

# TOWN OF NORTH PROVIDENCE SCHOOL DEPARTMENT

2240 Mineral Spring Avenue, North Providence, Rhode Island 02911  
(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, M.Ed., *Director of Student Services*  
Matthew Hicks, *Director of Human Resources*

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

Dear Parent / Guardian,

Listed below are the items required to complete **Grades 1 – 12** registration:

**1. Proof of residency**

- Notarized Affidavit of Residency by parent/legal guardian
- Notarized Landlord Affidavit by management company/property owner
- Mortgage Statement/Lease Agreement or notarized letter from property owner
- Major utility bill
- 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. Montoux 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**

*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.*

**North Providence School Department  
Specialized Services Section**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Current Grade: \_\_\_\_\_

	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? ***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.npsdspecialled.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.

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

<b>Home Language Code:</b>
----------------------------

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

<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

Telephone (401)222-4600 Fax (401)222-6178 TTY (800)745-5555 Voice (800)745-6575 Website: [www.ride.ri.gov](http://www.ride.ri.gov)

The R.I. Board of Education does not discriminate on the basis of age, sex, sexual orientation, gender identity/expression, race, color, religion, national origin, or disability.

### 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)     6 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 Screener: \_\_\_\_\_  
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:

\_\_\_\_\_

Telephone (401)222-4600    Fax (401)222-6178    TTY (800)745-5555    Voice (800)745-6575    Website: [www.ride.ri.gov](http://www.ride.ri.gov)

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North Providence School Department  
Release of Records Form

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

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

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

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

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

**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.

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

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.

**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

**North Providence High School**  
Phone: 401-233-1150 Fax: 401-349-3320

**Birchwood Middle School**  
Phone: 401-233-1120 Fax: 401-353-6903  
**Ricci Middle School**  
Phone: 401-233-1170 Fax: 401-232-5421

**Whelan Elementary**  
Phone: 401-233-1180 Fax: 401-353-1465  
**Centredale Elementary**  
Phone: 401-233-1145 Fax: 401-232-5279  
**Stephen Olney Elementary**  
Phone: 401-233-1160 Fax: 401-349-3656  
**McGuire Elementary**  
Phone: 401-233-1135, Fax: 401-228-8991  
**Greystone Elementary**  
Phone: 401-233-1130, Fax: 401-232-5403

North Providence School Department  
 Student Registration Form  
 Please complete one Student Registration Form for each child to be enrolled

(Please Print)  
 Student Information:

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

Last Name	First Name	MI	Preferred Name	Age
Entering Grade	M/F Gender	/ /	/ /	Date of Birth
				US Entry Date
				Birth Place
				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.**

**\*\*Are you Hispanic or Latino (choose only one)**

**What is your race? (Choose all that apply)**

Not Hispanic/Latino

Black or African American

Yes Hispanic/Latino

American Indian or Alaska Native

Two or More Races

Asian Region of Asia \_\_\_\_\_

Country of Family Background \_\_\_\_\_

Native Hawaiian or Pacific Islander

White

**Previous School Information**

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

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

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

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

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:**

Address	Unit #	City	State	Zip
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Internet Access @ home Y/N Are there any NO contact orders/custody issues? Y/N  
 Military Family? Y/N Are both parents in household? Y/N

(Contact 1)

Relationship Status	Date of Birth	Last	First	Marital
	(H/C/W)	(H/C/W)	(H/C/W)	
M / F				
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
	(H/C/W)	(H/C/W)	(H/C/W)	Marital Status
M / F				
Gender	Language	Preferred Phone #	Second Phone #	Third Phone #

Address \_\_\_\_\_

Email Address \_\_\_\_\_

Employer Name: \_\_\_\_\_ Work # \_\_\_\_\_ EXT \_\_\_\_\_

Military: YES / NO    Active: YES / NO    Branch of Service: \_\_\_\_\_

(Contact 3)

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

Relationship	DOB	Last	First	Preferred Phone #	Second Phone #
				(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.

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ DOB \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ DOB \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

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## North Providence School Department Media/Information Release Form

### 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.

Please indicate your rejection or permission for such to take place in regard to (your child) the student listed below.

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

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

I hereby grant the North Providence School Department official permission to disclose my child's demographical information to the person(s)/organization/agency listed below. I understand that this form authorizes the North Providence School Department official permission to disclose personally identifiable information from my educational record to this third party and I release this individual from any liability for acting in accordance with this.

#### Unites States Military

I give permission

I do not give permission

#### Higher Education

I give permission

I do not give permission

#### Public

I give permission

I do not give permission

#### District

I give permission

I do not give permission

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 \_\_\_\_\_



## **RESIDENCY**

**Residency verification is required for all registrations.**

**\*\*Every parent/ guardian MUST fill out and have notarized the Affidavit of Residency by Parent regardless of their living situation.**

**In addition** to the Affidavit of Residency by Parent, please fill out the following based on your residency:

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

- Mortgage statement
- A major utility bill.

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

- Notarized affidavit of residency by landlord or owner of the property
- Lease or notarized letter from your landlord (owner of the property) with the parent's name, student's name, student's date of birth and address stating that you live there
- A major utility bill.

*If utilities are included in your rent, it must be stated in the lease or written notarized letter from the Landlord (owner of the property).*

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

- Notarized affidavit of residency by landlord (between the parent and family member who owns the property)
- A notarized letter from the family member who owns the property with the parent's name, student's name, student's date of birth, address stating that you live there
- Owner/family member must provide their mortgage statement and a major utility bill

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

- Notarized affidavit of residency by landlord (family member/ owner of property)
- Lease agreement (family member/ owner of property)
- Notarized letter from the landlord with the parent's name, student's name, student's date of birth, address stating that you are residing there
- A major utility bill

*If utilities are included in the rent, it must be stated in the lease or written notarized letter from the Landlord (owner of the property).*

**Affidavits by other parties are not accepted**

**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**

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

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 the primary residence from me, in a tenancy at will from  
**Student Name** \_\_\_\_\_ 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)

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.

## 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	9th Grade			10th Grade		11th Grade		12th Grade	
	Fr	JV	Var	JV	Var	JV	Var	JV	Var
Baseball									
Basketball									
Cheerleading									
Cross Country									
Softball									
Football									
Golf									
Hockey									
Lacrosse									
Outdoor Track & Field									
Soccer									
Swimming									
Tennis									
Wrestling									
Volleyball									

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.

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

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

ANNUAL HEALTH HISTORY UP-DATE

**PLEASE NOTE:** The information on this form will be used to up-date your child's health records.

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.

NORTH PROVIDENCE SCHOOL DEPARTMENT  
Health Office  
Medication Authorization Sheet

Student Name: \_\_\_\_\_  
Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

The following medication will be dispensed by the School Nurse as deemed necessary:

- Tylenol (Acetaminophen) age appropriate dose
- Motrin (Ibuprofen) age appropriate dose
- Tums 1-2 tabs
- Cough Drops MIDDLE AND HIGH SCHOOL STUDENTS ONLY

Per policy, these medications are provided as needed. If your child continues to require these medications on a routine basis, it will be necessary to provide a completed North Providence Medication Authorization and Consent form signed by the student's primary care provider. These medications must be transported to school by an adult in an original container, labeled with the student's name.

PARENT GUARDIAN AUTHORIZATION

I have read and understand the North Providence Medication Policy. I request that my child be given the medication as described *above* in accordance with said policy. I understand that the school is rendering a service and I retain full responsibility for any effects resulting from the administration of said medication.

PLEASE NOTE: Your child will not receive any of the *above* medication until the Medication Authorization Sheet is on file.

Please list any allergies your child may have: \_\_\_\_\_

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

\_\_\_\_\_  
Date