

WAITS RIVER VALLEY SCHOOL

2026 - 2027

PRE-KINDERGARTEN REGISTRATION CHECKLIST

- _____ APPLICATION
- _____ STUDENT HEALTH INFORMATION CARD
- _____ WELL CHILD HEALTH EXAMINATION FORM
- _____ PROOF OF RESIDENCY FORM
- _____ HOUSEHOLD INCOME DATA COLLECTION
- _____ CAPSTONE APPLICATION
- _____ HANDBOOK ACKNOWLEDGEMENT
- _____ COPY OF BIRTH CERTIFICATE
- _____ COPY OF IMMUNIZATION RECORD

Date Accepted: _____ Accepted by: _____

Waits River Valley School

PRE-KINDERGARTEN

Thank you for your interest in the Waits River Valley School Pre-kindergarten Program where we offer a nurturing and stimulating environment for children 3-5 years of age.

In order to consider your child for enrollment, please submit the **completed application and accompanying documents by noon on Friday, May 1st** to Lisa Thompson in the main office. You can drop it off at school, email it to lisa.thompson@oesu.org or mail it to:

Waits River Valley School
Attention: Lisa Thompson
6 Waits River Valley School Road
East Corinth, VT 05040

The application's accompanying documents consist of your child's **Birth Certificate, Immunization Record, Proof of Residency, Capstone Head Start Application, and Vermont Application for Free & Reduced Meals**. Proof of residency is not required if you have another child enrolled at WRVS. Fully completed applications received in the initial application window will be dated then sorted according to the following criteria:

1. Any student currently enrolled in the program and not entering Kindergarten is guaranteed a spot in the same program for the following year. (not required to "reapply")
2. All other age eligible Topsham/Corinth students.
3. Non-resident, age eligible students.

Each application is viewed as an individual request and the lottery process does not guarantee sibling acceptance. If at any step, the amount of applications exceeds our program's capacity, a lottery will be conducted of those applicants at that step. A lottery is a system used to decide who will get or be given something by choosing names by chance.

Families will be notified via email by 5:00 PM on Monday, May 4th of their child's acceptance into our program or placement on a wait list. Families will be asked to confirm their acceptance of enrollment within one week of notification, allowing opportunity to access any waitlisted families in order of earliest dated registration packet received.

If you have any questions, please do not hesitate to reach out to me:

- At school: 802-439-5534
- My cell: 802-431-5172
- My email: carlotta.simonds-perantoni@oesu.org

Sincerely,

Carlotta Perantoni

Principal

Waits River Valley School

Waits River Valley School

PREKINDERGARTEN

6 Waits River Valley School Road
East Corinth, Vermont 05045
(P) 802-439-5534 (F) 802-439-6444



Application Form

STUDENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Name Usually Known By: _____ Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female

Mailing Address: _____ Town: _____ State: _____ Zip: _____

911 Physical Address: _____ Town: _____ State: _____ Zip: _____

Please check the box if your physical address is the same as your mailing address. ☐

Family Primary Phone No.: _____ ☐ Home ☐ Cell

Family Secondary Phone No.: _____ ☐ Home ☐ Cell ☐ Work

Please check the box if your child receives: ☐ IEP/Special Education Services ☐ 504 Services

Is your child of Hispanic or Latino origin? ☐ Yes ☐ No. Child's Home Language: _____

What races do you consider your child? Mark the one or more races that apply.

☐ Asian ☐ Black ☐ Native American or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ White

PARENT/GUARDIAN INFORMATION

Child resides with: ☐ Both Parents ☐ Parent 1 (specify below) ☐ Parent 2 (specify below) ☐ Other (specify below)

(If parents are separated or guardians are involved, please submit a copy of the most current court order on custody and visitation arrangements.)

Parent/Guardian 1: _____ Relationship to Student: _____

(Responsible Adult #1)

Mailing Address: _____ Town: _____ State: _____ Zip: _____

(If different from students)

911 Physical Address: _____ Town: _____ State: _____ Zip: _____

(If different from students)

Primary Phone No.: _____ ☐ Home ☐ Cell

Secondary Phone No.: _____ ☐ Home ☐ Cell ☐ Work

Email: _____

Parent/Guardian 2: _____ Relationship to Student: _____

(Responsible Adult #2)

Mailing Address: _____ Town: _____ State: _____ Zip: _____

(If different from students)

911 Physical Address: _____ Town: _____ State: _____ Zip: _____

(If different from students)

Primary Phone No.: _____ ☐ Home ☐ Cell

Secondary Phone No.: _____ ☐ Home ☐ Cell ☐ Work

Email: _____

EMERGENCY CONTACT INFORMATION

In an emergency, the parent/guardian listed as Responsible Adult #1 will be called first, the Parent/Guardian listed as Responsible Adult #2 will be called second. By listing a name or names in this section as an emergency contact, you are authorizing another person or people to pick up your student at school if you cannot be reached. Please be sure to notify anyone listed in the following two sections.

Name: _____ Relationship to Student: _____

Address: _____

Primary Phone No.: _____ Other Phone No.: _____

Name: _____ Relationship to Student: _____

Address: _____

Primary Phone No.: _____ Other Phone No.: _____

PICK-UP RELEASE INFORMATION

To better ensure the safety of your child, please provide us with the information below. If the person arriving at pick-up is not on this list, we will not release your child to that person until we receive consent from a parent/legal guardian. Additionally, please advise us if the regular pick-up person will be different on any given day.

List the people (including yourself) that are allowed to pick up your child.

1. Name: _____ Relationship to Student: _____

Phone No.: _____ Phone No.: _____

2. Name: _____ Relationship to Student: _____

Phone No.: _____ Phone No.: _____

3. Name: _____ Relationship to Student: _____

Phone No.: _____ Phone No.: _____

4. Name: _____ Relationship to Student: _____

Phone No.: _____ Phone No.: _____

5. Name: _____ Relationship to Student: _____

Phone No.: _____ Phone No.: _____

BUS INFORMATION – for 4-year-old scholars only

Will your child ride the bus to school?	Yes:	Morning:	Afternoon:	No:
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SIBLING INFORMATION

Name:	DOB:	Age/Grade:
Name:	DOB:	Age/Grade:
Name:	DOB:	Age/Grade:

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

For Official Use Only: Registrar's Initials: _____

Date Application Received: ____/____/____ Date Residency Verified: ____/____/____ Date Child Started: ____/____/____

Days and hours child is regularly scheduled to attend: _____

WAITS RIVER VALLEY SCHOOL 2026-2027 STUDENT HEALTH INFORMATION		
STUDENT LAST NAME:	FIRST NAME:	TEACHER:
HEALTH RELATED PROBLEMS (PLEASE CHECK ALL THAT APPLY AND LIST MEDICATIONS IN THE BOX BESIDE EACH MEDICAL CONDITION)		
HAS A DOCTOR, NURSE OR HEALTH PROFESSIONAL EVER SAID THAT YOUR CHILD HAS ASTHMA? ☐ YES ☐ NO ☐ DON'T KNOW/NOT SURE IF YES, DOES YOUR CHILD STILL HAVE ASTHMA? ☐ YES ☐ NO ☐ DON'T KNOW/NOT SURE		
☐ DIABETES ☐ SEVERE ☐ MEDICATION		
☐ ALLERGIES ☐ SEVERE ☐ MEDICATION		
☐ FOOD ALLERGIES ☐ SEVERE PLEASE LIST FOOD(S):		
EMERGENCY PROCEDURES:		
OTHER IMPORTANT INFORMATION CONCERNING MEDICAL HISTORY:		
DAILY MEDICATION NOT LISTED ABOVE:		
PLEASE NOTE: ALL MEDICATION MUST BE IN THE ORIGINAL CONTAINER AND BROUGHT IN TO THE SCHOOL NURSE BY AN ADULT. ALL INHALERS MUST BE KEPT IN THE NURSE'S OFFICE.		
PARENTAL AUTHORIZATION TO ADMINISTER MEDICINE (PLEASE CHECK ALL THAT APPLY)		
I HEREBY GIVE MY CONSENT FOR THE SCHOOL NURSE OR AN EMPLOYEE OF THE SCHOOL DISTRICT DESIGNATED BY THE PRINCIPAL TO: ☐ ADMINISTER THE MEDICATION LISTED ABOVE AS DIRECTED ON THE ORIGINAL PRESCRIPTION BOTTLE AND/OR THE ORIGINAL OVER THE COUNTER MEDICATION AS PRESCRIBED ON THE LABEL. ☐ ADMINISTER TYLENOL OR ACETAMINOPHEN ☐ ADMINISTER ADVIL OR IBUPROFEN ☐ ADMINISTER TUMS ☐ ADMINISTER COUGH DROPS ☐ ADMINISTER MINOR FIRST AID AND/OR ATHLETIC RELATED TREATMENTS.		
PARENT/GUARDIAN'S SIGNATURE: _____ DATE: _____		
STUDENT'S DOCTOR:	PHONE #:	DATE OF LAST PHYSICAL EXAM: / /
STUDENT'S DENTIST:	PHONE #:	DATE OF LAST DENTAL EXAM: / /
STUDENT'S EYE DOCTOR:	PHONE #:	DATE OF EYE DENTAL EXAM: / /
PLEASE SIGN BELOW NOTING YOUR CONSENT FOR THE SCHOOL NURSE TO CONTACT YOUR CHILD'S HEALTH CARE PROVIDERS IF NEEDED.		
PARENT/GUARDIAN'S SIGNATURE: _____ DATE: _____		
EMERGENCY CARE CONSENT		
IF THIS CHILD IS INJURED OR BECOMES SERIOUSLY ILL AT SCHOOL OR A SCHOOL FUNCTION, I HEREBY AUTHORIZE THE SCHOOL PRINCIPAL OR ANY AUTHORIZED SCHOOL PERSONNEL TO PROVIDE EMERGENCY MEDICAL TREATMENT AT A SCHOOL, DOCTORS OFFICE, OR HOSPITAL EMERGENCY ROOM, AS DEEMED NECESSARY IN THE EVENT I CANNOT BE CONTACTED TO GIVE MY CONSENT TO ADMINISTER THE SAME. ANY SPECIAL INSTRUCTIONS ARE LISTED AS FOLLOWS: _____ _____		
PARENT/GUARDIAN'S SIGNATURE: _____ DATE: _____		
DOES THIS CHILD HAVE HEALTH INSURANCE?		
☐ DR. DYNASUR/MEDICAID ☐ NONE WOULD YOU LIKE THE SCHOOL NURSE TO SEND YOU INFORMATION ON DR. DYNASUR? ☐ YES ☐ NO		
☐ PRIVATE INSURANCE COMPANY:		POLICY #:
WAITS RIVER VALLEY SCHOOL ASSUMES NO FINANCIAL RESPONSIBILITY FOR MEDICAL COST OF AN ACCIDENT OCCURRING TO A STUDENT WHILE PARTICIPATING IN A SPORT OR ANY OTHER SCHOOL ACTIVITY.		
CENSUS INFORMATION - PLEASE LIST BROTHERS' AND SISTERS' NAME AND DATE OF BIRTH		



Waits River Valley School

PRE-KINDERGARTEN

WELL CHILD HEALTH EXAMINATION FORM

Child's Name: _____

Date of Birth: _____ Date of Last Exam: _____

_____ This child has no health conditions or medications that impact enrollment in child care.

_____ This child has a condition or medication that should be known by the child care provider:

Health Care Provider's Name: _____

Health Care Provider's Signature: _____

Health Care Provider's Phone Number: _____

Date: _____

WAITS RIVER VALLEY SCHOOL

6 Waits River Valley School Road
E. Corinth, VT 05040
Phone: 802-439-5534
Fax: 802-439-6444

PROOF OF RESIDENCY FORM

Date: _____

Parent or Legal Guardian's Name(s) _____

PROOF OF RESIDENCY CRITERIA: The burden of proving residency or any other basis for entitlement to school enrollment or tuition assistance shall be on the student and/or his or her parent or guardian. For purposes of determining residency, the Board will apply the definitions contained in 16 V.S.A. §1075(a). Criteria for proving permanent residency shall include presentation of the following documents at the time of enrollment:

One of the following:

Tax bill for primary domicile	_____
Lease of property	_____
Rent Receipt	_____

And two of the following documents:

Voter registration	_____
Automobile registration	_____
Employment documentation	_____
Postal address (other than a P.O. Box)	_____
Telephone Bill	_____
Electric Bill	_____

Other indications of intent to reside permanently within the District: _____

Signed by School Official: _____ Date: _____

WAITS RIVER VALLEY SCHOOL

CARLOTTA SIMONDS-PERANTONI

6 Waits River Valley Road
E. Corinth, VT 05040
802-439-5534

Principal

April 2, 2026

Dear Parent/Guardian:

Waits River Valley School offers healthy meals every school day. **In School Year 2026-2027, all students will receive free breakfast and lunch at school.** Though the State of Vermont will support Universal School Meals we are still required to collect the **Household Income Data Collection** application from each family whose child attends WRVS as State and Federal funds are formulated from this very important form.

The information you give helps your school access federal and state education dollars. This funding supports reading, math, science, arts, PE, after-school and other vital programming. If all families fill out and return this form, we can determine our continued eligibility for Federal Grant Programs that support your school financially. We will also get more money for other school programs. It's important for you to know that this information drives multiple needs of your school and community. The information you provide is confidential. We follow strict federal rules to keep your information private.

If you have other questions or need help, please contact myself at carlotta.simonds-perantoni@oesu.org or Lisa Thompson at lisa.thompson@oesu.org or 802-439-5534.

Sincerely,

Carlotta Simonds-Perantoni

Principal

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.



Scan this QR code for the electronic version of this form, or go to:
education.vermont.gov/householdincome

2026-2027 Household Income Data Collection			
Help us provide the best education possible for your children. Filling out this form only takes a few minutes. It will help your community, your school and your property taxes. The information you give helps your school access federal and state education dollars. This funding supports reading, math, science, arts, PE, afterschool and other vital programming. The privacy of your household financial information is protected by law. Information collected through this form will be handled in accordance with privacy requirements. Only one form needed per household.			Please return this form to:

Section 1: Student Information - List all students in the household, Pre-Kindergarten through grade 12.			
First Name	MI	Last Name	Date of Birth Grade Level School Name

**If more spaces are required for additional names, please add them to the Section 1 table continued on reverse side of this form.*

Section 2: Assistance Programs - If your household receives assistance from any of the following programs, please check the appropriate box below.	
☐ 3SquaresVT (SNAP)	☐ Reach Up (TANF) <i>If you selected a Program, please skip to Section 4.</i>

Section 3: Household Income Information - Please select your household size and then the appropriate income range for that household size.	
Household size is the total number of people, including all children and adults, related and un-related, that live with you and share income and expenses. Combined annual income is the total amount of income of all household members, including children, from the following sources: Work, public assistance, child support, alimony, pensions, retirement, Social Security, SSI, VA benefits, and/or all other income. The amount should be before any deductions for taxes, insurance, medical expenses, child support, etc.	

Household Size	1	2	3	4	5	6	7	8
Combined Annual Income Range	☐ \$29,526 or less ☐ More than \$29,526	☐ \$40,034 or less ☐ More than \$40,034	☐ \$50,542 or less ☐ More than \$50,542	☐ \$61,050 or less ☐ More than \$61,050	☐ \$71,558 or less ☐ More than \$71,558	☐ \$82,066 or less ☐ More than \$82,066	☐ \$92,574 or less ☐ More than \$92,574	☐ \$103,082 or less ☐ More than \$103,082
	If your household has 9 or more people, please enter your information here: Household Size: Household Income:							

Section 4: Contact Information & Signature	
<i>"I certify (promise) that all information on this application is true, to the best of my knowledge, and that all income is reported."</i>	
Name of adult completing this form:	Signature of adult completing this form:
Town of Residence:	Email (optional): Phone (optional):

CONTINUED Section 1: Student Information					List all students in the household, Pre-Kindergarten through grade 12.
First Name	MI	Last Name	Date of Birth	Grade Level	School Name

*If more spaces are required for additional names, please attach them on another sheet of paper.

FOR SCHOOL USE ONLY

Instructions for School/District Staff:

- All costs associated with distributing, collecting, and reviewing these household income forms must be paid for with funds outside of the nonprofit school food service account.

Economic Status

Instructions:

After reviewing the reverse side of this form, Select the appropriate option below for this submission.

☐ Household is AT or BELOW the 185% cutoff.
 ☐ Household is ABOVE the 185% cutoff.

Other Programs

☐ Section 2 'Assistance Programs' selected

SCHOOL/DISTRICT STAFF

I have reviewed the household income form on the reverse of this page and have concluded that it is properly and completely filled out to the best of my knowledge.

Signature:

Printed Name:

Date:



Dear Families,

Are you looking for an opportunity for your child to attend preschool. Head Start works in collaboration with your local preschool to provide extra support for your child's early education. We currently have preschool openings and are looking for families. If interested, Head Start may be a great fit for your family!

Head Start is a federally funded preschool program that supports eligible families by partnering with local public schools to provide high-quality early childhood education. In addition to a strong educational foundation, we offer a wide range of services for children, families, and the schools we serve.

What Head Start offers:

- **Health & Nutrition Support:** Daily toothbrushing and tooth tutors, healthy meals, nutrition supports, and help find doctors and dentists
- **Screenings & Follow-up:** Vision, hearing, and developmental screenings
- **Classroom Support:** Specialist, curriculum planning, social and emotional support with Early MTSS, individualized child learning goals, and a home to school connection, Mental Health consultants
- **Teacher Support:** Professional development, coaching, and mentoring
- **Family Services:** Access to community resources, social services, guidance and family/community outings
- **School Support:** Financial assistance to help enhance classroom programs and materials

A Head Start application is included in the preschool registration packet. Please be sure to complete all the information and forms.

Together, we can give your child a strong start in school and beyond.

Warmly,

Linda Farr
Capstone Head Start Collaboration Manager
802-505-8465

CAPSTONE Head Start Eligibility Verification form

Date enrolled:
Last day of service:

PROGRAM: ☐ EHS ☐ Head Start LOCATION DESIRED:		
PROGRAM TYPE (Home base/Center base/Collaboration):		
Section 1: Child		
First Name:	Last Name:	D.O.B:
Sex: Male_____ Female_____	Race:	Hispanic/Latino: Yes_____ No_____
Primary Language:	Health Insurance:	Type of Insurance:
Secondary:	Yes_____ No_____	
Has the child received a disability or special health need diagnosis: Yes_____ No_____		
If yes, what diagnosis and who provided:		
Section II A: Parent/Guardian		
If PRENATAL, what is expected due date:		
Name:	D.O.B:	Relationship to child:
Living Address:		
Mailing Address:		
Cell #:	Home #:	Email:
Hispanic/Latino: Yes_____ No_____	Race:	
Primary Language:	Secondary Language:	Child lives w/ you: Yes_____ No_____
Section II B: Parent/Guardian		
Name:	D.O.B:	Relationship to child:
Living Address:		
Mailing Address:		
Cell #:	Home #:	Email:
Hispanic/Latino: Yes_____ No_____	Race:	
Primary Language:	Secondary Language:	Child lives w/ you: Yes_____ No_____
Section III: Additional Household Members		
**Check the box next to each CURRENTLY ENROLLED participant		
Name & D.O.B:	☐	Name & D.O.B:
Name & D.O.B:	☐	Name & D.O.B:
Name & D.O.B:	☐	Name & D.O.B:
Section IV: Alternate Contact		
Name:	Phone #:	Relationship to child:

CAPSTONE Head Start Eligibility Verification form

Date enrolled:
Last day of service:

Section V: Selection Criteria **Check all that apply <u>No Items Below:</u>			
For Staff Use Only			
Prenate/Sibling of enrolled child:	Homeless:	Family Plan/DCF Involvement:	
Foster Family:	Transition from EHS:	Enrolled in Brook Street HS:	
Kinship:	Teen Parent:	Agency or Partner Staff:	
Diagnosed Disability:	Military Family:	Head Start Staff:	
Categorically Eligible Categories: If a family is categorically eligible they are Tier I – select Tier I below and attach requested documentation. NO NEED TO COMPLETE INCOME VERIFICATION. Homeless - Attach copy of Self Declaration of Homelessness form Household member with Supplemental Security Income (SSI) – Attach a copy of the statement of eligibility bank statement showing SSI deposit. Foster Care – Attach a copy of the foster family verification form from DCF Public Assistance – Attach a copy of the signed Release of Information form along with a copy of the Reach Up/SNAP benefit determination letter from the case worker.			
Section VI: INCOME ELIGIBILITY: Check the appropriate eligibility category box and attach the Income Calculation Worksheet and applicable documentation used to calculate income			
Tier I:	Tier II:	Over Income:	Housing Cost Adjustment Utilized:
Section VII: Additional Information and Permission How did you hear about our program: _____ I give permission for Capstone Head Start to access my child's records on the Vermont Immunization Registry & the Vermont Lead Registry for the purpose of verifying child's date of birth and working together to ensure my child is up to date on immunizations and has received appropriate lead screenings: Yes _____ No _____ Application was completed in person: If not, state how (by phone or virtually) and reason: _____			
I understand the above information and certify this information to be correct to the best of my knowledge.			
Parent signature:		Date:	
Parent signature:		Date:	
Staff signature:		Date:	
TAM signature:		Date:	
ERSEA signature:		Date:	

Capstone Head Start honors community diversity and does not discriminate in hiring or providing services based on race, culture, language, national origin, religion, creed, political affiliation, family composition, marital status, sexual orientation, class, gender, age or mental/sensory/physical abilities.



Child's Name: _____

Please check or highlight any category that may apply (stop if one applies)

- ☐ SSI
☐ Public Assistance: TANF, Reach UP, SNAP
☐ Foster Care
☐ Unhoused/McKinney Vento Act (living with family, friends or others due to cost or lack of housing)

Or circle or highlight your gross household income:

Annual

Household /Family Size		Gross annual income	Gross annual income	Gross annual income
1	-	15,960	21,456	31,920
2	-	21,640	29,214	43,280
3	-	27,320	36,882	54,640
4	-	33,000	44,550	66,000
5	-	38,680	52,218	77,360
6	-	44,360	59,886	88,720
7	-	50,040	67,554	100,080
8	-	55,720	75,222	111,440
9	-	61,400	82,890	122,800
10	-	67,080	90,558	134,160

Monthly

Household /Family Size		Gross Monthly income	Gross Monthly income	Gross Monthly income
1	-	\$1,330	1,795	2,660
2	-	\$1,803	2,434	3,606
3	-	\$2,276	3,073	4,553
4	-	\$2,750	3,712	5,500
5	-	\$3,223	4,351	6,446
6	-	\$3,696	4,990	7,393
7	-	\$4,170	5,629	8,340
8	-	\$4,643	6,268	9,286
9	-	\$5,116	6,907	10,233
10	-	\$5,590	7,546	11,180