

KINDERGARTEN REGISTRATION

Name: _____
(Last) (First) (Middle)

Date of Birth: _____

Male (M) or
Female (F) _____

Place of Birth: _____

Address: _____

Mailing address *if different* than address listed above:

Child Resides With: _____ Father/Mother _____ Father _____ Mother _____ Other

Alternate mailing Name/Address: _____
(For non-custodial parent, guardian, or separated household)

Parent's Name: _____

Parent's Name: _____

Home Phone: _____

Home Phone: _____

Work Phone: _____

Work Phone: _____

Cell Phone: _____

Cell Phone: _____

Email Address: _____

Email Address: _____

Names of Brothers/Sisters: _____

DOB: _____

DOB: _____

DOB: _____

Please list those we may contact in case we are unable to reach you during the day.

Name of Contact	Relationship to Child	Phone Number(s)	Cell Number

Do you give the school nurse permission to contact your child's Pediatrician or the School Doctor in an emergency if you or your contacts cannot be reached? _____ Yes _____ No

Does your child have any allergies or special needs we should be aware of? _____ Yes _____ No

If yes, please explain: _____

Child's Pediatrician: _____ Phone: _____

Name of previous school attended (if applicable): _____

Regional School District No. 6

Registration & Residency Checklist

Student's Name: _____

PROOF OF RESIDENCY

Homeowners (Choose one)

_____ Mortgage Statement

_____ Property Tax Statement

_____ Insurance Policy

Renters

_____ Current Rental Agreement

AND

_____ Current Utility Bill

(electric, gas, or cable television, no telephone bills. All documentation must be in the same name and same address.)

(Principal's Signature)

(Date)

REGIONAL SCHOOL DISTRICT NO. 6
Goshea - Morris - Warren

AFFIDAVIT FOR PURPOSES OF RESIDENCY
(Local Resident)

STATE OF CONNECTICUT)
)ss:
COUNTY OF _____)

Personally appeared _____, who made oath to the following:

- 1. I am a resident of the Town of _____, State of Connecticut. My residence is located at _____
(street address)
- 2. A child by the name of _____ currently resides with me at the address stated above.
- 3. I receive _____ (pay) (no pay) _____ for provided such residence.
(cross out inapplicable response)
- 4. I intend such residence to be _____ (temporary) (permanent).
(cross out inapplicable response)

Subscribed and sworn to
before me, this _____
day of _____, 20____

Notary Public Signature

Notary Seal

REGIONAL SCHOOL DISTRICT NO. 6
Goshea - Morris - Warren

AFFIDAVIT FOR PURPOSES OF RESIDENCY
(Parent of Guardian)

STATE OF CONNECTICUT)
)ss:
COUNTY OF _____)

1. I am a (parent) (guardian) of _____
(cross out inapplicable response) *(name of child)*

2. I reside at _____ in the Town of _____
(street address) _____, State of Connecticut.

3. _____ currently (does not) (does)
(name of child) *(cross out inapplicable response)*
reside with me.

4. It is my intention that _____ reside with _____
(name of person) of the Town of _____, State of Connecticut, and that such residence be (permanent) temporary
(cross out inapplicable response)

5. I (do) (do not) now pay nor do I intend to pay
(cross out inapplicable response) _____ for allowing _____
(name of person) to reside with _____
(him/her)

Subscribed and sworn to
before me, this _____
day of _____, 20____

Parent or Guardian

Notary Public Signature

Notary Seal

Regional School District No. 6

98 WAMOGO ROAD • LITCHFIELD, CT 06759-3204 • (860) 567-7400
SERVING THE TOWNS OF WARREN, MORRIS AND GOSHEN

Welcome to our school!

We have a few questions about languages spoken at home. We are required by the US Department of Education to ask for this information because it will help us know how we can best support your child. The language information also helps us know how we can best communicate with you. Please share with us the language(s) spoken by your family and in your home.

Student information

Student first name:

Student last name:

Date of birth:

1) What is the primary language used in the home, regardless of the language spoken by the student?

2) What is the language most often spoken by the student?

3) What is the language the student first acquired?

Parent/guardian name (please print) _____

Parent/guardian signature _____

Date _____

Thank you for answering these questions. We look forward to working with your child.

10-11-17

Regional School District No. 6 does not discriminate on the basis of race, color, national origin, sex, disability, or age in its programs and activities and provides equal access to the Boy Scouts and other designated youth groups. The following people have been designated to handle inquiries regarding the non-discrimination policies:

Title IX Contact
Debbie Delisle
98 Wamogo Road, Litchfield, CT 06759
860-567-7400

Section 504 Contact
Debra Foley
98 Wamogo Road, Litchfield, CT 06759
860-567-6642

HEALTH UPDATE

STUDENT'S NAME: _____

Grade: _____

In the space below, list any changes that have occurred in your child's physical condition since the last date of attendance in school (i.e. glasses, contacts, ear tubes, hearing aids, etc.) along with the date prescribed.

In order that the school health program meets your child's needs, please complete the information below:

Does your child have any of the following conditions? If yes, please explain.

- | | | | | |
|----|--------------------|-----|----|--------------------|
| 1. | Heart condition | Yes | No | Comments: |
| 2. | Asthma | Yes | No | |
| 3. | Diabetes | Yes | No | _____ |
| 4. | Emotional issue | Yes | No | _____ |
| 5. | Allergies | Yes | No | Allergic to: _____ |
| | Describe reaction: | | | _____ |
| 6. | Seizures disorder | Yes | No | Explain: |
| 7. | Any other disorder | Yes | No | Explain: |
| 8. | Operations | Yes | No | Explain: |

If your child is currently on medication, please list the name of the medication and the dosage:

Connecticut State Statutes specifies that **NO MEDICATION** (including over-the-counter) may be given to a student without a **medication administration authorization** form filled out by the doctor and signed by the doctor and the parent or guardian. Cough drops, however, may be given by the school nurse with consent from a parent. (Not given to Pre-kindergarten students)

- Do you grant permission to the school nurse to administer **cough drops** to your child if necessary?
Yes _____ No _____
- In case of accident or serious illness, I request school personal contact me or any emergency contacts. If school personnel are unable to contact me or my emergency contacts, they may make the necessary arrangements.
Yes _____ No _____
- In the absence or unavailability of the school nurse, I give permission for a qualified school employee to administer epinephrine to my child if they are experiencing a life threatening undiagnosed allergic reaction.
Yes _____ No _____

Parent / Guardian Signature: _____

Date: _____