



January 2026

Dear Parents/Guardians of Incoming Kindergarten Students:

MERSD is pleased to announce the following information for kindergarten registration:

Kindergarten Registration: Week of February 9 - 13, 2026 8:00 A.M. – 3:00 P.M. Essex Elementary School

Parents are asked to submit registration materials during this time via email (excluding birth certificate) to Maggie Safrine safrinem@mersd.org or to arrange for in-person registration by contacting Maggie. All birth certificates must be brought in person to the school office for photocopying.

- **STEP ONE: Proof of Residency.** Before registering your child for kindergarten, it is **required** that you verify your residency through our Central Office in Manchester MA. **Families with older siblings currently enrolled at EES must also complete this process and should contact the district office to determine what is needed. Students currently enrolled in the MERSD Pre-kindergarten program do not need to complete residency again.**
 - Proof of Residency information can be found on the district web site at www.mersd.org under "Students & Families."
 - Please scan documentation to Amy LeJeune lejeunea@mersd.org in the MERSD district office (978-526-4919 for questions). Once your documentation has been verified you will receive notification from the district office confirming your child's residency. The Essex Elementary School (EES) office will also receive a copy of your verification.
- **STEP TWO: Registration.** After verifying residency, submit the following to EES during the week of February 9, 2026.
 - Original **Birth Certificate** (Must be verified in person and photocopied by school staff)
 - Updated health record which includes a current (within one year, 4- or 5-year-old) **Physical Exam**
 - **Immunization Record** (questions please reach out to Nicole Grasso Correnti grasso-correntin@mersd.org)
 - Current **Photograph** (for student file)
 - Completed **Registration Packet:** Registration Form, Home Language Survey, Developmental History, Preschool Observation, and Request for Records (all enclosed).

Parent/Guardian Orientation: Orientation introducing parents/guardians to district, school staff and programs will be held on Thursday, May 7, 2026, 3:30-4:15. This event is for parents/guardians only.

Kindergarten Screening: Incoming kindergarten students will participate in a screening held at Essex Elementary School. You will have the opportunity to sign up for one of two screening dates that are **tentatively** scheduled for Friday June 12th and Monday, June 15th. More information will be available as it gets closer.

Kindergarten Playdate- The Friends of EES will hold their annual Kindergarten playdate on the playground sometime in August. More details to follow.

School supply drop off- Families will have the opportunity to stop in the day before school starts (more info coming soon) to drop off school supplies and visit the classroom.

If we can be of further assistance to you, please do not hesitate to call the school office at (978) 768-7324 or email Maggie Safrine safrinem@mersd.org

Sincerely,

Kim Provost

Principal

Entry date: _____
LASID# _____
YOG _____

MERSD ELEMENTARY SCHOOL
REGISTRATION FORM

Entering Grade ☐ Teacher _____

Student Legal Name (please print clearly):

First Name: _____ Nickname: _____

Full Middle Name: _____

Last Name: _____

Date of Birth _____ Gender: _____

City/Town of Birth _____ State _____ County _____

Primary Residence of Child: _____

Primary Language Spoken in Home: _____

Race, select all that apply: ☐ African American ☐ Asian
☐ Caucasian ☐ Native American ☐ Pacific Islander

Other _____

Ethnicity: ☐ Hispanic or Latino

Parent/Guardian Information: (Please indicate custodial parent(s) and attach current custody agreement) ☐ Custody Agreement Attached

Name Parent/Guardian 1: _____ Custodial ☐ yes ☐ no

Place of birth: _____

Home phone _____ Cell phone: _____

Occupation: _____ Place of employment _____

Email: _____

Name Parent/Guardian 2: _____ Custodial ☐ yes ☐ no

Place of birth: _____

Home phone _____ Cell phone: _____

Occupation: _____ Place of employment _____

Email: _____

Previous Address:

Last School Attended:

Name of School: _____

School Address: _____

Phone: _____

Birth Certificate Information (To be completed by MERSD staff):

Person checking Birth Certificate must record from the certificate:

Child's name: _____

Date of Birth: ____/____/____

Person checking birth certificate and registration form: _____

Signature

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 ☐ M
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) _____	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 ☐ N ☐	Will you require an interpreter/translator at Parent-Teacher meetings? Y ☐ N ☐
Parent/Guardian Signature: X _____	Today's Date: _____ / _____ /20____ (mm/dd/yyyy)

**Manchester Essex Regional School District
DEVELOPMENTAL HISTORY FORM**

STUDENT INFORMATION

Last Name _____ First Name _____ M.I. _____

Date of Birth _____ Place of Birth _____ Preferred Name _____

PARENT INFORMATION

Parent/Guardian 1 Last Name _____ First Name _____

Home Address _____

Cell Phone _____ Work Phone _____

Email _____

Does this child reside with this parent/guardian? ☐ Yes | ☐ No

Parent/Guardian 2 Last Name _____ First Name _____

Home Address _____

Cell Phone _____ Work Phone _____

Email _____

Does this child reside with this parent/guardian? ☐ Yes | ☐ No

If parents/guardians are separated or divorced, who has custody:

Legal _____

Physical _____

If there is shared physical custody or visitation with a non-custodial parent, please describe below:

FAMILY HISTORY

Please check whether any of these are relevant to your child's history

☐ Adoption: Comments _____

☐ Foster Placement: Comments: _____

☐ Parent-Child Separation: Comments: _____

☐ Other: Comments _____

☐ History of emotional or learning problems in family history (parents, aunts/uncles, grandparents, etc.)

Additional Comments Regarding Any of the Above

SIBLING INFORMATION

Name _____ Gender ☐ Age _____ Lives in home ☐ Yes ☐ No

Name _____ Gender ☐ Age _____ Lives in home ☐ Yes ☐ No

Name _____ Gender ☐ Age _____ Lives in home ☐ Yes ☐ No

Name _____ Gender ☐ Age _____ Lives in home ☐ Yes ☐ No

Has an older sibling demonstrated difficulty in school? ☐ Yes ☐ No. If yes, please describe.

PRENATAL AND BIRTH HISTORY

Duration of pregnancy _____ Without complications ___ With complications ___
If with complications, please describe below:

Delivery: Without complications ___ With complications ___ (e.g. emergency delivery)
If with complications, please describe below:

Child's birth weight _____ Was special care needed? ___ Yes | ___ No
If yes, please describe below (type and duration):

DEVELOPMENTAL MILESTONES: At what age did your child first:
Sit with support ___ Sit without support ___ Crawl ___ If your child did not crawl, please describe

Walk _____ Use single words _____ Speak in simple sentences _____
Is your child toilet trained for daytime? ___ Yes | ___ No
Is your child toilet trained for nighttime? ___ Yes | ___ No

If your child is toilet trained for daytime, does he/she know how to independently manage this?
___ Yes | ___ Partially | ___ No

If no or partially, please describe what they can do and cannot do:

MEDICAL HISTORY

Has your child been diagnosed with a disability? ___ Yes ___ No
If yes, please describe _____

Does your child have a chronic medical condition? ___ No ___ Yes If yes, please list/describe
(e.g. Asthma, Stomachaches, Chronic Constipation, Headaches, Seizures, Recurrent Ear
Infections). If yes, please describe age of onset, current status and treatment (if applicable).

Is your child prescribed any medication on a regular basis? ☐ No | ☐ Yes

If yes, please describe _____

Does your child have any allergies? ☐ No | ☐ Yes

If yes, please describe _____

Please describe your child's general temperament _____

Describe your child's eating habits _____

Please indicate whether you have any of the following concerns about your child:

- ☐ Overly active
- ☐ Very short attention span
- ☐ Extreme shyness
- ☐ Significant separation anxiety
- ☐ Difficulties holding and using pencils or utensils
- ☐ Difficulties with ☐ riding a tricycle ☐ running ☐ catching
- ☐ Hearing difficulties
- ☐ Vision Difficulties
- ☐ Tantrums
- ☐ Fears, worries
- ☐ Sleep difficulties
- ☐ Chewing or swallowing difficulties
- ☐ Speech

If you checked any of the items above, please describe _____

EDUCATIONAL HISTORY

Does or has your child attended a preschool program? ☐ Yes | ☐ No

If yes, name of preschool _____

Dates Attended _____ Hours Per Day _____ Days Per Week _____

Please check if your child receives any of the following services ☐ Early Intervention |
☐ Speech | ☐ Occupational Therapy | ☐ Physical Therapy | ☐ Counseling | ☐ ABA Services

Has your child ever received a Neurodevelopmental, Occupational, Physical Therapy, Speech/Language or Neurological Evaluation? If yes, please comment below, including outcomes/findings _____

SOCIAL DEVELOPMENT

Please indicate your child's preferences regarding play and social interaction (Check all that apply).

☐ Solitary Play ☐ In Groups ☐ With Older Children
☐ With Younger Children ☐ Own Age Group No Preferences

Describe the child's relationships with his/her
Parents:

Siblings:

Other Family Members:

Does your child relate easily to non-family children and adults? ☐ Yes | ☐ No
If no, please describe:

Do you have any concerns about, or comments regarding your child that are not listed in the above questions? ☐ Yes | ☐ No
If yes, please describe:

*Please give this form
to your child's preschool*

MANCHESTER ESSEX REGIONAL SCHOOL DISTRICT
PRESCHOOL OBSERVATIONS

School Attending for Kindergarten: Essex Elementary School

Student's Name: _____ DOB: _____

Name of Preschool: _____

Phone number of Preschool: _____

Person completing form: _____ Date: _____

When completing this form, please keep in mind developmental levels and make a comparison between this student's behaviors as compared to others of the same age in regard to those tasks which are required in your program on a daily basis. The areas covered by this form are those listed in the regulations required for Kindergarten Screening in Massachusetts.

Please comment of the following skills exhibited by this student:

1. Communication and Language: _____

2. Articulation: _____

3. Gross motor coordination: _____

4. Fine motor coordination: _____

5. Memory skills: _____

6. Attention capacity and listening skills: _____

7. Activity level and Patterns: _____

8. Social relations with groups, peers and adults: _____

9. Behavioral adjustment: _____

10. Knowledge of sounds and letters: _____

11. Counting skills: _____

12. Please describe this student's learning style: _____

13. Is there any other information which would be helpful in making sure that this student will be comfortable in the kindergarten environment: Please consider:
Response to change and transition: _____

Approach to tasks: _____

Need for reinforcement: _____

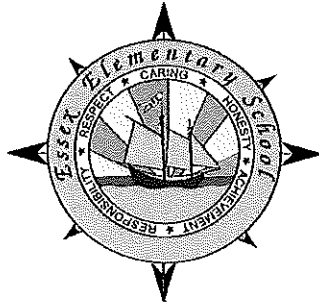
Need for structure or clarity: _____

Strengths & special interests: _____

Other significant concerns: _____

Please return completed form to student's anticipated elementary school:

Essex Elementary School
12 Story ST
Essex, MA 01929
Attention: Maggie Safrine



Dear parents/guardians of incoming students,

Welcome to Essex Elementary School! To be fully prepared for school entry for the coming school year, please submit the required documents by Friday, August 14th.

If your child has a physical or any required vaccines after that date, kindly send in the updated forms after their well-visit.

Please take the time to review your child's immunization record with your pediatrician. Please submit a copy of your child's record to the Health Office along with a current physical exam including a vision screening.

The Massachusetts Department of Public Health requires the following immunizations for all students entering kindergarten.

- 5 doses of DTaP vaccine
- 4 doses of Polio vaccine
- 3 doses of Hepatitis B
- 2 doses of MMR
- 2 doses of Varicella vaccine

More information can be found here:

<https://www.mass.gov/info-details/school-immunizations>

Please contact me with questions or concerns.

Thank You,

Nicole Grasso-Correnti RN
Essex School Nurse

MANCHESTER ESSEX REGIONAL SCHOOL DISTRICT
HEALTH SERVICES
ESSEX ELEMENTARY SCHOOL
978-768-7324

YEARLY HEALTH UPDATE

Name: _____ Grade _____
Last First Middle

PLEASE CIRCLE **YES** OR **NO** AND PROVIDE PERTINENT ADDITIONAL INFORMATION

ALLERGIES: PLEASE CIRCLE ALL THAT APPLY

BEE/INSECT STINGS	_____	EpiPen	Y	N
PEANUTS/NUTS	_____	EpiPen	Y	N
OTHER FOOD	_____	EpiPen	Y	N
SEASONAL	_____	EpiPen	Y	N
OTHER	_____	EpiPen	Y	N

HEALTH CONDITIONS: PLEASE CIRCLE ALL THAT APPLY

ASTHMA	_____	Y	N
SEIZURES	_____	Y	N
DIABETES	_____	Y	N
OTHER	_____	Y	N

MEDICATIONS:

Daily medications at home: _____

Daily medications to be taken at school: _____

Please provide us with any other information you think will be helpful to us regarding your child: _____

Health Insurance: YES NO Policy Name/Number _____

I give permission to the school nurse to share information relevant to my child's health as he/she determines appropriate for my son's/daughter's health and safety. Y N

Parent/Legal Guardian _____ Date _____

MANCHESTER ESSEX REGIONAL SCHOOL DISTRICT
HEALTH SERVICES
ESSEX ELEMENTARY SCHOOL
978-768-7324

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