s)' home address a temporary living arrangement? Please check one:**

____Yes, due to a loss of housing or economic hardship

____Yes, for reasons other than the above

____No

2. **If you answered yes to the above question, do you stay at night in any of the following locations (please check any that apply):**

____Motel/Hotel

____Temporarily with extended family or another family in a house, apartment or mobile home

____Vehicle

____Campsite

____Shelter/Transitional living home

____Other (in an arrangement that is not fixed, regular and adequate and is not described by the other choices)

Student Name(s):_____

Parent/Guardian Name(s):_____

Parent/Guardian signature:_____

Date:_____

BARNSTEAD SCHOOL HEALTH SERVICES

Name of Child:_____ Sex: M F

Date of Birth: _____/_____/_____ Place of Birth: _____

Home Address: _____

Telephone Number: _____-_____-_____

Father's Name:_____ Mother's Name:_____

Guardian's Name (If not listed above):_____

Persons Residing at home: Father ____ Mother____ Brothers/Sisters____ Other____

Family Doctor:_____ Family Dentist_____

Medication Allergy:_____ Other Allergy:_____

Does your child have an allergic reaction to Bee stings? Yes No

If yes, please give course of action to be taken at school if this occurs:_____

_____

Is your child on any medication? Name:_____ Dosage:_____

Reason:_____ Prescribing Doctor:_____

Has your Child Had:

	Date M/D/Y	Date M/D/Y	Date M/D/Y
ADHD/ADD		Cancer/Leukemia	Hearing Loss
Anemia		Chickenpox	Hepatitis
Arthritis		Convulsion/Seizures	Hernia
Asthma		Concussion	Lead
Back/Neck Injury		Diabetes	Lung Disease
Bladder/Kidney Disease		Headaches	Mononucleosis
Bleeding/Clotting Disorder		Heart Condition/Murmur	Speech
Surgery		Vision Loss/Correction	Orthopedic/Bone

Has your child ever had a vision exam done by an eye doctor? _____yes_____no

Does your child wear glasses?___ yes ____no Name of Eye Doctor:_____

Has your child had any hearing problems? ___ yes___no Name of Ear Doctor:_____

Has your child had tubes in his/her ears? ___ yes ___no If yes, date: _____/_____/_____

Has your child ever had a complete dental exam: ___ yes ___no If yes, date: _____/_____/_____

Operations-{type and date(s)}_____

Serious injuries or fractures – type and date(s)_____

Does your child have any diet or activity restrictions? Please explain:_____

Does your child have any physical disabilities? Please explain_____

_____

Does your child have any known emotional problems? Please explain_____

_____

Is your child presently under medical care for any reason? Please explain:_____

HEALTH HISTORY

Pregnancy

Was mother ill during pregnancy? _____Yes_____No If yes, what months?_____
Illness: _____
Did mother take medication during pregnancy? _____Yes _____No Please explain_____
_____
Labor prolonged (over 24 hours) _____Yes _____No

EARLY HISTORY – BIRTH & INFANCY OF CHILD

Was child: Full-term (9 mos.) _____ Premature_____ Weight at birth _____lbs _____oz
Was birth: Normal delivery_____ Breech_____ Caesarian_____
Injury or complication at time of birth or during first week: _____
RH Problem_____Yes _____No If yes, please explain:_____
Need for: Oxygen _____ Blueness (Cyanosis) _____ Incubator _____ Yellow Jaundice_____
Feeding Trouble _____ Seizure (convulsions) _____ Excessive Vomiting _____ Breathing Trouble _____
Diarrhea _____ Fever_____Other _____ Please explain_____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I authorize the school health nurse to release medical information on a need to know basis to faculty, support staff, bus driver and chaperones. This information may include, but not limited, to the following: medication, allergies, diagnosis (ie. Asthma, diabetes, seizures).

Parent/Guardian Signature_____ Date _____

CONSENT FOR MEDICAL INFORMATION

There may be occasions on which we need to contact your physician or dentist for health information. If you agree to allow such contact, please sign below.

Parent/Guardian Signature_____ Date _____

In the Health office, we use bacitracin, triple antibiotic ointment, calamine lotion and hydrocortisone ointment for basic first aid. Please cross out any of the above if you do not want it used on your son/daughter.

Please call the school nurse whenever you have a concern or new information relative to your child's health or safety.

(Health Services revised 3/21/2013)

BARNSTEAD ELEMENTARY SCHOOL
Center Barnstead, NH 03225
Kindergarten/First Grade Parent Interview Form

CHILD'S NAME: _____

PARENT'S NAMES: _____

COMPLETED BY: _____ DATE:___/___/___

1. DO YOU FEEL YOUR CHILD IS READY TO ENTER SCHOOL:
   ___YES ___NO

2. WHAT CONCERNS DO YOU HAVE ABOUT THIS?

_____

_____

3. HOW DOES YOUR CHILD FEEL ABOUT COMING TO SCHOOL?

_____

4. ANY PRESCHOOL OR DAYCARE EXPERIENCE? ___ YES ___NO
   WHAT WAS THE CHILD'S REACTION TO THIS?

_____

5. WHAT DO YOU SEE AS YOUR CHILD'S STRENGTHS?

_____

_____

ANY WEAKNESSES OR AREAS IN WHICH YOU WOULD LIKE TO SEE GROWTH: _____

_____

6. SUGGESTIONS OFFERED: _____

_____

7. ANYTHING ELSE WE SHOULD KNOW: _____

_____

_____

8. ESL CONCERNS? (Please see Home Language Survey Form.)

_____

BARNSTEAD ELEMENTARY SCHOOL
CENTER BARNSTEAD, NH 03225
(603) 269-5161

KINDERGARTEN QUESTIONNAIRE

Child's Name: _____ Nickname (if any): _____
Birthdate: _____/_____/_____

1. Please list the names and ages of the child's brothers and sisters:
   Name: _____ Age: _____
   Name: _____ Age: _____
   Name: _____ Age: _____
   Name: _____ Age: _____
2. Does your child have any difficulties with speech? _____
3. Does your child have any health problems (i.e., allergies, tubes in ears, asthma, A.D.D., etc.)?
   _____
   _____
4. Does your child have any special interests? _____
   _____
5. Is your child afraid of anything? _____
   _____
6. What responsibilities does your child have at home? _____
   _____
7. What form of discipline do you use at home? _____
   _____
8. What skills has your child acquired: (Please check all that apply.)

_____ knows address	_____ recognizes lower case letters
_____ knows phone number	_____ recognizes letter sounds
_____ knows birthday	_____ likes to listen to stories
_____ can say full name	_____ can tie shoes
_____ can print full name	_____ can button own clothing
_____ counts to (how far) _____	_____ can tell time
_____ knows the difference between right and left	_____ has experience with crayons
	_____ has experience with scissors
_____ can recognize numbers to 12	_____ knows how to use the bathroom correctly
_____ knows the names of colors	_____ recognizes capital letters

9. If your child is reading, how did he/she learn and how long has he/she been reading?
   _____
10. What are your expectations for the kindergarten program? What specific things would you like to see happen this year? _____
    _____
    _____
    _____

11. Would you be interested in helping in the classroom? Is there a particular day and time that is best for you? _____
12. Is there anything else that you would like to tell us about your child? _____

Hearing Status

Does your child:

- Talk in a very loud voice? ☐ no ☐ yes
- Turn up the volume on the radio and TV? ☐ no ☐ yes
- Hear you if his or her back is turned? ☐ no ☐ yes
- Hear you if you talk to him or her from the other room? ☐ no ☐ yes
- Have a history of ear infections? ☐ no ☐ yes

How many? _____ When was the most recent? _____

Has your child had a hearing test? ☐ no ☐ yes If yes, when: _____

Understanding Language

When you talk to your child, how much does he or she understand? Please check one:

☐ A few words ☐ Simple directions
☐ Many words and phrases ☐ Almost everything I say

Additional Comments/Examples: _____

Communicating With You

How does your child usually let you know what he or she wants? Please check all that apply:

☐ Cries ☐ Uses a few words
☐ Points to what he or she wants ☐ Says many words, but only says one word at a time
☐ Uses gestures (e.g., gestures for "give it to me") ☐ Says two or three word sentences
☐ Makes a few sounds ☐ Uses long sentences
☐ Makes many different sounds

Additional comments/examples: _____

Does your child:

- Answer when you talk to him or her? ☐ no ☐ yes
- Talk about what he or she is doing? ☐ no ☐ yes
- Ask for help? ☐ no ☐ yes
- Can the family understand your child's speech? ☐ no ☐ yes
- Can people outside of the family understand your child's speech? ☐ no ☐ yes

What does your child like to talk about? _____