# NEW STUDENT RESIDENCY AND REGISTRATION CHECKLIST REQUIRED DOCUMENTS

**RESIDENCIA DEL NUEVO ESTUDIANTE E INSCRIPCIÓN LISTA DE LOS DOCUMENTOS REQUERIDOS**

**STUDENT'S NAME:** _____
*Nombre del estudiante*

**SCHOOL NAME:** _____ **SCHOOL GRADE:** _____
*Nombre de la escuela* *Grado*

## RESIDENCY VERIFICATION *Verificación de Residencia*

1. _____ **Affidavit of: Parent/Guardian(Form A1) OR Sponsor (Form A2) OR Legal Residence (Form A3)**
***Declaración Jurada de: Padre o Tutor (Formulario A1) O Patrocinador (Formulario A2) O Residencia Legal (Formulario A3)***
2. _____ **Homeowners: Mortgage statement, deed or real estate tax bill**
***Propietarios: factura de la hipoteca, título de propiedad o impuesto sobre bienes inmuebles***
**OR**
**Renters: Current signed lease OR landlord Affidavit (Form B) Lease expiration date:** _____
***Inquilinos: contrato vigente firmado Y declaración jurada del propietario (Formulario B)*** ***Fecha de vencimiento del arrendamiento***
3. _____ **Two (2) current utility bills ☐ gas ☐ electric ☐ oil ☐ water ☐ cable only (No Telephone)**
***Dos facturas vigentes: gas/luz/combustible para la calefacción/agua/cable (La factura del teléfono no sirve)***
4. _____ **Parent/guardian's photo identification**
***Identificación con foto del padre/tutor***

## REGISTRATION *Inscripción*

5. _____ **Original or copy of original birth certificate or passport (*must have raised seal*)**
***Original o copia del acta de nacimiento o pasaporte original (debe tener sello en relieve)***
6. _____ **Registration form (basic student information form) (Form C)**
***Formulario de inscripción (Formulario básico con la información del estudiante) (Formulario C)***
7. _____ **Emergency Contact form (Form D)**
***Formulario con la información de contacto en caso de emergencia (Formulario D)***
8. _____ **Request for student records form (Form E)**
***Formulario para solicitar el expediente escolar del estudiante (Formulario E)***
9. _____ **Current report card / high school transcript**
***Boletín de notas actual / Expediente escolar de secundaria***

## HEALTH/OTHER *Salud/ Adicionales*

10. _____ **Health Assessment Record (Medical/immunization records) (Form F)** ***El informe médico y las vacunas (Formulario F)***
11. _____ **Permission for Treatment (Form G for K-8 Students, Form H for GHS Students)**
***Permiso para tratamiento (Formulario G para estudiantes de jardín de infantes a octavo grado, Formulario H para estudiantes de secundaria)***
12. _____ **Custody Paperwork (*if applicable*)**
***Los trámites de la custodia (si aplica)***
13. _____ **IEP Evaluations (*if applicable-special education)***
***Evaluaciones del plan de educación individual o IEP (si aplica – educación especial)***

***For School Office Use Only / Para uso exclusivo de la oficina escolar*** ***For Residency Office Use Only / Para uso exclusivo de la oficina de residenc***

# AFFIDAVIT OF PARENT / GUARDIAN
# GREENWICH PUBLIC SCHOOLS

I hereby certify that _____ is my_____
(Student's Name) (Relationship)

Moreover, that he/she resides with _____ who is_____
(Name of person) (Relationship/s)

at _____/_____
(Street #, Address) (Telephone #)

I further certify that this is intended to be a bona fide permanent address at which my child will be living for _____ days and _____ nights per week and that I am not providing payment for having my child reside with anyone.

As a parent/guardian of the student named on this form, and as a resident of the Town of Greenwich, I attest to the accuracy of the information contained in this form. Further, I certify that, as a permanent resident of the Town of Greenwich, the student is eligible for free school privileges. I agree to notify the Greenwich Public School Residency Office, at 290 Greenwich Avenue, Greenwich, CT 06830, within 15 days of termination of the student's permanent residency in the Town of Greenwich, in which event, the student will no longer be eligible for free school privileges.

**Finally, I understand that, should the student be found to be attending the Greenwich Public Schools illegally, the Town of Greenwich reserves the right to recover the costs of such education from me, the undersigned**.

I understand that a perjured or fraudulent statement may lead to my prosecution under the criminal statutes of the State of Connecticut. I also understand that this document may be used in a court of law as evidence against me.

Date: _____ Signature: _____

Print Name: _____

# AFFIDAVIT OF SPONSOR
# GREENWICH PUBLIC SCHOOLS

I hereby certify that _____ is my_____
(Student's Name) (Relationship)

moreover, that he/she legally resides with me at

_____
(Street #, Address, Telephone #)

I further certify that this is intended as a bona fide permanent address, that this student will be living with me ___ days and ___ nights per week, that I am not receiving payment for having this student with me, and that my sponsorship is not for the sole purpose of obtaining school accommodations.

I certify that this student is residing with me because _____

_____

As the sponsor of the student named on this form, and as a resident of the Town of Greenwich, I attest to the accuracy of the information contained in this form. Further, I certify that, as a permanent resident of the Town of Greenwich, the student is eligible for free school privileges. I agree to notify the Greenwich Public School Residency Office, at 290 Greenwich Avenue, Greenwich, CT 06830, within 15 days of termination of the student's permanent residency in the Town of Greenwich, in which event, the student will no longer be eligible for free school privileges. **Finally, I understand that, should the student be found to be attending the Greenwich Public Schools illegally, the Town of Greenwich reserves the right to recover the costs of such education from me, the undersigned**.

I understand that a perjured or fraudulent statement may lead to my prosecution under the criminal statutes of the State of Connecticut. I also understand that this document may be used in a court of law as evidence against me.
* * If you are the guardian of the student, please indicate the date and source of your authority:

Date _____ Authority _____

Signature of Sponsor_____ Print Name_____

# AFFIDAVIT OF LEGAL RESIDENCE / HOMELESS / SHELTER / DCF PLACEMENT GREENWICH PUBLIC SCHOOLS

The Greenwich Board of Education, in compliance with statute 10-253(d) of the State of Connecticut, requires this form to be completed for any student who claims residence in Greenwich and is not residing with his or her parent/guardian(s) and whose parent/guardian(s) are not residing in Greenwich. This form is required when there is a question about the child's actual residence. The student, parent/guardian and person with whom the student is living must fill out this form together.

Date _____

1. Student's Name _____ DOB: _____
(Last) (First) (Middle)

2. Student's Greenwich Address _____
(Street #, Address) (Telephone #)

3. Name of Person with Whom Student Lives _____

Relationship _____

Address _____
(Street #, Address) (Telephone #)

4. Date Student Moved to Greenwich _____
(Month) (Day) (Year)

5. Student's Former Address _____
(Street #, Address) (Town) (State)

6. Former School _____Grade _____

7. Name of Student's Father _____

Father's Address _____
(Street #, Address) (Town) (State) (Telephone #)

8. Name of Student's Mother _____

Mother's Address _____
(Street #, Address) (Town) (State) (Telephone #)

9. Name and Address of Student's Court Appointed Legal Guardian, if applicable:

_____

_____

Signature:_____ Print Name:_____

**AFFIDAVIT OF PROPERTY OWNER / LANDLORD**
**GREENWICH PUBLIC SCHOOLS**

I, _____,
(Name of Property Owner/Landlord or Property Manager)
as property owner or manager/agent of the dwelling located

at _____/ Telephone Landlord _____
(Street #, Address, City, State, Zip,

hereby certify that I am renting space in this dwelling on a
_____to _____ basis beginning on _____
(Week/Month/Year) (Week/Month/Year) (Date)

The following persons are identified as tenants having the right to be occupants in the dwelling:

- Maternal Parent/Guardian: _____
- Paternal Parent/Guardian: _____

Name of Child in Admittance Application:

Last: _____ First: _____ MI: _____

List all other persons residing in the dwelling:

| Last Name | First Name | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

As property owner/landlord, I certify that I will notify the Greenwich Public School Residency Office, in writing, at 290 Greenwich Avenue, Greenwich, CT 06830, within 15 days of termination of this tenancy relationship.

_____ _____
(Signature of Property Owner/Landlord) (Print Name)

# GPS
## Registration Form

Please PRINT clearly in blue or black ink.

**SCHOOL USE ONLY:**

**Start Date:** _____ **Entering Grade:** _____ **YOG:** _____

**Tuition Student:** ☐ **LASID:** ☐☐☐☐☐☐☐☐☐☐

**Out of District Student:** ☐ **Magnet Student:** ☐ **Sponsored Student:** ☐

Student's First Name: _____ Gender: F M N

Student's Middle Name: _____ Date of Birth: _____ (MM/DD/YYYY)

Student's Last Name: _____ Suffix: _____

**Has this student previously been enrolled in GPS?** Y N School: _____ Grade: _____

**Does this child have a sibling that currently attends GPS or is being registered at the same time?** Y N

*If yes, please list name(s):* _____

1. Military Status: Parent or Guardian is a member of the Armed Forces or serves on a FT National Guard Duty? Y N
2. Was the child born in any state defined as the 50 states, the District of Columbia and the Commonwealth of Puerto Rico? Y N
3. Migrant Status: A child who is or whose parent/spouse is a migratory agricultural worker who has moved within the past 36 months across state or district boundaries to obtain temporary or seasonal employment in agricultural or fishing work? Y N
4. Has the student previously attended school in the United States? Y N
   If yes, circle all grades attended: P3 PK K 1 2 3 4 5 6 7 8 9 10 11 12

**DOMINANT LANGUAGE INFORMATION** (required by state law)

5. What language is most often spoken by the student? _____
6. What is the primary language spoken in the home, regardless of the language spoken by the student? _____
7. What is the language the student first acquired? _____

**RACE/ETHNICITY** (required by state law)

8. Is the student Hispanic or Latino? Y N

   Definition: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin, regardless of race.

9. Is the student from one or more races using the following (choose all that apply):

☐ **American Indian or Alaskan Native:** a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ **Asian:** a person having origins of any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand or Vietnam.

☐ **Black or African American:** a person having origins in any of the black racial group of Africa.

☐ **Native Hawaiian or Pacific Islander:** a person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

☐ **White:** a person having origins in any of the original people of Europe, the Middle East or North Africa.

**STUDENT HOME RESIDENCE**

| House # | Street Name | Apt. # |
|---|---|---|
| | | |

| Town | State | Zip Code |
|---|---|---|
| | | |

Form C

## PARENT/GUARDIAN INFORMATION

| PARENT/GUARDIAN | | PARENT/GUARDIAN | |
|---|---|---|---|
| Name: | | Name: | |
| Relationship: | | Relationship: | |
| *If applicable* Maiden Name: | | *If applicable* Maiden Name: | |
| Home Address: | | Home Address: | |
| ***Designate ONE phone number to receive automated announcements (i.e. weather closures)*** | | ***Designate ONE phone number to receive automated announcements (i.e. weather closures)*** | |
| Home Phone #: | ☐ | Home Phone #: | ☐ |
| Cell Phone #: | ☐ | Cell Phone #: | ☐ |
| Work Phone #: | ☐ | Work Phone #: | ☐ |
| Primary Email: | | Primary Email: | |
| Highest Level of Education: | <HS High School Some College College Graduate | Highest Level of Education: | <HS High School Some College College Graduate |
| *Check all that apply:* | ☐ *Lives with* ☐ *Pick-up Privilege* ☐ *Receives Emails* ☐ *Portal Access (Aspen)* ☐ *Receives Mailings* | *Check all that apply:* | ☐ *Lives with* ☐ *Pick-up Privilege* ☐ *Receives Emails* ☐ *Portal Access (Aspen)* ☐ *Receives Mailings* |

## ACADEMIC HISTORY

Anticipated grade the student will enter (final determination by school): *circle one* P3 PK K 1 2 3 4 5 6 7 8 9 10 11 12

Name of most recent school student has attended (including pre-school): _____

State or Country: _____ Are you able to provide academic records? Y N

## DISCIPLINARY INFORMATION

Please provide the following required discipline information. *If you answer yes to any of the questions below, please explain.*

| | | |
|---|---|---|
| Has this student participated in a violent criminal offense, as determined by State Law, while on the grounds of a school? | Y | N |
| Has this student committed a gun-free schools violation (possession of a firearm or explosive device that resulted in expulsion)? | Y | N |
| Has this student participated in an "other weapon" incident resulting in expulsion? | Y | N |
| Does this student have any other discipline infractions (dangerous or criminal offenses)? | Y | N |

## NOTES/ADDITIONAL INFORMATION

_____

_____

_____

_____

**I certify that all of the information provided above is true.**

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

**Student Name:** _____ **Grade:** _____ **School:** _____

## Student Emergency Contact

| Parent/Guardian | |
|---|---|
| Name: | |
| Relationship: | |
| Home Phone #: | |
| Cell Phone #: | |
| Work Phone #: | |

| Parent/Guardian | |
|---|---|
| Name: | |
| Relationship: | |
| Home Phone #: | |
| Cell Phone #: | |
| Work Phone #: | |

List two emergency contacts who would have permission to pick up your child and assume temporary care of your child if you cannot be reached during an emergency. These contacts cannot be the same as parents or legal guardians, but may include grandparents, aunts, uncles, childcare providers, friends, and neighbors that live in the local area.

| Emergency Contact | |
|---|---|
| Name: | |
| Relationship: | |
| Home Address: | |
| Home Phone #: | |
| Cell Phone #: | |
| Work Phone #: | |

*Pick up privileges* ☐

| Emergency Contact | |
|---|---|
| Name: | |
| Relationship: | |
| Home Address: | |
| Home Phone #: | |
| Cell Phone #: | |
| Work Phone #: | |

*Pick up privileges* ☐

| Student's Doctor | |
|---|---|
| Name: | |
| Address: | |
| Phone Number: | |

| Student's Dentist | |
|---|---|
| Name: | |
| Address: | |
| Phone Number: | |

*By signing this form, you give permission for any of the designated emergency contacts to pick up your child in case of an emergency school closure, illness, or missed bus. Should any of your emergency contact information change during the school year, please remember you need to inform the school as soon as possible. You are also providing consent for the school to share the information on this form with authorized individuals.*

Parent or Legal Guardian's Signature: _____ Date: ____/____/_____

Print Last Name: _____ Print First Name: _____

****The information contained in this form is private and should be secured and accessed only be authorized individuals. This is needed to ensure compliance with HIPPA, FERPA, and individual rights to privacy.*

# GREENWICH PUBLIC SCHOOLS

## REQUEST FOR STUDENT RECORDS

(Please fill in all information in the blank spaces below.)

DATE: _____

**TO LAST SCHOOL ATTENDED:**

_____ _____
Name of School Dates Attended

_____ _____
Address Telephone #

_____ _____
City State Zip Code Fax #

**Permission is hereby given to release the following records for:**

_____ DATE OF BIRTH: _____
Print Student's Last Name First Name

- ☐ Academic Records
- ☐ Standardized Test Scores
- ☐ Health Records
- ☐ Special education/pupil personnel records (e.g. IEP, PPT minutes, evaluations, 504)
- ☐ Other (as specified) _____

**Please send to:**

Name: _____

School: _____

Address: _____

City, State, Zip: _____

Telephone #: _____ Fax #: _____

Email: _____

Parent/Guardian Signature: _____ Date: _____

Name (printed): _____ Relationship to Student: _____

Parent/Guardian Phone #: _____

Parent/Guardian Email: _____

Form **F**

# State of Connecticut Department of Education
# Health Assessment Record

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<br>❑ American Indian/ Alaskan Native<br>❑ Hispanic/Latino | ❑ Black, not of Hispanic origin<br>❑ White, not of Hispanic origin<br>❑ Asian/Pacific Islander<br>❑ Other |
| Primary Care Provider | | |
| 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** | | | ***Auditory Screening** | | | History of Lead level ≥ 5µg/dL ❑ No ❑ Yes | Date |
|---|---|---|---|---|---|---|---|
| Type: | Right | Left | Type: | Right | Left | | |
| With glasses | 20/ | 20/ | | ❑ Pass | ❑ Pass | ***HCT/HGB:** | |
| Without glasses | 20/ | 20/ | | ❑ Fail | ❑ Fail | ***Speech** (school entry only) | |
| ❑ Referral made | | | ❑ Referral made | | | 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

Form F HAR-3 REV. 1/2022

**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:<br>❑ Dentist | Completed by:<br>❑ MD/DO<br>❑ APRN<br>❑ PA<br>❑ Dental Hygienist | ❑ Yes<br>❑ Abnormal (Describe)<br>_____<br>_____<br>_____<br>_____<br>_____ | ❑ Yes<br>❑ No |

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

Form F

**Student Name:** _____ **Birth Date:** _____ HAR-3 REV. 1/2022

# 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)

**Religious Exemption:** _____

**Religious exemptions must meet the criteria established in Public Act 21-6: https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf.**

**Medical Exemption:** _____

**Must have signed and completed medical exemption form attached.**
**https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf**

### 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 through11th 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

# IMMUNIZATION REQUIREMENTS FOR ENROLLED STUDENTS IN CONNECTICUT SCHOOLS

## 2025-2026 SCHOOL YEAR

| | | |
|---|---|---|
| **Preschool** | | |
| Hepatitis B | 3 doses | last dose must be on or after 24 weeks of age |
| DTaP | 4 doses | by 18 months for programs that begin at 18 months |
| Polio | 3 doses | by 18 months for programs that begin at 18 months |
| MMR | 1 dose | must be on or after the 1st birthday |
| Varicella | 1 dose | must be on or after the 1st birthday |
| Hepatitis A | 2 doses | must be separated by 6 calendar months with 1st dose on or after the first birthday |
| HiB | 1 dose | may have more but at least one must be on or after the 1st birthday[1] |
| Pneumococcal | 1 dose | may have more but at least one must be on or after the 1st birthday[1] |
| Influenza | 1 or 2 doses | 1 dose administered yearly between August 1st and December 31st; 2 doses 28 days apart for those receiving flu for the first time.[1] |
| **Kindergarten** | | |
| Hepatitis B | 3 doses | last dose must be on or after 24 weeks of age |
| DTaP | 4 doses | last dose must be given on or after 4th birthday |
| Polio | 3 doses | last dose must be given on or after 4th birthday |
| MMR | 2 doses | separated by at least 28 days, 1st dose on or after 1st birthday |
| Varicella | 2 doses | separated by at least 3 months,1st dose on or after 1st birthday or verification of disease[2,3] |
| Hepatitis A | 2 doses | must be separated by 6 calendar months with 1st dose on or after the first birthday |
| HiB | 1 dose | may have more but at least one must be on or after the 1st birthday[1] |
| Pneumococcal | 1 dose | may have more but at least one must be on or after the 1st birthday[1] |
| **Grades 1-6** | | |
| Hepatitis B | 3 doses | last dose must be on or after 24 weeks of age |
| DTaP/Td | 4 doses | last dose must be given on or after 4th birthday; students who start the series at 7 or older only need 3 doses.[4] |
| Polio | 3 doses | last dose must be given on or after 4th birthday |
| MMR | 2 doses | separated by at least 28 days, 1st dose on or after 1st birthday |
| Varicella | 2 doses | separated by at least 3 months,1st dose on or after 1st birthday or verification of disease[2,3] |
| Hepatitis A | 2 doses | must be separated by 6 calendar months with 1st dose on or after the first birthday |
| **Grade 7-12** | | |
| Hepatitis B | 3 doses | last dose must be on or after 24 weeks of age |
| Tdap/Td | 1 dose | for students who have completed their primary DTaP series (see DTaP/Td requirements in Grade 1-6 section). Students who start the series at 7 or older only need 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap |
| Polio | 3 doses | last dose must be given on or after 4th birthday |
| MMR | 2 doses | separated by at least 28 days, 1st dose on or after 1st birthday |
| Varicella | 2 doses | separated by at least 3 months,1st dose on or after 1st birthday or verification of disease[2,3] |
| Hepatitis A | 2 doses | must be separated by 6 calendar months with 1st dose on or after the first birthday[5] |
| Meningococcal | 1 dose | students should receive conjugate vaccine |

Revised 1/30/2025

## Footnotes:

1. Not required for students age 5 and older.
2. A minimum interval of 28 days can be applied if the vaccine has already been administered
3. Verification of varicella disease: must be confirmed in writing by a MD, PA, or APRN
4. DTaP is not administered to children age 7 or older; Tdap may be administered to children 7 and older unless contraindicated
5. Hepatitis A requirement indicated for students born 1/1/07 or later

## Additional Series Information:

- All documented doses should meet the age and interval criteria in the Child and Adolescent Immunization Schedule recommended by the Advisory Committee for Immunization Practices (ACIP) and Published by the Centers for Disease Control and Prevention (CDC) - https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html
- Laboratory confirmation of immunity (a positive titer) is only acceptable for hepatitis A, hepatitis B, measles, mumps, rubella, and varicella
- Two live vaccines that are not administered the same day must be separated by a minimum of 28 days. If they are not separated by at least 28 days, the second dose is not valid.
- New entrants are any students who are new to the school district, including: all preschoolers, all students coming in from Connecticut private, parochial and charter schools located in the same or another community, all students entering kindergarten including those repeating kindergarten, and those moving from any public or private preschool program, even in the same school district. The one exception is students returning from private approved special education placements–they are not considered new entrants.

Contact the Immunization Program for questions regarding children's immunizations.
Email: DPH.Immunizations@ct.gov
Phone: (860) 509-7929

For the full legal requirements for school entry visit the Immunization Laws and Regulations page - https://portal.ct.gov/immunization/laws-and-regulations?language=en_US

| Commonly Administered Vaccines: | |
|---|---|
| **Vaccine:** | **Brand Name:** |
| DTaP/IPV/HiB | Pentacel |
| DTaP/IPV/Hep B | Pediarix |
| DTaP/IPV/Hep B/HiB | Vaxelis |
| DTaP/IPV | Kinrix, Quadracel |
| HiB/Hep B | Comvax |
| DTaP/HiB | Trihibit |
| MMRV | ProQuad |
| PCV 7 | Prevnar |
| PCV 13 | Prevnar 13 |
| PCV 15 | Vaxneuvance |
| PCV 20 | Prevnar 20 |
| Influenza | Fluzone, FluMist, Flucelvax, FluLaval, Fluarix, Afluria |

GREENWICH PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

Form G

# Permission for Treatment/ Risk Notification for K - 8

**Student's Name**_____ **School** _____ **Grade**_____

**Parent/ Guardian's Name**_____ **Telephone #** _____

**Student's Doctor** _____ **Doctor's #**_____

**Student's Dentist** _____ **Dentist's #**_____

**Emergency Contact Name (other than parent/ guardian):**_____ **Phone #**_____

## Authorization for Medical Care:

In the event of a medical emergency or illness, I hereby authorize Greenwich Public Schools to provide first aid, and/or to request emergency medical treatment and transportation to a hospital. Any hospital or emergency medical personnel are authorized to provide treatment to my child of such nature as they deem appropriate and to consult with the physician listed in the Student Profile.

* I understand that COVID-19 is a contagious disease that may continue to be present in the Greenwich community, and that all reasonable precautions have been taken by the school district to mitigate the spread by adhering to the latest guidelines as put forth by the CDC and the State Department of Public Health. With that, I understand and acknowledge that there will be a level of risk of contagion as would be accepted in any public venue.

** A child without a history of a severe allergic reaction may receive epinephrine from a certified teacher if a reaction is suspected (CT. Act 14-176). Please contact the nurse directly, if you do NOT wish your child to be included under this law.

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

## Student Health Insurance Information

Does your child have Health Insurance? ☐ Yes ☐ No

If your child is uninsured, we will provide you information on Connecticut's HUSKY PLAN. Your signature means that the school can provide you contact information for the Connecticut Department of Social Service. (Administrating agency of the HUSKY Plan) or information about how to enroll in HUSKY.

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

**GREENWICH PUBLIC SCHOOLS**
**SCHOOL HEALTH SERVICES**

Form H

## Permission for Treatment/ Risk Notification For GHS Only

**Student's Name**_____ **School** _____ **Grade**_____

Parent/Guardian Name _____ Telephone _____

**Authorization for Medical Care:**

In the event of a medical emergency or illness, I hereby authorize Greenwich Public Schools to provide first aid, and/or to request emergency medical treatment and transportation to a hospital. Any hospital or emergency medical personnel are authorized to provide treatment to my child of such nature as they deem appropriate and to consult with the physician listed in the Student Profile.

** A child without a history of a severe allergic reaction may receive epinephrine from a certified teacher if a reaction is suspected (CT. Act 14-176). Please contact the nurse directly, if you do NOT wish your child to be included under this law.

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

## Over-the-Counter Medications

In an effort to better serve the health needs of your child, we have developed a policy which allows us to administer certain over the counter medications to your child if necessary during the course of the school day. In accordance with our medication policy we are sending you this letter to allow you to give authorization for the school nurse to administer medications noted below to your child if necessary for your child's comfort and safety during the school day.

If you prefer to use only a name brand (i.e. "Advil") or liquid form of these medications, please bring a sealed, labeled container to the health office where it will be stored and used only for your child. Please feel free to call us if you have any questions at 203-625-8011. Please note: This policy pertains to *campus students only*.

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Acetaminophen<br>For minor aches, headache, pain, cramps<br>(Generic equivalent of Tylenol) | ☐ | ☐ | Ibuprofen<br>For muscle aches, headache, cramps<br>(Generic equivalent to Motrin or Advil) | ☐ | ☐ |
| Benadryl/Diphenhydramine<br>For hives or skin rash | ☐ | ☐ | Tums/Calcium Carbonate<br>For acid indigestion | ☐ | ☐ |

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

## Student Health Insurance Information

Does your child have Health Insurance? ☐ Yes ☐ No

If your child is uninsured, we will provide you information on Connecticut's HUSKY PLAN. Your signature means that the school can provide you contact information for the Connecticut Department of Social Service. (Administrating agency of the HUSKY Plan) or information about how to enroll in HUSKY.

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