GRISWOLD PUBLIC SCHOOLS

211 Slater Avenue, Griswold, CT 06351
Tel: (860) 376-7600 Fax: (860) 376-7607
griswoldpublicschools.org

Sean P. McKenna, Superintendent of Schools
Erik Christensen, Interim Director of Fiscal & Personnel Services

Glenn LaBossiere, Assistant Superintendent
Christopher Champlin, Director of Student Services

STUDENT REGISTRATION FORM

STUDENT INFORMATION:

Student Name: _____

Current Grade: _____ Today's Date: _____

Date of Birth: (M/D/Y) _____ Gender: ▢ M ▢ F ▢ Other: _____

Home Address: _____

GHS Use Only: Town: ▢ Griswold/JC ▢ Canterbury ▢ Lisbon ▢ Norwich ▢ Sprague ▢ Voluntown ▢ Franklin ▢ Preston

Place of Birth (City, State): _____

If not born in the USA; when did the student first attend school in the USA: _____

HOUSEHOLD:

Student lives with: ▢ Both Parents ▢ One Parent ▢ Other, please specify: _____

Parent/Guardian Name: _____

Relationship to Student: _____

Address (if different from student): _____

Primary Phone: _____ Work Phone: _____

Mobile Phone: _____ May we text you at this number? ▢ Y ▢ N

Email: _____

May transport student? ▢ Y ▢ N If No: Court Documents on File? ▢ Y ▢ N

▢ Employed on Federal Property If Yes: ▢ USPS ▢ DOD Branch: _____

▢ Member of the Armed Forces* If Yes: ▢ Active Duty ▢ Deployed ▢ Veteran Other: _____

Parent/Guardian Name: _____

Relationship to Student: _____

Address (if different from student): _____

Household Phone: _____ Work Phone: _____

Mobile Phone: _____ May we text you at this number? ▢ Y ▢ N

Email: _____

May transport student? ▢ Y ▢ N If No: Court Documents on File? ▢ Y ▢ N

▢ Employed on Federal Property If Yes: ▢ USPS ▢ DOD Branch: _____

▢ Member of the Armed Forces* If Yes: ▢ Active Duty ▢ Deployed ▢ Veteran Other: _____

GRISWOLD PUBLIC SCHOOLS
STUDENT REGISTRATION FORM

Other Children Living in the Household:

1. Name: _____ Date of Birth: (M/D/Y) _____
   Relationship to Student: _____ School Attending: _____
2. Name: _____ Date of Birth: (M/D/Y) _____
   Relationship to Student: _____ School Attending: _____
3. Name: _____ Date of Birth: (M/D/Y) _____
   Relationship to Student: _____ School Attending: _____
4. Name: _____ Date of Birth: (M/D/Y) _____
   Relationship to Student: _____ School Attending: _____

ETHNICITY/RACE: (definitions below)

1. Is this student Hispanic/Latino? ▢ Y ▢ N
2. What is your child's race(s)? Check one or more, even if you answered "Yes" to the first question.

▢ American Indian or Alaska Native ▢ Asian ▢ Black or African American
▢ Native Hawaiian or other Pacific Islander ▢ White

LANGUAGE:

What is the primary language used in the home, regardless of the language spoken by the student?
_____
What is the language most often spoken by the student? _____
What is the language the student first acquired? _____

EDUCATION HISTORY:

Name of student's last school/program: _____
Address of last school: _____
Grade last attended: _____
Does the student have a pending or existing disciplinary consequence such as suspension or expulsion? ▢ Y ▢ N

STUDENT SUPPORT:

Does your student receive special education services (IEP)? ▢ Y ▢ N
Does your student receive accommodations through a section 504 plan? ▢ Y ▢ N
Does your student receive academic intervention? ▢ Y ▢ N

HEALTH/MEDICAL:

Is this student covered by health insurance? ▢ Y ▢ N
Primary Physician Name: _____
Primary Physician Phone Number: _____

▢ In case of accident or serious illness, I request the school to contact me. In the event the school is unable to reach me, I hereby authorize the school to contact the student's physician and follow their instructions. If it is not possible to contact the physician, the school may make whatever arrangements are deemed necessary.

GRISWOLD PUBLIC SCHOOLS
STUDENT REGISTRATION FORM

EMERGENCY CONTACTS:

Please list emergency contacts in call order (include 1-4 individuals other than household members listed above). Contacts must be at least 16 years of age. These can be updated, as needed, via the Infinite Campus portal.

	Name	Phone	Relationship to Student & Household Member (HM)	Permission to Pick Up
1.			▢ HM	▢ Y ▢ N
2.			▢ HM	▢ Y ▢ N
3.			▢ HM	▢ Y ▢ N
4.			▢ HM	▢ Y ▢ N

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

For Internal Use:
The family has provided: ▢ Proof of Residency | ▢ Student Birth Certificate
Date Received: _____ Date Entered: _____ Enrollment Start Date: _____
Homeroom: _____

Race Definitions:

- Hispanic/Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- American Indian or Alaska 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 in 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 Philippines Islands, Thailand and Vietnam.
- Black or African American: A person having origins in any of the black racial groups of Africa.
- Native Hawaiian or Other 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 peoples of Europe, the Middle East, or North Africa.

Armed Forces Definition: The Army, Navy, Air Force, Marine Corps, or Coast Guard.
"Active Duty" means full-time in the active military services of the United States, including full-time training duty, annual training duty, and attendance, while in the active military service, of a school designated as a service school by law or by the Secretary of the military department and considered active military service.

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RELEASE OF RECORDS FORM

This form is used as an authorization to release, obtain, and/or exchange information for a student entering or exiting Griswold Public Schools. Please see page 2 for instructions on where to send records.

Date: _____

Student Name: _____

Date of Birth (M/D/Y): _____ Current Grade: _____

Address: _____
Street *City* *State* *Zip Code*

Pursuant to the Family Educational Rights and Privacy Act (FERPA), I hereby authorize Griswold Public Schools to: ▢ **obtain from** ▢ **release to** and/or ▢ **exchange** the specific information and/or records identified below.

From/To: _____
Name of school last attended or entering

Address: _____
Street *City* *State* *Zip Code*

Phone: _____ Fax: _____

Schools within the State of Connecticut will forward original health folders as prescribed by law (Section 10-206d, Connecticut General Statutes).

Information to be released:

▢ Official Academic Record, including Grades/ Transcripts and Standardized Assessment Results	▢ Complete Special Education or Section 504 Records, including current IEP or 504 Plan, Evaluations, and all Student Services Records
▢ Attendance Records	▢ McKinney-Vento Status
▢ School Health Records	▢ EL/MLL Status
▢ Discipline Records	▢ Phone Consultation
▢ Students entering from CT School: SASID #: _____	▢ Please forward free/reduced meal or free milk application, if applicable.

GRISWOLD PUBLIC SCHOOLS
RELEASE OF RECORDS FORM

I understand that the information to be disclosed is protected as an "educational record" under FERPA and that such information shall not be redisclosed unless permitted under FERPA. I further understand that the officers, employees, and agents of any party that receive protected information under FERPA may use such information only for purposes for which the disclosure is made.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

The above records should be sent to/from:

▢ **GRISWOLD ELEMENTARY SCHOOL (GES)**	▢ **GRISWOLD MIDDLE SCHOOL (GMS)**
gesattendance@griswoldpublicschools.org Phone: (860) 376-7610 Fax: (860) 376-7612	gmsoffice@griswoldpublicschools.org Phone: (860) 376-7630 Fax: (860) 376-7631
303 Slater Avenue, Griswold, CT 06351	211 Slater Avenue, Griswold, CT 06351
▢ **GRISWOLD HIGH SCHOOL (GHS)**	▢ **GRISWOLD SOULE STREET ACADEMY / SPECIAL EDUCATION DEPARTMENT**
Darlene Melgey, Registrar DMelgey@griswoldpublicschools.org Phone: (860) 376-7640 Fax: (860) 376-7684	Christopher Champlin, Director of Student Services Phone: (860) 376-7650 Fax: (860) 376-7607
267 Slater Avenue, Griswold, CT 06351	211 Slater Avenue, Griswold, CT 06351

GRISWOLD MIDDLE SCHOOL

211 Slater Avenue, Griswold, CT 06351
Tel: (860) 376-7630 Fax: (860) 376-7631
gms.griswoldpublicschools.org

Louis Zubek, Principal
Sean P. McKenna, Superintendent of Schools
Erik Christensen, Director of Fiscal & Personnel Services

Steven Bourque, Assistant Principal
Glenn LaBossiere, Assistant Superintendent of Schools
Christopher Champlin, Director of Student Services

SCHOOL NURSE NEW STUDENT CHECKLIST

To be completed by parent/guardian:

Student Name: _____ Date of Birth: (M/D/Y) _____

Parent/Guardian Name(s): _____

Best Phone Number: _____

Current Grade: _____

Name of student's last school/program: _____

Address of last school: _____

Phone number of last school: _____

Has student ever attended Griswold Public Schools? ▢ Y ▢ N If yes, what years? _____

If the student is from out of state, has the student ever attended a school in Connecticut?

▢ Y ▢ N If yes, where? _____

Please send parent/guardian to the health office with available documents.

For Internal Use: Date Received: _____
Parent/Guardian has provided:
▢ Copy of Physical / Date of Physical: _____
▢ Immunization Record ▢ TB Risk Assessment Form
▢ Postural Permission Slip ▢ Health Questionnaire

The above student has been cleared by the health office to enter GMS on: (Date) _____

Over the summer months, please scan Physicals and Immunizations to JEaton@griswoldpublicschools.org and RWnek@griswoldpublicschools.org for entry approval.

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 ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ 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			***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made		
Genitalia/ hernia					
Skin					

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 ❑ Fail	❑ Pass ❑ Fail	***HCT/HGB:**	
Without glasses	20/	20/				***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 Allergies ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source
*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

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 Completed by: ❑ Dentist	**Visual Screening** Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	**Normal** ❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	**Referral Made:** ❑ Yes ❑ No
Risk Assessment	**Describe Risk Factors**		
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____		❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ 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

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

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HEALTH QUESTIONNAIRE

Information provided will be shared with the appropriate staff as stated in the Family Education Right and Privacy Act (FERPA)

STUDENT NAME: _____ GRADE: _____

Please check yes (Y) or no/non-applicable (N). **My child...**

Y | N

☐ ☐ 1. Has been diagnosed with **ASTHMA.**

☐ ☐ 2. Has had **SEIZURE** activity in the past 12 months.

If yes, specify: _____

Medication: _____

3. Please list any **MEDICATION(S)** your child will need.

TO TAKE IN SCHOOL: _____

TO TAKE AT HOME: _____

☐ ☐ 4. Was seriously **ill/sustained injury** or **had surgery** in the last 12 months.

If yes, specify: _____

☐ ☐ 5. Is allergic to **Bees/Wasps**.

If yes, specify: _____

Medication: _____

☐ ☐ 6. Is allergic to **Medication/Latex/Other**.

If yes, specify: _____

☐ ☐ 7. Is allergic to **FOOD**.

If yes, which food(s): _____

Reaction(s): _____

Medication: _____

☐ ☐ 8. Is **DIABETIC**. If yes, please select: ▢ **TYPE I** ▢ **TYPE II**

☐ ☐ 9. Wears glasses/contacts.

☐ ☐ 10. Has a hearing aid and/or hearing problems.

☐ ☐ 11. Has specialized equipment (i.e. wheelchair, leg braces, assistive feeding devices, crutches, walker, catheterization supplies, ostomy supplies, diabetic meters, etc.)

If yes, specify: _____

☐ ☐ 12. Has a diagnosis of **ADHD**.

☐ ☐ 13. Has a diagnosis of **Anxiety**.

☐ ☐ 14. Has a diagnosis of **ASD (Autism Spectrum Disorder)**.

☐ ☐ 15. Has a diagnosis of **Bipolar**.

☐ ☐ 16. Has a diagnosis of **Depression**.

☐ ☐ 17. Has a diagnosis of **Manic Depression**.

☐ ☐ 18. Has **Headaches/Migraines**.

☐ ☐ 19. Is there anything you'd like to speak to the School Nurse about that is not on this list?

☐ ☐ 20. If necessary, may the School Nurse have your permission to contact your child's physician in regards to their health?

☐ ☐ 21. Does your child have Health Insurance?

Parent/Guardian Signature: _____ Date: _____

HEALTH QUESTIONNAIRE

GPS School Nurses:

GRISWOLD ELEMENTARY SCHOOL (GES)	GRISWOLD MIDDLE SCHOOL (GMS)	GRISWOLD HIGH SCHOOL (GHS)
Sarah McEwen RN SMcewen@griswoldpublicschools.org Health Assistant, Emily Kudlak (860)376-7615	Jessica Eaton, RN JEaton@griswoldpublicschools.org Health Assistant, Rebecca Wnek (860) 376-7624	Stephanie Bibeau RN, BSN *District Nurse Coordinator* SBibeau@griswoldpublicschools.org Health Assistant, Jenna Martin (860) 376-7647
303 Slater Avenue, Griswold, CT 06351	211 Slater Avenue, Griswold, CT 06351	267 Slater Avenue, Griswold, CT 06351

Connecticut Tuberculosis (TB) Risk Assessment

See ***the Connecticut TB Risk Assessment User Guide*** for more information about using this tool.

- Use this tool to identify asymptomatic **adults and children** for latent TB infection (LTBI) testing.
- This tool can be used for school-aged children to determine if a student should have a TB test.
- This risk assessment does not supersede any TB testing mandated by statute, regulation or policy.
- **Do not repeat testing** unless there are **new risk factors** since the last test.
  If initial negative screening test occurred prior to 6 months of age, repeat testing should occur at age 6 months or older.
- Do not treat for LTBI until active TB disease has been excluded:
  For persons with TB symptoms or an abnormal chest x-ray, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum acid-fast bacilli (AFB) smears, cultures and nucleic acid amplification testing (NAAT). A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

LTBI testing is recommended if any of the boxes below are checked.
☐ **Birth, travel, or residence** for at least 1 month in a country with an elevated TB rate
• Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
• If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the Connecticut Tuberculosis Risk Assessment User Guide for this list).
• IGRA is preferred over TST for non-U.S.-born persons ≥2 years old
☐ **Immunosuppression,** current or planned
• HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥2 mg/kg/day, or ≥15 mg/day for ≥1 month) or other immunosuppressive medication
☐ **Close contact** to someone with infectious TB disease • Should test if patient has never been tested for this exposure
Treat for LTBI if TB test result is positive and active TB disease is ruled out.

☐ **None of the above**: No TB testing is indicated **at this time**.*

Please complete all information below:

Patient/Student Name:_____ Date of Birth: ____ /____ /____

Provider's Name: _____ Assessment Date: ____ /____ /____

***See The Connecticut TB Risk Assessment: User Guide section "Local recommendations, mandated testing and other risk factors."**

Avoid testing persons at low risk

Routine testing of persons without risk factors is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

If necessary, prioritize persons with risks for progression

If health system resources do not allow for testing of all non-U.S. born persons from a country with an elevated TB rate, prioritize patients with at least one of the following medical risks for progression:

- diabetes mellitus
- smoker within past 1 year
- end stage renal disease
- leukemia or lymphoma
- silicosis
- cancer of head or neck
- intestinal bypass/gastrectomy
- chronic malabsorption
- body mass index ≤20
- immunosuppression (see TB Risk Assessment)
- Upper lobe fibrotic lesion that has not shown at least one year of stability on two chest radiographs, after evaluation to ensure not active

United States Preventive Services Task Force (USPSTF)

The USPSTF has recommended testing persons born in, or former residents of, a country with an elevated TB rate (regardless of length of time in the U.S.) and persons who live in or have lived in high-risk congregate settings such as homeless shelters and correctional facilities. Because the increased risk of exposure to TB in congregate settings varies substantially by facility and local health jurisdiction, clinicians are encouraged to follow local recommendations when considering testing among persons from these congregate settings. The USPSTF did not review data supporting testing among close contacts to persons with infectious TB or among persons who are immunosuppressed because these persons are recommended to be screened by public health programs or by clinical standard of care.

Local recommendations, mandated testing and other risk factors

Several risk factors for TB that have been used to select patients for TB screening historically or in mandated programs are not included among the components of this risk assessment. This is purposeful in order to focus testing on patients at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Examples of these populations might include: primary and secondary school students, healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, and others.

For public schools, Connecticut General Statutes Section 10-206 (b) and (c) mandate that each student have a health assessment at three time periods during his/her primary and secondary school education: “prior to public school enrollment,” during Grade 6 or 7, and during Grade 9 or 10. Connecticut General Statutes Section 10-206 (c) states that: “The assessment shall also include tests for tuberculosis…where the local or regional board of education, in consultation with the school medical advisor and the local health department, or in the case of a regional board of education, each local health department, determines that said screening or test is necessary...” The results of the risk assessment and testing, when done, should be recorded on the Connecticut State Department of Education (CSDE) Health Assessment Record (HAR-3); or on the CSDE Early Childhood Health Assessment Record; and in the student’s Cumulative Health Record (CHR-1).

Public school personnel (e.g. teachers) are not required to be tested for TB by any Connecticut state statute or regulation.

Age as a factor

Age is not considered in this risk assessment. However, children and younger adults have more years of expected life during which progression from latent infection to active TB disease could develop. Some programs or clinicians may additionally prioritize testing of younger non-U.S.-born persons where all non-U.S.-born are not tested. An upper age limit for testing has not been established but could be appropriate depending on individual patient TB risks, comorbidities, and life expectancy. This risk assessment tool is valid for both adults and children.

When to repeat a risk assessment and testing

Risk assessments should be completed for new patients, patients thought to have new potential exposures to TB since last assessment, and during routine pediatric well-child visits. Repeat risk assessments should be based on the activities and risk factors specific to the person. Persons who volunteer or work in health care settings might require annual testing and should be considered separately. Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment (unless they were <6 months of age at the time of testing). In general, new risk factors would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel.

Immunosuppression

The exact level of immunosuppression that predisposes to increased risk for TB progression is unknown. The threshold of steroid dose and duration used in the Connecticut TB Risk Assessment are based on data in adults and in accordance with ACIP recommendations for live vaccines in children receiving immunosuppression.

Foreign travel or residence

Travel or residence in countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with persons with infectious TB, high prevalence of TB in travel location, non-tourist travel). The one month duration of travel or residence used in this risk assessment is intended to identify travel most likely to involve TB exposure. TB screening tests can be falsely negative within the 8 weeks after exposure, so are best obtained 8 weeks after a person's return.

IGRA preference in non-U.S.-born persons ≥2 years old

Because IGRAs has increased specificity for TB infection in persons vaccinated with Bacillus Calmette-Guérin (BCG), IGRA is preferred over the TST for non-U.S.-born persons ≥2 years of age. IGRAs can be used in persons <2 years of age, however, there is an overall lack of data in this age group, which complicates interpretation of test results. In BCG vaccinated immunocompetent persons with a positive TST, it may be appropriate to confirm a positive TST with an IGRA. If IGRA is not done the TST result should be considered the definitive result.

Negative test for LTBI does not rule out active TB

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. A negative TST or IGRA in a patient with active TB disease can be a sign of extensive disease. Any suspicion for active TB disease or extensive exposure to TB should prompt an evaluation for active TB disease, including physical exam, symptom review, and 2-view chest x-ray.

Most patients with LTBI should be treated

Persons with risk factors who test positive for LTBI should generally be treated once active TB disease has been ruled out with a physical exam, chest radiograph and, if indicated, sputum AFB smears, cultures, and NAAT. However, clinicians should not feel compelled to treat a person with a positive TB test who does not have identified TB risk factors, especially if at higher risk of adverse reactions.

Emphasis on short course regimens for LTBI treatment

Shorter regimens for treating LTBI have been shown to be as effective as 9 months of Isoniazid, and are more likely to be completed. Use of these shorter regimens is preferred in most patients, although the 12 week regimen is not recommended for children <2 years of age. It is under study in pregnancy. Drug-drug interactions and contact to drug resistant TB are other contra-indications for shorter regimens.

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + Rifapentine	Weekly	12 weeks**

**11-12 doses in 16 weeks required for completion.

Refusal of recommended LTBI treatment

Refusal should be documented. Recommendations for treatment should be made at future encounters with medical services. If treatment is later accepted, TB disease should be excluded and chest x-ray repeated if it has been more than 6 months from the initial evaluation for children or adults 5 years or older and 3 months for children less than 5 years of age.

Persons with a history of LTBI, with or without treatment

A person with a history of a documented positive TB test does not need to have a TB test repeated at any interval. If a person with a history of LTBI has a new TB exposure, they should have a symptom assessment to ensure they are well; for persons with a negative symptom assessment, repeat chest radiographs are rarely indicated. Persons with LTBI who completed treatment do not need to be treated again, except in rare circumstances (e.g. exposure to a drug resistant strain of TB).

Symptoms that should trigger evaluation for active TB

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, weight loss, lymphadenopathy, hemoptysis or excessive fatigue.

Resources

Connecticut State Department of Public Health: Tuberculosis Control Program
https://portal.ct.gov/en/DPH/Infectious-Diseases/Tuberculosis/Tuberculosis-Control-Program

Connecticut State Department of Education: School Nursing
www.ct.gov/sde/schoolnurse

Centers for Disease Control and Prevention (CDC) Basic Information and Facts about Tuberculosis
https://www.cdc.gov/tb/topic/basics/default.htm

CDC: Fact Sheets for LTBI Regimens, Isoniazid+Rifapentine, Rifampin, and Isoniazid are available at the following URL:
https://www.cdc.gov/tb/publications/factsheets/treatment.htm

National Tuberculosis Controller's Association Provider Guidance: *Using the Isoniazid/Rifapentine to Treat Latent Tuberculosis Infection (LTBI)*
https://www.surveygizmo.com/s3/4592623/2018-3HP-Provider-Guidance-Download

American Academy of Pediatrics, Red Book Online, Tuberculosis are available at the following URL:
https://redbook.solutions.aap.org/chapter.aspx?sectionid=189640207&bookid=2205

Abbreviations

AFB= acid-fast bacilli
BCG= Bacillus Calmette-Guérin
IGRA= interferon gamma release assay
LTBI= latent TB infection
NAAT= nucleic acid amplification testing
TB= tuberculosis
TNF= tumor necrosis factor inhibitors (?)
TST= tuberculin skin test

GRISWOLD PUBLIC SCHOOLS
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griswoldpublicschools.org

Sean P. McKenna, Superintendent of Schools
Erik Christensen, Interim Director of Fiscal & Personnel Services
Glenn LaBossiere, Assistant Superintendent of Schools
Christopher Champlin, Director of Student Services

POSTURAL SCREENING

Public Act 15-215 requires female students in the 5th and 7th grades, and male students in the 9th grade to have a postural examination to determine the possibility of any spinal problems. In areas where screening is already being done, spinal variations have been detected in about four percent (4%) of the adolescent population and two percent (2%) have required active treatment or continued observation. The purpose of this program is to recognize the problem at its earliest stages so that the need for treatment can be determined and progressive spine deformity can be prevented.

The procedure for screening is a simple one. The school nurse inspects the child's spine as he/she stands and bends forward. If a spinal problem is suspected, the child will be rechecked at a second screening. If further consultation is recommended, parents/guardians of students who are found to have signs of a possible spinal abnormality will be notified and will be asked to see their own physicians for further evaluation.

This examination is being offered **free** to all female students in grades 5, and 7, and all male in grade 9 and will be done before the end of each school year. When you return this slip it will give us permission to perform this screening on your student from fifth through ninth grade. If at any time you wish to cancel this, you must contact the school nurse.

STUDENT NAME: _____

Please check one of the following:

1. _____ Please include my child in the postural screening being offered each year while my student is in grade 5, 7, (female) and grade 9 (male) in the Griswold Public Schools district.

2. _____ Do not include my child in the postural screening as we plan to have this done at a private physician's office and will send the results to the school before June of each school year.

3. _____ My child is currently under active treatment for a spinal problem.

Parent/Guardian Signature: _____ Date: _____

GRISWOLD PUBLIC SCHOOLS
POSTURAL SCREENING FORM

Please contact the School Nurse at your child's current school with any questions:

GRISWOLD MIDDLE SCHOOL (GMS)

Jessica Eaton RN
JEaton@griswoldpublicschools.org
Health Assistant, Rebecca Wnek
(860) 376-7624

211 Slater Avenue,
Griswold, CT 06351

GRISWOLD HIGH SCHOOL (GHS)

Stephanie Bibeau RN, BSN
District Nurse Coordinator
SBibeau@griswoldpublicschools.org
Health Assistant, Jenna Martin
(860) 376-7647

267 Slater Avenue,
Griswold, CT 06351

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Erik Christensen, Interim Director of Fiscal & Personnel Services

Glenn LaBossiere, Assistant Superintendent
Christopher Champlin, Director of Student Services

CONNECTICUT HOME LANGUAGE SURVEY

Welcome to Griswold Public Schools! We have a few questions about languages spoken at home. We are required by the US Department of Education to ask for this information because it will help us know how we can best support your child. The language information also helps us know how we can best communicate with you. Please share with us about the language(s) spoken by your family and in your home.

Student Name: _____ Date of Birth: (M/D/Y) _____

1. What is the primary language used in the home, regardless of the language spoken by the student?

   _____

2. What is the language most often spoken by the student?

   _____

3. What is the language the student first acquired?

   _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Thank you for answering these questions. We look forward to working with your child.

GRISWOLD MIDDLE SCHOOL

211 Slater Avenue
Griswold, CT 06351
860-376-7630

RECORD OF PARENT ANNUAL NOTICE
2026-2027 School Year

Dear Parent/Guardian,

The *Griswold Middle School Parent/Student Handbook* for the 2026-2027 school year has been posted electronically on the GMS website (https://gms.griswoldpublicschools.org/). Parents can still request a hardcopy of the student handbook. Please check off the appropriate box below.

It is important that you and your child read and review the contents of the *Parent/Student Handbook*. The *Parent/Student Handbook* contains notices of rights that you and your child have under law.

Relative to Griswold Board of Education policies,
I understand and consent to the responsibilities in the Griswold Board of Education's policies as outlined in this handbook. I also understand and agree that my child shall be held accountable for the behavior, interventions, and consequences outlined in the discipline policy at school and at school-sponsored or school-related activities, including school-sponsored travel, and for any school-related misconduct, regardless of time or location. I understand that any student who violates the school's rules of behavior shall be subject to disciplinary action, up to and including referral for criminal prosecution for violations of law.

Regarding student records,
I understand that certain information about students is considered directory information. Directory information includes: a student's name, address, telephone number, date and place of birth, participation in officially recognized activities and sports, dates of attendance, awards received at school, and most previous school attended. Directory information may be released by the district unless the parent or guardian objects to the release within ten days of the time this notice is issued.

Regarding the use of computers,
I understand the Griswold Public Schools provides computer access to students for educational purposes. I understand that any misuse of the computer network or software systems may subject students to Griswold Public Schools' sanctions as well as applicable **CT General Statutes, Section 53a-251 Computer Crime.**

Regarding video recorders on school buses,
I understand and acknowledge the district's procedures concerning the use of video recorders on school buses.
I also understand that my child shall be held accountable for his/her conduct on district transportation and for the consequences outlined in the district's discipline procedures for district-approved student transportation.

I have reviewed the ***Griswold Middle School Parent/Student Handbook and attendance policy*** **for 2026-2027.** My child has reviewed with me the student behavior expectations for GMS in this handbook.

Please sign and have your child return this notice to his/her home room teacher within the first week of school.

☐ I have read and reviewed the 2026-2027 student handbook.

☐ I am unable to view the handbook online and would like to receive a hardcopy of the 2026-2027 student handbook.

Student Name	**Student Signature**	**Date**
Parent/Guardian Name	**Parent/Guardian Signature**	**Date**

GRISWOLD PUBLIC SCHOOLS

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Sean P. McKenna, Superintendent of Schools
Erik Christensen, Director of Fiscal & Personnel Services
Glenn LaBossiere, Assistant Superintendent of Schools
Christopher Champlin, Director of Student Services

BUS TRANSPORTATION FORM

Student Transportation (STA) of Griswold, CT

Please fill out one form per student. TODAY'S DATE: _____

STUDENT NAME: _____ SCHOOL YEAR: _____

SCHOOL: ▢ GES ▢ GMS ▢ GHS ▢ GSSA ▢ TECH/VO-AG SCHOOL: _____ GRADE: _____

HOME ADDRESS: _____

Parent(s)/Guardian(s) Printed Name(s): _____
Parent(s)/Guardian(s) Phone Number(s): _____

DAILY TRANSPORTATION:

Please answer the following questions:

- Will your student need bussing? ▢ Yes ▢ No
  - If yes, from what address: ▢ Home Address Listed Above ▢ Other:

    _____
  - Will bussing be needed daily? If not, please specify days/dates student will not be utilizing bussing.

    _____
    _____
    _____
- Will your student be a walker? ▢ Yes ▢ No
- Will your student be a parent pick-up or Drop-off on a daily basis? ▢ Yes ▢ No
  - If yes, please specify: ▢ AM Drop-off ▢ PM Pick-up ▢ Both
- **GES Only:** Will your student be attending the *Wolverines Forward Before and After School Program*? ▢ Yes ▢ No
  - If yes, will they be attending AM WF, PM WF, or both? ▢ AM ▢ PM ▢ Both

Please list all other authorized people who can get your student off the bus (must be 16 or older):

_____

Form continued on next page

GRISWOLD PUBLIC SCHOOLS
BUS TRANSPORTATION FORM
Student Transportation (STA) of Griswold, CT

If your child attends daycare, please provide the following information:
Daycare Provider Name: _____
Address: _____
Phone Number: _____

Important information: Due to the variety of factors, exact pick-up and drop-off times can fluctuate daily; therefore, students should arrive at their scheduled bus stop at least 8 minutes prior to their pick-up time and wait at least 8 minutes after their pick-up time.

Parents/Guardians must meet their Preschool, Kindergarten, Grade 1, and/or Special Needs students at the bus stop in order for them to be dropped off. If an adult is not present, students will remain on the bus and be returned to the school office to be picked up.

Griswold Public Schools distributes alerts about school closures, delays and early dismissals to parents/guardians of students enrolled in GPS. Griswold families whose students attend another school should sign up for school closure notifications from one of our partner stations. Learn more here.

Making Changes: ***The Bus company will not make any changes to a student's pick up or drop off unless contacted by the respective school first.***
Temporary: To ensure the safety of all students, requests for transportation changes must be submitted in writing or via email to the appropriate school office. ***Telephone requests will not be accepted.*** Students will receive a bus pass to their new stop. ***For new requests, changes may take up to 48 hours to accommodate rerouting buses to new stops.***

Permanent change/move: If you're relocating within Griswold or your student has a new transportation schedule, please fill out this form and resubmit to your child's school.

Please return this completed form to the Griswold Public Schools Registration Office, located in the GPS Central Office, via email, fax, or in person.
GPSRegistration@griswoldpublicschools.org | Fax: (860) 376-7607| 211 Slater Avenue, Griswold, CT 06351

Contact your child's school main office or STA of Griswold at (860) 376-2860 with questions:

GRISWOLD ELEMENTARY SCHOOL (GES)	GRISWOLD MIDDLE SCHOOL (GMS)	GRISWOLD HIGH SCHOOL (GHS)
gesattendance@griswoldpublicschools.org	gmsoffice@griswoldpublicschools.org	ghsattendance@griswoldpublicschools.org
(860) 376-7610	(860) 376-7630	(860) 376-7640

Internal Use Only: ▢ GES ▢ GMS/GHS ▢ GSSA ▢ Tech/Vo-Ag: _____
Bus # AM _____ AM Time: _____
Bus # PM _____ PM Time: _____ Date filed: _____

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Glenn LaBossiere, Assistant Superintendent of Schools
Erik Christensen, Interim Director of Fiscal & Personnel Services
Kyle Gunderman, Director of Technology

STUDENT: ACCEPTABLE USE POLICY FOR COMPUTER, NETWORK, INTERNET & EMAIL SERVICES

Student access to the district computers, Network, Internet and other technology resources is provided to support student learning and research, and facilitate educational communication consistent with Griswold Public School's educational mission and curriculum goals.

I, _____, as a user of the Griswold Public School District's electronic information resources and computer networks, have read and will abide by the Acceptable Use Policy of the Griswold Board of Education and agree to the following conditions:

Rules of Acceptable Use:

1. All electronic information resources shall be used for educational purposes only.
2. Users will act responsibly, ethically, and legally while using computers and network, whether the property of Griswold Public Schools or personal equipment on campus.
3. Users will adhere to all copyright laws. Users must give credit to all work accessed via Internet. Permission should be obtained when appropriate.
4. Users will respect the privacy of others and protect password confidentiality.
    - Passwords are not to be shared with others.
    - Using another user's account or password is prohibited.
5. Users will be considerate of other technology users and will use polite and appropriate language at all times when accessing these resources.
6. Users will keep any personal information about themselves or others private while accessing the network or Internet.
7. Users will immediately report any problems or breaches of these responsibilities, or any inappropriate messages received, to the teacher or to the school personnel who are supervising use of these resources.
8. Users will take care of and respect all equipment or network resources at all times.
9. Users will not knowingly degrade or disrupt electronic information resources, services, or equipment, and understand that such activity may be considered to be a crime and includes, for example, tampering with computer hardware and software, vandalizing or modifying data without permission, invoking computer viruses, attempting to gain access to restricted or any unauthorized networks or network services, or violating copyright laws.
10. Users will act responsibly at all times and will avoid all other activities that are considered to be inappropriate in the electronic school environment, including purchasing products, harassing, bullying, discriminatory or threatening communications and behavior.
11. While network files will be respected, users must understand that all information may be accessed by technology staff and administration. Users should not assume that any information in network files is private or confidential.

STUDENT: ACCEPTABLE USE POLICY FOR COMPUTER, NETWORK, INTERNET & EMAIL SERVICES

Unacceptable Use Includes*:

1. Any use involving materials that are obscene, pornographic or otherwise inappropriate.
2. Using the computer to harm other people or their work.
3. Any action that interferes with the operation of the network, including sending chain letters to school users or outside parties.
4. Trespassing in another's folder, work or files.
5. Not obeying the rules of copyright regarding software; changing settings or installing software without permission.
6. Accessing, attempting to access or using another person's password to access any area or site that has been blocked, locked or to which access has been limited by the system administrator.
7. Users will not knowingly degrade or disrupt electronic information resources, services, or equipment, and understand that such activity may be considered to be a crime and includes, for example, tampering with computer hardware and software; vandalizing or modifying data without permission; invoking computer viruses; and attempting to gain access to restricted or any unauthorized networks or network services, or violating copyright laws.
   **This list is not all inclusive*

The use of electronic resources, including the Internet and network, is a privilege, not a right, and unacceptable use will result in withdrawal of these privileges and/or other disciplinary actions. All users are expected to exercise good judgment. The user's parent or guardian may be held financially accountable for any intentional damage to technology resources, equipment or network. The district's Superintendent of schools or his/her designee will determine when disciplinary action is necessary.

I acknowledge that _____ and _____
Student Name (please print) *Guardian Name*
have read, understand, and will abide by the above policy when using Griswold Public Schools' network and computer systems.

Student Signature: _____ Date: _____

School: ▢ GES ▢ GMS ▢ GHS ▢ GSSA Current Grade: _____

STUDENT: ACCEPTABLE USE POLICY FOR COMPUTER, NETWORK, INTERNET & EMAIL SERVICES

PARENTAL CONSENT

I give the Griswold Public School District permission to allow my child to access and use electronic information resources for educational and research purposes.

I have read this Acceptable Use Agreement and have explained and discussed its importance with my child.

I understand, and have explained to my child, that he/she may lose his/her privilege to use these resources at school and may face disciplinary action if he/she does not follow this Agreement and the Board's Policy. I understand that I may be held liable for costs incurred by my child's deliberate misuse of electronic information resources or of the District's electronic equipment or software programs.

I understand that the District will employ filtering programs, access controls, and active supervision by staff to protect students from any misuses and abuses as a result of their use of the District's electronic information services. I also understand that these controls, filters, and monitors are not foolproof and that my child may access material which I might consider controversial and offensive. I understand that the Griswold Public Schools District has no control over the content of the information available on the Internet. I will not hold the Griswold Board Of Education Board liable for materials my child obtains or views from these electronic information resources.

Parent/Guardian Signature: _____ Date: _____

Please contact the technology department with any questions:

GPS TECHNOLOGY DEPARTMENT
griswoldtechnology@griswoldpublicschools.org
Help Desk: (860) 376-7662

GRISWOLD ELEMENTARY SCHOOL (GES)

Joseph Bordeau, Principal
JBordeau@griswoldpublicschools.org

303 Slater Avenue,
Griswold, CT 06351

GRISWOLD MIDDLE SCHOOL (GMS)

Louis Zubek, Principal
LZubek@griswoldpublicschools.org

211 Slater Avenue,
Griswold, CT 06351

GRISWOLD HIGH SCHOOL (GHS)

Erin Palonen, Principal
EPalonen@griswoldpublicschools.org

267 Slater Avenue,
Griswold, CT 06351

GRISWOLD PUBLIC SCHOOLS

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ONE-TO-ONE DEVICE PROGRAM ACCEPTABLE USE AGREEMENT
SCHOOL YEAR 2026-2027; GRADES K-12

I have read the Griswold Public Schools' One-to-One Device Program Guidelines and all referenced Board policies.

1. I understand the procedures and requirements to which my child must comply, including the Acceptable Use Policy.
2. I accept responsibility for any damage or neglect that may result from my child while the device is in his/her possession or control, which may result in monetary charges.
3. I understand that my child may lose his/her device privileges and/or incur financial fees as a result of inappropriate behavior, damage, neglect, or loss to any District Device.
4. I understand my child must return the device, power adapter and cable when requested at the end of the school year. I understand that I will be charged for any missing or damaged equipment and cables.

The District's self-insurance program at a cost of $20.00 annually provides protection in the event of damage to the device. (Up to two incidents covered per year) **Insurance is only offered for 30 days from the date the student receives their Chromebook. <u>If the insurance is unpaid, you will be assuming full responsibility for damage, theft, or loss.</u>**
Payments can be made online under the Parent Portal, or checks can be sent to the main office at your child's school. Make checks payable to *Griswold Public Schools*; Check Memo Line: *Device Insurance: [Student Name]*

I understand and agree to the information and terms of the 1:1 device agreement:

Student Name: _____ Current Grade: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

I am opting in to the District's self-insurance program for this school year. ▢ Y ▢ N

I have provided $20.00 for the device insurance via:

▢ Check, Number _____
▢ Cash
▢ Paid Online
▢ I choose **not** to participate and will assume full cost of repair or replacement if needed.

If this will cause a financial hardship, please contact the GPS Director of Technology Kyle Gunderman at KGunderman@griswoldpublicschools.org, or contact your child's school principal.

ONE-TO-ONE DEVICE PROGRAM ACCEPTABLE USE AGREEMENT SCHOOL YEAR 2026-2027; GRADES K-12

Please contact the technology department with any questions:

GPS TECHNOLOGY DEPARTMENT
griswoldtechnology@griswoldpublicschools.org
Help Desk: (860) 376-7662

GRISWOLD ELEMENTARY SCHOOL (GES)

Joseph Bordeau
JBordeau@griswoldpublicschools.org

303 Slater Avenue,
Griswold, CT 06351

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Louis Zubek
LZubek@griswoldpublicschools.org

211 Slater Avenue,
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Erin Palonen
EPalonen@griswoldpublicschools.org

267 Slater Avenue,
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Christopher Champlin, Director of Student Services

PHOTO/VIDEO RELEASE

STUDENT NAME: _____
SCHOOL: ▢ GES ▢ GMS ▢ GHS ▢ GSSA
SCHOOL YEAR: _____ GRADE: _____ TEACHER: _____

The Griswold Board of Education retains the absolute right and permission to copyright and use, reuse and publish portraits, pictures and videos of my child or in which my child may be included, in whole or part, without restrictions as to changes or alterations in composite of photograph or video. The Griswold School System will use these photographs/videos and no fees will be collected or profits from these photographs/videos.

Photo Permission:

- ▢ YES
- ▢ NO

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Contacts:

GRISWOLD ELEMENTARY SCHOOL (GES)	GRISWOLD MIDDLE SCHOOL (GMS)	GRISWOLD HIGH SCHOOL (GHS)
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303 Slater Avenue, Griswold, CT 06351	211 Slater Avenue, Griswold, CT 06351	267 Slater Avenue, Griswold, CT 06351

Healthcare Provider's Certification of
In Process Required School Immunizations

Connecticut Immunization school entry requirements require that students whose initial immunizations have been given but additional required immunizations are in process to submit this certification from the student's physician, physician assistant (PA) or advance practice registered nurse (APRN) that the additional immunizations are in process in accord with guidelines and schedule specified by the Commissioner of Public Health (*Connecticut Department of Public Health Schedule For In Process Required School Immunizations*). Physicians, PAs, and APRNs must follow the CDC catch up schedule following the minimum spacing interval between doses and complete the administration of the additional required immunizations no later than 30-days after the minimal interval time period has occurred.

I certify that the student identified below is my patient and that I will provide any required school immunizations for the student's school enrollment which have not been administered as of this date in accord with the Connecticut Commissioner of Public Health Schedule For In Process Required School Immunizations.

Name of Primary Care Provider: _____

Please check one (provider granting exemption must be licensed as one of the following):

☐ Physician (M.D. or D.O.) ☐ Physician Assistant ☐ APRN

Connecticut License number: _____

Phone number: _____ Email: _____

Signature: _____ Date: _____

Patient/Student Information:

First name (in full) _____ Middle initial _____ Last name _____

Date of Birth _____

Mailing Address _____ City _____

State _____ Zip _____

Parent/Guardian: First Name _____ Last name _____

Primary phone number _____

School name _____

School address _____

City _____

State _____ Zip _____

Current Grade student is entering _____