

TOWN OF NORTH PROVIDENCE  
SCHOOL DEPARTMENT  
2240 Mineral Spring Avenue, North Providence, Rhode Island 0291  
(401) 233-1100 - FAX (401) 233-1106 - TDD (800) 745-6575

Joseph B. Goho, *Superintendent*  
Louise K. Seitsinger, M.Ed., *Assistant Superintendent*  
Lisa Casinelli, *Finance Director*  
Cynthia VanAvery, MA *Director of Special Education*  
Matthew Hicks, *Director of Human Resources*

**SCHOOL COMMITTEE**

Frank Pallotta, Ed.D. *Chair*  
Roderick E. DaSilva, *Vice Chair*  
Steven M. Andreozzi, *Clerk*  
Arthur Corsini  
Anthony R. Marciano, Sr., Esq.  
Gina M. Picard, M.Ed.  
Charles Pollock

Rev.01.12.2021

Dear Parent / Guardian:

These are the items you will need to complete your child's registration:

1. Proof of residency, Notarized Affidavit of Residency form by parent/legal guardian and a Notarized Landlord/management company/property owner Affidavit. *And* (2 other forms required – i.e.: Mortgage Statement/Lease, or a notarized letter from owner, (A notarized letter must include student(s) name, DOB, property address, owner name and phone number) *and* A Major utility bill) (Copies) Birth Certificate (original), Parent/Guardian ID
2. Written proof of physical exam and the following immunizations:
  - a. 5 doses of DTP/DTaP (diphtheria, tetanus, pertussis) vaccine (4 doses if last dose given after 4<sup>th</sup> birthday)
  - b. 4 doses Polio vaccine (3 doses if last dose given after 4<sup>th</sup> birthday)
  - c. 2 doses MMR (measles, mumps, rubella) vaccine
  - d. 3 doses Hepatitis B vaccine
  - e. 2 doses Varicella (chickenpox) vaccine (or a note signed by your child's doctor stating that the child has had chickenpox disease)
3. Montreux test (PPD) Tuberculosis- per the NP School Dept., the PPD is required only if entering from out of the country.
4. Evidence of a physical examination within the last twelve months before the start of school
5. Vision screening (may be done during physical examination)
6. Proof of lead screening
7. All registrations and documents can be emailed to [registration@npsd.k12.ri.us](mailto:registration@npsd.k12.ri.us)

The birth certificate will be returned to you immediately. The other documents will be kept at school as a part of your child's record. Free immunization clinics are held annually. The school nurse teacher will have a list of available clinics. Original documents will be returned.

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_

Current Grade: \_\_\_\_\_

Specialized Services Section

|  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| Does your child presently have an <i>Individualized Education Program (IEP)</i> ?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you providing a copy of your child's IEP?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your child transferring from another district?<br>***If yes, please identify the district _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child had a screening test with <i>Child Outreach</i> ?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child have a <i>Section 504 Plan</i> ?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child receive any other services not already mentioned? If yes, please explain:          | <input type="checkbox"/> | <input type="checkbox"/> |

**\*\*Should your child have an Individualized Education Program (IEP), please present that to the NPSD Registration Department at the time of registration. The Registration Department will notify the Special Education Office to address follow up questions, concerns, and placement.\*\***

Please refer to the North Providence Special Education webpage for additional information:  
<https://www.npsdspecial.ed.org/>



Angélica Infante-Green  
 Commissioner

## Home Language Survey (HLS)

To be completed by Parent or Guardian

Dear Parent or Guardian,

The information requested on this form is necessary for the most appropriate school placement of your child, and will not be used for any other purposes<sup>1</sup>.

Thank you for your collaboration.

|   |                                 |                                |
|---|---------------------------------|--------------------------------|
| Student Name:                               |                                 |                                |
| First                                       | Middle                          | Last                           |
| Date of Birth:                              |                                 | Place of Birth <sup>2</sup> :  |
| Month                                       | Day                             | Year                           |
| Parent or Guardian Relationship to student: |                                 |                                |
| <input type="checkbox"/> Mother             | <input type="checkbox"/> Father | <input type="checkbox"/> Other |
| Home Language Code:                         |                                 |                                |

| Language Background<br>(Please check all that apply)  |   |   |
|---|---|---|
| 1. What is the primary language used in the home, regardless of the language spoken by the student? | <input type="checkbox"/> English <input type="checkbox"/> Other | _____<br>Specify                        |
| 2. What is the language most often spoken by the student?   | <input type="checkbox"/> English <input type="checkbox"/> Other | _____<br>Specify                        |
| 3. What is the language that the student first acquired?  | <input type="checkbox"/> English <input type="checkbox"/> Other | _____<br>Specify                        |
| 4. What language(s) does your child understand?   | <input type="checkbox"/> English <input type="checkbox"/> Other | _____<br>Specify                        |
| 5. What language(s) does your child speak?  | <input type="checkbox"/> English <input type="checkbox"/> Other | _____<br>Specify                        |
|   |   | <input type="checkbox"/> Does not speak |
| 6. What language(s) does your child read?   | <input type="checkbox"/> English <input type="checkbox"/> Other | _____<br>Specify                        |
|   |   | <input type="checkbox"/> Does not read  |
| 7. What language(s) does your child write?  | <input type="checkbox"/> English <input type="checkbox"/> Other | _____<br>Specify                        |
|   |   | <input type="checkbox"/> Does not write |

<sup>1</sup> Required by Rhode Island Law (R.I.G.L. § 16-54-2) and the Equal Educational Opportunity Act (20 U.S.C. §1703(f))

<sup>2</sup> Families are not required to provide the place of birth, but providing the information can help LEAs to better prepare to be culturally responsive.  
 Last Updated: 4/30/2020

### Family Interview -- Educational History

1. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes  No  Not sure

\*If yes, please explain: \_\_\_\_\_

How severe do you think these difficulties are?  Minor  Somewhat severe  Very severe

2a. Has your child ever been referred for a special education evaluation in the past?  No  Yes\*

\*If referred for an evaluation, has your child been identified?  No  Yes\*

\*If referred for an evaluation, and identified, has your child ever received any special education services in the past?

No  Yes

Type of services received: \_\_\_\_\_

2b. Age at which services received (Please check all that apply):

Birth to 3 years (Early Intervention)  3 to 5 years (Special Education)  5 years or older (Special Education)

2c. Does your child have an Individualized Education Program (IEP), or 504 plan?  No  Yes

3. In which language do you prefer to receive oral communications from the school or district?

English  Other \_\_\_\_\_

Specify

4. In which language do you prefer to receive written communications from the school or district?

English  Other \_\_\_\_\_

Specify

5. Indicate date first enrolled in ANY U.S. school \_\_\_\_\_

(mm/dd/yyyy)

Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

Date

Print Parent/Guardian Name \_\_\_\_\_

#### OFFICIAL, ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLS

Name: \_\_\_\_\_

Position: \_\_\_\_\_

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS: \_\_\_\_\_

#### NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLS AND CONDUCTING INDIVIDUAL INTERVIEW:

Name: \_\_\_\_\_

Position: \_\_\_\_\_

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS: \_\_\_\_\_

Oral Interview Necessary:  YES  NO

Date of Individual Interview: \_\_\_\_\_

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

#### NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING THE LANGUAGE SCREENING ASSESSMENT

Name: \_\_\_\_\_

Position: \_\_\_\_\_

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS: \_\_\_\_\_

#### NAME/POSITION OF QUALIFIED PERSONNEL REPORTING THE LANGUAGE SCREENING SCORES

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Date of Screening: \_\_\_\_\_

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

Name of the Language Screening Assessment: \_\_\_\_\_

Score achieved: \_\_\_\_\_

Proficiency Level Achieved: Entering 1  / Beginning 2  / Developing 3  / Expanding 4  / Bridging 5  / Reaching 6

FOR STUDENTS WITH AN IEP OR 504 PLAN, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED: \_\_\_\_\_

# North Providence School Department ~ Student Registration Form

Please complete one Student Registration Form for each child to be enrolled

Student Information: (Please Print) Date: \_\_\_\_\_

|                |  |               |  |             |                |   |
|----------------|--|---------------|--|-------------|----------------|---|
| Last Name      | <input type="checkbox"/> <input type="checkbox"/><br>M / F | First Name    | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>/ / /<br>Date of Birth | All         | Preferred Name | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Age |
| Entering Grade | Gender   | Date of Birth | US Entry Date  | Birth Place | ELL, IEP OR    | 504 (CHOOSE)  |

Current Address: \_\_\_\_\_ APT#: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Cell: \_\_\_\_\_ Relationship: \_\_\_\_\_ Parent/Guardian Cell: \_\_\_\_\_ Relationship: \_\_\_\_\_

*\*\*\*Enrollment is based on space availability. A student's school assignment may be subject to change. \*\*\**

## Ethnic Background

In order to identify students correctly (as mandated by federal and state law), and as the family prefers, please check or circle the most appropriate group with whom you choose to have your child to be identified. This information will be used for reporting total counts of pupils and will not be released in a personally identifiable form without your permission. Please select from the listings below. *\*\*Please note, per State of RI guidelines, if (X) is chosen for Hispanic/Latino, you MUST also choose a race. Thank you.*

|   |   |
|---|---|
| <p><u>**Are you Hispanic or Latino (choose only one)?</u></p> <p><input type="checkbox"/> Not Hispanic/Latino</p> <p><input type="checkbox"/> Yes Hispanic/Latino</p> <p><input type="checkbox"/> Two or More Races</p> <p>Country of Family Background _____</p> | <p><u>What is your race? (Choose all that apply)</u></p> <p><input type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> American Indian or Alaska Native</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Native Hawaiian or Pacific Islander</p> <p><input type="checkbox"/> White</p> |
|---|---|

## Previous School Information

School Name: \_\_\_\_\_ Grade last entered: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Signature of Parent / Legal Guardian (Adult): \_\_\_\_\_

## Office Use Only:

IEP/504 \_\_\_\_\_ ELL \_\_\_\_\_ School Assignment \_\_\_\_\_

Start Date \_\_\_\_\_ Bus Route # \_\_\_\_\_ Nurse's Approval \_\_\_\_\_ Registrar Approval \_\_\_\_\_

# North Providence School Department ~ Student Emergency Information

(For emergency and informational purposes only)

Student's DOB: \_\_\_\_\_

Student Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Resident Address Information:

|                 |        |      |       |     |
|-----------------|--------|------|-------|-----|
| Number / Street | Unit # | City | State | Zip |
|-----------------|--------|------|-------|-----|

Internet Access @ home Y / N                      Military Family? Y / N  
 Are there any NO contact orders? Y / N                      Are there any custody issues? Y / N  
 Are both parents in household? Y / N  
 (Contact 1)

Head of Household information (Parent / Guardian living in home ONLY)

|                      |                  |                          |                |               |               |                |
|----------------------|------------------|--------------------------|----------------|---------------|---------------|----------------|
| Relationship         | Date of Birth    | Last                     | First          | S / M         | W / D         | Marital Status |
| M / F                | (H/C/W)          | (H/C/W)                  | (H/C/W)        |               |               |                |
| Gender               | Language         | Preferred Phone #        | Second Phone # | Third Phone # | Email Address |                |
| Employer Name: _____ |                  |                          | Work # _____   | EXT _____     |               |                |
| Military: YES / NO   | Active: YES / NO | Branch of Service: _____ |                |               |               |                |

**(Contact 2)**

|                      |                  |   |                |               |               |                |
|----------------------|------------------|---|----------------|---------------|---------------|----------------|
| Relationship         | Date of Birth    | Last                                    | First          | S / M         | W / D         | Marital Status |
| M / F                | (H/C/W)          | (H/C/W)                                 | (H/C/W)        |               |               |                |
| Gender               | Language         | Preferred Phone #                       | Second Phone # | Third Phone # | Email Address |                |
| Employer Name: _____ |                  |   | Work # _____   | EXT _____     |               |                |
| Military: YES / NO   | Active: YES / NO | Branch of Service: _____ Address: _____ |                |               |               |                |

**(Contact 3 Emergency)**

(Emergency - will only be called if any of the above cannot be reached)

|              |     |      |       |                   |                |               |
|--------------|-----|------|-------|-------------------|----------------|---------------|
| Relationship | DOB | Last | First | Preferred Phone # | Second Phone # | Email Address |
|              |     |      |       | (H/C/W)           | (H/C/W)        |               |

Please list names of other children in household, which are in the North Providence School System or pre-school children who will eventually enter Kindergarten in North Providence. Please use back of this form if you need additional space. Thank you.

**Siblings**

|      |       |    |        |     |        |       |
|------|-------|----|--------|-----|--------|-------|
| Last | First | MI | Gender | DOB | School | Grade |
|      |       |    | M / F  | / / |        |       |
| Last | First | MI | Gender | DOB | School | Grade |
|      |       |    | M / F  | / / |        |       |

\*\*\* North Providence School Department Policy - Anyone NOT listed on this form WILL NOT be able to dismiss a student unless prior arrangements by a guardian have been made in writing. Identification of any person dismissing a student must be checked at all dismissals. \*\*\*

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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## North Providence School Department Media Information Form Rev. 01.22.2021

Dear Parents/Guardians:

Please complete the form below and return to (your child's) teacher.

I understand on occasion print photographers and TV camera people may be in the school to photograph/tape news stories and talk to students regarding events at schools or schools in general. Also, NPSD may photograph and video for educational purposes. Likewise, teachers and administrators may use phones and other devices to post photographs and/or videos of students for classroom assignments, extracurricular activities or school activities, programs and student showcases or presentations on school web pages and appropriate social media outlets. This is with the understanding that neither NPSD nor its representatives will reproduce said photograph, interview or likeness for any commercial value or receive monetary gain. While we are participating in Distance Learning if a parent sends us a picture they would need to give us written consent to posting it on school/district websites and school/district social media. Please indicate your rejection or permission for such to take place in regard to (your child) the student listed below.

THIS PERMISSION WILL EXTEND OVER THE 2021-2022 SCHOOL YEAR.

\_\_\_\_\_ I give permission for my child to be photographed, recorded and videotaped by the media & educators in educational or school situation, To be utilized on School/District Social Media/Website Accounts.

\_\_\_\_\_ I do not give permission for my child to be photographed, recorded and videotaped by the media & educators in educational or school situations.

\_\_\_\_\_ (My child) may be interviewed by the media and educators regarding school or educational situations or school situations, to be utilized on School/ District Social Media/Website Accounts.

\_\_\_\_\_ (My child) may not be interviewed by the media and educators regarding school or educational situations.

Please understand that failure to return this release form within ten (10) school days from the date of distribution will constitute approval of the above request.

Please sign and return this form

Parent/Guardian Signature \_\_\_\_\_

Student's Name \_\_\_\_\_

Date \_\_\_\_\_ Grade \_\_\_\_\_ Class \_\_\_\_\_

The North Providence School Department does not discriminate on the basis of age, sex, religion, national origin, color or handicap in accordance with applicable laws and regulations. Individuals with disabilities, who require assistance or special arrangements to participate in a program or activity sponsored by the North Providence School Department, please contact superintendent's office. We request that you provide a 48-hour notice so that the proper arrangements may be made.

North Providence School Department  
Release of Records Form

Date: \_\_\_\_\_

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Previous School Name: \_\_\_\_\_

City / Town: \_\_\_\_\_ State: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Dear Sir or Madam,

The Above mentioned student has registered in the North Providence School Department. We are requesting that all academic, attendance, discipline and health records be forwarded to the address listed below.

Thank you in advance for your immediate attention to this request.

Sincerely, NPSD Staff

\_\_\_\_\_

Parent / Guardian:

In order to receive the necessary records from your child's previous school, it is required that a release form be signed. The following form, signed by the parent or legal guardian of the above named student, will grant the North Providence School Department the necessary permission to request and receive previous school records.

I hereby request that you release the records for the above named student to the North Providence School Department.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(Parent / Legal Guardian / Adult)

Records to be released to:

North Providence School Department  
2240 Mineral Spring Avenue  
North Providence, RI 02911  
Phone: 401-233-1100 Fax: 401-233-1106  
Attn: Central Registration

NPHS: Phone: 401-233-1150, Fax: 401-349-3320

Birchwood MS: Phone: 401-233-1120, Fax: 401-353-6903

Ricci MS: Phone: 401-233-1170, Fax: 401-232-5421

Whelan Elem.: Phone: 401-233-1180, Fax: 401-353-1465

Stephen Olney Elem.: Phone: 401-233-1160, Fax: 401-349-3656

McGuire Elem.: Phone: 401-233-1135, Fax: 401-228-8991

Centredale Elem.: Phone: 401-233-1145, Fax: 401-232-5279

Greystone Elem.: Phone: 401-233-1130, Fax: 401-232-5403



## **RESIDENCY**

Residency is required for all registrations

Please email all document to [registration@npsd.k12.ri.us](mailto:registration@npsd.k12.ri.us)

### **IF YOU OWN YOUR RESIDENCE**

You must fill out the affidavit of residency by parent and provide a mortgage statement and a major utility bill.

### **IF YOU RENT YOUR RESIDENCE**

You must fill out the affidavit of residency by parent and have it notarized. Your landlord (owner of the property) must fill out the affidavit of residency by landlord and have it notarized. You must also provide a lease or notarized letter from your landlord (owner of the property) with the parent's name, students name, students date of birth and address stating that you live there AND a major utility bill. If utilities are included in your rent, make sure it states it in the lease or written notarized letter from the Landlord (owner of the property).

### **IF YOU LIVE WITH A FAMILY MEMBER**

You must fill out the affidavit of residency by parent and have it notarized. Your family member (owner of the property) must fill out the affidavit of residency by landlord/owner and have it notarized. You must also provide a lease or notarized letter from your family member with the parent's name, students name, student's date of birth, address stating that you live there, AND the owner must provide their mortgage statement and a major utility bill. If utilities are included, make sure it states it in the lease or written notarized letter from the family member (owner of the property).

**Affidavits by other parties are not accepted**

SEE AFFIDAVITS IN THIS PACKET

RESIDENCY

AFFIDAVIT OF RESIDENCY BY PARENT

NORTH PROVIDENCE PUBLIC SCHOOLS  
2240 Mineral Spring Avenue  
North Providence, RI 02911

In Re: \_\_\_\_\_  
Name of Student

AFFIDAVIT OF RESIDENCY BY PARENT

\_\_\_\_\_ appeared before me on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ and after first being placed under oath, did depose, swear and affirm to the following facts:

- (1) I am the natural or adoptive parent of \_\_\_\_\_ whom I have physical custody and possession.
- (2) I currently reside at \_\_\_\_\_, which is located in the Town of North Providence, State of Rhode Island.
- (3) \_\_\_\_\_ actually resides and lives with me at said address.
- (4) I acknowledge that an attendance officer or School Department designee may visit for the purpose of verifying such residence.
- (5) I acknowledge that this Affidavit is being submitted under oath to the North Providence School Department for the purpose of determining whether \_\_\_\_\_ is eligible to attend school in the North Providence School System.
- (6) In support of this Affidavit, I have attached certain exhibits which are true, accurate and correct.
- (7) All the information contained herein is true and accurate.

\_\_\_\_\_  
Parent's Signature

STATE OF RHODE ISLAND  
COUNTY OF PROVIDENCE

OATH NOTARY

In \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me personally appeared \_\_\_\_\_ and after reading the above Affidavit and after first being placed under oath, did swear to the truth and accuracy of said Affidavit.

\_\_\_\_\_  
Signature of Notary Public

Notary Commission Expires:

\_\_\_\_\_  
(FORM A)

NOTICE: IF YOU PROVIDE FALSE INFORMATION UNDER OATH YOU WILL BE REFERRED FOR PROSECUTION FOR PERJURY. A PERSON WHO IS FOUND GUILTY OF PERJURY MAY RECEIVE UP TO TWENTY YEARS IN JAIL.

IF YOU PROVIDE FALSE INFORMATION THE SCHOOL DISTRICT WILL COMMENCE IN APPROPRIATE LEGAL ACTION TO COLLECT THE VALUE OF EDUCATIONAL SERVICES THE STUDENT RECEIVES. SUCH COLLECTION EFFORTS WILL INCLUDE ATTACHMENT AND LEVY OF REAL ESTATE, WAGES AND PERSONAL PROPERTY.

**Affidavits by other parties are not accepted**

NORTH PROVIDENCE SCHOOL DEPARTMENT

**Residency Affidavit – Landlord/Shared Tenancies/Owner  
AFFIDAVIT**

My name is \_\_\_\_\_ and I hereby depose and certify as follows:  
Landlord/Owner/Management Company of residence

*Please complete all three items and sign below.*

1. I am the owner/landlord/management company of property located at \_\_\_\_\_  
(Address where parent lives)
  
2. \_\_\_\_\_ who is the parent or legal guardian of  
Parent/Guardian or Student over 18  
\_\_\_\_\_, leases property as their  
Student Name  
primary residence from me, in a tenancy at will, from month to month.
  
3. I hereby state that the party named above resides with me and/or at the address above.

Signed under the pains and penalties of perjury this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Landlord/owner/management company Signature

Print Name: \_\_\_\_\_

Print Address: \_\_\_\_\_

Print Telephone Number: \_\_\_\_\_

*As the applicant submitting this Residency/Landlord Affidavit, I swear, under pains and penalties of perjury, that the information above is accurate and understand that the information contained in this legal affidavit is subject to verification by a residency investigator.*

\_\_\_\_\_  
Parent/Guardian or Student over 18 Signature

Print Name: \_\_\_\_\_

Print Address: \_\_\_\_\_

Print Telephone Number: \_\_\_\_\_

STATE OF RHODE ISLAND  
COUNTY OF PROVIDENCE

**OATH NOTARY**

In \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_, before me personally appeared \_\_\_\_\_ and after reading the above Affidavit and after first being placed under oath, did swear to the truth and accuracy of said Affidavit.

\_\_\_\_\_  
Signature of Notary Public

Notary Commission Expires:

(FORM A)

**Affidavits by other parties are not accepted**

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Arthur Corsini  
Anthony R. Marciano, Sr., Esq.  
Gina M. Picard, M.Ed.  
Charles Pollock

Dear Parent/Guardian:

Health examinations are required by law to be carried out periodically during the child's school experience. Dental examinations must be done annually in grades K-5 and 7. These are of importance to the child's education because it is a means of discovering defects which might be corrected.

Since regulations provide that all students in grades K-5 and 7 have an annual dental examination and that pupils entering kindergarten and grade seven, must have a physical examination, we are asking that you have your child examined by the family physician and dentist during the summer. The school department also requests that an interim physical be done periodically for students.

Kindly have the enclosed medical form and yellow dental card completed by your physician and dentist and returned by your child to the school in September.

The School Department physician and dentist will be available during the school year to examine those children who have not been examined by their family doctor.

Thank you for your cooperation in this matter.

Sincerely,

Certified School Nurse/Teacher  
North Providence School Department

The North Providence School Department does not discriminate on the basis of age, sex, religion, national origin, color or handicap in accordance with applicable laws and regulations. Individuals with disabilities, who require assistance or special arrangements to participate in a program or activity sponsored by the North Providence School Department, please contact superintendent's office. We request that you provide a 48-hour notice so that the proper arrangements may be made.

NORTH PROVIDENCE SCHOOL DEPARTMENT

ANNUAL HEALTH HISTORY UP-DATE

PLEASE NOTE: The information on this form will be used to up-date your child's health records. Please complete this form and return to Certified School Nurse Teacher as soon as possible. Thank you.

Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

HEALTH INFORMATION

If your child has a pre-existing diagnosis or condition, please indicate: \_\_\_\_\_

List allergies: \_\_\_\_\_

If allergic to bee stings and/or food do they require an EpiPen? Yes No

List surgeries: \_\_\_\_\_

List serious illnesses or injuries: \_\_\_\_\_

List any health conditions that CSNT needs to be aware of: \_\_\_\_\_

Please check if any of the following health problems exist:

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Throat Infections (frequent)          |
| <input type="checkbox"/> Bone or Joint Disease  | <input type="checkbox"/> Eczema                                |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Dental Problems                       |
| <input type="checkbox"/> Seizures   | <input type="checkbox"/> Ear Infections/Tubes: Left Right Both |
| <input type="checkbox"/> Heart Problems   | <input type="checkbox"/> Menstrual Problems                    |
| <input type="checkbox"/> Kidney Problems  | <input type="checkbox"/> Headaches/Migraines                   |
| <input type="checkbox"/> Vision Problems (does she/he require glasses/contact lenses? Yes No) |  |

If yes to any of the above please explain: \_\_\_\_\_

Please list medications your child is currently taking and the reason why:

Medication: \_\_\_\_\_ Reason: \_\_\_\_\_

Medication: \_\_\_\_\_ Reason: \_\_\_\_\_

Signature Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*Please note the following information regarding health screenings in the school\*\*\*\*

Vision- Children are screened upon entry and in 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, 7<sup>th</sup> and 9<sup>th</sup> grades;

Hearing-Pre-K, K, 1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> and any new students without prior hearing screening

Dental-all students in pre-K-5<sup>th</sup> and grade 7                      Scoliosis Grades 6, 7, and 8

These screenings are administered by trained personnel. If you elect not to have any of these screenings done in school, satisfactory evidence must be provided to the school nurse stating that the same exam/test has been completed within the preceding 6 months by the students' health care provider. Please submit this *documentation by October 1<sup>st</sup> to the school nurse.*

School Name & Address:

Grade: \_\_\_\_\_



# STATE OF RHODE ISLAND SCHOOL PHYSICAL FORM

Health Care Provider Name and Address:

Phone: \_\_\_\_\_

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHQ Section 8.4)

|                    |       |        |               |          |
|--------------------|-------|--------|---------------|----------|
| Student Name: Last | First | Middle | Date of Birth | Sex      |
| Address: Street    | Apt # | City   | State         | Zip Code |
|                    |       |        | Home Phone    |          |

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

| IMMUNIZATIONS                                     | Please enter dates in MM/DD/YYYY format |  |  |   |
|---|---|--|--|---|
| Hepatitis B                                       |   |  |  |   |
| Diphtheria-Tetanus-Pertussis<br>DTaP < 7 years    |   |  |  |   |
| Pneumococcal Conjugate<br>PCV                     |   |  |  |   |
| Polio   |   |  |  |   |
| Haemophilus influenzae Type B<br>Hib              |   |  |  |   |
| Measles-Mumps-Rubella<br>MMR                      |   |  |  |   |
| Varicella   |   |  |  | <input type="checkbox"/> Student has history of varicella disease |
| Tetanus-Diphtheria-Pertussis<br>Tdap/Td > 7 years |   |  |  |   |
| Rotavirus   |   |  |  |   |
| Hepatitis A                                       |   |  |  |   |
| Meningococcal                                     |   |  |  |   |
| HPV   |   |  |  |   |
| Influenza   |   |  |  |   |

Medical Exemption:

Hep B   
  DTaP   
  PCV   
  Polio   
  Hib   
  MMR   
  Varicella   
  Td/Tdap   
  Rotavirus   
  Hep A   
  Mening   
  HPV   
  Influenza

### PHYSICAL EXAMINATION

Date of PE \_\_\_\_/\_\_\_\_/\_\_\_\_      Height \_\_\_\_\_      Weight \_\_\_\_\_      BP \_\_\_\_\_

PLEASE NOTE ANY HEALTH PROBLEM, CHRONIC HEALTH CONDITION OR DISABILITY THAT MAY AFFECT BEHAVIOR OR HEALTH AT SCHOOL:

1. ASTHMA: No  Yes  If yes, complete an Asthma Action Plan ([www.health.ri.gov/publications/actionplans/2012AsCma.pdf](http://www.health.ri.gov/publications/actionplans/2012AsCma.pdf))
2. ALLERGIES: No  Yes  (Please explain) \_\_\_\_\_ EPINEPHRINE AUTO-INJECTOR REQUIRED: No  Yes   
If student has a severe allergy (food, insect, other) complete a Food Allergy & Anaphylaxis Emergency Care Plan ([www.foodallergy.org/document/06c91e234](http://www.foodallergy.org/document/06c91e234))
3. DIABETES: No  Yes  If yes, complete a Physician Order Form For Students With Diabetes ([www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf](http://www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf))
4. OTHER: \_\_\_\_\_

Treatment Plan: \_\_\_\_\_

RESTRICTIONS: Can participate in physical education/sports: Fully  With limitation

MEDICATION (REQUIRED AT SCHOOL): No  Yes  (Please list) \_\_\_\_\_

Other medication(s) that may affect behavior or health at school: \_\_\_\_\_

|  |  |  |
|--|--|--|
| LEAD SCREENING (Required for children < 6 years old)<br>Student is in compliance with lead screening requirements:<br>Yes <input type="checkbox"/> No <input type="checkbox"/> | SCOLIOSIS SCREENING:<br>Yes <input type="checkbox"/> No <input type="checkbox"/> | VISION SCREENING (Children entering Kindergarten)<br><input type="checkbox"/> Passed Screening <input type="checkbox"/> Screened & referred for comprehensive exam<br><input type="checkbox"/> Referred for comprehensive exam, but not screened<br>Screening / Referral Date: _____      Comprehensive Exam Date: _____ |
| TUBERCULOSIS (If required by school district)<br>Date of TB test: _____  |  |  |

HEALTH CARE PROVIDER SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

## Athletic Participation Form

Student's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Previous School: \_\_\_\_\_

While at the former high school the student participated on which of the following sports team(s). Please place a check mark (✓) to all that apply.

| SPORT                 | 9 <sup>th</sup> Grade |    |     | 10 <sup>th</sup> Grade |     | 11 <sup>th</sup> Grade |     | 12 <sup>th</sup> Grade |     |
|-----------------------|-----------------------|----|-----|------------------------|-----|------------------------|-----|------------------------|-----|
|                       | Fr                    | JV | Var | JV                     | Var | JV                     | Var | JV                     | Var |
| Baseball              |                       |    |     |                        |     |                        |     |                        |     |
| Basketball            |                       |    |     |                        |     |                        |     |                        |     |
| Cheerleading          |                       |    |     |                        |     |                        |     |                        |     |
| Cross Country         |                       |    |     |                        |     |                        |     |                        |     |
| Fast Pitch Softball   |                       |    |     |                        |     |                        |     |                        |     |
| Football              |                       |    |     |                        |     |                        |     |                        |     |
| Golf                  |                       |    |     |                        |     |                        |     |                        |     |
| Hockey                |                       |    |     |                        |     |                        |     |                        |     |
| Lacrosse              |                       |    |     |                        |     |                        |     |                        |     |
| Outdoor Track & Field |                       |    |     |                        |     |                        |     |                        |     |
| Soccer                |                       |    |     |                        |     |                        |     |                        |     |
| Swimming              |                       |    |     |                        |     |                        |     |                        |     |
| Tennis                |                       |    |     |                        |     |                        |     |                        |     |
| Wrestling             |                       |    |     |                        |     |                        |     |                        |     |

I understand that if I have given any false information I will be immediately declared ineligible for any and all athletic participation.

Student's Signature \_\_\_\_\_

Date \_\_\_\_\_

I understand that if any of the information provided above is false, the above named student will be declared ineligible for any and all athletic participation.

Parent/Legal Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_

FOR STUDENTS ENTERING KINDERGARTEN ONLY

NORTH PROVIDENCE SCHOOL DEPARTMENT  
KINDERGARTEN QUESTIONNAIRE

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

1. Were there any delays in developmental milestones (sitting, crawling, walking, talking, etc.)?  yes  no
  2. Is your child completely toilet trained?  yes  no
  3. Has your child been trained to wash his/her hands as necessary?  yes  no
  4. Has your child attended nursery school?  yes  no If yes, where? \_\_\_\_\_ How long? \_\_\_\_\_
  5. Did your child attend Child Outreach?  yes  no Date of Screening: \_\_\_\_\_
  6. Can your child put on a coat or sweater?  yes  no use a zipper?  yes  no tie or buckle shoes?  yes  no
  7. Does your child blow his/her nose without help when needed?  yes  no
  8. Does child have brothers?  Older  Younger? Does child have sisters?  Older  Younger?
  9. Does your child get along with other children?  yes  no
  10. How would you describe your child's general behavior or personality? \_\_\_\_\_
  11. Does your child wear glasses?  yes  no Does your child have difficulty hearing?  yes  no
  12. Does your child have allergies?  yes  no if yes, specify the type of allergies \_\_\_\_\_
  13. Does your child require an Epi-pen (epinephrine auto-injection) in case of anaphylaxis?  yes  no
  14. Did your child ever have seizures, convulsions or "spells"?  yes  no Is your child a diabetic?  yes  no
  15. Is your child under a physician's care for an acute or chronic disease or illness?  yes  no if "yes", describe condition on back of this form.
  16. Is your child on medication?  yes  no if "yes", what is the medication? \_\_\_\_\_
  17. Should child be prohibited from any activity?  yes  no Type of activity? \_\_\_\_\_
  18. Please list a brief medical history (pre-school illnesses, operations, speech or birth defects, accidents or other important data) on the back of this sheet.
  19. Does your child eat breakfast?  yes  no Lunch?  yes  no
  20. Does your child know and is he/she able to tell:  
His/her first and last name  yes  no His/her street address  yes  no His/her parent's name  yes  no  
His/her telephone number  yes  no His/her unlisted telephone number  yes  no
  21. Is your child  right handed?  left handed?  ambidextrous Can he print his/her name?  yes  no
  22. Does he recognize colors?  yes  no shapes?  yes  no numbers?  yes  no letters?  yes  no
  23. Can your child use crayons?  yes  no scissors?  yes  no paste?  yes  no paint?  
 yes  no
-



Child's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Child Outreach is a developmental screening system designed to screen all 3-5 year olds annually prior to kindergarten entry. Children are screened in the areas of vision, hearing, general development, speech/language, and social/emotional development. Child Outreach is an important first step in the identification of children who may require further evaluation or intervention. Accordingly, the North Providence School Department conducts a Child Outreach screening program. Parents will receive a summary of Child Outreach screening results by mail. All personal information and screening results collected during the screening process are treated in strictest confidence.

The Department of Education is responsible for the general supervision of the Child Outreach Screening Program. The Department of Health maintains the KIDSNET data system, which hosts Child Outreach data on behalf of Rhode Island public school systems. KIDSNET, a secure database, also includes children's vaccinations, lead screenings, preventive health services, and other developmental screenings. The information in KIDSNET can be used to coordinate care, assure that preventive health services are provided, and identify children who may need medical and/or developmental support. No personal information or screening results however will be released without your written consent to anyone other than early childhood personnel in the public school district in which you reside and the Rhode Island Department of Elementary and Secondary Education and the Rhode Island Department of Health for regulatory purposes.

1. I have read the above statements and give permission for my child to be screened by the North Providence School Department's Child Outreach program and for the results and recommendations of the screening, including any necessary special education referral and eligibility determination, to be included in the Child Outreach database within KIDSNET.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

2. I have read the above statements and give Child Outreach and the Department of Health/KIDSNET permission to share the results and recommendations of my child's screening, including any necessary special education referral and eligibility determination, with his/her primary care provider (doctor) for the purposes of coordinating care, assuring the provision of preventative health services and identifying children who may need medical and/or developmental support.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor: \_\_\_\_\_ Office/Practice Name: \_\_\_\_\_  
Address: \_\_\_\_\_

3. I have read the above statements and give Child Outreach and the Department of Health/KIDSNET permission to share the results and recommendations of my child's screening, including any necessary special education referral and eligibility determination, with his/her preschool/childcare program for the purposes of educational planning.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Preschool/Childcare Program: \_\_\_\_\_  
Address: \_\_\_\_\_

*Consent in effect from August 2021 - September 2022* Form updated February 2021

*You have the right to revoke consent at any time by contacting your local school district. You also have the right to inspect your child's education records and to request that KIDSNET correct any information which you believe is inaccurate.*

The RI Special Education Procedural Safeguards Notice Model Form, which explains parents' rights under Part B of the Individuals with Disabilities Education Act, can be found at <http://www.ride.ri.gov/Portals/0/Uploads/Documents/Students-and-Families-Great-Schools/Special-Education/Special-Education-Regulations/RI-Special-Education-Procedural-Safeguards-Notice-Model-Form.pdf>

If you have any questions about parental rights, including consent to screen, please contact RIDE's Special Education Call Center at 401-222-8999.