

# Wales Elementary School

Tantasqua/Union 61 Regional School District

320A Brookfield Rd., Fiskdale, MA 01518

(508)347-3077

FAX (508)347-2697

*Deborah Boyd*

Superintendent of Schools

## PK - 6 PARENT REGISTRATION CHECKLIST

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

### **Parent/Guardian Provide:**

- Affidavit of Student Residency
- 2 Proof of Residence documents
  - o 1 of Category A –
    - *Current paid real estate tax on place of residence*
    - *Purchase and Sale Agreement for place of residence*
    - *Rental or Lease Agreement for place of residence*
  - o 1 of Category B with current residence address-
    - *Utility bill under parent/guardian name*
    - *Voter registration for parent/guardian*
    - *Valid Driver's license*
- Photo ID of Parent(s) /Guardian(s)
- Birth Certificate
- Emergency Information Card
- Home Language Survey
- Physical Exam (recent) and Immunization Record
- Registration Form
- Request for Records Release
- Internet Permission and Publicity Release
- Method of Communications
- Documentation of custody arrangements if applicable
  - o *If there is a restraining order, any other custody orders or a caregiver affidavit form please provide school with a copy of the relevant court documents or forms*

### **Your child's previous school will provide:**

- Disciplinary Record/Status
- Copy of cumulative file
- MA Transfer Card if applicable
- IEP (Individual Education Plan) if applicable
- 504 Accommodation Plan if applicable

**Parent/Guardian Initials** \_\_\_\_\_  
**Date Signed** \_\_\_\_\_

**Staff Initials** \_\_\_\_\_  
**Date Received** \_\_\_\_\_

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## REGISTRATION FORM

Student is entering grade: \_\_\_\_\_ Date: \_\_\_\_\_

❖ **Student Name:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

First Middle Last Suffix

Email: \_\_\_\_\_ Town of Residence: \_\_\_\_\_  
Year of Graduation: \_\_\_\_\_ Grade Level: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ City of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Mailing if different: \_\_\_\_\_  
Phone: \_\_\_\_\_ Unlisted?  yes  no

❖ **Guardian's Name:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

Title First Last  
Email: \_\_\_\_\_ Workplace: \_\_\_\_\_

Legal Status (choose one; Custodial parent, Non-custodial parent; Foster parent, other (specify): \_\_\_\_\_

Does this guardian have the right to dismiss the student?	YES	NO
Does this guardian have the right to receive the student?	YES	NO
Does this guardian live with the student?	YES	NO
Does this guardian receive student's mail separately?	YES	NO

Street Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Mailing if different: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Unlisted?  yes  no  
Work Phone: \_\_\_\_\_

❖ **Guardian's Name:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

Title First Last  
Email: \_\_\_\_\_ Workplace: \_\_\_\_\_

Legal Status (choose one; Custodial parent, Non-custodial parent; Foster parent, other (specify): \_\_\_\_\_

Does this guardian have the right to dismiss the student?	YES	NO
Does this guardian have the right to receive the student?	YES	NO
Does this guardian live with the student?	YES	NO
Does this guardian receive student's mail separately?	YES	NO

Street Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Mailing if different: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Unlisted?  yes  no  
Work Phone: \_\_\_\_\_

All students, regardless of race, color, sex, gender identity, religion, limited English proficiency, national origin, sexual orientation, disability, or housing status, have equal access to the general education program and the full range of any occupational/vocational education programs offered by the district.

Please list other children in the household:

NAME	DATE OF BIRTH	GRADE

❖ **Emergency Contact**

Relationship to student: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

❖ **Emergency Contact**

Relationship to student: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

***If there is a restraining order, any other custody orders or a caregiver affidavit form please provide the school with a copy of the relevant court documents or forms.***  
 .....

Please answer BOTH questions 1 and 2.

1. Is this student Hispanic or Latino? (choose only one)

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

2. What is the student's race? (choose one or more)

- 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).
- Black or African American (a person having origins in any of the black racial groups of Africa).
- Native Hawaiian or Other Pacific Islander (a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands).
- White (a person having origins in any of the original peoples of Europe, the Middle East, or North Africa).

\_\_\_\_\_

**Military Family Status** - this student is a child of (PLEASE CHECK ONE):

- An active duty member of the uniformed services, National Guard and Reserve on active duty orders
- A member or veteran who is medically discharged or retired within one (1) year
- A member who has died on active duty
- Does not apply

School Transferred From: \_\_\_\_\_  
*District and School Names*

\_\_\_\_\_  
*Street/PO BOX*

\_\_\_\_\_  
*City/State/Zip Code*

**Will your child be entering this school with:**

<b>An IEP?</b>	_____ <b>yes</b>	_____ <b>no</b>
<b>A 504 plan?</b>	_____ <b>yes</b>	_____ <b>no</b>
<b>Remedial services in math?</b>	_____ <b>yes</b>	_____ <b>no</b>
<b>Remedial services in reading?</b>	_____ <b>yes</b>	_____ <b>no</b>
<b>Does your child currently receive occupational therapy?</b>	_____ <b>yes</b>	_____ <b>no</b>
<b>Does your child currently receive physical therapy?</b>	_____ <b>yes</b>	_____ <b>no</b>
<b>Does your child currently receive speech services?</b>	_____ <b>yes</b>	_____ <b>no</b>
<b>Child is left handed</b> _____	<b>Child is right handed</b> _____	

\*\*\*\*\*

**PUBLICITY RELEASE**

On occasion, there will be publicity concerning your child's school program. We would like your permission to release your child's photograph/video in conjunction with such publicity.

\_\_\_\_\_ I give permission to release a photograph/video and name of my child for school related publicity

\_\_\_\_\_ I don't give my permission to release a photograph/video and name of my child for school related publicity

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

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

\_\_\_\_\_  
*Date*

\*\*\*\*\*

**FOR OFFICE USE**

**HOMEROOM** \_\_\_\_\_

**BUS IN** \_\_\_\_\_ **ADDRESS** \_\_\_\_\_

**BUS OUT** \_\_\_\_\_ **ADDRESS** \_\_\_\_\_

**STAFF INITIALS OF RECEIPT** \_\_\_\_\_

All students, regardless of race, color, sex, gender identity, religion, limited English proficiency, national origin, sexual orientation, disability, or housing status, have equal access to the general education program and the full range of any occupational/vocational education programs offered by the district.

**Wales Elementary School**  
**Tantasqua Regional/Union 61 School Districts Affidavit of Student Residency**  
**Please initial each statement**

\_\_\_\_\_ I/we are the parent(s) or legal guardian(s) of \_\_\_\_\_ and  
*Print student's full name*  
wish to enroll the above named student in \_\_\_\_\_ School District.  
*Print district name*

\_\_\_\_\_ I/we understand that pursuant to the laws of the Commonwealth of Massachusetts and the policy of the Tantasqua Regional/Union 61 School Districts that only students who actually reside in the towns of Brimfield, Brookfield, Holland, Sturbridge and Wales may attend district schools.

\_\_\_\_\_ I/we hereby certify that the above named student is/will be residing at the following address:

Physical street address number/apt/unit \_\_\_\_\_  
Physical town of residence \_\_\_\_\_  
Effective Date \_\_\_\_\_  
Home Telephone \_\_\_\_\_  
Cell Telephone \_\_\_\_\_  
Alternate Telephone \_\_\_\_\_

\_\_\_\_\_ I/we acknowledge that I am/we are required to notify the Tantasqua Regional/Union 61 School Districts for the purpose of determining the above student's eligibility to attend the district schools on the basis of residency. If said student is enrolled in the Tantasqua Regional/Union 61 Districts based upon the information provided and it is subsequently determined that the student does not actually reside in Brimfield, Brookfield, Holland, Sturbridge, or Wales I/we understand that the student's enrollment in the Tantasqua Regional/Union 61 School Districts will be promptly terminated and I/we will be jointly and severally liable to the Tantasqua Regional/Union 61 School Districts for the student's tuition for the full academic year(s).

\_\_\_\_\_ I/we further certify that I am/we are the parent(s) or legal guardian(s) of the above student.

\_\_\_\_\_ *Print parent/guardian full name and relationship*  
\_\_\_\_\_ *Print parent/guardian full name and relationship*

\_\_\_\_\_ I/we understand that all applicants must reside in the town of Brimfield, Brookfield, Holland, Sturbridge, or Wales per MGL Ch.76 Section 5 which states that every person shall have a right to attend the public schools of the town where he/she actually resides, subject to the following section. No school committee is required to enroll a person who does not actually reside in the town unless said enrollment is authorized by law or by the school committee. Any person who violates or assists in the violation of this provision may be required to remit full restitution to the town of the improperly-attended public schools. No person shall be excluded from or discriminated against in admission to a public school of any town, or in obtaining the advantages, privileges and courses of study of such public school on account of race, color, sex, religion, national origin, sexual orientation or homelessness. Amended by st. 1971, c. 622, c.1; st. 1973, c.925, s. 9A, st. 1993, c. 282; st. 2004, c. 352, s. 33.

\_\_\_\_\_ I/we understand that a school selected must immediately enroll a homeless child or youth, even if the child or youth is unable to produce the records normally required for enrollment (such as previous academic records, records of immunization, and other required health records, proof of residency, proof of guardianship, birth certificates or other documentation), has missed application or enrollment deadlines during a period of homelessness, or has outstanding fees.

Under penalties of perjury I/We attest that the above information is correct and true.

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

For School Use Only

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Received at School Approved

All students, regardless of race, color, sex, gender identity, religion, limited English proficiency, national origin, sexual orientation, disability, or housing status, have equal access to the general education program and the full range of any occupational/vocational education programs offered by the district.

**Tantasqua Regional/Union 61 School Districts  
Student/Family Residence Questionnaire**

The McKinney Vento Homeless Education Act ensures the educational rights for students who are homeless.

**Presently, are you and/or your family living in any of the following situations?**

*\*Check all that applies.*

- A. Staying in a shelter (family shelter, domestic violence shelter, youth shelter) or FEMA trailer
- B. Waiting on foster care placement
- C. Sharing the housing of others due to loss of housing, economic hardship or similar reason
- D. Living in a car, park, campground, abandoned building, or other inadequate accommodation
- E. Temporarily living in a motel or hotel due to loss of housing, economic hardship or similar reason
- F. Living alone as a minor student(s) without an adult (unaccompanied youth)

**If you checked any box above please complete the remainder of this form and submit it to school personnel. If you did not check any box above, you do not need to complete or submit this form.**

**Please list all children currently living with you.**

First	Middle	Last	M/F	DOB	Grade	School Name

**The undersigned parent/guardian certifies that the information provided above is accurate.**

Print Parent/Guardian Name

Signature

Date

\_\_\_\_\_  
(Area Code) Phone number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Your children have the right to:

- Continue to attend school in the school attended before you became homeless (school of origin).
- Receive transportation to the school of origin.
- Enroll in school without giving a permanent address and attend classes while the school arranges for a school transfer, immunization records or other documents needed for enrollment.
- Receive the same special programs and services, if needed, as provided to all other children served in these programs.
- Have enrollment disputes quickly addressed.

***If you wish to have a copy of this document, please ask the staff person helping you today to make one.***

TRSD/U61 staff assisting with this process:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Copies to:

1. TRSD/U61 Special Education Director

2. School Nurse



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**What adults does your child live with? Please check all appropriate persons and days. Please give the school a copy of any court custody papers or caregiver authorization forms.**

**Additionally, please include for each parent or guardian, a copy of a photo ID.**

	Monday	Tuesday	Wednesday	Thursday	Friday	Weekend
Mother						
Stepmother						
Father						
Stepfather						
Grandmother						
Grandfather						
Other						

Parent/Guardian

Signature \_\_\_\_\_

Date \_\_\_\_\_

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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			
_____ <b>First Name</b>	_____ <b>Middle Name</b>	_____ <b>Last Name</b>	F <input type="checkbox"/> M <input type="checkbox"/> <b>Gender</b>
_____ <b>Country of Birth</b>	____/____/____ <b>Date of Birth (mm/dd/yyyy)</b>	____/____/____ <b>Date first enrolled in ANY U.S. school(mm/dd/yyyy)</b>	
School Information			
____/____/____ <b>Start Date in New School (mm/dd/yyyy)</b>		_____ <b>Name of Former School and Town</b>	_____ <b>Current Grade</b>
Questions for Parents/Guardians			
<b>What is the primary language used in the home, regardless of the language spoken by the student?</b>  _____  _____	<b>Which language(s) are spoken with your child?</b> (include relatives -grandparents, uncles, aunts,etc. - and caregivers)  _____ seldom / sometimes / often / always  _____ seldom / sometimes / often / always		
<b>What language did your child first understand and speak?</b>  _____	<b>Which language do you use most with your child?</b>  _____		
<b>How many years has the student been in U.S. Schools? (not including pre-kindergarten)</b>  _____	<b>Which languages does your child use? (circle one)</b>  _____ seldom / sometimes / often / always  _____ seldom / sometimes / often / always		
<b>Will you require written information from school in your native language?</b> <input type="checkbox"/> Y <input type="checkbox"/> N  <b>If yes, what language?</b>  _____	<b>Will you require an interpreter/translator at Parent-Teacher meetings?</b> Y <input type="checkbox"/> N <input type="checkbox"/>  <b>If yes, what language?</b>  _____		
<b>Parent/Guardian Signature:</b>  X	____/____/____ <b>Today's Date: (mm/dd/yyyy)</b>		

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# MASSACHUSETTS SCHOOL HEALTH RECORD

## Health Care Provider's Examination

Name \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_

Medical History \_\_\_\_\_

### Pertinent Family History

### Current Health Issues

- Y N
- Allergies: Please list: Medications \_\_\_\_\_ Food \_\_\_\_\_ Other \_\_\_\_\_  
History of Anaphylaxis to \_\_\_\_\_ Epi-Pen®:  Yes  No
- Asthma: Asthma Action Plan  Yes  No (Please attach)
- Diabetes:  Type I  Type II
- Seizure disorder: \_\_\_\_\_
- Other (Please specify) \_\_\_\_\_

**Current Medications (if relevant to the student's health and safety)** Please circle those administered in school; a separate medication order form is needed for each medication administered in school.

### Physical Examination

Date of Examination: \_\_\_\_\_

Hgt: \_\_\_\_\_ (\_\_\_\_%) Wgt: \_\_\_\_\_ (\_\_\_\_%) BMI: \_\_\_\_\_ (\_\_\_\_%) BP: \_\_\_\_\_

(Check = Normal / If abnormal, please describe.)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> General _____     | <input type="checkbox"/> Lungs _____     | <input type="checkbox"/> Extremities _____ |
| <input type="checkbox"/> Skin _____        | <input type="checkbox"/> Heart _____     | <input type="checkbox"/> Neurologic _____  |
| <input type="checkbox"/> HEENT _____       | <input type="checkbox"/> Abdomen _____   | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Dental/Oral _____ | <input type="checkbox"/> Genitalia _____ |  |

### Screening:

- |   |  |   |
|---|--|---|
| Vision: Right Eye <input type="checkbox"/> (Pass) <input type="checkbox"/> (Fail) | Hearing: Right Ear <input type="checkbox"/> (Pass) <input type="checkbox"/> (Fail) | Postural Screening: <input type="checkbox"/> (Pass) <input type="checkbox"/> (Fail) |
| Left Eye <input type="checkbox"/> <input type="checkbox"/>                        | Left Ear <input type="checkbox"/> <input type="checkbox"/>                         | (Scoliosis/Kyphosis/Lordosis)   |
| Stereopsis <input type="checkbox"/> <input type="checkbox"/>                      |  |   |

Laboratory Results:  Lead \_\_\_\_\_ Date \_\_\_\_\_  Other \_\_\_\_\_

The entire examination was normal:

**Targeted TB Skin Testing:**  Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):

TB Test Type:  TST  IGRA Date: \_\_\_\_\_ Result:  Positive  Negative  Indeterminate/Borderline

Referred for evaluation to: \_\_\_\_\_ Date: \_\_\_\_\_  Low risk (no TB test done)

This student has the following problems that may impact his/her educational experience:

- |   |                                   |  |   |
|---|-----------------------------------|--|---|
| <input type="checkbox"/> Vision           | <input type="checkbox"/> Hearing  | <input type="checkbox"/> Speech/Language | <input type="checkbox"/> Fine/Gross Motor Deficit |
| <input type="checkbox"/> Emotional/Social | <input type="checkbox"/> Behavior | <input type="checkbox"/> Other           |   |

Comments/Recommendations:

Y  N This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions: \_\_\_\_\_

Y  N Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.

Signature of Examiner Circle: MD, DO, NP, PA Date \_\_\_\_\_

\_\_\_\_\_  
Please print name of Examiner.

Group Practice \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Please attach additional information as needed for the health and safety of the student.

MDPH 10/29/20

# CERTIFICATE OF IMMUNIZATION

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

Date of Birth:     /     /     Sex:   M   F

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date	Vaccine Type	Vaccine		Date	Vaccine Type
<b>Hepatitis B</b> (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1			<b>Measles, Mumps, Rubella</b> (e.g., MMR, MMRV)	1		
	2				2		
	3			<b>Varicella</b> (Var, MMRV)	1		
	4				2		
<b>Diphtheria, Tetanus, Pertussis</b> (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1			<b>Meningococcal Quadrivalent</b> MenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2				2		
	3			<b>Meningococcal Serogroup B (Men B)</b> MenB-FHbp MenB-4C	1		
	4				2		
	5				3		
	6			<b>Seasonal Influenza</b> Inactivated IIV4, IIV4-ID, IIV3, IIV3-ID, IIV3-HD, RIV3-IM, ccIIV3-IM	1		
	7				2		
	8				3		
<b>Haemophilus influenzae type b</b> (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1			Live Attenuated LAIV, LAIV4 (quadrivalent)	4		
	2				5		
	3				6		
	4				7		
<b>Polio</b> (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1			<b>2009 H1N1 Influenza</b> Inactivated or Live	1		
	2				2		
	3			<b>Pneumococcal Polysaccharide</b> (PPSV23)	1		
	4				2		
	5				<b>Hepatitis A</b> (HepA, HepA-HepB)	1	
			2				
<b>Pneumococcal Conjugate</b> (PCV13, PCV7)	1			<b>Human Papillomavirus</b> (9vHPV, 4vHPV, 2vHPV)	1		
	2				2		
	3				3		
	4						
<b>Rotavirus</b> (e.g., RV5: 3-dose series, RV1: 2-dose series)	1			<b>Zoster (shingles)</b>	1		
	2			<b>Other:</b>	1		
	3				2		

## CERTIFICATE OF IMMUNIZATION (continued)

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

\* Must also check Chickenpox History box.

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: <ul style="list-style-type: none"> <li>• physician interpretation of parent/guardian description of chickenpox</li> <li>• physical diagnosis of chickenpox, or</li> <li>• serologic proof of immunity</li> </ul>

*I certify that this immunization information was transferred from the above-named individual's medical records.*

**Doctor or nurse's name** (please print): \_\_\_\_\_ **Date:**     /     /

**Signature:** \_\_\_\_\_

**Facility name:** \_\_\_\_\_

# *Wales Elementary School*

41 Main Street ~ P.O. Box 247  
Wales, MA 01081

**Mrs. Kerri Mahota**  
Principal

Phone: 413-245-7748  
Fax: 413-245-4422  
[www.tantasqua.org/wales](http://www.tantasqua.org/wales)

## RELEASE OF RECORDS

Date \_\_\_\_\_

I hereby authorize the \_\_\_\_\_

to release the following information and consent to verbal exchange for:

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ Transfer Card

\_\_\_\_\_ Health Record

\_\_\_\_\_ Cumulative Record

\_\_\_\_\_ Special Reports and tests (including any Chapter 766 reports, testing and educational plans)

\_\_\_\_\_ Letter of discipline status (MGL Ch. 71 Sec. 37L)

**Any additional information not listed here, which is available, would be appreciated. Thank you very much for your cooperation.**

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

Phone Number \_\_\_\_\_

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***Tantasqua Regional/School Union 61 Districts***

**320A Brookfield Rd., Fiskdale, MA 01518**

**(508)347-3077**

**FAX (508)347-2697**

***Deborah Boyd***

Superintendent of Schools

## **Internet Permission & Publicity Release Form**

**Please see reverse side for permission form!**

**Please complete, sign & return this form**

Dear Parents,

An increasing amount of curriculum and research is now delivered or accessed via the Internet. Use of the Internet is common throughout Tantasqua/Union 61 School Districts. A wealth of high quality, accurate educational material is available to classrooms through this medium.

Children without signed Internet permission forms are not allowed to use the District's Internet. Students who do not receive permission to use the Internet are given alternate options, but are not able to fully participate in lessons that have been specifically designed to follow the Massachusetts Technology Literacy Standards.

Parents concerned about children accessing inappropriate material need to know that school computers are protected by the district's firewall, web filtering appliances, and anti-virus/anti-malware programs which are monitored and updated on an hourly basis. Internet use by students is primarily done through the school's Intranet home page, containing links to teacher-selected websites. Although older students may conduct independent Internet searches, it is always under the supervision of a teacher on a filtered network connection.

It is very important to complete the permission-granting process by the beginning of the school year, in order not to delay use of this important educational tool. When parents sign the Internet Permission form, they support their children's learning by allowing full use of the school's resources fostering 21<sup>st</sup> century skills.

**Parents:**


- 1- Please read the Acceptable Electronic Network Use Policy and **explain the contents to your child**. This policy can be found in the Parent-Student Handbook and on the District Website.
- 2- You will need to complete a separate form for each child in your family .


**If you have any questions please feel free to contact the school.  
We hope you have a very successful school year!**

CHILD'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_

*\*Please circle YES or NO for each section below.  
If any permission areas are left blank, we will assume this means NO.*

<b>Yes</b>	<b>No</b>	I give my child permission to use <b>Internet</b> .
<b>Yes</b>	<b>No</b>	I give my permission to release <b>project</b> on school website, provided that <b>ONLY</b> the first name and last initial of my child is used.
<b>Yes</b>	<b>No</b>	I give my permission to release <b>photograph/video</b> of my child for use on school website provided my child's name is <b>NOT</b> used.
<b>Yes</b>	<b>No</b>	I have read the <b>Acceptable Electronic Network Use Policy</b> & explained its contents to my child.
<b>Yes</b>	<b>No</b>	I have read and understand the <b>Parent-Student Handbook</b> .

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

\_\_\_\_\_  
Date 



***Tantasqua Regional/School Union 61 Districts***

**320A Brookfield Rd., Fiskdale, MA 01518**

**(508)347-3077**

**FAX (508)347-2697**

***Deborah Boyd***

Superintendent of Schools

**EMAIL COMMUNICATION**

A goal of the Tantasqua/School Union 61 Districts is to decrease the amount of paper notices going home in student's backpacks. The Parent/Student Handbook, Monthly Calendar of Events, breakfast and lunch menus and other forms of communication are either emailed to parents or available on the school website.

We will be using the email addresses provided by you on your child's registration form.

\_\_\_\_\_ Check here if you do **NOT** wish to receive this information via email and would like to continue receiving them in a paper format.

Your Child's Name \_\_\_\_\_

Grade \_\_\_\_\_

Parent Signature \_\_\_\_\_

All students, regardless of race, color, sex, gender identity, religion, limited English proficiency, national origin, sexual orientation, disability, or housing status, have equal access to the general education program and the full range of any occupational/vocational education programs offered by the district.



## **BUS COMPANIES**

*Please be advised that bus routes now appear on the Tantasqua district site under "bus routes" link:*

<http://www.tantasqua.org/TRSD/busroutes/index.htm>

Brimfield, Brookfield, Holland and Wales  
McCarthy & Sons Bus Company  
413-245-1470

# *Wales Elementary School*

41 Main Street ~ P.O. Box 247  
Wales, MA 01081

**Mrs. Kerri Mahota**  
Principal

Phone: 413-245-7748  
Fax: 413-245-4422  
[www.tantasqua.org/wales](http://www.tantasqua.org/wales)

## *Wales Elementary School* Student Handbook Acknowledgement Form

School Year 2025/26

Wales Elementary School policy stipulates that both parents/guardian and students review the Student handbook. <http://www.tantasqua.org/wales/files/docs/studenthandbook.pdf>

**Signatures of both you and your child are required.**

I have reviewed the Student Handbook

Student's Name (print): \_\_\_\_\_

Parent/Guardian's signature: \_\_\_\_\_

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

## Tantasqua & Union 61 Toileting Admission Procedure:

Child's Name: \_\_\_\_\_

Your child is expected to be toilet trained before entering preschool. Children are encouraged to use the bathroom on a regular basis during the school day and can use the bathroom at any time by asking the teacher.

Your child is considered toilet trained when:

- *he/she can initiate use of the bathroom.*
  
- *he/she can pull clothing up & down independently.*
  
- *he/she can wipe themselves.*
  
- *he/she can flush the toilet & participate in hand washing.*

We understand that occasional accidents may occur. All accidents are documented and children are expected to participate in changing their clothes. However, if this becomes a once a week or more occurrence, a parent/guardian meeting will be scheduled to discuss the next step. This may result in a temporary removal from the preschool program until independent toileting is achieved. Tuition refunds will ***not*** be issued. The preschool cannot guarantee that a vacancy for your child will be available once independent toileting is achieved.

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

## Early Childhood Education Experience Survey

Please check next to the option that best describes your child's preschool experience in the school year prior to entering Kindergarten. Select one option only, and indicate hours where applicable. Thank you!

Name of child: \_\_\_\_\_

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

- My child did not have any formal early childhood program experience.
- My child did not have any formal early program experience but participated in Coordinated Family and Community Engagement (CFCE) services.
- My child did not have any formal early program experience but participated in Parent Child Home Program (PCHP) services.
- My child did not have formal early childhood program experience but participated in **BOTH** Coordinated Family and Community Engagement (CFCE) **AND** Parent Child Home Program (PCHP) services.
- My child attended a Licensed Family Child Care Provider (indicate hours below)
- \_\_\_\_\_ for less than 20 hours per week
- \_\_\_\_\_ for 20+ hours per week
- My child attended a Center Based Program (indicate hours below)
- \_\_\_\_\_ for less than 20 hours per week
- \_\_\_\_\_ for 20+ hours per week
- My child attended **BOTH** a Licensed Family Child Care Provider **AND** a Center Based Program (indicate hours below)
- \_\_\_\_\_ for less than 20 hours per week
- \_\_\_\_\_ for 20+ hours per week

### **Definitions:**

**Coordinated Family and Community Engagement (CFCE) Services:** Locally based programs serving families with children birth through school age (e.g. parent/child playgroups, parent-child activities).

**Parent Child Home Program (PCHP):** home visiting model program funded through the Department of Early Education and Care.

**Licensed Family Childcare:** refers to EEC licensed child care in a group setting in a home. It may include provider providing care to children from multiple families.

**Center-Based Care:** refers to care for children in a group setting, including public and private preschools, Head Start, daycare centers, and integrated public preschools.

# Wales Elementary School

## Preschool & Kindergarten Questionnaire

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

### **FAMILY BACKGROUND**

Student \_\_\_\_\_ Nickname, if any \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Mailing Address \_\_\_\_\_

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

Relationship to the Student \_\_\_\_\_ email address \_\_\_\_\_

Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_

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

Relationship to the Student \_\_\_\_\_ email address \_\_\_\_\_

Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Marital status of students' parents \_\_\_\_\_

Student lives with \_\_\_\_\_

Has there been a divorce, death, or illness in the family which might affect your child? \_\_\_\_\_

Is your child Left- handed? \_\_\_\_\_ Right handed? \_\_\_\_\_ Uses Both? \_\_\_\_\_

Describe any holiday tradition your family may participate in \_\_\_\_\_

### **SOCIAL AND SCHOOL EXPERIENCES**

Pre-School Experience:

Formal Schooling or daycare? Please give names, dates, and days/weeks. \_\_\_\_\_

Other experiences? \_\_\_\_\_

Does your child play quietly or actively? \_\_\_\_\_

Does your child have any difficulty sharing? \_\_\_\_\_

Does your child have the opportunity to play with other children? \_\_\_\_\_

Does your child prefer to play alone? \_\_\_\_\_ with others? \_\_\_\_\_

With older children? \_\_\_\_\_ with younger children? \_\_\_\_\_

How does your child get along with other children? \_\_\_\_\_

Would you say your child is a leader or a follower? \_\_\_\_\_

What activities does your child enjoy outdoors? \_\_\_\_\_ Indoors? \_\_\_\_\_

Does your child enjoy watching television? \_\_\_\_\_ About how many hours a day? \_\_\_\_\_

Does your child enjoy video games? \_\_\_\_\_ About how many hours a day? \_\_\_\_\_

What does your child like to do best at home? \_\_\_\_\_

Does he/she have any favorite games or toys? \_\_\_\_\_

Does your child have a pet? \_\_\_\_\_

### **SCHOOL ADJUSTMENT**

Can your child? (Yes or No)

Tell his/her full name? \_\_\_\_\_ Tell his/her address? \_\_\_\_\_ Count to ten? \_\_\_\_\_

Print his/her first name? \_\_\_\_\_ Identify color? \_\_\_\_\_ Complete task begun? \_\_\_\_\_

Tell left from right? \_\_\_\_\_ Pick up after him/herself? \_\_\_\_\_

Does your child recognize all alphabet letters? \_\_\_\_\_ Say the alphabet from memory? \_\_\_\_\_

Does your child listen to and follow directions well? \_\_\_\_\_

Do you read to your child? \_\_\_\_\_ What kind of stories does he/she like? \_\_\_\_\_

Is your child able to remember songs and rhymes? \_\_\_\_\_

Has your child had experiences with paints, crayons, pencils, scissors, and paste? \_\_\_\_\_

Is your child able to sit and listen to a story for 5-10 minutes? \_\_\_\_\_

Does your child display any special talents such as in music, art, performing for others, leading other children, engaging in physical activities? \_\_\_\_\_

What would you like your child to learn in school? \_\_\_\_\_

What would you like your child's teacher to know about your child? \_\_\_\_\_

Is there anything else you feel the school should know about your child before he/she begins?\_

---

**Does your child (Yes or No)**

Dress him/her self?\_\_\_\_\_ Put on boots?\_\_\_\_\_ Zip? \_\_\_\_\_ Tie?\_\_\_\_\_

Button?\_\_\_\_\_ Use a nose tissue?\_\_\_\_\_ Use the toilet independently?\_\_\_\_\_

What would you say are your child's strengths? \_\_\_\_\_

---

Does your child have any special fears (dogs, darkness, etc.)?\_\_\_\_\_

---

Does your child have any lingering habits (security blanket, thumbsucking, etc.)?\_\_\_\_\_

---

How does your child usually get along with his/her brothers and sisters? \_\_\_\_\_

---

Is your child able to separate easily from the parent? \_\_\_\_\_

Are there things your child does that you think are unusual? \_\_\_\_\_

---

Do you have any special concerns about your child? \_\_\_\_\_

---

What words would you use to describe your child?\_\_\_\_\_

In what kind of learning environment is your child most comfortable?\_\_\_\_\_

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Is there any other information that will help us understand your child? \_\_\_\_\_

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Additional comments \_\_\_\_\_

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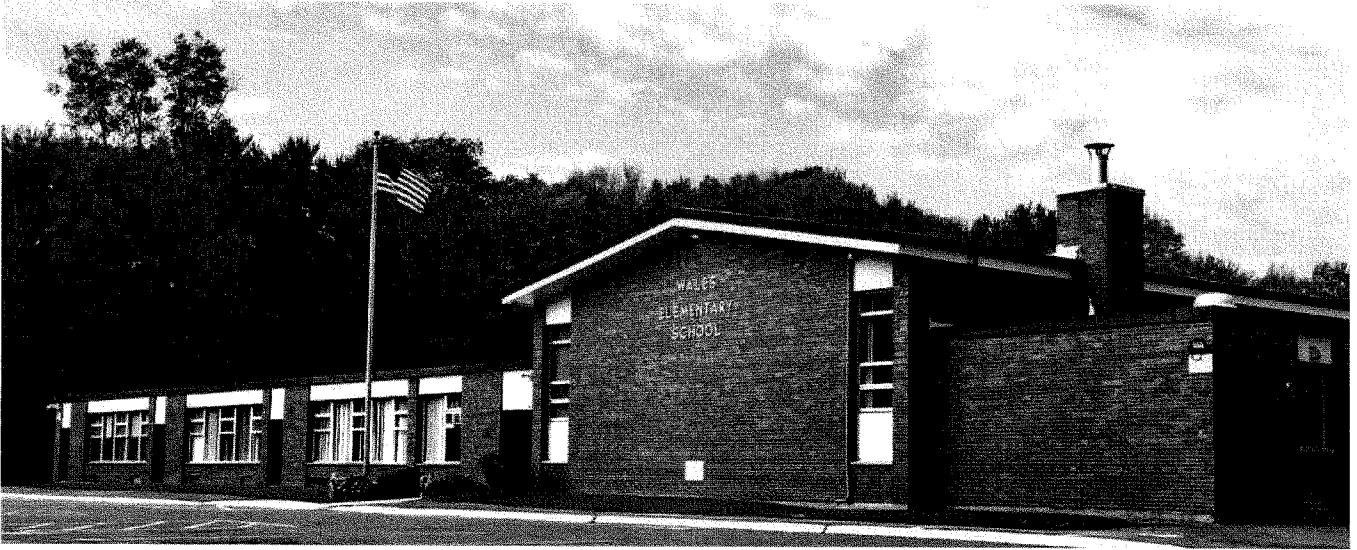
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Form completed by \_\_\_\_\_

Relationship to child \_\_\_\_\_

# **Wales Elementary School**

## **Health Office Registration Forms**



Please return completed forms as soon as possible.



# Wales Elementary School

## Kindergarten

Dear Parents/ Guardians

The Massachusetts General Laws require the following for your child's entrance into kindergarten.

1. A copy of your child's **birth certificate** or other proof of guardianship
2. A signed and dated **Physical Exam** form with **vision and hearing test**
3. Documentation of **lead screening**

**Current required immunizations to enter kindergarten are:**

- 5 doses DTP (Diphtheria, Pertussis, Tetanus) unless the 4th dose is given on or after the 4th birthday
  - 4 doses of Polio
  - 3 doses of Hepatitis B
  - 2 doses of MMR (Measles, Mumps, Rubella)
  - 2 doses of Varicella (or documentation of reliable chickenpox history or documentation of serology)
- 
- Student Medical/ Developmental History (annual)
  - Physical Examination by your child's physician must include **Immunizations, Height, Weight, BMI, Vision & Hearing Screening, Lead Test & TB Risk Assessment**
  - Emergency Information Card (annual)
  - MDPH Dental form, if not on file

\*A signed and dated Medical or Religious Exemption Letter is required annually if your child does not receive the state mandated immunizations.

1. Additionally, the Massachusetts Department of Public Health strongly recommends a dental examination prior to school entrance.
2. Any previous school records, including Special Education records are required for entry.

**\*Important- Parents, please complete forms and BRING THEM WITH YOU ON YOUR CHILD'S KINDERGARTEN SCREENING DATE or if this is your child's second year in attendance at WES you may send the documents to the Health Office as soon as possible. Medical documents may be faxed in directly from the doctor's office to school to #413-245-4422**

**Tantasqua Regional & Union 61 School District  
Wales Elementary School**

Date: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_

Name of child: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Presently lives with: \_\_\_\_\_ Relationship: \_\_\_\_\_

Mother's name: \_\_\_\_\_  
Address: \_\_\_\_\_

Father's name: \_\_\_\_\_  
Address: \_\_\_\_\_

Does the child live between two homes? Yes  No   
 • Who has physical custody? \_\_\_\_\_  
 • Who has legal custody? \_\_\_\_\_

**Medical History**

Has your child experienced any of the following?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Major medical problems	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization
<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Serious infection	<input type="checkbox"/>	<input type="checkbox"/>	Allergy _____ <input type="checkbox"/> EpiPen
<input type="checkbox"/>	<input type="checkbox"/>	Prolonged and/or high fever	<input type="checkbox"/>	<input type="checkbox"/>	Physical Disability
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Broken bone
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes

If yes, please give detail of history and include physicians or specialists and hospitals they are followed by:

\_\_\_\_\_

Please give detail history of allergies and include any medications they take:

\_\_\_\_\_

Does your child wear glasses? \_\_\_\_\_ Hearing aides? \_\_\_\_\_

Has your child ever been limited from physical activity? Yes  No   
 If yes, when? \_\_\_\_\_ How long? \_\_\_\_\_

**Does your child take any medication on a regular basis?** Yes  No

If yes, name of medications: \_\_\_\_\_

Is it necessary to give at school? Yes \_\_\_\_\_ No \_\_\_\_\_

What effects do you see from the medication? \_\_\_\_\_

List any other medical history not covered that you think is important for us to know in order that we may give your child the best opportunity for learning.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### School History

Has your child ever been *diagnosed* with a learning disability? Yes  No   
If yes, when? \_\_\_\_\_ By whom? \_\_\_\_\_

- Specific disability: \_\_\_\_\_
- Were services received? Yes  No   
If yes, what services? \_\_\_\_\_ For how long? \_\_\_\_\_

### Psychological History

Has your child ever been diagnosed with a mental health disorder?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	Tic Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Post Traumatic Stress Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Bi-Polar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Personality Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Tourette's Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive/Compulsive Disorder

Other: \_\_\_\_\_

Does your child take any medications to treat the above conditions? Yes  No

If yes, name of medication: \_\_\_\_\_

Is it necessary to give at school? Yes  No

What effects do you see from the medication? \_\_\_\_\_

Is your child currently receiving, or ever received, counseling? Yes  No

- Out-of-school counseling Yes  No
- Out-of-school Psychotherapist Yes  No
- Out-of-school Psychiatrist Yes  No

Is there anything not covered in this history you think is important for us to know so we can give your child the best opportunity for learning? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is your child covered by health insurance? Yes  No  Name: \_\_\_\_\_

Does your child have dental insurance? Yes  No  Name: \_\_\_\_\_

I give the nurse permission to share my child's health information with appropriate school personnel for the purpose of improving my child's total level of wellness regarding their personal health and safety.

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

## EMERGENCY INFORMATION CARD

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

\_\_\_\_\_ Allergy – Emergency Info

Student Name: \_\_\_\_\_  
                            First                              (MIDDLE NAME)                              Last

Home Phone # \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Where can parents be reached if not at home:

Mothers name: \_\_\_\_\_ Cell #: \_\_\_\_\_

Work Place & Phone #: \_\_\_\_\_

Fathers name: \_\_\_\_\_ Cell #: \_\_\_\_\_

Work Place & Phone #: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached and will be willing to transport your child home from school in an emergency:

1. Name: \_\_\_\_\_ Tel. \_\_\_\_\_

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

2. Name: \_\_\_\_\_ Tel. \_\_\_\_\_

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

**\*IMPORTANT: PLEASE FILL OUT BACK SIDE\***

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH DENTAL CERTIFICATE

This is to certify that \_\_\_\_\_

is receiving dental care from this office \_\_\_\_\_

Has had all dental work that is necessary \_\_\_\_\_

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

*(If you have already submitted a form of this nature, you do not need to resubmit another dental certificate.)*

# *Wales Elementary School*

41 Main St/P.O. Box 247  
Wales, MA 01081

***Mrs. Kerri Mahota***  
Principal

Phone: 413-245-7748

Fax: 413-245-4422

[www.tantasqua.org/wales](http://www.tantasqua.org/wales)

Dear Parents/Guardians:

This letter is to inform you that a staff member at Wales Elementary School has a severe life-threatening allergy to *peanuts and tree nuts*. Strict avoidance of this allergen is the only way to prevent a life threatening allergic reaction. We are asking for your assistance in providing the staff member with a safe environment.

Due to these circumstances, we are asking that products containing the known allergen NOT be sent with your child to eat at school. Any exposure to the allergen through scent, contact or ingestion can cause a severe reaction. If your child has eaten anything containing the allergen prior to coming to school, please be sure your child's hands have been thoroughly washed. If exposed to the allergen, the staff member may develop a life threatening allergic reaction that requires emergency medical treatment.

We appreciate your support of these procedures. If you have any questions, please contact me.

Sincerely,  
***Kerri Mahota***

Mrs. Kerri Mahota  
Principal

*All students, regardless of race, color, sex, gender identity, religion, limited English proficiency, national origin, sexual orientation, disability, or housing status, have equal access to the general education program and the full range of any occupational/vocational education programs offered by the district.*

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