*****This page must accompany the child's full registration packet*****

White River Valley Supervisory Union

Bethel Chelsea Granville Hancock Rochester Sharon South Royalton Stockbridge Strafford Tunbridge

Act 166: Universal Prekindergarten Tuition Request Form / Intent to Enroll Form 2019-2020 School Year

By completing and submitting this form, you are either 1) requesting that your child be considered for a prekindergarten space through your local public prekindergarten program **or** 2) requesting tuition reduction for your child to attend a pre-qualified private prekindergarten program.

Child's Name: _____ Date of Birth: _____

Name of Parent/Guardian: _____ Phone: _____

Address: _____

E-mail Address: _____

Our family lives in: _____ School District

Please check the applicable options:

_____ Please consider my child for a enrollment at my local public prekindergarten program.

----- OR-----

(PreK children are eligible for either public PreK OR Act 166 tuition, but not both)

_____ Please check here if you plan to enroll your child in a **pre-qualified private prekindergarten program.** Schools will provide up to $3,356.00 per school year (10 hours per week for 35 weeks) to one pre-qualified private prekindergarten provider if the child's registration is complete before the start of the school year. The school does not manage enrollment at private programs; please contact the private prekindergarten program you are interested in. **Children must be 3 years old by September 1, 2019 to apply**.

My child is enrolled at _____.

By enrolling in a public PreK program or requesting tuition funds, I agree to:

- ❑***complete the registration process*** with my school district of residence, which includes proof of residency and proof of age (birth certificate). Schools are required to provide families with household income forms as well. I understand that if I do not register my child, I will not receive tuition. Note: If your child was registered last year, you will be asked to review the information on file;
- ❑***follow the attendance policy*** provided by the prekindergarten program and ensure that my child attends prekindergarten consistently. I understand it is my responsibility to notify the Supervisory Union/School District if we move or if my child stops attending prekindergarten or changes programs;
- ❑***authorize the release of information*** between my child's prekindergarten program to communicate with my school district about my child's development, enrollment, attendance, registration and suspension/expulsion.

_____ _____

Parent/Legal Guardian Signature Date

Please send this form and your child's registration packet to the Registrar at your School District of residence

Internal use only: copy to: ____Registrar, ____Act 166 Designee, _____other: _____

*****This page must accompany the child's full registration packet*****

WHITE RIVER VALLEY SUPERVISORY UNION

PREKINDERGARTEN STUDENT REGISTRATION AND EMERGENCY FORM

Bethel Chelsea Granville Hancock Rochester South Royalton Strafford Stockbridge Tunbridge

Please print and complete all sides and return as soon as possible. Thank you.

This section completed by Office Only: Enrollment Date: _____ ***Student ID:*** _____ ***State ID*** _____ ***Dated Completed:*** _____

Student Legal Name: _____ _____
Last First Middle Date of Birth

Student Preferred Name: _____ ____
Gender

Legal Guardian: _____ Relationship: _____

Physical Address **(required)**: _____
Street City State Zip

Preschool/Childcare Center Last Attended: _____ Last Day of Attendance: _____

Public or Private Prequalified Program Choice: _____ ☐

Race **(required)**: _____Ethnicity _____

Father/Guardian Information Circle One: 911 Address Yes No	**Mother/Guardian Information Circle One: 911 Address Yes No**
Name: _____	Name: _____
Custodial Parent? _____Yes _____ No	Custodial Parent? _____Yes _____ No
Mailing Address: _____	Mailing Address: _____
Town of Legal Residence: _____	Town of Legal Residence: _____
Home Phone: _____ Cell Phone _____	Home Phone: _____ Cell Phone _____
Employer: _____ Work Phone: _____	Employer: _____ Work Phone: _____
Email:	Email:

Siblings of Child:

Name	Age	Grade	School	Name	Age	Grade	School
_____	____	_____	_____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____	_____	_____

Is the student in DCF custody?_____ If DCF placed, does a biological parent live in WRVSU District? _____

State Place Information - Agency Name: _____ Caseworker _____ Phone # _____

Is the student *currently* on an **I.E.P.**? _____ Has the student *ever been* on an **I.E.P.**? _____

Has the family moved to work on a farm or in logging within the last three years? YES / NO (*If YES, complete Migrant Worker Form)*

Native Language (*if other than English*): _____ ESL Services needed? _____

Please list any adults who may be contacted or can assume temporary care of your child/ren if the school cannot contact you by phone. This adult must be willing and able to take your child during school hours.

This page must accompany the child's full registration packet

WHITE RIVER VALLEY SUPERVISORY UNION
Proof of Vermont Residence

I affirm that _____(child name) is eligible to attend school / private program

to receive public tuition funds from _____, Vermont, my town of residence.

Because we, his/her parent(s) or guardian(s) _____(names),

□ Have purchased a home within the town of _____, Vermont, which is occupied as our legal residence

□ Have leased a home within the town of _____, Vermont, which is occupied as our legal residence

□ Are living with a resident from _____, Vermont, which is occupied as our legal residence

As proof of this residence, I have presented and attached a copy of **ONE** of the following documents showing the physical address of the residence:

□ Purchase Agreement*
□ Warranty Deed*
□ Lease Agreement*
□ Voter Registration (copy of receipt or Town Clerk's confirmation) *
□ Notarized letter from the resident of the school district with whom I am residing accompanied by proof of their residency*
□ Transitional Housing*

Or **TWO** of the following bills which show the physical address of the residence:

□ Utility bill which shows the physical address of the residence*
□ Other (example: valid Vermont Driver's License which shows the physical address of the residence) *

*Please black out or otherwise remove any information you choose to have remain private. Items presented for proof of residence must show the resident's name and the 911 physical address of the residence. Physical address may be different than mailing address.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Note: You must notify your PreK program immediately if your family moves out of your town of residence.

Proof of Eligibility: Children must be 3 on or before September 1, 2019

□ Copy of Child's Birth Certificate or
□ Copy of Well Child Visit with Date of Birth and Doctor's signature

Signature of School Official: _____

Primary/Home Language Survey for All Kindergarten and Incoming Students

Instruction for schools in completing the survey:

1. Interview the parents/guardians of **ALL** new Kindergarten and incoming students in grades K-12 and record all information requested.
2. Provide interpreting services whenever necessary.
3. Please check to see that **all questions** on the form are answered.
4. A copy of any survey with a language other than English should be referred to the ESL teacher for further screening to determine if the student is an **English Language Learner (ELL).**
5. Surveys for students identified as ELLs should be faxed (802-479-1829) or mailed to: Jim McCobb, ELL Program Coordinator, Vermont Agency of Education, 219 North Main Street, Suite 402, Barre, VT 05641.
6. Place the original survey form in the student's permanent file.
7. For questions contact Jim McCobb at (802) 479-1273.

Student Information (Parents/Guardians should complete this section.)			
First Name:	Last Name:	Date of Birth (Month/Day/Year)	Gender: F ☐ M ☐
Country of Birth:	Date of Entry in U.S. (Month/Day/Year):	Date student first began **Kindergarten (or higher grade)** in **any** U.S. school (Month/Day/Year):	

Questions for Parents/Guardians	**Response**
What is the native language of each parent/guardian?	
What language(s) are spoken in your home?	
Which language did your child learn first?	
Which language does your child use most frequently at home?	
Which language do you most frequently speak to your child?	
What other languages does your child know?	

School Information (School Staff should complete this last section based on information gathered from parent/guardian.)

What school **will** the student attend?		
Beginning date in this school (Month/Day/Year):	What grade will the student enter?	Person Conducting Survey:

*****Medical forms only need to be filled out if your child is attending a public prekindergarten. *****

White River Valley Supervisory Union New Enrollment Health Form

Bethel Chelsea Granville Hancock Rochester Sharon South Royalton Stockbridge Strafford Tunbridge

Parents/Guardians please circle your town of residence

Student name_____
(Please print in ink) Last First Date of Birth Grade

MEDICAL HISTORY

1. Has your child ever been a **patient in a hospital** (other than a few days after birth)?
☐ No (If no, go to question #2.)
☐ Yes (If yes, explain why and when below.)

2. Birth History: At how many weeks gestation was your child born? _____. What if any complications were there?

My child was in the hospital because:	**When**
Example: Bike accident-concussion	5 years old

3. Is your child taking any **prescription medicines**?
☐ Yes - Please list the child's medicines below OR
☐ No. My child does not take any prescription medicines. (If no, go to question #3)
☐ Yes ☐ No. Does your child use an inhaler or breathing treatments? If YES, please list medicine below.

Name of medicine	**Amount / size of pill**	**How many pills or doses does your child take at**
Example: Dexedrine	10 mg	1 morning 1 noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed

4. What **over-the-counter medicines** does your child take **regularly**?
☐ Vitamins
☐ Herbal medicine (please list)

_____
☐ Other medicines like Tylenol, Advil or something else? (Please list)

_____

_____
☐ **None**, my child does not take any over-the-counter medicines regularly.

** Please note: Confidential information about your student's health may be shared only with other school staff that need to know to protect your child's safety. They are told to keep this health information private and not to share with anyone else. If there is health information you would like not to be shared, please contact the school nurse.*

Please turn page over.

Student name_____
(Please print in ink) Last First Date of Birth Grade

5. Does your child have any **allergic reaction** (bad effect) from any of the following? (Check all that apply.)
☐ Outside or Indoor allergies, (*for example: hay fever, grass, pollen, cats …*) **Please list below ↓**
☐ Food Allergies (*for example: peanuts, milk, wheat ...)* **Please list below ↓**
☐ Insect or Animal Allergies (*for example: bees, wasps, cats…)* **Please list below ↓**
☐ Medicine or shots (*immunization*). **Please list below ↓**
☐ **No**, my child has no allergies that I know of.
Does your child have an **Epi-Pen** or **Auvi-Q?** ☐ Yes ☐ No If **YES**, please bring one to school.

My child is allergic to:	**What happens when your child has a reaction?**
Example: amoxicillin	Diarrhea (runny poop)

6. Has your child had any of the following **medical problems or injuries**? (Examples in parenthesis)
Describe **your child's** problem for each ☒ **Yes** on the lines at the bottom of the page ↓.

Chicken Pox--Date if had chickenpox:	☐ Yes ☐ No
Surgery --Date of any surgeries:	☐ Yes ☐ No
Head Injury or **Concussion**	☐ Yes ☐ No
Ear infections *(often has them, ear tubes, etc.)*	☐Yes ☐ No
Nose problems *(sinus infections, nose bleeds)*	☐Yes ☐ No
Eye problems *(blurry vision, wears glasses, lazy eye)*	☐Yes ☐ No
Hearing problems *(has trouble sometimes, wears hearing aid)*	☐Yes ☐ No
Mouth or throat problems *(Strep throat, swallowing problems)*	☐Yes ☐ No
Constipation *(problems having a bowel movement (BM))*	☐Yes ☐ No
Problems **peeing** *(bed wetting, pain when peeing)*	☐Yes ☐ No
Back problems *(crooked back, back pain)*	☐Yes ☐ No
Muscle and bone problems *(weak muscles, pain in joints)*	☐Yes ☐ No
Skin problems *(acne, flaking skin, rashes, hives)*	☐Yes ☐ No
Seizures *(shaking fits or convulsions)*	☐Yes ☐ No
ADD/ADHD *(problems paying attention, sitting still)*	☐Yes ☐ No
Breathing problems *(cough, asthma)*	☐Yes ☐ No
Heart problems *(fast or irregular heartbeat, murmur, birth defect)*	☐Yes ☐ No
Feelings or emotions (*depression, anxiety, fears)*	☐Yes ☐ No
Other:	☐Yes ☐ No

_____/_____ _____
Signature and /Relationship to Student **Date**

Student Name _____
(Please print in blue or black ink) Last First M/F Date of Birth Grade

White River Valley Supervisory Union Annual Medical Authorization Form

Bethel Chelsea Granville Hancock Rochester Sharon South Royalton Stockbridge Strafford Tunbridge

Please circle your town of residence

Legal Guardian: _____ Relationship _____

Physical address:_____
Street City State Zip code

Father/ Guardian Information	**Mother/ Guardian Information**
Name _____	Name _____
Custodial Parent ____Yes _____ No	Custodial Parent ____Yes _____ No
Mailing Address_____	Mailing Address_____
Town of legal address _____	Town of legal address _____
Home #: _____Cell #_____	Home #: _____Cell #_____
Employer:_____ Work #_____	Employer:_____ Work #_____
Email:	Email:

**Please list any adults who may be contacted and assume temporary care of your child if the school cannot contact you by phone. This adult must be willing and able to take care of your child during school hours.

Emergency contact one	**Emergency contact two**
Name _____	Name _____
Custodial Parent ____Yes _____ No	Custodial Parent ____Yes _____ No
Mailing Address_____	Mailing Address_____
Town of legal address _____	Town of legal address _____
Home #: _____Cell #_____	Home #: _____ Cell _____
Employer :_____ Work #_____	Employer :_____ Work #_____
Email: _____	Email: _____
Occupation:	Occupation:

Insurance information

Dr. Dinosaur/Medicaid MVP VHAP PCP VT BC/BS CIGNA None Other: _____
Policy number: _____ Group number _____

If No, **dial 1- 855-899-9600** for Vermont Health Connect info
https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action]

Doctor's Name:	Phone
What was the date of your child's last well child visit* received by their primary care provider? **Date:**_____	
Dentist's Name:	Phone
What was the date of your child's last dental exam received by their dentist? **Date:**_____	

*** A comprehensive well-care (physical) visit is not a sick appointment.**

HealthHub: Students at our school have access to medical care through the HealthHub School Based Clinic. This provides them the opportunity to see a Pediatrician. This doctor can help with health maintenance for certain problems (asthma, depression, ADHD), sick visits, sports physicals/well child check-ups, immunizations etc. This doctor would not replace your primary care doctor but provides a service to help parents and students miss less work/class time. All visit notes are shared with your child's primary doctor. In addition, dental hygiene and mental health services are available. I am interested in my child receiving HealthHub Services and would like more information.

Signature of Guardian_____ **OVER>>>>>>>>>>>**

Student Name _____
(Please print in blue or black ink) Last First M/F Date of Birth Grade

STUDENT'S MEDICAL HISTORY:

1. Does your child have any **allergic reaction** (bad effect) from any of the following? (Check all that apply.)

☐ Outside or Indoor allergies, (*for example: hay fever, grass, pollen, cats …*) **Please list below ↓**

☐ Food Allergies (*for example: peanuts, milk, wheat ...)* **Please list below ↓**

☐ Insect or Animal Allergies (*for example: bees, wasps, cats…)* **Please list below ↓**

☐ Medicine or shots (*immunization*). **Please list below ↓**

☐ **No**, my child has no allergies that I know of.

2. Does your child have an **Epi-Pen** or **Auvi-Q?** ☐ Yes ☐ No If **YES**, please bring one to school.

My child is allergic to: *Example (amoxicillin)*	**What happens when your child has a reaction?** *Diarrhea, rash, difficulty breathing*

3. ASTHMA: Has a doctor, nurse, or other health professional EVER said that your child has asthma?

_____ Yes _____ No _____ Don't know/not sure

If yes, does your child STILL have asthma?

_____ Yes _____ No _____ Don't know/not sure

4. Is your child taking any **prescription medicines**? **(Please include medications administered at home and during the school day)**

☐ Yes - Please list the child's medicines below

☐ No. My child does not take any prescription medicines. (If no, go to question #5)

☐ Yes ☐ No. My child uses an inhaler or breathing treatments? If YES, please list medicine below.

Name of medicine: ***Example:*** *dexedrine*	**Amount /dose** *10mg*	**How many pills or doses does your child take at** ***1*** *morning*	*½ noon*	*dinner*	*bed*
		___morning	____noon	____dinner	___bed
		___morning	____noon	____dinner	___bed
		___morning	____noon	____dinner	___bed

**If daily medication is to be administered at school, it must come in with a signed doctor's order and in a current pharmacy labeled bottle.

5. My child wears corrective lenses? YES_____ NO _____ Hearing aids? YES _____ NO _____

The following non-prescription medications are available from the school nurse and can be given according to age, weight and manufacturer's instructions at nurse/designee discretion. ***Please cross out*** if you do not wish your child to receive this medication while at school. Parents will be notified of any student receiving Ibuprofen, Acetaminophen, or Benadryl.

Ibuprofen (Advil) Acetaminophen (Tylenol) Benadryl Bacitracin Antacid tabs Skin lotion

Sunscreen Vaseline Eye Wash Eye drops Cough drops Orajel Wound Wash

I give permission to exchange health information between my child's primary care provider or dental provider and the school nurse, including vision and hearing screening information:

_____ **Parent/Guardian Signature**

In the event that your child has serious illness or injury, and if we are unable to reach a parent/guardian, please understand that School personnel will seek emergency medical care, including transportation to a medical facility. Emergency Personnel will make further decisions based on need. I understand the plan.

_____ **Parent/Guardian Signature**

*****This page only needs to be filled out if your child is attending a public prekindergarten listed below.*****

WHITE RIVER VALLEY SUPERVISORY UNION

Bethel Preschool Rochester Preschool Sharon Preschool and Child Care
South Royalton Preschool Stockbridge Preschool

Walking Field Trip Permission and Media Release

Student's Name: _____

My child resides in: _____

As a parent or legal guardian of the student named above:

□ I give permission for my child to go on walking field trips with her/his class.

□ I DO NOT give permission for my child to go on walking field trips with her/his class.

□ I give permission for my child to be photographed while engaged in school activities. I understand that the photos or videos may be displayed at school, without identifying name or caption, on the school website, or in the public media.

□ I DO NOT give permission for my child to be photographed while engaged in school activities. I understand that the photos or videos may be displayed at school, without identifying name or caption, on the school website, or in the public media.

□ I give permission for my child's school work to be published without identifying name or caption to appear on any district, school, or teacher website connected with the White River Valley Supervisory.

□ I DO NOT give permission for my child's school work to be published without identifying name or caption to appear on any district, school, or teacher website connected with the White River Valley Supervisory.

_____ _____

Parent/Guardian Signature Date

VMEP, UVM Extension
327 US Route 302, Suite 1, Barre, VT 05641
1-866-860-1382 ext. 208 & Fax: (802) 476-2006

Vermont Migrant Education Program
Agricultural Employment Survey

Please complete this form and return it to the school office.
Schools will mail all completed forms to the address listed above. All information provided is confidential.

Parent Name _____ Date completed_____

Address_____

Home/Cell Phone _____Message phone_____

Have you, your spouse or companion moved in the last three years?

☐ **Yes** If yes from where? _____ Please complete the rest of this form.

☐ **No** **You do not need to complete the rest of this form. Thank you!**

In the past three years, have ☐ you, ☐ your spouse, or ☐ companion
☐ worked in agriculture or logging?
☐ looked for work in agriculture or logging?
☐ currently working in agriculture or logging?

☐ **No**

Please check off all that apply:

☐ on any type of farm such as dairy, beef, sheep, turkey, chicken, egg, fish, emu, fruit or vegetable farm
☐ commercial greenhouse or nursery
☐ hauling milk or other raw agricultural products
☐ cheese plant, cannery, milk bottling plant or other food processing plant
☐ trimming and harvesting Christmas trees/ wreath making
☐ logging activities such as cutting trees/firewood, brush cutting, chipping, debarking trees, forestry or timber work, tree planting/pruning
☐ in a slaughterhouse or smokehouse
☐ replanting or restoring land used for mining or clear cutting purposes
☐ harvesting crops such as apples, grapes, hay, corn, and berries
☐ commercial fishing or fish farming

Please list all children ages 0 to 22 in your household: (list additional names on bottom of form)

Child:	Grade:	School:
Child:	Grade:	School:
Child:	Grade:	School:
Child:	Grade:	School:

08/2013

If your family qualifies for the Migrant Education Program, your child may receive **FREE** educational support services which may include free books, tutoring, summer programs, and/or resource referrals for services in your area.

Please return this form to school!

Cultivating Healthy Communities

VMEP, UVM Extension
327 US Route 302, Suite 1, Barre, VT 05641
1-866-860-1382 ext. 208 & Fax: (802) 476-2006

Program Narrative

WHO:

The Vermont Migrant Education Program serves **children and youth** (ages 3 – 21) whose families move from one school district to another to obtain temporary or seasonal work in agriculture or logging. There are no income guidelines used to determine eligibility.

WHAT:

The Program works with parents and teachers to provide **free educational support** to help students transition into their new schools. Support to schools and families may include:

- Instructional support
- Free books
- School and home coordination
- On-going school contact
- Preschool support
- Agency referral and coordination
- Summer support services
- Home visits
- Literacy based activities for families in their homes

HOW:

Recruitment Specialists contact schools, farms, agencies, and businesses to locate families whose children may be eligible for program services. Visits are then arranged to discuss the program and determine eligibility. To refer students please contact us at the above address.