Torrington Public Schools Registration

ABOUT THE CHILD

Last name: ____________________________
First name: ____________________________ Middle Name: ____________________________
Address: ____________________________ Telephone (area code): (____) ____________________________
Date of Birth: ____________________________ Place of Birth: ____________________________

ABOUT THE PARENTS

Child lives with (check all that apply):

☐ Parent 1: Last name: ____________________________ First name: ____________________________ Middle Initial: ____
  Preferred Title: Att., Dr., Mr., Mrs., Mr. Rev. Maiden Name: ____________________________
  Address: (if different from student) ____________________________
  Occupation: ____________________________ Place of Employment: ____________________________ Town: ____________________________
  Home Phone (____) Cell Phone (____) Work Phone: (____)
  Email address: ____________________________

☐ Parent 2: Last name: ____________________________ First name: ____________________________ Middle Initial: ____
  Preferred Title: Att., Dr., Mr., Mrs., Mr. Rev. Maiden Name: ____________________________
  Address: (if different from student) ____________________________
  Occupation: ____________________________ Place of Employment: ____________________________ Town: ____________________________
  Home Phone (____) Cell Phone (____) Work Phone: (____)
  Email address: ____________________________

☐ Guardian: Last name: ____________________________ First name: ____________________________ Middle Initial: ____
  Preferred Title: Att., Dr., Mr., Mrs., Mr. Rev.
  Address: (if different from student) ____________________________
  Occupation: ____________________________ Place of Employment: ____________________________ Town: ____________________________
  Home Phone (____) Cell Phone (____) Work Phone: (____)
  Relationship to Child: [Circle One] Step-Parent, Foster Parent, Grandparent, Other: ____________________________
  Email address: ____________________________

☐ Other: Last name: ____________________________ First name: ____________________________ Middle Initial: ____
  Address: (if different from student) ____________________________
  Occupation: ____________________________ Place of Employment: ____________________________ Town: ____________________________
  Home Phone (____) Cell Phone (____) Work Phone: (____)
  Relationship to Child: [Circle One] Step-Parent, Foster Parent, Grandparent, Other: ____________________________
  Email address: ____________________________

PLEASE BE CERTAIN TO ALERT YOUR CHILD'S SCHOOL IF THE INFORMATION ABOVE CHANGES!!
MILITARY
Is a parent of the child a member of the Armed Forces on active duty or serves on full-time National Guard Duty?  
Y  N  [Circle One]

LEGAL RESTRICTIONS
Are there any restraining orders or other legal actions pending?  
Y  N  [Circle One]
Please submit copy of restraining orders or other pertinent documents. If this information changes, please notify school immediately.

EMERGENCY CONTACTS (Other than parents; this section must be completed for your child’s safety.)
Name: ________________________________ Relationship to child: ________________________________
Address: ________________________________
Home Phone ( ) Work Phone ( ) Cell Phone: ( )
Name: ________________________________ Relationship to child: ________________________________
Address: ________________________________
Home Phone ( ) Work Phone ( ) Cell Phone: ( )
Name: ________________________________ Relationship to child: ________________________________
Address: ________________________________
Home Phone ( ) Work Phone ( ) Cell Phone: ( )

After School Day Care Provider: (If applicable) ________________________________
Address: ________________________________
Home Phone ( ) Cell Phone ( ) Work Phone: ( )

AFTER SCHOOL PERMISSION
Is your child allowed to stay after school for special activities or extra help?  
Y  N  [Circle one]
If your child may stay, how much advance notice would you require? ________________________________
(If a child stays after school, parents are responsible for transportation home. Contact will be made prior to your child remaining after school.)

CHILD’S HEALTH HISTORY
Physician’s name: ________________________________ Telephone #: ________________________________
Does your child have any significant medical history or current medical concerns?  
Y  N  [Circle one]
Is your child regularly or intermittently on any medication/s?  
Y  N  [Circle one]

INSURANCE
Is your child covered by health insurance?  
Y  N  [Circle one]

ETHNICITY
Is this child Hispanic/Latino?  
Y  N  [Circle one]

RACE
What is the child’s race?  [Circle one or more]
American Indian  Black or African American  Native Hawaiian or Other Pacific Islander  White or Hispanic / Latino
Alaska Native  Asian  American

PLEASE BE CERTAIN TO ALERT YOUR CHILD’S SCHOOL IF THE INFORMATION ABOVE CHANGES!!
FAMILY LANGUAGES
First language the child learned: ____________________________________________
Language spoken BY the child at home: ____________________________________
Language spoken by parent/s/grandparents TO child at home: __________________
Who speaks English at home or on the phone: Parent 1 Parent 2 Other:__________
Circle all that apply Name/Relationship to Child

PREVIOUS SCHOOL HISTORY
Has your child ever attended Torrington Public Schools? Y N [Circle one]
If so, which ones? ______________________________________________________
Has your child ever attended Pre-School, Day Care or Head Start? [Circle one if it applies, if no, leave blank]
If yes, please list name of school and location: ________________________________
Has your child ever received Special Education Services? Y N [Circle one]
If yes, where and when: __________________________________________________

IMMIGRANT
Has your child attended school in the United States for 3 or more full academic years? Y N [Circle one]

SIBLING INFORMATION (Please list siblings and their date of birth)
Brothers
Name Date of Birth School
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Sisters
Name Date of Birth School
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

PLEASE NOTE THAT IN ORDER TO REGISTER YOUR CHILD, YOU MUST PROVIDE THE FOLLOWING:
1. BIRTH CERTIFICATE
2. HEALTH/IMMUNIZATION INFORMATION
3. PROOF OF RESIDENCY (month to month utility bill, signed lease or mortgage)

Parent's/Guardian's Signature ___________________________ Date ___________

[For Office Use Only]
Registration date: ____________________ Anticipated entrance date: __________ Actual entrance date: __________
REVISED: 9/12/2017

PLEASE BE CERTAIN TO ALERT YOUR CHILD'S SCHOOL IF THE INFORMATION ABOVE CHANGES!!
Torrington High School Pre-School Lab Policy

The Torrington High School Pre-School Lab is an integral part of Child Development classes amongst THS students. High school students will be involved in pre-school activities directly relating to emotional, physical, cognitive and social development. All high school students are constantly supervised by certified classroom staff.

The preschool day will include a variety of activities such as free play, music, fine and gross motor games, art, science, math and literacy activities, and outdoor experiences. All children are encouraged to participate in activities. Individuality and independence is strongly encouraged among all areas. The four year old students also work on a variety of kindergarten readiness skills. It is required that your child be potty trained prior to entering the program.

Hours of Operation:

Monday through Thursday 3 year olds 9:00 a.m. – 11:30 a.m.
Monday through Thursday 4 year olds 12:20 p.m. – 2:50 p.m.

Please be prompt in dropping off and picking up your children. Also, please make sure to park in designated areas (there is no parking permitted in the fire lane and it is strongly recommended that families park in designated preschool parent parking spaces in the lot) to ensure safety.

Families will receive a calendar for the upcoming school year. In the event of inclement weather including school closings, delayed openings or early dismissals, the THS Preschool Lab will follow the protocols of Torrington Public Schools. Please listen to the radio or T.V. news for announcements. With delayed openings (90 minutes, 2 hours or 3 hours) the morning class will be canceled for that day, and the afternoon class will run at the normal time.

Attendance:

Children are expected to attend the preschool lab the assigned days per week unless ill or arrangements are made in advance. In the case of an absence, please notify us in advance whenever possible. The direct phone number to call is 860-294-4720.

For more information, please feel free to visit our website link on the main website for Torrington Public Schools. www.Torrington.org
PARENT/GUARDIAN PERMISSION FOR
MEDIA PUBLICATION
OF PERSONALLY IDENTIFIABLE INFORMATION

I have reviewed Torrington Board of Education Regulations and Policy No. and understand the reasons for granting Torrington Public Schools appropriate permission.

Student Name______________________________

Name of School______________________________

I certify that I am the parent or legal guardian of the above mentioned individual and am authorized to give permission and consent.

☐ Permission is given for the above-named student(s) photograph, digital image or published school related works to appear in print, web pages, videotapes; public and/or commercial television.

☐ Permission is not given for the above-named student(s) photograph, digital image or published school related works to appear in print, web pages, videotapes; public and/or commercial television.

______________________________
Signature of Parent/Guardian

______________________________
Date
PAYMENT SCHEDULE

SEPTEMBER #1
OCTOBER #2
NOVEMBER #3
DECEMBER #4
JANUARY #5
FEBRUARY #6
MARCH #7
APRIL #8
MAY #9
JUNE #10

TOTAL: $1600.00 FOR YEAR
     $160.00 PER INSTALLMENT
Checks payable to: THS Central Treasury
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
Does your child have dental insurance? Y N
Does your child have HUSKY insurance? Y N

* If applicable

If your child does not have health insurance, call 1-877-CT-HUSKY

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
Any allergies to food, bee stings, insects Y N
Any allergies to medication Y N
Any other allergies Y N
Any daily/ongoing medications Y N
Any health problems Y N
Any problems with vision Y N
Any major illness or injury Y N
Uses contacts or glasses Y N
Weight concerns Y N
Any hearing concerns Y N
Any concerns breathing or coughing Y N

Developmental — Any concern about your child’s:
1. Physical development Y N
2. Movement from one place to another Y N
3. Social development Y N
4. Emotional development Y N
5. Ability to communicate needs Y N
6. Interaction with others Y N
7. Behavior Y N
8. Ability to understand Y N
9. Ability to use their hands Y N

Sleeping concerns Y N
High blood pressure Y N
Eating concerns Y N
Toiletting concerns Y N
Birth to 3 services 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
# Immunization Record

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

<table>
<thead>
<tr>
<th>Vaccine (Month/Day/Year)</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
<th>Dose 4</th>
<th>Dose 5</th>
<th>Dose 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP/DTaP/DT</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>IPV/OPV</td>
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<tr>
<td>MMR</td>
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<tr>
<td>Measles</td>
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<tr>
<td>Mumps</td>
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<tr>
<td>Rubella</td>
<td></td>
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<tr>
<td>Hib</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Hepatitis A</td>
<td></td>
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<td></td>
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<tr>
<td>Hepatitis B</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCV* vaccine</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Rotavirus</td>
<td></td>
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<td></td>
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<tr>
<td>MCV**</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tdap/Td</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Pneumococcal conjugate vaccine**

**Meningococcal conjugate vaccine**

### Disease history for varicella (chickenpox)

- Exemption: Religious ______
- Medical: Permanent ______
- Temporary ______
- Date ______

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

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

1. Laboratory confirmed immunity also acceptable
2. Physician's 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 of the child completed the primary series before age 13 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 receive 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