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., Ms., 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., Ms., 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., Ms., 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

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)

<table>
<thead>
<tr>
<th>Brothers</th>
<th></th>
<th>Sisters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Date of Birth</td>
<td>School</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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!!
THS Preschool Lab Policies- updated 9/8/21

The Torrington High School Pre-School Lab is an integral part of Child Development classes amongst THS students. High school students will observe and participate in preschool activities relating to the different stages of child development (personal/social, cognitive, physical). All high school students are supervised at all times by the Lead Teacher and paraprofessional in the classroom.

The preschool day includes a variety of large and small group learning experiences including Circle Time and Read-Aloud, Free Play and Center Time, Fine and Gross Motor Games, Art, Music, Math, Science and Outdoor Experiences. All children are encouraged to explore their individuality and independence as well as share and cooperate with peers. The 4-year old students work on a variety of Kindergarten Readiness skills. It is strongly encouraged that your child be potty trained prior to entering the program.

**Hours of Operation:**

3 year olds: Monday, Tuesday, Thursday, and Friday 9:00-11:30am  
(half-day schedule: 9-11am)  
4 year olds: Monday, Tuesday, Thursday and Friday 12:20-2:50pm  
(half-day schedule: 11am-1pm)  
*There is no class on Wednesdays for students*

Please be prompt in dropping off and picking up your children. There is no parking in the bus/fire circle, please park in the lot and bring your child right to our door to ensure safety. Families will received a yearly calendar that we follow, as well. During inclement weather, preschool will follow TPS protocols. When there is a delay, the morning class is canceled that day; when there is an early dismissal, the afternoon class is canceled that day.

**Attendance:**

Attendance is extremely important, however, if your child is ill we ask that you call or email to let us know as much in advance as possible. The direct number to the preschool is (860) 294-4720. You may also email the teacher at any time at jnikirk@torrington.org. For more information, visit our link on the main TPS website at www.torrington.org.

Thank you for you interest in the Preschool Lab! 😊
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

Ensuring Student Privacy and Safety...
Adopted May 7, 2003
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
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**

<table>
<thead>
<tr>
<th>Child’s Name (Last, First, Middle)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>☐ Male ☐ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street, Town and ZIP code)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian Name (Last, First, Middle)</td>
<td>Home Phone</td>
<td>Cell Phone</td>
</tr>
<tr>
<td>Early Childhood Program (Name and Phone Number)</td>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>☐ American Indian/Alaskan Native ☐ Hispanic/Latino</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Black, not of Hispanic origin ☐ Asian/Pacific Islander</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ White, not of Hispanic origin ☐ Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Health Care Provider:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Dentist:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Insurance Company/Number* or Medicaid/Number*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child have health insurance? ☐ Y ☐ N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child have dental insurance? ☐ Y ☐ N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child have HUSKY insurance? ☐ Y ☐ N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* If applicable

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**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.

<table>
<thead>
<tr>
<th>Any health concerns</th>
<th>Y ☐ N</th>
<th>Frequent ear infections</th>
<th>Y ☐ N</th>
<th>Asthma treatment</th>
<th>Y ☐ N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies to food, bee stings, insects</td>
<td>Y ☐ N</td>
<td>Any speech issues</td>
<td>Y ☐ N</td>
<td>Seizure</td>
<td>Y ☐ N</td>
</tr>
<tr>
<td>Allergies to medication</td>
<td>Y ☐ N</td>
<td>Any problems with teeth</td>
<td>Y ☐ N</td>
<td>Diabetes</td>
<td>Y ☐ N</td>
</tr>
<tr>
<td>Any other allergies</td>
<td>Y ☐ N</td>
<td>Has your child had a dental examination in the last 6 months</td>
<td>Y ☐ N</td>
<td>Any heart problems</td>
<td>Y ☐ N</td>
</tr>
<tr>
<td>Any daily/ongoing medications</td>
<td>Y ☐ N</td>
<td>Very high or low activity level</td>
<td>Y ☐ N</td>
<td>Emergency room visits</td>
<td>Y ☐ N</td>
</tr>
<tr>
<td>Any problems with vision</td>
<td>Y ☐ N</td>
<td>Weight concerns</td>
<td>Y ☐ N</td>
<td>Any major illness or injury</td>
<td>Y ☐ N</td>
</tr>
<tr>
<td>Uses contacts or glasses</td>
<td>Y ☐ N</td>
<td>Problems breathing or coughing</td>
<td>Y ☐ N</td>
<td>Any operations/surgeries</td>
<td>Y ☐ N</td>
</tr>
<tr>
<td>Any hearing concerns</td>
<td>Y ☐ N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Developmental — Any concern about your child’s:**

<table>
<thead>
<tr>
<th>1. Physical development</th>
<th>Y ☐ N</th>
<th>5. Ability to communicate needs</th>
<th>Y ☐ N</th>
<th>Sleeping concerns</th>
<th>Y ☐ N</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Movement from one place to another</td>
<td>Y ☐ N</td>
<td>6. Interaction with others</td>
<td>Y ☐ N</td>
<td>High blood pressure</td>
<td>Y ☐ N</td>
</tr>
<tr>
<td>7. Behavior</td>
<td>Y ☐ N</td>
<td>8. Ability to understand</td>
<td>Y ☐ N</td>
<td>Eating concerns</td>
<td>Y ☐ N</td>
</tr>
<tr>
<td>9. Ability to use their hands</td>
<td>Y ☐ N</td>
<td>10. Ages to 3 services</td>
<td>Y ☐ N</td>
<td>Toileting concerns</td>
<td>Y ☐ N</td>
</tr>
<tr>
<td>3. Social development</td>
<td>Y ☐ N</td>
<td>Preschool Special Education</td>
<td>Y ☐ N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Emotional development</td>
<td>Y ☐ N</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**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**

ED 191 REV. 3/2015 C.G.S. Section 10-16q, 10-20g, 19a.75(a), 19a-87b(2) P.H. Code Section 19a-79-5a(2)(2), 19a-87b-10b(2)
# Immunization Record

**Child’s Name:**

**Birth Date:**

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>
<td></td>
<td></td>
<td></td>
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<tr>
<td>IPV/OPV</td>
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<tr>
<td>MMR</td>
<td></td>
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</tr>
<tr>
<td>Measles</td>
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<tr>
<td>Mumps</td>
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<tr>
<td>Rubella</td>
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<tr>
<td>Hib</td>
<td></td>
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<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>
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</tr>
<tr>
<td>Varicella</td>
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<tr>
<td>PCV* vaccine</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Rotavirus</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>MCV**</td>
<td></td>
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<tr>
<td>Influenza</td>
<td></td>
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<tr>
<td>Tdap/Td</td>
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</tr>
</tbody>
</table>

**Disease history for varicella (chickenpox)**

<table>
<thead>
<tr>
<th>Exemption:</th>
<th>(Date)</th>
<th>(Confirmed by)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical: Permanent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>†Recertify Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 (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>
</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>
</tr>
<tr>
<td>MMR</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>1 dose after 1st birthday¹</td>
<td>1 dose after 1st birthday¹</td>
<td>1 dose after 1st birthday¹</td>
<td>1 dose after 1st birthday¹</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>
</tr>
<tr>
<td>Hib</td>
<td>None</td>
<td>1 dose</td>
<td>2 doses</td>
<td>2 or 3 doses depending on vaccine given²</td>
<td>1 booster dose after 1st birthday²</td>
<td>1 booster dose after 1st birthday²</td>
<td>1 booster dose after 1st birthday²</td>
<td>1 booster dose after 1st birthday²</td>
</tr>
<tr>
<td>Varicella</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>1 dose after 1st birthday³</td>
<td>1 dose after 1st birthday³</td>
<td>1 dose after 1st birthday³</td>
<td>1 dose after 1st birthday³</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 birthday⁴</td>
<td>1 dose after 1st birthday⁴</td>
<td>1 dose after 1st birthday⁴</td>
<td>1 dose after 1st birthday⁴</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>1 dose after 1st birthday⁵</td>
<td>1 dose after 1st birthday⁵</td>
<td>1 dose after 1st birthday⁵</td>
<td>1 dose after 1st birthday⁵</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>
</tr>
</tbody>
</table>

1. Laboratory confirmed immunity also acceptable
2. Physical 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 13 months. Children who receive the first dose of Hib vaccine 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:**

**Date Signed:**

**Printed/Stamped Provider Name and Phone Number:**