TO PARENTS/GUARDIANS REGISTERING STUDENTS AT SHELTON PUBLIC SCHOOLS:

Has the student ever attended Shelton schools? ☐ **Yes** ☐ **No**

Please provide a copy of the following:

☐ **Birth Certificate/Passport/Visa (student)**

☐ **State Issued Driver's License/ID Card/ Passport/Visa (parent/guardian identification)**

Residency Requirements:

☐ ***TWO PROOFS OF RESIDENCY ARE REQUIRED:***

1st proof of residency: Deed to home, dated rental agreement, notarized letter from landlord or owner acknowledging residency, escrow papers or signed mortgage commitment.

2nd proof of residency: Current utility bill, telephone bill (land-line only), cable bill.

Invalid proofs of residency include, but are not limited to:
Non-utility bills, medical bills, tax bills, and cellphone bills

Medical Requirements:

☐ **Statement of Immunization**

☐ **Last Report Card (reports cards to Grade 9, if applicable)**

☐ **Kindergarten/6th grade/9th grade - physical required**

☐ **Out-of-state - physical required**

☐ ***Affidavit (if required)**
Required in the event that the child/children and parent/guardian reside with a non related adult or a family member.

☐ **Special Services – Recent I.E.P., notes, PPT Notes, current P/Ed battery tests**

No student will be permitted to register for classes without these documents. Parents who falsify information could be held responsible for full payment of educational costs.

If a student is under 18, must be accompanied by parent/guardian.

If you have any questions, please contact your school office.

NOTES: **Tel.** _____ **Fax** _____

_____

_____

_____

_____

Revised 3/21/18
File: Forms

SHELTON PUBLIC SCHOOLS – REGISTRATION FORM

OFFICE USE ONLY

STUDENT ID#: **ENTER DATE:** / /

School:	Grade:	Homeroom:
HR Teacher:	House:	Counselor:
Bus a.m.:	Bus p.m.:	Stop:

STUDENT'S LEGAL NAME: _____

LAST **FIRST** **MIDDLE**

MALE ☐ **FEMALE** ☐

Has your child been a student in the Shelton School System before: **Yes** ☐ **No** ☐

If yes, what most recent school did your child attend? BH☐ ES☐ LH☐ MOH☐ SS ☐ PH☐ SIS☐ SHS☐

Expected entry grade: K☐ 01☐ 02☐ 03☐ 04☐ 05☐ 06☐ 07☐ 08☐ 09☐ 10☐ 11☐ 12☐

HOME ADDRESS: _____

HOME TEL: (_____) _____-_____ **D.O.B.** _____/_____/_____

Is the student Hispanic or Latino? Yes ☐ No☐

Is the student from one or more of these races? (Choose all that apply)

American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White
☐	☐	☐	☐	☐

Student resides with: **Mother**☐ **Father**☐ **Grandparent**☐ **Foster parent**☐ **Stepmother**☐ **Stepfather**☐ **Legal Guardian**☐

Student's Legal Guardian: **Mother**☐ **Father**☐ **Grandparent**☐ **Foster parent**☐ **Stepmother**☐ **Stepfather**☐ **Legal Guardian**☐

Name Parent/Guardian 1:		**Relationship:**	**Home#:**
Address: (if different)		**Daytime#:**	**Cell#:**
Email Address:		**Place of Employment:**	
Name Parent/Guardian 2:		**Relationship:**	**Home#:**
Address: (if different)		**Daytime#:**	**Cell#:**
Email Address:		**Place of Employment:**	
Legal Guardian: (if different from above) DOCUMENTATION REQUIRED		**Relationship:**	**Home#:**
Address: (if different)		**Daytime#:**	**Cell#:**
Email Address:		**Place of Employment:**	

REGISTRATION FORM – PART 2

List the names of all brothers and sisters in the SHELTON SCHOOL SYSTEM

LEGAL NAME/S:	PLEASE CIRCLE ONE:
	BH ES LH MOH SS PH SIS SHS
	BH ES LH MOH SS PH SIS SHS
	BH ES LH MOH SS PH SIS SHS

Place of Birth: _____ **Verify: Birth Certificate ☐ Passport ☐ Visa ☐**
City State Country

Born in the U.S: Yes ☐ No ☐ Date enrolled in any US school _____

Military Family: Does your child have a parent/guardian that is a member of the Armed Forces on active duty or serves on full-time National Guard duty? Yes ☐ No ☐

Did your child attend: Head Start ☐ Nursery School ☐ Licensed Day Care ☐ Public Preschool ☐ Private Preschool ☐

What school did your child last attend?

Address:

Has the student received any special education services? Yes ☐ No ☐
(IEP services such as: speech language, occupational therapy, physical therapy)

Is the student receiving any 504 services? Yes ☐ No ☐ If yes to either of the two previous questions, where?

Student's Doctor: **Phone:**

Address:

Hospital Preference:

Names of relatives or neighbors we may call who are willing to assume responsibility for your child if we are unable to contact you:

First Contact:	Relationship to Student:	Phone:
Second Contact:	Relationship to Student:	Phone:

Does your child have any medical conditions which may require special or emergency treatment?
Yes ☐ No ☐ (IF YES, contact the school nurse.)

By my signature below, I certify that all questions have been answered truthfully. If information concerning residence proves to be invalid, the guardian/parent signee will be responsible for payment in full of all education costs.

Signature of parent or guardian: **Date:**

Shelton Public Schools
Home Language Survey

Welcome to our school! 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 Information

Student first name: Student last name:

Country of birth:

Date of birth:

Date first enrolled in any US school:

---

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 name (please print)

Parent/guardian signature Date

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

SHELTON PUBLIC SCHOOLS
SHELTON, CONNECTICUT

Verification of Residence

NEW ENROLLEE/STUDENT TRANSFER/CHANGE OF ADDRESS *(within Shelton)*

Parent/Legal Guardian Statement

I (print name)_____the parent or legal guardian of(name) _____

(address)_____certify that the above named student actually lives full time

(typically 7 days per week) at the above address. The telephone number at the same address is _____

and the telephone number in an emergency is_____. **Grade _____**

This information and the documents provided are accurate. I authorize representatives of the Shelton Public Schools to verify this information, and I understand falsification of any information or documents required for this verification will result in revocation of registration for the student, and may lead to liability for tuition and to criminal penalties for fraud.

Parent/Guardian Signature:_____Date: _____

For Transfers *only*

Current School *(send records)* _____ **New School** _____

FOR OFFICE USE ONLY

In order to verify district residence, the child over 18, parents or guardians, or an emancipated minor must sign aboveand provide documents from any of the items listed below.

__ 1. Copy of two of the following at address within the district in the parent's or guardian's name:
- __ a. Deed to home or dated rental agreement showing student(s)name
- __ b. Escrow papers or signed mortgage commitment
- __ c. Current utility or telephone bills (land line only)
- __ d. Notarized letter from landlord or owner acknowledging parent/guardian's and student's residence

__ 2. S:1A to be filled out by person with whom family and student reside. Verification visit byResidency Confirmation staff will follow; **child may attend school.**

__ 3. Verification visit by Residency Confirmation staff (for situations not covered by 1 and 2); **child may not attend school until complete.**

Documents seen by:_____on _____

Shelton Intermediate School
675 Constitution Boulevard North
Shelton, CT 06484
Phone (203) 926-2000
Fax (203) 926-2017
http://shelton-intermediate-school.echalksites.com

John P. Skerritt, Principal

Victoria L. Sargeant, Assistant Principal

Leadership * Teamwork * Focus

Date: _____

This form will authorize your last school to provide us with transcripts and records. Please complete the required information and sign this form.

Last School Attended: _____

Address: _____

City/State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

* *

Dear Principal or Registrar:

I do hereby authorize you to release all records and transcripts on the below named student to Shelton Intermediate School at the address above. **Please provide all health records, withdrawal grades, dates of attendance, psychological evaluations, test scores and semester grades.**

Signed: _____
(Parent/Guardian)

Student's Name: _____

Age: _____ Grade: _____ Date of Birth: _____ Gender: _____

SHELTON PUBLIC SCHOOLS

HEALTH INFORMATION DATA (Complete Both Sides & Sign)

Health Record

Registration Date_____

Child's Name:_____ Date of Birth:_____

Parent's Name:_____ Home Phone:_____

Address:_____ Bus. Phone:_____

Child's Physician:_____ Phone:_____

Grade:_____Teacher_____School:_____

Has your child had any of the following diseases?	YES	NO	DATE
Scarlet Fever / Strep Throat (1 ____ 2 ____)	_____	_____	_____
Poliomyelitis	_____	_____	_____
Pneumonia / Bronchitis (1 ____ 2 ____)	_____	_____	_____
Rheumatic Fever	_____	_____	_____
Diabetes	_____	_____	_____
Lyme Disease	_____	_____	_____
Chicken Pox Disease ☐ Vaccine ☐	_____	_____	_____
Tuberculosis	_____	_____	_____
5th Disease	_____	_____	_____
Epilepsy	_____	_____	_____
Other (Identify)_____	_____	_____	_____

Do any of these conditions exist or have they existed?

Vision Difficulty (Glasses) Y ☐ N ☐	_____	_____	_____
Hearing Difficulty (Tubes) Y ☐ N ☐	_____	_____	_____
Speech Difficulty	_____	_____	_____
Asthma (medication for school Y ☐ N ☐	_____	_____	_____
Allergies environment (Foods list on back)	_____	_____	_____
Nuts (Epi-pen Y ☐ N ☐)	_____	_____	_____
Physical Handicaps	_____	_____	_____
Premature Baby # weeks_____Birth wt._____	_____	_____	_____
Convulsions	_____	_____	_____
Bee Sting Allergy (needs epi-pen Y ☐ N ☐)	_____	_____	_____

Please explain any of the above and what is done to minimize or alleviate the specific condition.

(over)

Is your child on any daily medication? YES ☐ NO ☐

If yes, name medication. _____

(If medication is to be administered in school. Connecticut State 10-212A requires a physician's authorization and parent signature.) (Please obtain form from nurse.)

Has your child had any of the following:

Operations? YES ☐ NO ☐ DATE

If yes, date and kind _____

Serious Accidents? Explain _____

Hospitalizations? Explain _____

Other: _____

Comment: Please list any other information concerning your child's health which you feel would be helpful to the school. Use a separate sheet of paper if necessary.

_____

_____

_____

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_____

_____

_____

_____

Please complete both sides and return on date of registration.

_____
Parent Signature

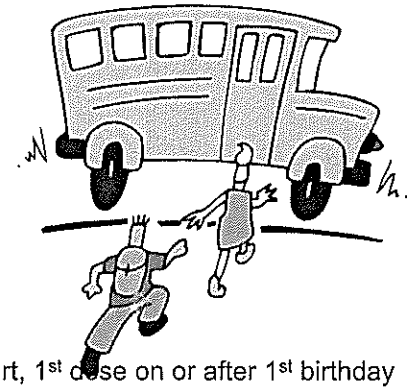
_____
Date

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

IMMUNIZATION REQUIREMENTS FOR ENROLLED STUDENTS IN CONNECTICUT SCHOOLS

2022-2023 SCHOOL YEAR



PRESCHOOL

Hep B:	3 doses, last one on or after 24 weeks of age
DTaP:	4 doses (by 18 months for programs with children 18 months of age)
Polio:	3 doses (by 18 months for programs with children 18 months of age)
MMR:	1 dose on or after 1st birthday
Varicella:	1 dose on or after 1st birthday or verification of disease
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday
Hib:	1 dose on or after 1st birthday
Pneumococcal:	1 dose on or after 1st birthday
Influenza:	1 dose administered each year between August 1st-December 31st (2 doses separated by at least 28 days required for those receiving flu for the first time)

KINDERGARTEN

Hep B:	3 doses, last dose on or after 24 weeks of age
DTaP:	At least 4 doses. The last dose must be given on or after 4th birthday
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday
Hib:	1 dose on or after 1st birthday for children less than 5 years old
Pneumococcal:	1 dose on or after 1st birthday for children less than 5 years old

GRADES 1-6

Hep B:	3 doses, last dose on or after 24 weeks of age
DTaP/Td:	At least 4 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses.
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday

GRADE 7-10

Hep B:	3 doses, last dose on or after 24 weeks of age
Tdap/Td:	1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday
Meningococcal:	1 dose

Revised 1/21//2022

GRADES 11-12	Hep B:	3 doses, last dose on or after 24 weeks of age
	Tdap/Td:	1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
	Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
	MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
	Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
	Meningococcal:	1 dose

- DTaP vaccine is not administered on or after the 7th birthday.
- Tdap can be given in lieu of Td vaccine for children 7 years and older unless contraindicated.
- Hib is required for all Pre-K and K students less than 5 years of age.
- Pneumococcal Conjugate is required for all Pre-K and K students less than 5 years of age.
- Hep A requirement for school year 2022-2023 applies to all Pre-K through 10th graders born 1/1/07 or later.
- Hep B requirement for school year 2022-2023 applies to all students in grades K-12. Spacing intervals for a valid Hep B series: at least 4 weeks between doses 1 and 2; 8 weeks between doses 2 and 3; at least 16 weeks between doses 1 and 3; dose 3 must be administered at 24 weeks of age or later.
- Second MMR for school year 2022-2023 applies to all students in grades K-12.
- Meningococcal Conjugate requirement for school year 2022-23 applies to all students in grades 7-12
- Tdap requirement for school year 2022-2023 applies to all students in grades 7-12
- If two live virus vaccines (MMR, Varicella, MMRV, Intra-nasal Influenza) are not administered on the same day, they must be separated by at least 28 days (there is no 4 day grace period for live virus vaccines). If they are not separated by at least 28 days, the vaccine administered second must be repeated.
- Lab confirmation of immunity is **only** acceptable for Hep A, Hep B, Measles, Mumps, Rubella, and Varicella.
- **VERIFICATION OF VARICELLA DISEASE:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

For the full legal requirements for school entry visit:
https://portal.ct.gov/DPH/Immunizations/Immunization--Laws-and-Regulations

If you are unsure if a child is in compliance, please call the Immunization Program at (860) 509-7929.

New Entrant Definition:

*New entrants are any students who are new to the school district, including **all** preschoolers and all students coming in from Connecticut private, parochial and charter schools located in the same or another community. **All pre-schoolers, as well as all students entering kindergarten**, including those repeating kindergarten, and those moving from any public or private pre-school program, even in the same school district, **are considered new entrants.** The one exception is students returning from private approved special education placements–they are not considered new entrants.

Commonly Administered Vaccines:

Vaccine:	Brand Name:	Vaccine:	Brand Name:
DTaP-IPV-Hib	Pentacel	MMRV	ProQuad
DTaP-HIB	TriHibit	PCV7	Prevnar
HIB-Hep B	Comvax	PCV13	Prevnar 13
DTaP-IPV-Hep B	Pediarix	DTaP-IPV	Kinrix, Quadracel
Hepatitis A	Havrix, Vaqta	Influenza	Fluzone, FluMist, Fluviron, Fluarix, FluLaval
DTap-IPV-Hib-Hep B	Vaxelis		Flucelvax, Afluria

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

Allergies *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	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ 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 through 11th 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

Shelton Public School System

Video/ Photo Activities Release Form

Dear Parent/ Guardian:

Your child is or will be involved in a classroom/school activity which may necessitate their being videotaped or a picture image being taken of them or their name posted in the media. These videotapes, images, and/ or names will not be used for any commercial purposes. The picture images and/ or names may however be used in conjunction with a newspaper article or other school sponsored media outlet.

Please acknowledge your consent of the above mentioned activity by signing the slip below and returning it by

Thank You,

Name of Teacher /School System Employee/ School Sponsored Activity

Please check one and fill out remaining form.

☐ I **give** my consent for my child

to be videotaped and/ or photographed.

☐ I **do not give** my consent for my child

to be videotaped and/ or photographed.

Parent/Guardian Signature:

Printed Name of Parent/Guardian:

Date: