

64 West Main Street, Norton, MA 02766

Phone: (508) 285-0100 Fax: (508) 285-0199

Student Name: _____
(Please print)

By checking this box and typing my name in required fields,
 I am electronically signing my application.

New Student Registration Kindergarten

Required Forms / Documents Checklist

<input type="checkbox"/>	NPS Registration Form
<input type="checkbox"/>	NPS Home Language Survey
<input type="checkbox"/>	NPS Verification of Residency Form (with residency proof attached) or NPS Residency Affidavit
<input type="checkbox"/>	Early Childhood Education Experience Survey
<input type="checkbox"/>	ASQ:SE-2 Ages and Stages Questionnaire
<input type="checkbox"/>	Birth Certificate Copy
<input type="checkbox"/>	Health Record Copy (including immunizations)
<input type="checkbox"/>	Parent / Guardian Photo Identification

Complete registration packets should be returned to the Norton Public Schools Central Office located at 64 West Main Street.

Our Mission: Promote individual talents and maximize each student's potential.

It is the policy of Norton Public Schools to provide a learning environment free from discrimination or harassment. All students, regardless of race, color, sex, religion, national origin, limited English proficiency, sexual orientation, gender identity, disability, or housing status, have equal access to all programs including athletics and other extracurricular activities.

Student Registration Date: _____

Student Information	<i>Please Print</i>			GRADE ENTERING: _____	
Student's Last Name	SASID: _____				
Student's First Name					
Student's Middle Name	(Enter <i>NMN</i> If Student Has No Middle Name)				
Street Address	Apt # _____				
City, State Zip Code					
Primary Contact Phone					
Sex (Circle One)	Female	Male	Non-Binary		
Birth Date (Month / Day / Year)					
School (Circle One)	JCS	LGN	HAY	NMS	NHS
Place Of Birth					
State of Birth					
First Language					
Country Of Origin					
Race (You May Circle More Than One)	01 White			04 American Indian Or Alaska Native	
	02 Black Or African American			05 Native Hawaiian Or Other Pacific Islander	
	03 Asian				
Ethnicity (Circle One)	No, Not Hispanic Or Latino		Yes, Hispanic Or Latino		
Baby Sitter/Day Care (If Applicable)	Name: _____			Phone: _____	
Does your child have an Individualized Ed. Plan or 504 Plan? (Circle One)	IEP	504 Plan	No Plan		
Student's Physician					
Student's Dentist					
Is your child covered by health insurance? (Circle One)	Yes	No			
Please list other family members enrolled in Norton Public Schools					

Parent/Guardian Contact Information	Father/Guardian 1	Mother/Guardian 2		
Name				
Cell Phone				
Email				
Employer				
Business/Work Phone				
Pupil Lives With (Circle One)	Both Parents	Father	Mother	Guardian
Custodial Issues (Circle One)	Yes	No		If there are any legal issues concerning custodial / parental rights, please explain on the reverse side.
Release Only To:				

Emergency Contact Information	Emergency Contact 1	Emergency Contact 2
Name		
Relationship		
Emergency Phone		

If there are any legal issues concerning custodial / parental rights, please explain below.

Home Language Survey

Massachusetts Department of Elementary and Secondary Education regulations require that *all* schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. If a language other than English is spoken in the home, the District is required to do further assessment of your child. Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

Student Information			
First Name _____	Middle Name _____	Last Name _____	Gender F <input type="checkbox"/> M <input type="checkbox"/>
Country of Birth _____	Date of Birth (mm/dd/yyyy) _____ / _____ / _____	Date first enrolled in ANY U.S. school (mm/dd/yyyy) _____ / _____ / _____	
School Information			
Start Date in New School (mm/dd/yyyy) _____ / _____ /20_____		Name of Former School and Town _____	Current Grade _____
Questions for Parents/Guardians			
What is the primary language used in the home, regardless of the language spoken by the student? _____	Which language(s) are spoken with your child? (include relatives -grandparents, uncles, aunts, etc. - and caregivers) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always		
What language did your child first understand and speak? _____	Which language do you use most with your child? _____		
How many years has the student been in U.S. Schools? (not including pre-kindergarten) _____	Which languages does your child use? (circle one) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always		
Will you require written information from school in your native language? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, what language? _____	Will you require an interpreter/translator at Parent-Teacher meetings? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, what language? _____		
Parent/Guardian Signature: X _____	Today's Date: (mm/dd/yyyy) _____		

Verification of Residency

STUDENT'S NAME _____
[Last] [First] [Middle Initial]

RESIDENCE _____
[House Number/Street] [Apartment #] [Zip Code]

DATE OF BIRTH _____
[Month] [Day] [Year]

THE ABOVE-LISTED STUDENT IS REGISTERING AT -
[Check One]

- | | |
|--|---|
| <input type="checkbox"/> L. G. Nourse Elementary School
<input type="checkbox"/> H. A. Yelle Elementary School
<input type="checkbox"/> Norton High School | <input type="checkbox"/> J. C. Solmonese Elementary School
<input type="checkbox"/> Norton Middle School |
|--|---|

VERIFICATION OF RESIDENCY

I UNDERSTAND THAT A STUDENT MUST RESIDE IN NORTON TO ATTEND THE NORTON PUBLIC SCHOOLS. AS THE ADULT WITH WHOM THIS STUDENT IS RESIDING AT THE ADDRESS SHOWN ABOVE, I HEREBY CERTIFY THAT I AM THE STUDENT'S

[Please Check Relationship Below]

- PARENT
 LEGAL GUARDIAN
 OTHER RELATION _____
[PLEASE SPECIFY]

I AGREE TO NOTIFY SCHOOL AUTHORITIES OF ANY CHANGE OF ADDRESS WITHOUT DELAY.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY THIS --

_____ day of _____, _____
[Date] [Month] [Year]

PRINT NAME SIGNATURE

TYPE OF RESIDENCY PROOF ACCEPTED

- PURCHASE AND SALES AGREEMENT
 UTILITY RECEIPT
 REAL ESTATE TAX BILL
 RENT RECEIPT
 OTHER DOCUMENTATION _____
[Please Specify]

Date School Staff Person Accepting Proof of Residency
 REFERRED TO ATTENDANCE OFFICER

Early Childhood Education Experience Survey

Please check next to the option that best describes your child's preschool experience **in the school year prior to entering Kindergarten**. Select one option only, and indicate hours where applicable. Thank you!

Name of Child: _____ Date of Birth: _____

<input type="checkbox"/>	(01) My child did not have any formal early childhood program experience.
<input type="checkbox"/>	(02) My child did not have formal early childhood program experience but participated in Coordinated Family and Community Engagement* (CFCE) services.
<input type="checkbox"/>	(03) My child did not have formal early childhood program experience but participated in Parent Child Home Program* (PCHP) services.
<input type="checkbox"/>	(04) My child did not have formal early childhood program experience but participated in BOTH Coordinated Family and Community Engagement* (CFCE) AND Parent Child Home Program* (PCHP) services.
<input type="checkbox"/>	My child attended a Licensed Family Child Care Provider* (indicate hours below). (05) ___ for less than 20 hours per week (06) ___ for 20+ hours per week
<input type="checkbox"/>	My child attended a Center Based Program* (indicate hours below). (07) ___ for less than 20 hours per week (08) ___ for 20+ hours per week
<input type="checkbox"/>	My child attended BOTH a Licensed Family Child Care Provider* AND a Center Based Program* (indicate hours below). (09) ___ for less than 20 hours per week (10) ___ for 20+ hours per week
* Coordinated Family and Community Engagement (CFCE) Services: locally based programs serving families with children birth through school age (e.g. parent/child playgroups, parent-child activities).	
* Parent Child Home Program (PCHP): home visiting model program funded through the Department of Early Education and Care.	
* Licensed Family Childcare: refers to EEC licensed child care in a group setting in a home. It may include care in the home of a family member, if the provider is both a relative and an EEC licensed child care provider providing care to children from multiple families	
* Center-Based Care: refers to care for children in a group setting, including public and private preschools, Head Start, day care centers, and integrated public preschools.	

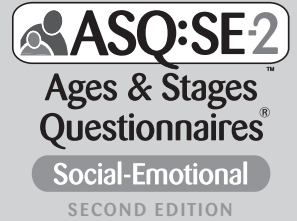
Have there been any specific concerns about your child during their time in preschool? If so, please explain.

Has your child ever been asked to leave a preschool or daycare due to behavioral concerns? If so, please explain.



60 Month Questionnaire

54 months 0 days through 72 months 0 days



Date ASQ:SE-2 completed: _____

Child's information

Child's first name: _____ Child's middle initial: _____ Child's last name: _____

Child's date of birth: _____

Child's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

City: _____ State/province: _____ ZIP/postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Relationship to child: Parent Guardian Teacher Other: _____
 Grandparent/other relative Foster parent Child care provider _____

People assisting in questionnaire completion: _____

Program information

(For program use only.)

Child's ID #: _____ Age at administration in months and days: _____

Program ID #: _____

Program name: _____

Questions about behaviors children may have are listed on the following pages. Please read each question carefully and check the box that best describes your child's behavior. Also, check the circle if the behavior is a concern.

Important Points to Remember:

- Answer questions based on what you know about your child's behavior.
- Answer questions based on your child's *usual* behavior, not behavior when your child is sick, very tired, or hungry.
- Caregivers who know the child well and spend more than 15-20 hours per week with the child should complete ASQ:SE-2.
- Please return this questionnaire by: _____
- If you have any questions or concerns about your child or about this questionnaire, contact: _____
- Thank you and please look forward to filling out another ASQ:SE-2 in _____ months.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
1. Does your child look at you when you talk to her?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
2. Does your child cling to you more than you expect?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
3. Does your child like to be hugged or cuddled?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
4. Does your child talk or play with adults he knows well?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
5. When upset, can your child calm down within 15 minutes?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
6. Does your child seem too friendly with strangers?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
7. Does your child settle herself down after exciting activities?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
8. Does your child seem happy?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____



TOTAL POINTS ON PAGE _____

60 Month Questionnaire



Check the box that best describes your child's behavior. Also, check the circle if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
9. Does your child cry, scream, or have tantrums for long periods of time?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
10. Is your child interested in things around him, such as people, toys, and foods?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
11. Does your child go to the bathroom by herself? (Reminders and help with wiping are okay.)	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
12. Does your child have eating problems? For example, does he stuff food, vomit, eat things that are not food, or _____? (Please describe.) _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
13. Does your child stay with activities she enjoys for at least 15 minutes (other than watching shows or videos, or playing with electronics)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
14. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
15. Does your child do what you ask him to do? For example, does he wash his hands or wait to take a turn when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
16. Does your child seem more active than other children her age?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
17. Does your child sleep at least 8 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
18. Does your child use words to tell you what he wants or needs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE _____

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
19. Does your child use words to describe her feelings and the feelings of others? For example, does she say, "I'm happy," "I don't like that," or "She's sad?"	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
20. Does your child move from one activity to the next with little difficulty (for example, from playtime to mealtime)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
21. Does your child explore new places, such as a park or a friend's home?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
22. Does your child do things over and over and get upset when you try to stop him? For example, does he rock, flap his hands, spin, or _____? (Please describe.) _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
23. Does your child hurt herself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
24. Does your child follow rules at home or at child care?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
25. Does your child destroy or damage things on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
26. Does your child stay away from dangerous things, such as fire and moving cars?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
27. Does your child show concern for other people's feelings? For example, does he look sad when someone is hurt?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
28. Do <i>other</i> children like to play with your child?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____



TOTAL POINTS ON PAGE _____

60 Month Questionnaire



Check the box that best describes your child's behavior. Also, check the circle if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
29. Does <i>your child</i> like to play with other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
30. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
31. Does your child take turns and share when playing with other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
32. Does your child show an unusual interest in or knowledge of sexual language and activity?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
33. Does your child wake three or more times during the night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
34. Is your child too worried or fearful? If "sometimes" or "often or always," please describe: _____ _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
35. Does your child have simple back-and-forth conversations with you? For example: Parent: "It's raining!" Child: "And cold outside." Parent: "Let's get your coat." Child: "I got it!"	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
36. Has anyone shared concerns about your child's behaviors? If "sometimes" or "often or always," please explain: _____ _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE _____

OVERALL Use the space below for additional comments.

37. Do you have concerns about your child's eating, sleeping, or toileting habits?
If yes, please explain:

YES NO

38. Does anything about your child worry you? If yes, please explain:

YES NO

39. What do you enjoy about your child?
