When returning your completed forms

Please include the following:

Birth Certificate

Proof of residency

(i.e. utility bill and lease or mortgage)

Immunizations

AMESBURY PUBLIC SCHOOLS

Where children come first!

REQUEST FOR STUDENT RECORDS

To: _____

_____

_____

Request Records for Student:

_____

Student's Name (please print)

Grade: _____

The above student has enrolled in our school. Please send all pertinent educational, special education, psychological and health records to:

☐ Amesbury Elementary School
20 South Hampton Road
Amesbury, MA 01913
Phone: 978-388-3659
Fax: 978-388-4961

☐ Cashman Elementary School
193 Lions Mouth Road
Amesbury, MA 01913
Phone: 978-388-4407
Fax: 978-388-4479

☐ Amesbury Middle School
220 Main Street
Amesbury, MA 01913
Phone: 978-388-0515
Fax: 978-388-1626

Authorization to Release Pupil's Records

I have enrolled my child, _____, in the Amesbury Public Schools

and authorize you to release all school records to this school.

_____ _____

Signature of Parent or Guardian Date

Relationship to child: _____

2012

LASID # _____ **SASID #** _____

AMESBURY PUBLIC SCHOOLS
AMESBURY, MASSACHUSETTS 01913

STUDENT DATA SHEET

Please print (legal names, no nicknames)

First Name: _____ **Full Middle Name:** _____

Last Name: _____ **Gender: Male**_____ **Female** _____

Address: _____ **Apt. #** _____

City of Residence: _____ **Home Phone:** _____

Parent/Guardian Names: _____

Date of Birth: (month/day/year) _____ **City of Birth:** _____

State of Birth: _____ **Country of Birth:** _____ **Country of Origin:**_____

School Last Attended: _____

Grade: _____ **EL Services:** _____ **Special Needs:** _____ **Title 1:** _____

Parent email: _____ **Student email:** _____

Ethnic Background ***(select only one)***

- ☐ No, not Hispanic or Latino
- ☐ Yes, Hispanic or Latino: a person of Cuban, Mexican, Chicano, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race

Race ***(you may select one or more races.)***

- ☐ White: a person having origins in any of the original peoples of Europe, the Middle East, or North Africa
- ☐ Black or African American: a person having origins in any of the black racial groups of Africa
- ☐ 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 Philippine Islands, Thailand and Vietnam
- ☐ Native Hawaiian or other Pacific Islanders: a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

Military Family Status – Defined as: students who are children of:

- ☐ Active duty members of the uniformed services, National Guard and Reserve on active duty orders
- ☐ Members or veterans who are medically discharged or retired within one year
- ☐ Members who die on active duty

Parent/Guardian Signature: _____ **Date:** _____

Early Screening Inventory·Revised™ Meisels et al.

Parent Questionnaire

Date _____

CHILD INFORMATION

CHILD'S NAME _____ ☐ Male ☐ Female

HOME ADDRESS Street _____ Apt _____

City _____ State _____ Zip _____

Phone (_____) _____ Date of Birth _____

Who is completing this Parent Questionnaire? Name _____

Relationship to child _____

FAMILY

With whom has the child lived for most of the past year? _____

_____

Other children in the family ... many older? _____ How many younger? _____

Other people living in the household _____

What language(s) are spoken at home? ☐ English ☐ Other (specify) _____

PRESCHOOL/CHILD CARE HISTORY

Has your child attended preschool/child care before? ☐ Yes ☐ No

If yes, for how long? ☐ 6 months ☐ 1 year ☐ 2 years ☐ more than 2 years

Name of child's present or most recent school _____

PEARSON

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MEDICAL HISTORY

Birth

Were there any significant problems during pregnancy? ☐ Yes ☐ No

If yes, please explain:

Was your child more than 3 weeks premature? ☐ Yes ☐ No

If yes, how many weeks premature? _____

Baby's birth weight _____

Did the baby stay in the hospital longer than the mother? ☐ Yes ☐ No

If yes, please explain:

At the time of birth, did the baby — have seizures ☐ Yes ☐ No

turn blue? ☐ Yes ☐ No

Child's Health Since Birth

EYES

Has your child ever had trouble seeing? ☐ Yes ☐ No

Does your child hold books and objects close to his or her face? ☐ Yes ☐ No

Have your child's eyes ever looked crossed? ☐ Yes ☐ No

Have you ever suspected that your child has vision problems? ☐ Yes ☐ No

If yes, please explain:

EARS

Has your child had frequent ear infections? ☐ Yes ☐ No

Has your child ever had trouble hearing? ☐ Yes ☐ No

Have you ever suspected that your child has hearing problems? ☐ Yes ☐ No

If yes, please explain:

COORDINATION

Has your child ever had trouble walking, climbing, reaching, holding on to things? ☐ Yes ☐ No

If yes, please explain:

Child's Health Since Birth continued

Has your child ever had any significant injuries or hospitalizations? ☐ Yes ☐ No

If yes, please explain:

Does your child have allergies? ☐ Yes ☐ No

If yes, please explain:

Is your child presently on any medications? ☐ Yes ☐ No

If yes, please explain:

Please describe any other health concerns: ☐ Yes ☐ No

SOCIAL, EMOTIONAL, AND SELF-HELP SKILLS

Can your child —

- feed him or herself using a spoon and/or a fork? ☐ Yes ☐ No
- wash and dry his or her own hands? ☐ Yes ☐ No
- help with dressing or dress with little assistance? ☐ Yes ☐ No
- stay with a babysitter? ☐ Yes ☐ No
- speak so that he or she can be understood by others? ☐ Yes ☐ No
- express his or her thoughts and needs easily? ☐ Yes ☐ No

Do you have any concerns about your child's appetite or willingness to try different foods? ☐ Yes ☐ No

If yes, please explain:

Do you have any concerns about your child's sleeping patterns (going to bed with difficulty or waking often during the night)? ☐ Yes ☐ No

If yes, please explain:

Is your child —	highly active?	☐ Yes	☐ No
	very quiet?	☐ Yes	☐ No
Is your child —	toilet trained during the day?	☐ Yes	☐ No
	in need of help with toileting?	☐ Yes	☐ No
Does your child —	play with blocks, boxes, cups, or other construction toys without help?	☐ Yes	☐ No
	use crayons and/or markers to scribble or draw?	☐ Yes	☐ No
	listen to stories being read?	☐ Yes	☐ No
	turn pages of a book and look at pictures?	☐ Yes	☐ No
	recall stories or events?	☐ Yes	☐ No
	enjoy playing alone or with imaginary friends?	☐ Yes	☐ No
	talk with your friends/relatives who come to visit?	☐ Yes	☐ No
	follow simple, age-appropriate directions?	☐ Yes	☐ No

What are your child's favorite activities?

Does your child have opportunities to play with other children? ☐ Yes ☐ No

How many hours a day does your child spend watching TV? _____

Does he or she sit very close to the TV? ☐ Yes ☐ No

Does he or she turn up the volume very high? ☐ Yes ☐ No

Are there other things you would like to tell us about your child?

AMESBURY PUBLIC SCHOOLS

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Home Language Survey

Massachusetts Department of Elementary and Secondary Education regulations require that *all* schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. If a language other than English is spoken in the home, the District is required to do further assessment of your child. Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

Student Information

First Name _____ Middle Name _____ Last Name _____ F ☐ M ☐ Gender

Country of Birth _____ Date of Birth (mm/dd/yyyy) ___/___/___ Date first enrolled in ANY U.S. school (mm/dd/yyyy) ___/___/___

School Information

Start Date in New School (mm/dd/yyyy) ___/___/20___ Name of Former School and Town _____ Current Grade _____

Questions for Parents/Guardians

What is the native language(s) of each parent/guardian? (circle one) _____ (mother / father / guardian) _____ (mother / father / guardian)	**Which language(s) are spoken with your child?** (include relatives -*grandparents, uncles, aunts,etc.* - and caregivers) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always
What language did your child first understand and speak?	**Which language do you use most with your child?**
Which other languages does your child know? (circle all that apply) _____ speak / read / write _____ speak / read / write	**Which languages does your child use? (circle one)** _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always
Will you require written information from school in your native language? Y ☐ N ☐	**Will you require an interpreter/translator at Parent-Teacher meetings?** Y ☐ N ☐
Parent/Guardian Signature: X	**Today's Date:** ___/___/20___ (mm/dd/yyyy)

CONFIDENTIAL HEALTH HISTORY

NAME _____ SEX _____ D.O.B. _____
LAST FIRST MIDDLE

FATHER _____ EMPLOYER _____ PHONE _____

MOTHER _____ EMPLOYER _____ PHONE _____

Guardian is: Father Mother Other (Name) _____

Address: _____ Phone _____

List Brothers and Sisters and their date of birth:

NAMES: _____ DATE OF BIRTH: _____

_____

_____

_____

_____

_____

Do you consider your child's health to be Good _____ Fair _____ Poor _____?

Is there any reason why your child cannot participate in full school activities? Y N

Does your child have any medical concerns: - Allergies? Y N

Do these concerns require daily medication of treatment? Y N

Does you child have frequent ear infections? (more than two a year)
or is hearing impaired? Y N

Does your child wear glasses? Y N

If you have answered YES (Y) to any of the above questions please explain below.

_____
Signature Date