NORWICH FREE ACADEMY

Office of the Registrar

REGISTRATION PACKET

Welcome to NFA.

This packet will streamline your child's registration process. You may download and print this packet, or pick one up at the Allis House on campus (see map).

Several pieces of information are required to enroll your child.

- The **medical information** required for enrollment is enclosed.
- The following **documents**:
    - All forms in this packet
    - Residency Affidavit, completed and signed by your town's Superintendent of Schools. Please check with your town for their requirements
    - Legal parent/guardian picture ID
    - Proof of guardianship (if not birth parent or if divorced): Adoption papers, court order, guardianship papers from probate court, or DCF Form 603
    - Student's birth certificate (long form)
    - All Academic records (Transcripts, test, report cards, etc.)
    - Bring current Individual Education Plan (IEP) for special education students
    - 504 Plan
    - Student's immunization record and last physical

A parent or legal guardian must be present at the registration appointment. If English is not your first language and you would like to bring an interpreter with you, please feel free to do so.

ONCE YOU HAVE ALL OF THE ABOVE INFORMATION AND HAVE COMPLETED THE ENCLOSED FORMS, PLEASE CALL 860-425-5605 TO MAKE AN APPOINTMENT.

If you have questions, please feel free to contact me at the number listed above.

To fax information prior to your meeting, address it to: Registrar – NFA at (860) 889-7124 or you may email the information to pishkam@nfaschool.org.

Sincerely,

Melody A. Pishka
Registrar

NORWICH FREE ACADEMY

Medical Center

Connecticut State Law requires all **new entering and re-entering** students be completely immunized before they start school. Requirements are as follows:

- **Measles, Mumps, and Rubella (MMR)**

Two doses at least one month apart

- **DPT/Tdap**

Three doses, one of which must be a Tdap- final dose after eleventh birthday

- **Polio**

At least three doses - final dose on or after fourth birthday

- **Varicella (Chickenpox)**

Proof of disease or date of Varicella immunizations; Two doses required at least one month apart

- **Hepatitis B**

Three doses

- **Meningitis**

One dose

- **Tuberculosis**

Recent tuberculosis screening with results, or note from licensed care provider stating not at high risk for tuberculosis.

Out-of-State Transfer Students must provide

- **Physical examination** performed within the past year.

Out-of-Country Transfers must provide:

- **Physical examination** performed within the past year
- **Tuberculosis Screening** results within past six (6) months

****Please address any health or medical questions to the Medical Center****
860-425-5551

State of Connecticut Department of Education

Health Assessment Record

CONNECTICUT STATE DEPARTMENT OF EDUCATION

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	❑ Black, not of Hispanic origin
Primary Care Provider	❑ American Indian/ Alaskan Native	❑ White, not of Hispanic origin
	❑ Hispanic/Latino	❑ Asian/Pacific Islander
		❑ Other
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____
Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No

Risk Assessment	**Describe Risk Factors**	
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other _____

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian Date

_____

Signature of health care provider DMD / DDS / MD / DO / APRN / PA / RDH Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 7/2018

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption: Religious _____ **Medical:** Permanent _____ Temporary _____ **Date:** _____

Renew Date: _____ _____ _____ _____

Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.
Medical exemptions that are temporary in nature must be renewed annually.

Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

Connecticut Tuberculosis (TB) Risk Assessment

See ***the Connecticut TB Risk Assessment User Guide*** for more information about using this tool.

- Use this tool to identify asymptomatic **adults and children** for latent TB infection (LTBI) testing.
- This tool can be used for school-aged children to determine if a student should have a TB test.
- This risk assessment does not supersede any TB testing mandated by statute, regulation or policy.
- **Do not repeat testing** unless there are **new risk factors** since the last test.
  If initial negative screening test occurred prior to 6 months of age, repeat testing should occur at age 6 months or older.
- Do not treat for LTBI until active TB disease has been excluded:
  For persons with TB symptoms or an abnormal chest x-ray, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum acid-fast bacilli (AFB) smears, cultures and nucleic acid amplification testing (NAAT). A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

LTBI testing is recommended if any of the boxes below are checked.
☐ **Birth, travel, or residence** for at least 1 month in a country with an elevated TB rate
• Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
• If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the Connecticut Tuberculosis Risk Assessment User Guide for this list).
• IGRA is preferred over TST for non-U.S.-born persons ≥2 years old
☐ **Immunosuppression,** current or planned
• HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥2 mg/kg/day, or ≥15 mg/day for ≥1 month) or other immunosuppressive medication
☐ **Close contact** to someone with infectious TB disease
• Should test if patient has never been tested for this exposure
Treat for LTBI if TB test result is positive and active TB disease is ruled out.

☐ **None of the above**: No TB testing is indicated **at this time**.*

Please complete all information below:

Patient/Student Name:_____ Date of Birth: ____ /____ /____

Provider's Name: _____ Assessment Date: ____ /____ /____

***See The Connecticut TB Risk Assessment: User Guide section "Local recommendations, mandated testing and other risk factors."**

Authorization for the Administration of Medication by School Personnel

In Connecticut schools, administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the school with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth___/___/___ Today's Date___/___/___

Medication Name/Generic Name of Drug_____Controlled Drug ☐ YES ☐ NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration_____If PRN, frequency_____

Medication shall be administered: Start Date:___/___/___End Date:___/___/___

Relevant Side Effects of Medication_____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title_____Phone Number (___) _____

Prescriber's Address_____Town _____

Prescriber's Signature_____Date___/___/___

Prescriber's authorization for self-administration: YES ☐ NO ☐

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered at school, I and I give permission for the exchange of information between the prescriber and the school nurse that is necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

Parent/Guardian Signature_____Relationship_____Date___/___/___

Parent /Guardian's Address_____Town_____State_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber (when applicable) and must be authorized by a parent/guardian in accordance with board policy. In a school: 1. inhalers for asthma and cartridge injectors for life-threatening allergies require authorization by the prescriber and a parent/guardian only; 2. students may possess, self-administer or possess and self-administer medications for medically-diagnosed life-threatening allergies; and 3. students who are six years of age or older may possess and self-supply an over-the-counter sunscreen product with only the parent/guardian written authorization.

Student to self-administer medication specified on this form: YES ☐ NO ☐

Parent/Guardian authorization and signature: _____
Signature Date

School nurse, if applicable, approval for self-administration: _____
Signature Date

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

NORWICH FREE ACADEMY

Medical Center

Authorization for NFA Supplied Medication

Acetaminophen, Pepto Bismol and Maalox will be provided by the Medical Center for those students with appropriately completed medication orders. The school nurse has my permission to administer the following medications ***as ordered by NFA's Medical Advisor*** on an "as needed" basis during the school day.

Student's Name: _____ Date of Birth: _____ Grade:_____

Medication Allergy: _____

Medication shall be administered from : _____ to: _____
Month/Day/Year Month/Day/Year

Over the Counter Medication	**Dosage and Time**	**Conditions/Symptoms**	**Possible Side Effects**	**Comments**
Tylenol (Acetaminophen)	650 mg q 4 hrs prn (or 15 mg/kg)	General discomfort or fever	Nausea, jaundice, Abdominal pain	
Peptol Bismol (Bismuth Subsalicylate)	30 mL or 2 TBSP Every ½ to 1 hour prn. May repeat x1	Diarrhea, nausea, heartburn, indigestion, upset stomach	Bleeding, ringing in ears, hearing loss	
Maalox (Aluminum hydroxide/ Magnesium hydroxide)	2 tsp x1 prn	Heartburn, indigestion, pressure, bloating	Constipation, diarrhea, increased thirst, stomach cramps	

Authorization of the Parent/Guardian for the Administration of the above Medication

Parent/Guardian Signature: _____ **Date:** _____

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NORWICH FREE ACADEMY

Medical Center

Special Health Conditions Information Sheet

A. If your child has Asthma:

1. And requires use of an inhaler while at school, an Authorization of Medication form is enclosed for both the authorized prescriber and you to complete and return to the Medical Center. Please have your child's licensed care provider complete the enclosed Asthma Action Plan.
2. Inhalers may be self-administered and carried by the student at school only with written permission from both the authorized prescriber and the parent. The school nurse will meet with your child to review inhaler use after receiving the medication order.

B. If your child has Diabetes:

1. Contact your child's physician to determine if she/he would prefer to have glucose testing routinely performed at school, as well as insulin and/or glucagon administered at school.
2. If your doctor orders medication to be administered at school, an Authorization for Administration of Medication form is enclosed for both the authorized prescriber and you to complete and return to the Medical Center prior to the start of the school year.
3. This order must be updated each school year.

C. If your child has a Bee Sting/Food Allergy/Life Threatening Allergy/Medical Condition

1. Please provide a signed letter from your child's doctor with instructions the school is to follow in the event he/she experiences an allergic reaction while at school or while attending a field trip or sport activity.
2. Fill out and return the enclosed Special Health Conditions form.
3. If medication is required, an Authorization for Administration of Medication form is enclosed for both the Authorized prescriber and you to complete and return to the Medical Center prior to the start of the school year.
4. If your child requires medication for an allergy, please know that your child will not be eligible to attend field trips or sports activities until the medication order is on file in the Medical Center. (A new order is required each school year.) When an epinephrine kit (Epi Pen or Ana Kit) is required for your child, this medication may be carried by the student at school if both your child's physician and you agree to your child's self-administration of this medication. If your child has an order to self-administer an Epi Pen, he/she must have this medication with him/her to attend field trips or sport activities. The school nurse will meet with your child to review Epi Pen use after receiving the medication order.
5. Bring any emergency medication to the Medical Center at NFA to be available if necessary, OR please let us know if your child will be carrying the medication on his/her person for self-treatment.
6. If your son/daughter needs to use the Epi Pen or Ana Kit, please be sure he/she knows to inform the Medical Center immediately.
7. If your child has a food allergy return the Medical Statement for Children Requiring Special Meals to the Medical Center after your child's licensed care provider has completed the form. A copy of this will be forwarded to the cafeteria director.
8. An Individualized Health Care Plan is developed if your child has a life threatening allergy.

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D. If your child has Glycogen Storage Disease:

An individualized health care plan will be established and the school nurse will meet with your child after the Diabetic Management Plan is received from your child's licensed care provider to review the plan.

E. If your child requires medication at school:

1. ALL oral medications needed to be given during school hours are given by the SCHOOL NURSES. DO NOT send medication of any kind in any amount to school with your child with instructions for him/her to "take it on his/her own." The child will not be permitted to assume this responsibility. If your child must receive medication during school hours, please abide by the following:
2. An AUTHORIZATION FOR MEDICATION form signed by both authorized prescriber AND parent which includes the name of the medication, reason for the medication, the dosage and length of time to be given must be on file. NO medication will be given without this completed form. This applies to all medications given by the nurse in the Medical Center as well as to emergency medications which may be self-administered by the student. A new signed Authorization form is required each school year. The Medical Center will have Acetaminophen (Tylenol), Pepto Bismol, and Maalox available to students once a completed licensed care provider's order for any of these medications are received.

F. Postural screening will be provided to ninth grade males who did not receive testing in grade 8. This will occur in the Medical Center beginning in the fall semester.

G. Should your child transfer from Norwich Free Academy to another school within Connecticut his/her cumulative health record will be sent to the new school. If your child transfers out of state, the Medical Center will provide you with a copy of his/her latest physical and a copy of immunizations upon your request.

If you have any questions, please call us at 860-425-5552, 860-425-5550, or 860-425-5553. Thank you for your cooperation.

NORWICH FREE ACADEMY

Medical Center

Special Health Conditions and Medical Information Form

To better care for your child, please provide us with the following information. Notify the Medical Center of any changes throughout the school year.

Student Name_____ Date of Birth _____ Grade_____
Parent/Guardian Name_____
Address_____ Phone _____
Primary Physician_____ Phone _____

Please circle **Y** if "yes" or **N** if "no". Explain all "yes" answers in the space provided below.

Allergies to food or bee stings	Y	N	Neck or back injuries	Y	N	Bleeding disorder	Y	N
Allergies to medication	Y	N	Muscle or joint injury	Y	N	Asthma	Y	N
Any other allergies	Y	N	Excessive Weight gain/loss	Y	N	Seizures	Y	N
Medication required for allergy	Y	N	Concussion(s)	Y	N	Diabetes	Y	N
Vision problems	Y	N	Fainting or blacking out	Y	N	ADD/ADHD	Y	N
Hearing problems	Y	N	Heart problem	Y	N	Gastrointestinal condition	Y	N
Speech problems	Y	N	High blood pressure	Y	N	Chronic headaches	Y	N
Learning disability	Y	N	Surgeries	Y	N	Routinely taking medication	Y	N
Immunodeficiency	Y	N	Depression/Psych. Diagnosis	Y	N	Other		

Please explain all "yes" answers below to include dates and details. If taking medication (routine or as needed) list name of medication, dose and reason for taking medication.

_____
_____
_____

Should your child have any limitation that would restrict him/her from participating in school activities, including gym, we need documentation from your child's licensed care provider stating the specific restrictions required and the reason.

Postural Screening for scoliosis (curvature of the spine) is required per CT law on all ninth grade male students who did not receive testing in grade 8 and will be performed in the Medical Center.

Does your child have health insurance? Yes ☐ No ☐

If your child is uninsured and you would like to participate in Connecticut's HUSKY Plan, the application can be downloaded at http://www.huskyhealth.com. If you would like more information concerning the plan, you may contact HUSKY Information Hotline at 1-877-284-8759.

List specialists, clinics, therapists, or other health care providers consulted for your child, the condition involved, and dates of the most recent exam. Norwich Free Academy may contact health care providers/physicians listed as needed.

Health Care Provider	Condition	Date Last Seen

_____ _____
Parent/Guardian Signature Date

Medical Statement for Meal Modifications in School Nutrition Programs

This form applies to requests for meal modifications for children participating in the U.S. Department of Agriculture's (USDA) school nutrition programs. Schools and institutions are required to make reasonable meal modifications for children whose physical or mental impairment restricts their diet. For guidance on meal modifications and instructions for completing this form, see the Connecticut State Department of Education's (CSDE) *Guidance and Instructions: Medical Statement for Meal Modifications in School Nutrition Programs*.

Note: The USDA requires that the medical statement includes information about the child's physical or mental impairment that is sufficient to allow the school food authority (SFA) to understand how the physical or mental impairment restricts the child's diet; an explanation of what must be done to accommodate the child's disability; and if appropriate, the food or foods to be omitted and recommended alternatives. **Schools and institutions should not deny or delay a requested meal modification because the medical statement does not provide sufficient information.** When necessary, schools and institutions should work with the child's parent or guardian to obtain the required information.

Section A – Completed by parent or guardian

1. Name of child: _____ 2. Birth date: _____
3. Name of parent or guardian: _____
4. Phone number (with area code): _____ 5. E-mail address: _____
6. Address: _____ City: _____ State: _____ Zip: _____
7. In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPA), I hereby authorize _____
   name of child's recognized medical authority
   to release such protected health information of my child as is necessary for the specific purpose of special diet information to _____ and I consent to allow the recognized medical authority to freely
   name of school district
   exchange the information listed on this form and in my child's records with the school district as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that I may rescind permission to release this information at any time, except when the information has already been released.
8. Signature of parent or guardian: _____ 9. Date: _____

Section B – Completed by child's recognized medical authority

This section must be completed by the child's physician, physician assistant, doctor of osteopathy, or advanced practice registered nurse (APRN). APRNs include nurse practitioners, clinical nurse specialists, and certified nurse anesthetists who are licensed as APRNs.

10. **Physical or mental impairment:** Does the child have a physical or mental impairment that restricts the child's diet?
    ☐ **No** ☐ **Yes:** Describe how the child's physical or mental impairment restricts the child's diet.

11. **Diet plan:** Explain the meal modification for the child. Attach a specific diet plan, if needed.

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Section B – Completed by child's recognized medical authority, continued

12. **Food omissions and substitutions:** List foods to be omitted from the child's diet and foods to be substituted**.**

13. **Food texture:** List foods that require a change in texture. Indicate "all" if all foods should be prepared in this manner.
    - ☐ Cut up or chopped into bite-size pieces: _____
    - ☐ Finely ground: _____
    - ☐ Pureed: _____

14. **Equipment:** List any special equipment or utensils needed.

15. **Additional information:** Indicate any other information about the child's eating or feeding patterns that will assist in providing the requested meal modification.

16. Name of recognized medical authority: _____ 17. Phone number (with area code): _____

18. Signature of recognized medical authority: _____ 19. Date: _____

20. Office Stamp:

This form is available at https://portal.ct.gov/-/media/SDE/Nutrition/NSLP/SpecDiet/MedicalStatementSNP.pdf.

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To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

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Inquiries regarding the Connecticut State Department of Education's nondiscrimination policies should be directed to: Levy Gillespie, Equal Employment Opportunity Director/Americans with Disabilities Coordinator (ADA), Connecticut State Department of Education, 450 Columbus Boulevard, Suite 607, Hartford, CT 06103, 860-807-2071, levy.gillespie@ct.gov.

NORWICH FREE ACADEMY

Residency Affidavit and Pre-Registration Approval Form

I _____ _____ am seeking enrollment at
Name *DOB*

Norwich Free Academy effective _____, 20____.

I currently reside at:

_____
Street *City* *State* *Zip Code*

I currently live with _____ _____
Name(s) *Telephone No.*

who is/are my (check one):

____ parent(s) ____ legal guardian ____ spouse ____ friend
____foster home ____ family relative (indicate relationship): _____
____other

If other, please explain _____

I have been living at this address since _____
Day / Month / Year

_____ _____
Previous Residency *Years / Months*

Last school attended _____

Year attended _____ Number of credits earned _____ Grade _____

I am a (check one): ____ Regular Education Student ____ Special Education Student

_____ _____
Parent / Legal guardian Signature *Date*

The town of _____ has reviewed this form and is recommending that the above-named individual complete the registration process for Norwich Free Academy. The Town of _____ assumes the cost of tuition for this individual for the remainder of his/her high school career as long as the above-named individual maintains the residency as stated above or remains within the sending district. Please note that this does not include potential fifth-year students who need additional approval from the sending town.

_____ _____
Superintendent's Signature *Date*

Please return to:
Registrar's Office
305 Broadway
Norwich, CT 06360
860-425-5605