SAYLES SCHOOL

25 Scotland Road
Baltic, CT 06330
860-822-8264 Fax 860-822-1347

Dear Parents/Guardians of Incoming Pre-K Students:

Welcome to Sayles School. This packet contains the forms necessary for registering your child in the Sprague School District.

All documents **must** be submitted to school **prior to entry**. No child will be admitted until **all** information is received or special arrangements for obtaining the information have been made.

1. **PUPIL REGISTRATION FORM** (NOTE) There are two sides to be filled out.

2. **VERIFICATION OF RESIDENCE** (NOTE) You must provide us with 3 of the listed documents to verify your residence in Sprague. ***You must have a physical street address. No PO Box Numbers.***

3. **EMERGENCY INFORMATION** (NOTE) There are two sides to be filled out.

4. **INCOME VERIFICATION** (NOTE) Please fill in and provide documentation

5. **HEALTH ASSESSMENT RECORD** The front is to be filled out by you, the parent/guardian, and the back by the physician. NOTE: A physical examination within ONE year of the school entry date is acceptable. All currently required immunization must be documented on this record. Your pediatrician will know the latest requirements. Child must also have a flu vaccine.

6. **YEARLY HEALTH UPDATE**

7. Copy of **BIRTH CERTIFICATE** or **REGISTRATION OF BIRTH**

8. **IF APPLICABLE**: Medical exemptions, Authorization for the administration of medicines by school personnel, and Husky Health Plan

If you have any questions, or need assistance, please call Mrs. Debra Hawks, Early Childhood Assistant at extension 115.

Sayles School
Town of Sprague
25 Scotland Road, Baltic, CT 06330

Pupil Registration Form

Entry Date:_____

Birth Certificate _____ **Grade** _____
Registration Date _____ **Records Sent For** _____
Immunization Complete_____ **Teacher** _____
Physical Exam _____ **Special Education** _____

Pupil's Name_____
Last First Middle
Address_____ Village_____

Mailing Address (if different than above)_____ Home Phone_____

Male____ Female____ Non-Binary____ Born in the United States of America Yes____ No____

Birthday: Month_____ Day_____ Year_____ Place of Birth_____
City & State

Adults In Home Active Duty/National Guard Yes___ No___

Mother/Guardian – Custodial Yes or No (circle one) Maiden Name_____

Name:_____ Relationship:_____
Last First Middle

Occupation:_____ Employed by:_____ Phone:_____

Father/Guardian – Custodial Yes or No (circle one)

Name:_____ Relationship:_____
Last First Middle

Occupation:_____ Employed by:_____ Phone:_____

Please list other persons living in household:

Name	**Yr. Of Birth**	**Name**	**Yr. Of Birth**
1._____		**3.**_____	
2._____		**4.**_____	
5._____		**6.**_____	
7._____		**8.**_____	

Please share with us any family situations that might be helpful to us in working with your child, e.g., divorce, separation, death or serious illness within the immediate family

_____

_____

Schools previously attended: (account for last three years including pre-school)

School	Street	State	Zip	Phone#
School	Street	State	Zip	Phone#
School	Street	State	Zip	Phone#

RACE / ETHNICITY, State Reporting Requirements

Starting at the beginning of the 2010-2011 school year, the USDE will require race and ethnicity to be collected by the State Department of Education (SDE) using the following two-part question:

1) Is the student Hispanic / Latino (please choose one) ☐YES / ☐NO

2) Is the student from one or more races using the following (choose all that apply)

☐American Indian or Alaskan Native ☐Asian ☐Black or African American

☐Native Hawaiian or Pacific Islander ☐White

ASSESSMENT OF DOMINANT LANGUAGE

The assessment of dominant language is required by all state school districts under the Bilingual Education law to help determine if a need exists to establish a bilingual education program for non-English speaking Sprague students.

1. What language did your child learn to speak first? _____
2. What is the primary language spoken by you or other persons residing in your home? _____
3. What is the primary language spoken by your child when she/he is at home? _____

_____I acknowledge receipt of the student/parent handbook signature packet.

_____ _____

Date Signature of Parent/Guardian

Sprague School District
25 Scotland Road ~ Baltic, CT 06330

Sayles School
"A Friend of Core Knowledge"

Phone: 860.822.8264
Fax: 860.822.1347

Website
http://www.saylesschool.org

Emergency Information

Student Information			
Name:	First	Middle	Last
Birth Date: / /	**Teacher:**		**Grade:**
Street Address:			**Apt. #:**
P.O. Box:	**Village:**		**Zip Code:**
Home Phone #:		**Cell Phone #:**	
Regular Bus #:		**Alt Bus #:**	

Names of other children at Sayles School			
Name:		**Teacher:**	
Name:		**Teacher:**	
Name:		**Teacher:**	
Name:		**Teacher:**	

Parent / Guardian Information Name of parent(s) / guardian(s) with whom child lives				
Name:	First	Middle	Last	**E-Mail:**
Relation to child:		**Home Phone #:**		
Employer:		**Work Phone #:**		
Name:	First	Middle	Last	**E-Mail:**
Relation to child:		**Home Phone #:**		
Employer:		**Work Phone #:**		

Sprague School District
25 Scotland Road ~ Baltic, CT 06330

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http://www.saylesschool.org

Emergency Information (continued)

Emergency Contacts List two persons who can transport and assume responsibility for the child when parent(s) / guardian(s) are not available.	
Name: First Middle Last	
Relation to child:	**Phone #:**
Employer:	**Employer Town:**
Name: First Middle Last	
Relation to child:	**Phone #:**
Employer:	**Employer Town:**

Emergency Closing		
In the event of an **Emergency School Closing**, do you want your child to go home? If **No**, where do you want the school to send your child?	☐ Yes	☐ No
NOTE: This alternative caregiver **must** reside along your child's present bus route and must be made aware of any arrangements you have made with your children to go there.		
Name: First Middle Last		
Street Address:	**Apt. #:**	
Village:	**Phone #:**	

Physician Information	
Doctor #1:	**Phone #:**
Doctor #2:	**Phone #:**

Signature: Parent / Guardian	/ / Date

Town Of Sprague
Sayles School

New Enrollee Verification of Residence Form

Parent/Legal Guardian Statement

I (print name)_____the parent or legal guardian of (name/s)

_____(address)_____

_____certify that the above named student/s actually lives full-time

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

_____ and the telephone number in an emergency is_____.

This information and the documents provided are accurate. I authorize representatives of the Sprague Public School 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/s.

Parent/Guardian Signature:_____Date:_____.

In order to verify district residence, the child over 18, parents or guardians, or an emancipated minor must sign above and must provide three documents from any of the numbers (1,2,3,4,5) listed below.

___1. Copy of one of the following at address within district in parent's name:
   a. Deed to home
   b. Escrow papers of signed mortgage commitment
   c. Rent receipt for latest month with landlord's name, address, and telephone number
   d. Dated rental agreement showing student/s name or signed and dated letter from landlord or homeowner acknowledging parent's residence and student/s residence

___2. Either of the following showing address within district in parent's name:
   a. Most recent utility bills (phone, gas, electric)
   b. Deposit receipt for gas, electric and phone service start-up

___3. Copy of driver's license or State ID card with picture showing current address (no temporaries). If address has been changed, this cannot be accepted.

___4. Either of the following showing delivery to residence address within district in parent's name:
   a. A major moving company receipt for moving household goods
   b. Receipt from local firm showing delivery of newly purchased major appliance or furniture

___5. Currently active bank account checkbook with name and address imprinted. (Bank may be contacted to verify existence of account).

___6. Verification visit by Residency Confirmation staff on (date)_____

Documents seen by (signature):_____on_____.

SPRAGUE PUBLIC SCHOOLS
EARLY CHILDHOOD PROGRAM - PRESCHOOL
INCOME VERIFICATION

Funding sources for our preschool program require that 60% of the families that have students in the preschool are at or below 75% of the State Median Income. In order for us to determine your eligibility, please provide us with the following information:

Estimated Yearly Gross Income	$
# of Family Members.	

Failure to complete this form will indicate income over 75% of the State Median Income, and priority will be give to families who meet the above guidelines to ensure that the district is in compliance with the School Readiness Grant.

Acceptable verification may include:

	Pay Stubs
	Child Support
	Income Tax Statement
	Unemployment
	W2 Form
	Letter from Employer
	Other: (Specify)

Office Use Only

	Income Eligible
	Over Income

I certify that the information provided above is accurate and truthful to the best of my knowledge.

Parent/Legal Guardian's Signature:_____ Date:_____

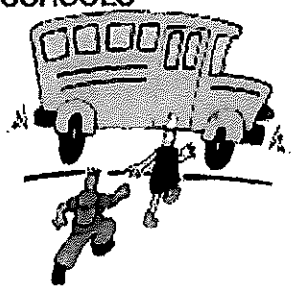
Verifying Staff Member Signature:_____ Date:_____

C:preschool\schoolreadinesspreschool(10/29/08)

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

IMMUNIZATION REQUIREMENTS FOR ENROLLED STUDENTS IN CONNECTICUT SCHOOLS 2017-2018 SCHOOL YEAR



PRESCHOOL

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
Hep B:	3 doses, last one on or after 24 weeks of age
Varicella:	1 dose on or after 1st birthday or verification of disease
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)
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday

KINDERGARTEN

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
Hep B:	3 doses, last dose on or after 24 weeks of age
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease
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
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday

GRADES 1-5

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
Hep B:	3 doses, last dose on or after 24 weeks of age
Varicella:	2 doses separated by at least 3 months-1st 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

GRADE 6

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
Hep B:	3 doses, last dose on or after 24 weeks
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease

Revised 12/12/2016

2017 - 2018 Immunization Requirements, cont'd

GRADES 7-12		
	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 a total of 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
	Meningococcal:	1 dose
	Hep B:	3 doses, last dose on or after 24 weeks of age
	Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease

- DTaP vaccine is not given on or after the 7th birthday and may be given for all doses in the primary series.
- Tdap can be given in lieu of Td vaccine for children 7 years and older unless contraindicated. Tdap is only licensed for one dose.
- Hib is not required for children 5 years of age or older.
- Pneumococcal is required for all Pre-K and K students less than 5 years of age.
- Hep A requirement for school year 2017-18 applies to all Pre-K, K, 1st , 2nd, 3rd, 4th & 5th graders born 1/1/07 or later.
- Hep B requirement for school year 2017-2018 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 should not be given before 24 weeks of age.
- Second MMR for school year 2017-2018 applies to all students in grades K-12.
- Meningococcal Conjugate requirement for school year 2017-18 applies to all students in grades 7-12
- Tdap requirement for school year 2017-18 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 www.ct.gov/dph/cwp/view.asp?a=5136&Q=467374&PM=1
- 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
Hepatit's A	Havrix, Vaqta	Influenza	Fluzone, FluMist, Fluviron, Flzarix, FluLaval

2

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance?	Y	N	If your child does not have health insurance, call **1-877-CT-HUSKY**
Does your child have dental insurance?	Y	N	
Does your child have HUSKY insurance?	Y	N	

* If applicable

Part I — 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	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental			Any heart problems	Y	N
Any daily/ongoing medications	Y	N	examination in the last 6 months	Y	N	Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place			6. Interaction with others	Y	N	Eating concerns	Y	N
to another	Y	N	7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

All medications taken in child care programs require a separate Medication Authorization Form signed by an authorized prescriber and parent/guardian.

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

☐ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT_____in/cm_____% *Weight_____lbs._____oz./_____% BMI____/____% *HC_____in/cm_____% (Birth – 24 months) *Blood Pressure_____/_____ (Annually at 3 – 5 years)

Screenings

***Vision Screening**
☐ EPSDT Subjective Screen Completed (Birth to 3 yrs)
☐ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

☐ Unable to assess
☐ Referral made to: _____

***Hearing Screening**
☐ EPSDT Subjective Screen Completed (Birth to 4 yrs)
☐ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	☐ Pass	☐ Pass
	☐ Fail	☐ Fail

☐ Unable to assess
☐ Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** | *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ☐ No ☐ Yes

***TB:** High-risk group? ☐ No ☐ Yes
Test done: ☐ No ☐ Yes Date: _____
Results: _____
Treatment: _____

***Dental Concerns** ☐ No ☐ Yes
☐ Referral made to: _____
Has this child received dental care in the last 6 months? ☐ No ☐ Yes

*Result/Level: *Date

Other:

***Developmental Assessment:** (Birth – 5 years) ☐ No ☐ Yes **Type:**

Results:

*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 an Asthma Action Plan
☐ Rescue medication required in child care setting: ☐ No ☐ Yes

Allergies ☐ No ☐ Yes: _____
Epi Pen required: ☐ No ☐ Yes
History/risk of Anaphylaxis: ☐ No ☐ Yes: ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Unknown source
If yes, please provide a copy of the Emergency Allergy Plan

Diabetes ☐ No ☐ Yes: ☐ Type I ☐ Type II
Seizures ☐ No ☐ Yes: Type: _____

Other Chronic Disease: _____

☐ This child has the following problems which may adversely affect his or her educational experience:
☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical ☐ Emotional/Social ☐ Behavior
☐ This child has a developmental delay/disability that may require intervention at the program.
☐ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

☐ No ☐ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
☐ No ☐ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
☐ No ☐ Yes This child may fully participate in the program.
☐ No ☐ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

☐ No ☐ Yes Is this the child's medical home? ☐ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

Child's Name: _____ Birth Date: _____ REV. 3/2015

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Influenza						
Tdap/Td						

Disease history for varicella (chickenpox) _____
(Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____
†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born on or after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped *Provider* Name and Phone Number

Sprague School District
25 Scotland Road ~ Baltic, Connecticut 06330

Yearly Health Update

Child's Name: _____ Grade / Teacher: _____

Please take the time to fill out the questionnaire below thoroughly so we may care for your child properly.

		Yes	No
1.	Do you have any concerns about your child's general health (eating, sleeping, weight, etc.)?	☐	☐
2.	Does your child have any specific illness or problem?	☐	☐
3.	Does your child have any allergies (food, insects, medications, etc.)?	☐	☐
4.	Does your child take any medication (daily or occasionally)?	☐	☐
5.	Does your child have any problems with vision, hearing or speech (glasses, contacts, etc.)?	☐	☐
6.	Has your child had any hospitalization, operation or major illness? Specify below.	☐	☐
7.	Has your child had any significant injury or accident? Specify below.	☐	☐
8.	Would you like to discuss anything with the school nurse about your child's health?	☐	☐
9.	Is your child covered by health insurance? Y or N	Company Name:	Policy #:

Please explain "yes" answers here. For illness/injury, include year/child's age at the time:

** If your child will be taking medication at school, an authorization form must be filled out by the physician.

Parent / Guardian Authorization for Release of Information

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school. I give Sayles School permission to treat and/or transport my child in the event of an emergency.

Parent / Guardian Signature: _____ Date: _____

Parent / Guardian Authorization for Administration of Acetaminophen

Under the standing orders of our medical advisor, Acetaminophen (Tylenol) may be given to students with parent/guardian written permission for headaches, earaches, menstrual cramps and toothaches. If you wish to allow your child to receive Acetaminophen for these ailments at school please complete the following:

I give permission for my child to receive Acetaminophen (Tylenol) at school per manufacturer's dosing.

Yes: ☐ No: ☐

Parent / Guardian Signature: _____ Date: _____

Administration of Acetaminophen Log

Date	Time	Dose	Comments	Signature

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations require a physician's or dentist's written order and parents' or guardian's authorization for a nurse to administer medications or in her absence, the principal or teacher to administer medications. Medications must be in pharmacy prepared containers and labeled with name of child, name of drug,strength, dosage, frequency, physician's or dentist's name and date of original prescription.

PHYSICIAN'S OR DENTIST'S ORDER

Date_____

Name of Child:_____Date of Birth_____
Address_____
Condition for which medication is being administered during school hours:
_____
Name of medication:_____
Dose, method of administration, and time of administration:
_____
Date(s) medication is to be administered: From:_____To:_____
Relevant side effects to be observed, if any:_____
_____
If there are side effects, plan for management:_____
_____
Is this a Controlled Drug? ( ) NO ( ) YES If yes, provide DEA Number:_____

SELF-ADMINISTRATION (OPTIONAL): This child is capable of, and may be allowed to administer his/her own medication as prescribed. ( ) YES ( ) NO

Physician's or Dentist's name: (Print)_____
Address:_____Phone_____

Physician's or Dentist's signature:_____Date_____

Nurse/Principal/Teacher's signature:_____Date_____

PARENT/GUARDIAN AUTHORIZATION

To School Personnel: Date_____
I hereby request that the above medication, ordered by the physician/dentist for my son/daughter _____, be administered by school personnel. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 45 school day supply of said medication.I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond to close of school.

OR

I hereby request that my son/daughter_____, be allowed to self-administer the above ordered medication pending approval by appropriate school personnel.

Name:(Print)_____Relationship to Child_____
Address:_____

Signature:_____Phone_____

Does Your Child Have Health Insurance?

Connecticut's HUSKY Plan offers low-cost or free health care

Dear Parent/Guardian,

Is your child protected by health insurance? If not, your school and the State of Connecticut want to help. Please fill out this form and return it to your child's teacher, school nurse or school office. The school will then contact Connecticut's HUSKY Plan to help connect your student with health insurance coverage.

Healthy kids do well in school! HUSKY pays for doctor visits (including physical exams), prescriptions, emergency care, vision and dental care, mental health care, special health care needs and more. It's for children under age 19 in families of all incomes. Over 230,000 children now have their health care covered by the HUSKY Plan.

If your child is uninsured and you would like to participate in Connecticut's HUSKY Plan, please fill out and return this form to your child's teacher, school nurse, or school office. Your signature means that the school can provide your contact information to the Connecticut Department of Social Services (administering agency of the HUSKY Plan) or its enrollment contractor so that a HUSKY customer service representative may call you, send you an information kit, and begin the application process to insure your child's health.

Parent/guardian's name *(please print)*:_____

Parent/guardian's signature:_____

Street address: _____

City or town: _____, CT Zip code: _____

Name(s) and age(s) of uninsured child(ren): _____

_____

_____

Best phone number for the HUSKY representative to call you at? (area code first): ( ) _____

If you want an information & application kit sent to you, *please check here:* ☐

OR: If you want to find out more information on HUSKY right away, call the HUSKY information hotline--1-877-CT-HUSKY (1-877-284-8759).
Hours are 8:30 a.m.-8 p.m. Monday-Thursday; 8:30 a.m.-6 p.m. Friday; and 10 a.m.-2 p.m. Saturday. You can apply by phone or request an information kit.

OR: Visit HUSKY at www.huskyhealth.com. *Check out our colorful website & download the application.*

This partnership of Connecticut schools and the HUSKY Plan is from the HUSKY enrollment initiative proposed by Governor M. Jodi Rell and approved by the General Assembly in Section 119 of Public Act 07-02, June Special Session. Special thanks to the Connecticut Department of Education, Connecticut Department of Social Services, Regional Education Service Centers, and all caring school personnel throughout the state as we join with parents to bring health coverage to all Connecticut children.

¿Tiene su Hijo un Seguro Médico?

El Plan HUSKY de Connecticut ofrece un seguro médico de bajo costo o gratis

Estimado Padre/Tutor

¿Está su hijo protegido por un seguro médico? Si no, su escuela y el Estado de Connecticut desean ayudarlo. Por favor llene este formulario y devuélvalo al maestro de su hijo, a la enfermera o a un funcionario de la escuela. La escuela se pondrá en contacto con el Plan HUSKY de Connecticut para ayudarlo a conectar a su estudiante con covertura de seguro médico.

¡Los niños saludables tienen éxito en la escuela! HUSKY paga por las visitas al médico (incluyendo los exámenes físicos), las recetas, servicios de emergencia, visión, dental, de salud mental, necesidades de servicios especiales y mucho más. Es para los niños menores de 19 años en familias de todos ingresos. Más de 230,000 niños tienen ahora su servicio médico con el Plan HUSKY.

Si su hijo no tiene seguro y a usted le gustaría participar en el Plan HUSKY de Connecticut, por favor llene este formulario y devuélvalo al maestro de su hijo, a la enfermera o a un funcionario de la escuela. Su firma significa que la escuela puede ofrecer su información de contacto al Departamento de Servicios Sociales de Connecticut (la agencia que administra el plan HUSKY) o al centro de inscripción de modo que un representante del servicio al cliente de HUSKY pueda llamarlo, enviarle un paquete de información y comenzar el proceso de inscripción para asegurar la salud de su hijo.

Nombre del padre/tutor *(por favor use letra de molde)*:_____

Firma del padre/tutor _____

Dirección: _____

Pueblo o ciudad: _____, CT Código Postal: _____

Nombre(s) y edad(es) del(de los) niños sin seguro: _____

_____

_____

¿Cuál es el número de teléfono más apropiado para que un representante de HUSKY lo llame (código del area primero)?: ( ) _____

Si desea que le enviemos un paquete de información e inscripción, *por favor marque aquí*:_____

O: Si usted desea encontrar más información acerca de HUSKY ahora mismo, llame a la línea directa de información de HUSKY - 1-877-CT-HUSKY (1-877-284-8759).

El horario es: 8:30 a.m.-8 p.m. de lunes a jueves; 8:30 a.m.-6 p.m. los viernes; y 10 a.m.-2 p.m. los sábados. Puede solicitar un paquete de información o pedir información por teléfono.

O: Visite a HUSKY en el internet en www.huskyhealth.com. *Examine nuestro interesante página del internet y baje la información.*

Esta asociación de las escuelas de Connecticut y el Plan HUSKY procede de la Iniciativa de inscripción de HUSKY propuesta por la Gobernadora M. Jodi Rell y aprobada por la Asamblea General en la Sección 119 del Acto Público 07-02, Sesión Especial de junio. Gracias especiales al Departamento de Educación de Connecticut, al Departamento de Servicios Sociales de Connecticut, a los Centros Regionales de Servicio de Educación, y a todos los funcionarios escolares que se unen con los padres para traer la cobertura de salud a todos los niños de Connecticut.