

This page must accompany the child's full registration packet

White River Valley Supervisory Union

Bethel Chelsea Granville Hancock Rochester Sharon South Royalton Stockbridge Strafford Tunbridge

Act 166: Universal Prekindergarten Tuition Request Form / Intent to Enroll Form 2018-2019 School Year

By completing and submitting this form, you are either 1) requesting that your child be considered for a prekindergarten space through your local public prekindergarten program or 2) requesting tuition reduction for your child to attend a pre-qualified private prekindergarten program.

Child's Name: _____ Date of Birth: _____

Name of Parent/Guardian: _____ Phone: _____

Address: _____

E-mail Address: _____

Our family lives in: _____ School District

Please check the applicable options:

_____ Please consider my child for a enrollment at my local public prekindergarten program.

----- OR-----

(PreK children are eligible for either public PreK OR Act 166 tuition, but not both)

_____ Please check here if you plan to enroll your child in a **pre-qualified private prekindergarten program**. Schools will provide up to \$3,267.00 per school year (10 hours per week for 35 weeks) to one pre-qualified private prekindergarten provider if the child's registration is complete before the start of the school year. The school does not manage enrollment at private programs; please contact the private prekindergarten program you are interested in. **Children must be 3 years old by September 1, 2018 to apply. Children who are 5 years old by September 1, 2018 are not eligible for Act 166 Tuition.**

My child is enrolled at _____

By enrolling in a public PreK program or requesting tuition funds, I agree to:

- complete the registration process** with my school district of residence, which includes proof of residency and proof of age (birth certificate). Schools are required to provide families with household income forms as well. I understand that if I do not register my child, I will not receive tuition. Note: If your child was registered last year, you will be asked to review the information on file;
- follow the attendance policy** provided by the prekindergarten program and ensure that my child attends prekindergarten consistently. I understand it is my responsibility to notify the Supervisory Union/School District if we move or if my child stops attending prekindergarten or changes programs;
- authorize the release of information** between my child's prekindergarten program to communicate with my school district about my child's development, enrollment, attendance, registration and suspension/expulsion.

Parent/Legal Guardian Signature

Date

Please send this form and your child's registration packet to the Registrar at your School District of residence

Internal use only: copy to: _____ Registrar, _____ Act 166 Designee, _____ other: _____

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**WHITE RIVER VALLEY SUPERVISORY UNION
PREKINDERGARTEN STUDENT REGISTRATION AND EMERGENCY FORM**

Bethel Chelsea Granville Hancock Rochester South Royalton Strafford Stockbridge Tunbridge

Please print and complete all sides and return as soon as possible. Thank you.

This section completed by Office Only: Enrollment Date: _____ Student ID: _____ State ID _____ Dated Completed: _____

Student Legal Name: _____
Last First Middle Date of Birth

Student Preferred Name: _____
Gender

Legal Guardian: _____ Relationship: _____

Physical Address (required): _____
Street City State Zip

Preschool/Childcare Center Last Attended: _____ Last Day of Attendance: _____

Public or Private Prequalified Program Choice: _____

Race (required): _____ Ethnicity _____

Father/Guardian Information	Circle One: 911 Address Yes No	Mother/Guardian Information	Circle One: 911 Address Yes No
Name: _____		Name: _____	
Custodial Parent? ____ Yes ____ No		Custodial Parent? ____ Yes ____ No	
Mailing Address: _____		Mailing Address: _____	
Town of Legal Residence: _____		Town of Legal Residence: _____	
Home Phone: _____ Cell Phone _____		Home Phone: _____ Cell Phone _____	
Employer: _____ Work Phone: _____		Employer: _____ Work Phone: _____	
Email: _____		Email: _____	

Siblings of Child:

Name	Age	Grade	School	Name	Age	Grade	School
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Is the student in DCF custody? _____ If DCF placed, does a biological parent live in WRV SU District? _____

State Place Information - Agency Name: _____ Caseworker _____ Phone # _____

Is the student *currently* on an I.E.P.? _____ Has the student *ever been* on an I.E.P.? _____

Has the family moved to work on a farm or in logging within the last three years? YES / NO (If YES, complete Migrant Worker Form)

Native Language (if other than English): _____ ESL Services needed? _____

Please list any adults who may be contacted or can assume temporary care of your child/ren if the school cannot contact you by phone.
This adult must be willing and able to take your child during school hours.

This page must accompany the child's full registration packet

**WHITE RIVER VALLEY SUPERVISORY UNION
Proof of Vermont Residence**

I affirm that _____ (child name) is eligible to attend school / private program to receive public tuition funds from _____, Vermont, my town of residence.

Because we, his/her parent(s) or guardian(s) _____ (names),

- Have purchased a home within the town of _____, Vermont, which is occupied as our legal residence
- Have leased a home within the town of _____, Vermont, which is occupied as our legal residence
- Are living with a resident from _____, Vermont, which is occupied as our legal residence

As proof of this residence, I have presented and attached a copy of **ONE** of the following documents showing the physical address of the residence:

- Purchase Agreement*
- Warranty Deed*
- Lease Agreement*
- Voter Registration (copy of receipt or Town Clerk's confirmation) *
- Notarized letter from the resident of the school district with whom I am residing accompanied by proof of their residency*
- Transitional Housing*

Or **TWO** of the following bills which show the physical address of the residence:

- Utility bill which shows the physical address of the residence*
- Other (example: valid Vermont Driver's License which shows the physical address of the residence) *

*Please black out or otherwise remove any information you choose to have remain private. Items presented for proof of residence must show the resident's name and the 911 physical address of the residence. Physical address may be different than mailing address.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Note: You must notify your PreK program immediately if your family moves out of your town of residence.

Proof of Eligibility: Children must be 3 on or before September 1, 2018

- Copy of Child's Birth Certificate or
- Copy of Well Child Visit with Date of Birth and Doctor's signature

Signature of School Official: _____

Primary/Home Language Survey for All Kindergarten and Incoming Students

Instruction for schools in completing the survey:

1. Interview the parents/guardians of **ALL** new Kindergarten and incoming students in grades K-12 and record all information requested.
2. Provide interpreting services whenever necessary.
3. Please check to see that **all questions** on the form are answered.
4. A copy of any survey with a language other than English should be referred to the ESL teacher for further screening to determine if the student is an **English Language Learner (ELL)**.
5. Surveys for students identified as ELLs should be faxed (802-479-1829) or mailed to:
Jim McCobb, ELL Program Coordinator, Vermont Agency of Education, 219 North Main Street, Suite 402, Barre, VT 05641.
6. Place the original survey form in the student's permanent file.
7. For questions contact Jim McCobb at (802) 479-1273.

Student Information (Parents/Guardians should complete this section.)			
First Name:	Last Name:	Date of Birth (Month/Day/Year)	Gender: F <input type="checkbox"/> M <input type="checkbox"/>
Country of Birth:	Date of Entry in U.S. (Month/Day/Year):	Date student first began Kindergarten (or higher grade) in any U.S. school (Month/Day/Year):	
Questions for Parents/Guardians		Response	
What is the native language of each parent/guardian?			
What language(s) are spoken in your home?			
Which language did your child learn first?			
Which language does your child use most frequently at home?			
Which language do you most frequently speak to your child?			
What other languages does your child know?			
School Information (School Staff should complete this last section based on information gathered from parent/guardian.)			
What school will the student attend?			
Beginning date in this school (Month/Day/Year):	What grade will the student enter?	Person Conducting Survey:	

Medical forms only need to be filled out if your child is attending a public prekindergarten.

White River Valley Supervisory Union New Enrollment Health Form

Bethel Chelsea Granville Hancock Rochester Sharon South Royalton Stockbridge Strafford Tunbridge

Parents/Guardians please circle your town of residence

Student name _____

(Please print in ink)

Last

First

Date of Birth

Grade

MEDICAL HISTORY

1. Has your child ever been a **patient in a hospital** (other than a few days after birth)?

No (If no, go to question #2.)

Yes (If yes, explain why and when below.)

2. Birth History: At how many weeks gestation was your child born? _____. What if any complications were there?

My child was in the hospital because:	When
Example: Bike accident-concussion	5 years old

3. Is your child taking any **prescription medicines**?

Yes - Please list the child's medicines below OR

No. My child does not take any prescription medicines. (If no, go to question #3)

Yes No. Does your child use an inhaler or breathing treatments? If YES, please list medicine below.

Name of medicine	Amount / size of pill	How many pills or doses does your child take at			
Example: Dexedrine	10 mg	<u>1</u> morning	<u>1</u> noon	<u> </u> dinner	<u> </u> bed
		<u> </u> morning	<u> </u> noon	<u> </u> dinner	<u> </u> bed
		<u> </u> morning	<u> </u> noon	<u> </u> dinner	<u> </u> bed
		<u> </u> morning	<u> </u> noon	<u> </u> dinner	<u> </u> bed

4. What **over-the-counter medicines** does your child take **regularly**?

Vitamins

Herbal medicine (please list)

Other medicines like Tylenol, Advil or something else? (Please list)

None, my child does not take any over-the-counter medicines regularly.

** Please note: Confidential information about your student's health may be shared only with other school staff that need to know to protect your child's safety. They are told to keep this health information private and not to share with anyone else. If there is health information you would like not to be shared, please contact the school nurse.*

Please turn page over.

Student name _____

(Please print in ink)

Last

First

Date of Birth

Grade

5. Does your child have any **allergic reaction** (bad effect) from any of the following? (Check all that apply.)

- Outside or Indoor allergies, (for example: hay fever, grass, pollen, cats ...) **Please list below ↓**
- Food Allergies (for example: peanuts, milk, wheat ...) **Please list below ↓**
- Insect or Animal Allergies (for example: bees, wasps, cats...) **Please list below ↓**
- Medicine or shots (immunization). **Please list below ↓**
- No, my child has no allergies that I know of.

Does your child have an **Epi-Pen** or **Auvi-Q**? Yes No If **YES**, please bring one to school.

My child is allergic to:	What happens when your child has a reaction?
Example: amoxicillin	Diarrhea (runny poop)

6. Has your child had any of the following **medical problems or injuries**? (Examples in parenthesis) Describe **your child's** problem for each **Yes** on the lines at the bottom of the page ↓.

Chicken Pox --Date if had chickenpox:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery --Date of any surgeries:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head Injury or Concussion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear infections (often has them, ear tubes, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nose problems (sinus infections, nose bleeds)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye problems (blurry vision, wears glasses, lazy eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing problems (has trouble sometimes, wears hearing aid)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mouth or throat problems (Strep throat, swallowing problems)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation (problems having a bowel movement (BM))	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems peeing (bed wetting, pain when peeing)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back problems (crooked back, back pain)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle and bone problems (weak muscles, pain in joints)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin problems (acne, flaking skin, rashes, hives)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures (shaking fits or convulsions)	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADD/ADHD (problems paying attention, sitting still)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing problems (cough, asthma)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart problems (fast or irregular heartbeat, murmur, birth defect)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Feelings or emotions (depression, anxiety, fears)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature and /Relationship to Student

Date

Student Name _____
 (Please print in blue or black ink) Last First M/F Date of Birth Grade

STUDENT'S MEDICAL HISTORY:

1. Does your child have any **allergic reaction** (bad effect) from any of the following? (Check all that apply.)

- Outside or Indoor allergies, (for example: hay fever, grass, pollen, cats ...) **Please list below** ↓
- Food Allergies (for example: peanuts, milk, wheat ...) **Please list below** ↓
- Insect or Animal Allergies (for example: bees, wasps, cats...) **Please list below** ↓
- Medicine or shots (immunization). **Please list below** ↓
- No, my child has no allergies that I know of.

2. Does your child have an **Epi-Pen** or **Auvi-Q**? Yes No If YES, please bring one to school.

My child is allergic to: <i>Example (amoxicillin)</i>	What happens when your child has a reaction? <i>Diarrhea, rash, difficulty breathing</i>

3. **ASTHMA:** Has a doctor, nurse, or other health professional EVER said that your child has asthma?

_____ Yes _____ No _____ Don't know/not sure

If yes, does your child STILL have asthma?

_____ Yes _____ No _____ Don't know/not sure

4. Is your child taking any **prescription medicines**? (Please include medications administered at home and during the school day)

- Yes - Please list the child's medicines below
- No. My child does not take any prescription medicines. (If no, go to question #5)
- Yes No. My child uses an inhaler or breathing treatments? If YES, please list medicine below.

Name of medicine: <i>Example: dexedrine</i>	Amount /dose <i>10mg</i>	How many pills or doses does your child take at			
		<i>1 morning</i>	<i>1/2 noon</i>	<i>dinner</i>	<i>bed</i>
		___ morning	___ noon	___ dinner	___ bed
		___ morning	___ noon	___ dinner	___ bed
		___ morning	___ noon	___ dinner	___ bed

**If daily medication is to be administered at school, it must come in with a signed doctor's order and in a current pharmacy labeled bottle.

5. My child wears corrective lenses? YES _____ NO _____ Hearing aids? YES _____ NO _____

The following non-prescription medications are available from the school nurse and can be given according to age, weight and manufacturer's instructions at nurse/designee discretion. **Please cross out** if you do not wish your child to receive this medication while at school. Parents will be notified of any student receiving Ibuprofen, Acetaminophen, or Benadryl.

- Ibuprofen (Advil) Acetaminophen (Tylenol) Benadryl Bacitracin Antacid tabs Skin lotion**
Sunscreen Vaseline Eye Wash Eye drops Cough drops Orajel Wound Wash

I give permission to exchange health information between my child's primary care provider or dental provider and the school nurse, including vision and hearing screening information:

_____ Parent/Guardian Signature

In the event that your child has serious illness or injury, and if we are unable to reach a parent/guardian, please understand that School personnel will seek emergency medical care, including transportation to a medical facility. Emergency Personnel will make further decisions based on need. I understand the plan.

_____ Parent/Guardian Signature

This page only needs to be filled out if your child is attending a public prekindergarten listed below.

WHITE RIVER VALLEY SUPERVISORY UNION

Bethel Preschool Rochester Preschool Sharon Preschool and Child Care
South Royalton Preschool Stockbridge Preschool

Walking Field Trip Permission and Media Release

Student's Name: _____

My child resides in: _____

As a parent or legal guardian of the student named above:

- I give permission for my child to go on walking field trips with her/his class.
- I DO NOT give permission for my child to go on walking field trips with her/his class.

- I give permission for my child to be photographed while engaged in school activities. I understand that the photos or videos may be displayed at school, without identifying name or caption, on the school website, or in the public media.
- I DO NOT give permission for my child to be photographed while engaged in school activities. I understand that the photos or videos may be displayed at school, without identifying name or caption, on the school website, or in the public media.

- I give permission for my child's school work to be published without identifying name or caption to appear on any district, school, or teacher website connected with the White River Valley Supervisory.
- I DO NOT give permission for my child's school work to be published without identifying name or caption to appear on any district, school, or teacher website connected with the White River Valley Supervisory.

Parent/Guardian Signature

Date



VMEP, UVM Extension
 327 US Route 302, Suite 1, Barre, VT 05641
 1-866-860-1382 ext. 208 & Fax: (802) 476-2006

Vermont Migrant Education Program Agricultural Employment Survey

Please complete this form and return it to the school office.
 Schools will mail all completed forms to the address listed above. All information provided is confidential.

Parent Name _____ Date completed _____

Address _____

Home/Cell Phone _____ Message phone _____

Have you, your spouse or companion moved in the last three years?

Yes If yes from where? _____ Please complete the rest of this form.

No You do not need to complete the rest of this form. Thank you!

In the past three years, have **you**, **your spouse**, or **companion**

worked in agriculture or logging?

looked for work in agriculture or logging?

currently working in agriculture or logging?

No

Please check off all that apply:

<input type="checkbox"/> on any type of farm such as dairy, beef, sheep, turkey, chicken, egg, fish, emu, fruit or vegetable farm <input type="checkbox"/> commercial greenhouse or nursery <input type="checkbox"/> hauling milk or other raw agricultural products <input type="checkbox"/> cheese plant, cannery, milk bottling plant or other food processing plant <input type="checkbox"/> trimming and harvesting Christmas trees/ wreath making	<input type="checkbox"/> logging activities such as cutting trees/firewood, brush cutting, chipping, debarking trees, forestry or timber work, tree planting/pruning <input type="checkbox"/> in a slaughterhouse or smokehouse <input type="checkbox"/> replanting or restoring land used for mining or clear cutting purposes <input type="checkbox"/> harvesting crops such as apples, grapes, hay, corn, and berries <input type="checkbox"/> commercial fishing or fish farming
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Please list all children ages 0 to 22 in your household: (list additional names on bottom of form)

Child: _____	Grade: _____	School: _____
Child: _____	Grade: _____	School: _____
Child: _____	Grade: _____	School: _____
Child: _____	Grade: _____	School: _____

08/2013

If your family qualifies for the Migrant Education Program, your child may receive **FREE** educational support services which may include free books, tutoring, summer programs, and/or resource referrals for services in your area.

Please return this form to school!



Cultivating Healthy Communities

University of Vermont Extension and U.S. Department of Agriculture, cooperating, offer education and employment to everyone without regard to race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, and marital or familial status.



VMEP, UVM Extension
327 US Route 302, Suite 1, Barre, VT 05641
1-866-860-1382 ext. 208 & Fax: (802) 476-2006

Program Narrative

WHO:

The Vermont Migrant Education Program serves **children and youth** (ages 3 – 21) whose families move from one school district to another to obtain temporary or seasonal work in agriculture or logging. There are no income guidelines used to determine eligibility.

WHAT:

The Program works with parents and teachers to provide **free educational support** to help students transition into their new schools. Support to schools and families may include:

- Instructional support
- Free books
- School and home coordination
- On-going school contact
- Preschool support
- Agency referral and coordination
- Summer support services
- Home visits
- Literacy based activities for families in their homes

HOW:

Recruitment Specialists contact schools, farms, agencies, and businesses to locate families whose children may be eligible for program services. Visits are then arranged to discuss the program and determine eligibility. To refer students please contact us at the above address.