Up-Island Regional School District
8 State Road
PO Box 60
Chilmark, MA 02535

CHILMARK
SCHOOL
SINCE 1861

Susan O. Stevens, Principal
Mary Ambulos, Secretary
508 645-2562 phone
508 645-2460 fax

Chilmark School Student Registration

Child's name:_____ Gender:_____
First Middle Last

Place of Birth:_____ Date of Birth:_____

Race: American Indian or Alaskan Native_____ Asian Pacific Islander_____ Black_____ White_____ Hispanic:_____

Father's Name:_____

Occupation:_____

Mother's name:_____

Occupation:_____

Place of Birth:_____ Place of Birth:_____

Guardian:_____ Guardian Address:_____
(If different from parent)
Child's Physical Address:_____

Child's Mailing Address:_____

Home Phone Number:_____

Daytime or cell number: Mother:_____ Father:_____

E mail Address:

1)_____

2)_____

Other children in Family:
Name:_____ Age:____ Name:_____ Age:____

Name:_____ Age:____ Name:_____ Age:____

Previous School Experience:_____

Current Preschool/Daycare/Other:_____

Bus Student: Yes_____ No_____

Where children come together, to live, to love, to learn

CHILMARK
SCHOOL

Beatrice Whiting RN
Chilmark School Nurse
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Chilmark, MA 02535

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KINDERGARTEN REGISTRATION - HEALTH REQUIREMENTS

Dear Parent,

The Massachusetts Department of Public Health requires that the following information be presented before your child is allowed to start school. These documents will be kept in your child's medical files in the nurse's office.

- **MOST RECENT PHYSICAL EXAM** must be within one year of school enrollment.
- **IMMUNIZATION RECORD** which indicates that your child has received the following required vaccines:
    - 5 doses DTap (diphtheria, tetanus, and pertussis)
    - 4 doses Polio
    - 3 doses Hepatitis B
    - 2 doses MMR (measles, mumps and rubella)
    - 2 doses Varicella (chicken pox) or a physician documented evidence of natural disease
- **YOUR CHILD'S LEAD SCREENING** one lab result from any date prior to start of school

If your child is missing vaccines or is behind schedule, please make an appointment with your pediatrician as soon as possible. A signed medical or religious immunization exemption may be submitted; form is available upon request and must be renewed yearly.

Kindergarten is such an exciting time for both parents and children! I look forward to meeting you all.

If you have questions, please don't hesitate to contact me.

Nurse Bea

KINDERGARTEN ENTRY - PARENT QUESTIONNAIRE

Child's Full Name: _____ Date of Birth _____

Child's doctor: _____

Approximate date of last visit: _____ Reason for visit: _____

Your child's general state of health: Excellent_____ Good_____ Fair_____ Poor_____

Have there ever been any concerns about your child's height, weight, or growth? _____

Please check all that apply to your child:

friendly	_____	cooperative	_____
easily angered	_____	extremely quiet	_____
independent	_____	a daydreamer	_____
fearful	_____	clumsy	_____
short attention	_____	shy	_____
easy going	_____	easily upset	_____
cries easily	_____	stubborn	_____
difficult to handle	_____	outgoing	_____
overactive	_____	often hurts self	_____
unexplained tantrums	_____	separates easily from parent	_____

other (describe) _____

How does your child usually handle conflicts with other children? _____

_____

How does your child usually express anger or frustration? _____

_____

Have you ever had serious questions or concerns about your child's behavior, emotional or mental health? _____ If so, describe: _____

LANGUAGE DEVELOPMENT

Is there a family history of learning difficulties, speech or language problems, inherited illnesses or conditions? _____ If so, please specify: _____

Check any which apply to your child now:

Speaks clearly most of the time	_____
Has difficulty with some speech sounds	_____
Often is difficult to understand	_____
Talks in long sentences and paragraphs	_____
Usually talks in short sentences (2-4 words)	_____
Understands most directions and conversations	_____
Needs directions given one step at a time	_____
Seems confused or needs things repeated	_____
Can talk about things that have happened to her/him	_____
People outside our family don't seem to understand what he/she says	_____
Sometimes misinterprets what is said	_____
Remembers favorite stories and can tell general idea	_____
Sings short songs or says nursery rhymes	_____
Tells about his/her feelings, e.g. happy, sad, mad	_____

I have concerns about my child's speech or language.	Yes_____	No_____
I have concerns about my child's hearing.	Yes_____	No_____
I have concerns about my child's vision.	Yes_____	No_____
I have concerns about my child's learning.	Yes_____	No_____

Please us this space to include any other information you would like to share to help us to get to know your child better:

CHILMARK SCHOOL

Kindergarten and New Student Health History Form

Student's Name _____ **Birth Date**___/___/___ **Today's Date:** ___/___/___

Child's Birth Weight: _____

Any complications or problems with this pregnancy or birth?

Please explain: _____

_____

_____

Please check any allergies your child has:

____ Bee stings
____ Environmental – Please list: _____
____ Foods – Please list: _____
____ Latex
____ Medications – Please list: _____
____ Others: _____

Does your child have a doctor's order for an EPI-PEN? Yes No

Are there any foods your child should/does not eat because of Family, religious or personal preferences?

_____

_____

_____

Are you concerend about your child's weight? Yes No

Does your child have trouble sleeping? Yes No

Does your child have a condition which limits her/her physical activity? Yes No

Please explain: _____

_____

Has your child had any operations? Please give dates & details:

Appendix _____
Tonsils, Adenoids _____
Ear Tubes _____
Other _____

Please list any medicaitons you chid is currently taking:

_____

_____

_____

Please check if your child has any of the following :

____ Speech concerns
____ Hearing or ear problems
____ Vision Problems
___ Receives speech therapy
___ Wears hearing aids
___ Wears glasses

Instructions for wearing: _____

_____

Please check any problems your child has had:

___ Asthma
___ Broken bones or other bone/joint problems
___ Cancer
___ Congenital Abnormality
___ Dental
___ Eczema or other Skin Disorder
___ Emotional
___ Kidney, Bladder or other Urinary Tract Disorder
___ Intestintinal Disorders
___ Serious Accidents
___ ADHD
___ Convulsions
___ cystic Fibrosis
___ Epilepsy
___ Heart Condition
___ Frequent Headaches
___ Nose Bleeds
___ Serious Head Injury

Please give dates & details: _____

_____

_____

_____

Give dates if your child has had any of the following illnesses:

___ Chicken Pox
___ Measles
___ Herpes
___ Polio
___ Rheumatic Fever
___ Strep Throat
___ Tuberculosis
___ German measles
___ Meningitis
___ Mumps
___ Pneumonia
___ Scarlet Fever
___ Tonsillitis
___ Whooping Cough