# Newbury Elementary School

# 2026 - 2027

## Pre Kindergarten Registration Checklist

_____ STUDENT INFORMATION FORM

_____ REGISTRATION CHECKLIST

_____ HOUSEHOLD INCOME DATA COLLECTION

_____ HANDBOOK ACKNOWLEDGEMENT

_____ CAPSTONE APPLICATION

_____ STUDENT HEALTH INFORMATION FORMS (2)

_____ BIRTH CERTIFICATE

_____ IMMUNIZATION RECORD

Date Accepted:_____

Accepted by:_____

# ORANGE EAST SUPERVISORY UNION

Blue Mountain Union • Bradford Elementary • Newbury Elementary • Oxbow High School
River Bend Career & Technical Center • Thetford Elementary • Waits River Valley School

# STUDENT INFORMATION FORM

## STUDENT INFORMATION

**Legal** *Last* Name: _____ **Legal** *First* Name: _____ **Legal** *Middle* Name _____

*Post* Name: _____ Preferred Last Name: _____ Preferred First Name: _____

Birth Date: _____ **Legal** Gender: ☐ Female ☐ Male Grade Level: _____

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

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

Family Primary Phone No.: _____ Type: ☐ Home ☐ Cell

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

## RACE/ETHNICITY INFORMATION

Is your child of Hispanic or Latino origin? ☐ Yes ☐ No

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

## PREVIOUS SCHOOL INFORMATION

Previous School's Name City & State Years Attended (example: 2021-2022)

_____

## FAMILY INFORMATION

**Contact phone numbers, address and email addresses will be used to distribute important school and district information. Online access to student records will be provided to each Parent/Responsible Adult listed below.**

**List in order of priority to contact: Parent/Responsible Adult #1:** Lives with student ☐ Yes ☐ No

(If no, provide full address below) ☐ Check to receive mailings

☐ Mother ☐ Father ☐ Guardian ☐ Other (please specify relationship) _____

Last Name: _____ First Name: _____

Email Address: _____ Preferred Gender: Female Male

Address (if different from student): _____ Town: _____ State: _____ Zip: _____

Mailing Address (if different ): _____ Town: _____ State: _____ Zip: _____

Primary Phone No.: _____ Type: ☐ Home ☐ Cell ☐ Work

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

**Parent/Responsible Adult #2:** Lives with student ☐ Yes ☐ No (If no, provide full address below) ☐ Check to receive mailings

☐ Mother ☐ Father ☐ Guardian ☐ Other (please specify relationship) _____

2026-2027

Last Name: _____ First Name: _____

Email Address: _____ Preferred Gender: Female Male

Address (if different from student): _____ Town: _____ State: _____ Zip: _____

Mailing Address (if different): _____ Town: _____ State: _____ Zip: _____

Primary Phone No.: _____ Type: ☐ Home ☐ Cell ☐ Work

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

**SIBLINGS (Please list first and last name of each sibling living with student):** _____

_____

## EMERGENCY CONTACTS

**In an emergency, the parent/guardian listed above 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.**

Name: _____ Relationship to Student: _____

Address: _____

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

Name: _____ Relationship to Student: _____

Address: _____

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

## PREKINDERGARTEN STUDENTS ONLY

☐ Pre-K ☐ EE Prekindergarten Program Name: _____

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

## HIGH SCHOOL STUDENTS ONLY

☐ Dual Enrollment ☐ Early College

_____

Signature of Parent/Responsible Adult: _____ Date: _____

## Office Use Only

Student Name: _____ State ID No. _____

Entry Date: _____ Grade: _____ Teacher/Advisor: _____

AM Bus No.: _____ PM Bus No.: _____ Entered by: _____

### National School Lunch Program

☐ Free ☐ Reduced ☐ Not-Eligible ☐ Declined

# Orange East Supervisory Union

64 Main Street | PO Box 396 | Bradford, VT 05033


**Registration Checklist**

**All documents are required prior to enrollment and/or any services**

| | | | |
|---|---|---|---|
| **Name of Student :** _____<br>**ID Number :** _____<br>**Start Date :** _____<br>**School :** _____ | | | |
| **OESU Student Information Form** | | | |
| **Birth Certificate (copy)** | | | |
| **Residency Verification**<br>➢ Please provide **one** of the following:<br>❖ Copy of current tax bill<br>❖ Copy of lease agreement<br>❖ Copy of rent receipt<br>❖ Mortgage statement<br><br>➢ Please provide **two** of the following:<br>❖ Voter Registration<br>❖ Automobile Registration<br>❖ Employment Verification<br>❖ Post Address (other than a P.O. Box)<br>❖ Utility Bill (must be within the last 30 days)<br><br>***** All documents must show your name and physical address within the OESU district***** | | | |
| **Custody Paperwork Collected(if applicable)**<br>**Flag placed on Student Profile** | **Yes** | **No** | **NA** |
| **Free and Reduced Lunch Paperwork** | **Yes** | **No** | **NA** |
| **DCF Contact Information ( if applicable)**<br>**Name:** | **Yes** | **No** | **NA** |
| **Homeless Status**<br>**Has the OESU Homeless Liaison been contacted** | **Yes**<br>**Yes** | **No**<br>**No** | **NA**<br>**NA** |
| **Comments:** | | | |

All documentation can be submitted electronically, any documentation needs to be clear and readable, the preference is in color, but not required. **For questions on documentation or to submit paperwork, please contact Mae Tucker - mae.tucker@oesu.org or 802-222-7025.**

# Newbury Elementary SCHOOL

214 Pulaskit Street
Newbury, VT

August 26, 2026

Dear Parent/Guardian:

Newbury Elementary 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 NES 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 me at labette.page@oesu.org or 802-866-5621.

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, audiotape, 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.

VERMONT
AGENCY OF EDUCATION

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

| **2026-2027 Household Income Data Collection** | Please return this form to: |
|---|---|
| **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.** | |

**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 |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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| | | | | | |
| | | | | | |

**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)* *If you selected a Program, please skip to Section 4.*

**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 | ☐ $40,034 or less | ☐ $50,542 or less | ☐ $61,050 or less | ☐ $71,558 or less | ☐ $82,066 or less | ☐ $92,574 or less | ☐ $103,082 or less |
| | ☐ More than $29,526 | ☐ More than $40,034 | ☐ More than $50,542 | ☐ More than $61,050 | ☐ More than $71,558 | ☐ More than $82,066 | ☐ More than $92,574 | ☐ 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 certify (promise) that all information on this application is true, to the best of my knowledge, and that all income is reported."*

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** |
| | | | | | |
| | | | | | |
| | | | | | |
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| | | | | | |

*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:

# Family Handbook Acknowledgement



This handbook may be updated from time-to-time; notice will be provided as updates are implemented.

Please sign the acknowledgement below, detach it from the handbook, and return it to the Newbury Elementary School Pre-Kindergarten prior to enrollment.

Thank you for acknowledging the policies and procedures we have established for the safety and welfare of all children in our care. We look forward to getting to know you and your family. Please cut along the dotted line and return the section below to your child's teacher. Thank you.

---

I have received the Newbury Elementary Pre-Kindergarten Family Handbook. I acknowledge that it is my responsibility to understand and familiarize myself with the Family Handbook and to ask for clarification of any policy, procedure or information that I do not understand.

Parent/Guardian Signature _____ Date _____

Pre-Kindergarten Staff Signature _____ Date_____

# 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:<br>Male_____ Female_____ | Race: | Hispanic/Latino:<br>Yes_____ No_____ |
| Primary Language:<br><br>Secondary: | Health Insurance:<br><br>Yes_____ No_____ | Type of Insurance: |
| Has the child received a disability or special health need diagnosis: Yes_____ No_____<br><br>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:<br>Yes_____ No_____ | Race: | |
| Primary Language: | Secondary Language: | Child lives w/ you:<br>Yes_____ No_____ |

## Section II B: Parent/Guardian

| Name: | D.O.B: | Relationship to child: |
|---|---|---|
| Living Address: | | |
| Mailing Address: | | |
| Cell #: | Home #: | Email: |
| Hispanic/Latino:<br>Yes_____ No_____ | Race: | |
| Primary Language: | Secondary Language: | Child lives w/ you:<br>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 No Items Below: ☐

*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.

**Newbury Elementary School 2026-2027**

**ANNUAL HEALTH UPDATE & EMERGENCY AUTHORIZATION FORM**

**PURPOSE:** To enable parents/caregivers to AUTHORIZE emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Parents/ caregivers must return this form to the school. The original form and any copies may be used to identify the medical options of the undersigned parent/caregiver. The original form stays with the school nurse.

School District _____ School Building _____ Home Room Teacher _____ Grade _____

**Student's Full Name**

**Last** **First** **Middle initial** **(He, Her, They)**

| | |
|---|---|
| Doctor's Name: | Phone |
| What was the date of your child's last comprehensive annual well care visit* received in their medical home? Date: _____ | |
| Dentist's Name: | Phone |
| What was the date of your child's last dental exam received in their dental home? Date: _____ | |

*** Comprehensive well care visit is not an exam for a specific injury, illness, condition, or sports clearance form completion.**

**STUDENT'S MEDICAL HISTORY:**

- **ALLERGIES: Serious- Requires epinephrine: (please describe)** _____

Requires Medication? _____ Yes _____ No

**If Yes, Please send medication and a copy of the Allergy Plan to the school nurse.**

- **ASTHMA:** Has a doctor, nurse, or other 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

**Please send an inhaler and copy of the Asthma Action Plan to the school nurse.**

- **DIABETES? Yes ____ NO _____**
- **SEIZURES? Yes ____ NO _____ *If yes please send a copy of the Seizure Action Plan and Medication to the school nurse.**
- **OTHER CHRONIC HEALTH CONDITIONS:** _____
- **MEDICATIONS taken on a regular basis (Please explain):**

_____

- **USE CORRECTIVE LENSES? YES_____ NO _____ HEARING AIDS? YES _____ NO _____**

**Does your child have health insurance? Yes ____ No ____** If No, **dial 1- 855-899-9600** for Vermont Health Connect info [https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action]

**IN CASE OF AN EMERGENCY INVOLVING MY CHILD, WHEN I CAN NOT BE REACHED:** I hereby give consent to transport my child for medical care and authorize the providers and hospital to give any reasonable and customary medical and health care deemed necessary at my expense. It is understood that I will be financially responsible for all emergency care.

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

*I give my permission for the school nurse to communicate with my dental provider:*

**€ Yes € No**

*I give permission to exchange health information between my child's primary care provider and the school nurse, including vision and hearing screening information:* **€ Yes € No**

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

(Pg. 1 of 2) **Complete Form on Other Side**Please indicate if student has had or is currently under treatment for any of the following conditions:

**_____BLEEDING DISORDERS** _____
**_____EAR/HEARING PROBLEMS** _____
**_____HEART PROBLEMS**
**_____HIGH BLOOD PRESSURE**
**_____HOSPITALIZED FOR SERIOUS ILLNESS, SURGERY OR ACCIDENTS?** _____
**_____OTHER allergies: (Please list)** _____ _____

**_____ MENTAL HEALTH CONDITION and treatment (Please explain):**
_____
_____
**_____MUSCULAR WEAKNESS OR PARALYSIS**
**_____MIGRAINE HEADACHES**

Any specific concerns about the health and wellbeing of your child? (check all that apply and please describe)

- € Emotional or behavioral health
- € Growth and Development
- € Physical health
- € Oral health
- € Nutrition

Other:

Would you like assistance with other non-healthcare related resources? (check all that apply)

- € Food
- € Housing or Rent
- € Utilities (heat, electricity, internet)
- € Childcare
- € Transportation
- € Interpreter or Other assistance: _____

_____ _____ _____

**Signature – Parent or Guardian** _____ **Relationship to student** **Date**

2026-2027

# NON-PRESCRIPTION MEDICATION PERMISSION FORM

Name:_____ Grade:_____
Homeroom Teacher:_____

If you wish your child to be given Acetaminophen (Tylenol), Ibuprofen (Motrin) or any other over the counter medication under the judgment and supervision of the school nurse, please check below. Aspirin will NOT be given to students.

I give my permission for_____
at Newbury Elementary School to be given the non-prescription medications I have checked below if needed:

_____ Ibuprofen
_____Acetaminophen
_____Tums, Mint, Cough Drop
_____Ointments/Creams: Bacitracin, Hydrocortisone, Benadryl, Calamine
_____Sunscreen, Insect Repellant (may contain DEET), Orajel
_____ Benadryl

Medications will be given for headache, discomfort (toothache, ankle sprain, etc). Ibuprofen and Acetaminophen will not be given for fever in order to allow students to remain in school.

We keep a small supply of medication at school for unexpected problems. If you think your child will need medication at school, please send it to us in the original container. All medications will be kept in the health office. All medications other than the ones listed above require written permission from the physician.

You may contact us any time during the school year to change or revoke permission.

**By signing below, I am indicating that my child has previously taken the medication(s) I have checked, and has not had an allergic reaction.**

_____ **Date**_____
Parent/Guardian signature