



Welcome to Valley View Community School Kindergarten Class of 2034

Dear Parent/Guardians:

We are writing this letter to inform you of the Kindergarten Screening process and to try to answer any questions that you may have. Your child will meet with a few different friendly staff members to assess some of his/her skills and also just to get to know him/her. This is not something they need to study for or anything they need to worry about! It is designed to be fun for them and to give our staff a chance to assess your child's development. If the staff member finds that there are areas that your child would benefit from working over the summer to prepare for kindergarten then they will give you that information at screening. The following are some of the different staff members and what they will be doing with your child:

Speech and Language: Speech and language will be looking at your child's expressive (how they put words together into sentences) and receptive (how they are understanding language being spoken to them) language skills. They will also gather some information on how your child is producing their speech sounds (articulation) in words and sentences.

Occupational Therapy: OT looks at "fine motor" skills or how your child uses their eyes and hands together to print, draw, glue, cut and color. They will also check to see how your child interacts with their environment through their senses, for example are they sensitive to touch or loud noises? How is their attention span?

School Nurse: The nurse will check your child's height, weight, ears and eyes. If there are any medical concerns or questions you have for the nurse then this is an opportunity for you to ask.

Screening Teachers: This is the opportunity for our teachers to meet the incoming students. They follow a standardized test to assess where your child is academically. Your child will be asked about letter recognition, number identification, counting, shape identification, biographical information, writing, and drawing.

School Counselor: The School Counselor will meet with you while your child is visiting all those friendly staff members. This will be the time where you can share all the wonderful things about your child and if there are any concerns you have about your child entering kindergarten.

Bus Coordinator: Lynn Ellis, will talk to you about transportation for your child once they enter kindergarten.

Registration Packets are due June 1st. And must include the following information to be considered a completed packet:

- All Registration paperwork must be completed
- Child's Birth Certificate
- Child's last physical exam and shot record
- Proof of Residency (lease or mortgage paperwork, or utility bill)
- Court paperwork if applicable

Kindergarten Screening will be held June 14th through June 22nd. You will sign up for your child's screening time via Signup Genius, so make sure you include your email address on the registration form. Signups will begin on June 7th and will be on a first come, first serve basis.

We look forward to meeting all of our new Valley View Kindergarten students! If you have any questions, please feel free to contact us at 755-4757.

With a warm welcome,
Blake McGurty , Principal

Valley View Community School

Student Information

Student Name: _____ Date of Birth: _____ Grade: _____
Home Address: _____ Mailing Address: Same as Home Address Homeroom: _____
City, State, Zip: _____ Different: _____ Place of Birth: _____
Home Phone: _____
Email Addresses: _____ Court Orders Filed: yes / no Gender: _____
Please Notify the School with Written Restrictions or Court Orders

Home Language **Circle all the numbers that pertain to your child**
English (00) French (01) Spanish (02) Chinese (03) Greek (04) Finnish (05) Italian (06)
Portuguese (07) Polish (08) Japanese (09) American Sign (10) Vietnamese (11)
German (12) Other (99)

Ethnicity **Circle all numbers that pertain to your child**
(1)-American Indian/Alaskan Native (2)-Asian (3)-Hispanic/Latino
(4)-Black (5)-White (6)-Native Hawaiian or other Pacific Islander (7)-Black/White

Parent/Guardian Information

Mothers Name: _____ Custodial Parent
Mailing Address: _____ check if the same as above
if different: _____ **Home Phone:** _____
Employer Name: _____ **Cell Phone:** _____
Employer Phone: _____

Fathers Name: _____ Custodial Parent
Mailing Address: _____ check if the same as above
if different: _____ **Home Phone:** _____
Employer Name: _____ **Cell Phone:** _____
Employer Phone: _____

Guardians Name: _____
Mailing address: _____ check if same as above
if different: _____ **Home Phone:** _____
Employer Name: _____ **Cell Phone:** _____
Employer Phone: _____

Step Parent's Name: _____
Mailing Address: _____ check if same as above
if different: _____ **Home Phone:** _____
Employer Name: _____ **Cell Phone:** _____
Employer Phone: _____

Emergency Contact Information:

Please list three other adults who would be willing to assume temporary care of your child and/or be contacted in case of our inability to contact a parent or guardian.

Contact 1 Name	Relationship	Daytime Phone Number	Cell Phone
_____	_____	_____	_____
Contact 2 Name	Relationship	Daytime Phone Number	Cell Phone
_____	_____	_____	_____
Contact 3 Name	Relationship	Daytime Phone Number	Cell Phone
_____	_____	_____	_____

Notes:

Student Name: _____

In case of an unexpected early dismissal due to an emergency situation (i.e.: snow storm) my child should:

___ Follow regular end of day procedure

___ Walk to the home of: _____ Phone: _____

___ Take bus _____ to the home of: _____ Phone: _____

___ Be picked up by: _____ Phone: _____

___ My child has been instructed in the procedure to follow if there is an emergency dismissal from school. In the event of an area of school emergency, all SAU 61 students will follow their school's emergency guidelines.

In case of accident or serious illness, I request that the school call me. If the school is unable to reach me, I authorize the school to call the emergency contacts listed on the previous page. The school may also make whatever arrangements seem necessary, including calling an ambulance and transporting my child to the nearest hospital, unless otherwise instructed.

Parent Signature: _____ Date: _____

Please indicate YES or NO on the following with your initials on the appropriate line.

HANDBOOK: I/We have read the Student Handbook with my/our student. YES NO
___ ___

INTERNET PERMISSION: I/We have read and signed the technology form with my/our student. YES NO
___ ___

VIDEO RELEASE: Permission is hereby granted for my student to participate in photographed and videotaped school activities. I understand that such photographs and videotaped productions are being used for educational and/or school related purposes only, and that as such, these photos and programs may be printed in local newspapers and/or shown on local cable television stations or the district website. I also understand that these photos and programs will not be duplicated or sold for profit. YES NO
___ ___

WEBSITE PERMISSION: I will allow my child's writing, picture, movie or sound recording to be published on the school website. YES NO
___ ___

NEWSPAPER: I grant permission for my child's photo to appear in the newspaper. YES NO
___ ___

HOME COMPUTER ACCESS: Does your child have access to a computer at home? YES NO
___ ___

HOME COMPUTER INTERNET ACCESS: Does your home computer have internet access? YES NO
___ ___

PARENT IN MILITARY: Does your child have a parent or guardian that is actively enlisted and/or deployed? If yes please circle: mother, father, step-mom, step-dad, guardian, other: _____ YES NO
___ ___

SOCIAL DIRECTORY: We would like to offer a social directory which can be used by families to make contact with other families in their class and will be given to the whole class. This would be helpful in setting up play dates, planning birthday parties etc. Would you like to be part of this network? YES NO
___ ___

SCHOOLWIDE TITLE 1: I have read the Title 1 letter and understand my rights as a parent of a student attending a schoolwide Title 1 school. YES NO
___ ___

PTA: Parent Teacher Association YES NO
___ ___

Parent Signature: _____ Date: _____

Previous School Information:

Name of School: _____

Town: _____ City: _____

Does your child have an IEP or 504? _____

Parent Information Form

Child's Full Name _____ Date _____

Date of Birth _____ Phone _____

Form filled out by (name) _____ Relationship _____

We have found the following information important in helping the school understand and work with your child. Please answer the questions with as much detail and as objectively as you can. Please list, in order, (oldest first) the first and last names of all the children and adults in your family. Please include step-children and step parents and any other people living in your household. Include the child who you are registering today so that we may see where he/she fits in the family. If a child is not living at home, please indicate. Thank you for taking the time to fill this out.

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

1. What is your child's living situation? (i.e. spends weekends at father's house; spends school week at mother's house; lives with both parents 7 days a week, etc.)

2. Age child crawled _____ walked _____ talked _____ completely toilet trained _____

3. Were there any difficulties during pregnancy or at birth? Birth weight? _____
(i.e. was child premature?)

4. Is child a bed wetter or do they wet/soil their pants during the day? _____

5. Can child dress unassisted? _____ Tie own shoes? _____

6. Has your child ever received any special services/support? (i.e., speech, OT, PT, counseling, neurological exam) _____

(over)

7. If there has been a death, a divorce, or an emotional/behavioral issue, please specify.

8. Please list 3-5 strengths that you feel your child has.

-
-
-
-
-

9. Please write down any concerns you have about your child (i.e. has a quick temper; very shy; has difficulties with transition; depends on others to tell them what to do; needs help in the bathroom, etc.)

10. Please share any additional comments below that you would want our school to know.

Valley View Community School

Health Information and Medication Sheet

Student: _____ Date of Birth _____

Parent: _____

Doctor Name and Phone Number _____

Does your child have any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Ear Tubes |
| <input type="checkbox"/> Behavioral issues | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Nutritional Concerns |

Stomach/Bowel Problems

Orthopedic (bone or muscle) Problems

Kidney/Urinary Tract Problems

Please list and explain any allergies to food, medication or insects. _____

Does your child take any medications on a regular schedule? Yes No

If yes, list any prescription or over the counter medications your child takes and why.

***A doctor's note is needed for all prescription medications.

Will medication need to be given at school? _____ What time? _____

If your child has asthma, what inhalers are used at home? _____

At school? _____

Does your child have any history of serious illness, surgery or injury? Yes No

If yes, explain. _____

Please turn this paper over.

Over the Counter Medication (OTC) Authorization Form

Before any child can receive an OTC medication at school, the parent/guardian must sign this form giving permission. Please put your initials on the following OTC medications you would like your child to receive at the discretion of the school nurse. If you do not want your child to receive any of these, please initial the last one.

***Please note: If your child needs chewable Tylenol, please send it in.**

Antibiotic ointment [cuts] (Bacitracin) _____

Anti itch gel [rashes] (Calagel) _____

Chewable Tylenol _____

Acetaminophen [headaches] (Tylenol) _____

Ibuprofen [muscle/joint pain] (Advil) _____

Cough drops _____

Antacid tablets [stomach] (Tums) _____

Benadryl [allergy, rash or swelling] _____

ALL OF THE ABOVE! _____

I DO NOT want my child to receive any of the above OTC medications at this time. _____
(initial)

Parent Signature _____ Date _____

A phone call will be attempted for any significant symptoms that your child may present. Please keep the nurse informed of any phone number changes. If unable to reach a parent by phone, a note will be written regarding any important or unusual issues.

All medications sent to the nurse's office must be in the original container with the child's name on it!

Is there anything that we need to know about your child or family that would help us to understand them better?

TITLE XV EDUCATION

CHAPTER 200 HEALTH AND SANITATION

School Health Services

Section 200:32

200:32 Physical Examination of Pupils. – There shall be a complete physical examination by a licensed physician, physician assistant, or advanced practice registered nurse of each child prior to or upon first entry into the public school system and thereafter as often as deemed necessary by the local school authority. The result of the child's physical examination shall be presented to the local school officials on a form provided by the local school authorities. No physical examination shall be required of a child whose parent or guardian objects thereto in writing on the grounds that such physical examination is contrary to the child's religious tenets and teachings.

Source. 1971, 499:1. 1996, 277:1, eff. Aug. 9, 1996. 2009, 54:5, eff. July 21, 2009.



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
BUREAU OF INFECTIOUS DISEASE CONTROL

Lori A. Shibinette
 Commissioner

Lisa M. Morris
 Director

29 HAZEN DRIVE, CONCORD, NH 03301
 603-271-4482 1-800-852-3345 Ext. 4482
 Fax: 603-271-3850 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

New Hampshire
School Immunization Requirements 2021-2022

Refer to page 2 for minimum ages and intervals

Diphtheria, Tetanus, and Pertussis DTaP DT/DTP Tdap/Td	6 years and under: 4 or 5 doses with the last dose given on or after the 4 th birthday 7 years and older: 3, 4, or 5 doses with the last dose given on or after the 4 th birthday Grades 7-12: 1 dose of Tdap is required for entry into 7 th grade
Polio	Grades K-9: 3 or 4 doses with the last dose given on or after the 4 th birthday and the last 2 doses separated by 6 months or more Grades 10-12: 3 doses, with the last dose given on or after the 4 th birthday OR 4 doses regardless of age at administration
Hepatitis B	Grades K-12: 3 doses at acceptable intervals
Measles, Mumps, and Rubella MMR	Grades K-12: 2 doses; the first dose must be administered on or after the 1 st birthday
Varicella (Chicken Pox)	Grades K-12: 2 doses with the first dose administered on or after the 1 st birthday OR laboratory confirmation of immunity

- Children must have proof of all required immunizations, documentation of immunity, or valid exemptions, in order to be admitted or enrolled in any school in New Hampshire. Documentation of immunity by confirming laboratory test is acceptable for Measles, Mumps, Rubella, Varicella, and Hepatitis B.
- A child may be “conditionally” enrolled when the parent or guardian provides:
 - 1) Documentation of at least one dose for each required vaccine; AND
 - 2) The appointment date for the next dose of required vaccine.
- All immunizations must meet minimum age and interval requirements for each vaccine. A 4-day grace period is allowed; however, live attenuated vaccines (MMR, Varicella, or nasal influenza vaccine) that are not administered on the same day must be administered at least 28 days apart.
- Medical and religious exemptions have specific requirements. Information is available at: <https://www.dhhs.nh.gov/dphs/immunization/exemptions.htm>
- The 2021 Immunization Schedule from the CDC’s Advisory Committee on Immunization Practices can be found here: <https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html>

Minimum Age & Interval Schedule for Valid Vaccine Doses - New Hampshire School Immunization Requirements 2021/2022

Vaccine	Dose #	Minimum Age	Minimum Interval Between Doses	Notes
Diphtheria, Tetanus, and Pertussis DTaP	DTaP – Dose 1	6 weeks	4 weeks between Dose 1 & 2	<p>All children must have a valid dose on or after the 4th birthday.</p> <p>For children 6 years and under, the 5th dose is not necessary if the 4th dose was administered at age 4 years or older and is at least 6 months after the previous dose.</p> <p>* A 4th dose inadvertently administered as early as age 12 months may be counted if at least 4 months since dose 3.</p> <p>If dose 1 is given at age 7 or older, only 3 doses are needed (as long as 6 months between dose 2 and 3); can be Tdap or Td as long as one of the doses is Tdap.</p> <p>Students are required to have a dose of Tdap prior to 7th grade.</p> <p>* Tdap given on or after the 7th birthday meets this requirement per NH Administrative Rule He-P 301.14.</p>
	DTaP – Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	DTaP – Dose 3	14 weeks	6 months between Dose 3 & 4*	
	DTaP – Dose 4	12 months	6 months between Dose 4 & 5	
	DTaP – Dose 5	4 years	-----	
Tetanus, Diphtheria, and Pertussis Tdap	Tdap – Dose 1	7 years	<i>ACIP recommends that children age 7 through 9 years who receive Tdap or DTaP inadvertently or as part of a catch-up series should receive the routine Tdap dose at 11–12 years.*</i>	
	IPV – Dose 1	6 weeks	4 weeks between Dose 1 & 2	
	IPV – Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	IPV – Dose 3	14 weeks	4 weeks to 6 months between Dose 3 & 4*	
Polio IPV	IPV – Dose 4	4 years	-----	<p>*Kindergarten through 9th Grade: 3 or 4 doses, with one dose on or after the 4th birthday and at least 6 months after the previous dose.</p> <p>If a combined IPV/OPV polio schedule was used, the total number of doses needed is the same as an all IPV schedule.</p> <p>Any OPV dose(s) given on or after April 1, 2016 do not count towards the polio vaccine requirement and the series must be completed with IPV.</p>
	HepB – Dose 1	Birth	4 weeks between Dose 1 & 2	<p>Minimum age for Dose 3 is at least 24 weeks of age.</p>
	HepB – Dose 2	4 weeks	8 weeks between Dose 2 & 3	
	HepB – Dose 3	24 weeks	16 weeks between Dose 1 & 3	
MMR – Dose 1	12 months	4 weeks between Dose 1 & 2		
Measles, Mumps, and Rubella MMR	MMR – Dose 2	13 months	-----	<p>Live attenuated vaccines not administered on the same day must be administered at least 28 days apart.</p>
	VAR – Dose 1	12 months	12 weeks between Dose 1 & 2*	<p>Live attenuated vaccines not administered on the same day must be administered at least 28 days apart.</p> <p>*If first dose administered at age 13 or older, the minimum interval between Dose 1 and Dose 2 is 4 weeks.</p>
VAR – Dose 2	15 months	-----		

Pre-school Students 3-5 Years Old

New Hampshire Immunization Requirements 2021-2022

Refer to page 2 for minimum ages and intervals

DIPHTHERIA, TETANUS, PERTUSSIS (DTaP/DTP/DT)

3-5 years	Four doses. The 3 rd and 4 th dose must be separated by at least 6 months.
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POLIO

3-5 years	Three doses. Any OPV dose(s) given on or after April 1, 2016 does not count toward the polio vaccine requirement and the series must be completed with IPV.
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MEASLES, MUMPS, and RUBELLA (MMR)

3-5 years	One dose. This dose must be administered on or after age 12 months.
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HAEMOPHILUS INFLUENZAE TYPE B (Hib)

3-5 years	One dose on or after 15 months of age OR Four doses with the last dose administered on or after 12 months of age OR see catch-up schedule below* Hib is not required for children \geq 5 years of age.
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HEPATITIS B

3-5 years	Three doses given at acceptable intervals. See attached schedule (page 2)
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VARICELLA (CHICKEN POX)

3-5 years	One dose. This dose must be administered on or after age 12 months. OR laboratory confirmation of chicken pox disease.
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*Hib catch-up vaccination schedule:

- If unvaccinated at 15-59 months: 1 dose needed.
- If dose 1 given before 12 months and dose 2 before 15 months, 3rd and final doses must be 8 weeks after dose 2.
- If dose 1 given at 7-11 months, dose 2 must be at least 4 weeks later and 3rd and final dose given at 12-15 months or 8 weeks after dose 2 (whichever is later).
- If dose 1 given at 12-14 months, 2nd and final dose must be at least 8 weeks after dose 1.
- If **PedvaxHIB** brand used, call NHIP for recommended schedule and requirements for dosing.

Brand Names for Vaccines

Alphabetical List

May be used as a reference when reviewing immunization records.
This is a list of many vaccine brand names.

Not all are required for school, pre-school, or childcare admittance.

Brand Name	Vaccine(s)/Abbreviation
ActHIB®	Haemophilus influenzae type b (Hib)
Adacel®	Tetanus, Diphtheria, Pertussis (Tdap)
Boostrix®	Tetanus, Diphtheria, Pertussis (Tdap)
Daptacel®	Diphtheria, Tetanus, Pertussis (DTaP)
DT	Diphtheria, Tetanus (DT)
Engerix B®	Hepatitis B (HepB)
Hiberix®	Haemophilus influenzae type b (Hib)
Infanrix®	Diphtheria, Tetanus, Pertussis (DTaP)
Ipol®	Polio (IPV)
Kinrix®	Diphtheria, Tetanus, Pertussis (DTaP) & Polio (IPV)
M-M-R II	Measles, Mumps, Rubella (MMR)
Pediarix®	Diphtheria, Tetanus, Pertussis (DTaP), Polio (IPV), & Hepatitis B (HepB)
PedvaxHIB®	Haemophilus influenzae type b (Hib)
Pentacel®	Diphtheria, Tetanus, Pertussis (DTaP), Polio (IPV), & Haemophilus influenzae type b (Hib)
ProQuad®	Measles, Mumps, Rubella & Varicella (MMRV)
Quadracel®	Diphtheria, Tetanus, Pertussis (DTaP) & Polio (IPV)
RecombivaxHB®	Hepatitis B (HepB)
TDVAX™	Tetanus, Diphtheria (Td)
Tenivac®	Tetanus, Diphtheria (Td)
Varivax®	Varicella (Chicken Pox, VAR)

See <https://www.cdc.gov/vaccines/terms/usvaccines.html> for other vaccine brand names.

**SAU #61 FARMINGTON
PHYSICAL EXAMINATION**

NAME: _____ DOB: _____ SEX: M F GRADE: _____

PHYSICIAN'S NAME: _____

WT: _____ HT: _____ ALLERGIES: _____

LEAD LEVEL _____

HEARING: R ear _____ L ear _____ VISION: R eye _____ L eye _____

Eyes _____ Ears _____ Nose _____ Throat _____ Teeth _____

Lungs _____ Heart _____ Chest _____ Liver _____ Spleen _____

Abdominal masses or problems: _____

Bowels: _____ Bladder: _____

Joint Function:

Neck _____ Shoulder _____ Elbows _____ Wrists _____ Hands _____

Hips _____ Knees _____ Ankles _____ Feet _____

Neurological _____ Seizures _____ Medication _____

Diabetes _____ Asthma _____ ADD/ADHD _____ Medication _____

Description of any abnormal findings that would impact upon learning:

Is the child taking any prescription medications? _____ Name of medication: _____

PLEASE ATTACH A COPY OF THE IMMUNIZATION RECORD

I certify that I have examined this student and he/she may compete in all supervised, school athletic and physical education activities.

Date of Exam: _____ Physician Signature: _____

GUIDELINES FOR SENDING AND KEEPING ILL STUDENTS HOME FROM SCHOOL

Information for parents:

Please notify the school nurse of any illness or medical condition for which your child is being treated or monitored.

A parent, guardian or designated contact will be notified immediately to pick up a child from school who presents any of the following conditions:

- Signs or symptoms of a communicable disease
- Localized rash causing acute discomfort or systemic rash of undetermined origin as a sign of potential illness
- An oral temperature greater than 100 degrees
- Signs or symptoms of acute illness, serious accident/injury
- Vomiting (not related to a single event such as gagging, positioning, mucous, eating)
- Diarrhea of two or more loose, watery stools
- Asthma symptoms that do not respond to prescribed medication, or no prescribed medication is available at school for treatment of asthma symptoms
- Diabetes with a blood sugar greater than 400 and positive ketones or inadequate supplies to treat diabetes at school
- Uncontrolled coughing
- Pink eye or purulent conjunctivitis (defined as pink or red conjunctiva with white or yellow discharge). The student must receive treatment for 24 hours before returning to school or provide a note from a health care provider stating that the condition is not contagious and the student may return to school.
- Lice or nits. Parent is notified, but student does not have to go home until the end of the school day. Written instructions, which have been provided by the school nurse, are sent home with the student. Appropriate treatment, according to written instructions, must be given before the student can return to school. The student should be returning to school within 2 days.
- According to the assessment of the Nurse, if staying in the classroom is counterproductive to the student's education, or the safety and wellness of others, a decision may be made to send the student home
- Any child kept home or sent home from school should remain home until they are symptom free without medication for 24 hours. (Except as stated above for lice and pink eye)
- Any additional guidelines necessary for special needs students will be addressed in the Individualized Health Care Plan
- In the event of a student medical emergency, school personnel may call 911 and the student may be transported to a medical facility via ambulance. The cost of services provided by ambulance, private physician, clinic, hospital, or dentist remain the responsibility of the parent/guardian and will not be assumed by the school district or district personnel.

The Farmington School District and the Department of Education requires all school employees to report and issues of suspected child abuse including medical neglect to the guidance department and to Child Protective Services. Our goal is to provide a safe, health environment that promotes learning for all students.

Home Language Survey

School: _____ District: _____ Date: _____

Student Information			
First name:	Last name:	Date of Birth:	Gender: <input type="checkbox"/> female <input type="checkbox"/> male
Country of Birth:	Date of entry in U.S.:	Date first enrolled in a U.S. school: Month Year	Current grade:

Family Information	
Name of parent/legal guardian:	Phone number:
Address:	<input type="checkbox"/> Please translate school notices. Language _____

Questions for Parents/Guardians	Response
Please list all languages spoken in your home.	
Which language did your child first hear or speak?	
If English is the only language listed, stop here. If another language is listed, please answer the rest of the questions.	
Which language(s) do you speak to your child?	
Which language(s) does your child speak at home with adults?	
Which language(s) does your child speak at home with other children?	

For parents and guardians: If a language other than English is listed above, an ESOL teacher will test your child to find out if he or she can speak, understand, read, and write well in English. The results will be sent to you within 30 days. Based on the results of the test, your child may be eligible to enroll in an English language (ESOL) class at school. Parents/guardians may accept or decline ESOL program services for their child.

Instructions for survey administrator:

1. Please provide an interpreter when necessary.
2. If responses indicate a language other than English, please contact the ESOL teacher and provide her/him with a copy of this survey. Date of referral to ESOL teacher: _____
3. File original Home Language Survey in student's cumulative folder.

***Farmington School District
Farmington, NH***

Policy # 5117 - Legal Residency of A Student

Legal residency for the purpose of enrollment in a district school shall be defined by RSA 193:12 as amended in 1997 and effective January 1, 1998. RSA 193:12 states "...the legal residence of a pupil shall be as follows: In the case of a minor, the legal residence is where his or her parents reside except that:

- (1) If the parents live apart and are not divorced, legal residence is the residence of the parent with whom the child resides.
- (2) In a divorce decree where parents are awarded joint legal custody, the legal residence of a minor child is the residence of the parent with whom the child resides. If a parent is awarded sole or primary physical custody by a court of competent jurisdiction in this or any other state, legal residence of a minor child is the residence of the parent who has sole or primary physical custody. If the parent with sole or primary physical custody lives outside the state of New Hampshire, the pupil does not have residence in New Hampshire.
- (3) If the minor is in the custody of a legal guardian appointed by a New Hampshire court of competent jurisdiction or a court of competent jurisdiction in another state, territory or country, legal residence is where the guardian resides. If the department of health and human services has been appointed legal guardian the residence of the minor is where the child is placed by the department or the court. Legal guardianship shall not be appointed solely for the purpose of allowing a pupil to attend school in a district other than the district of residence of the minor's parent or parents. Whenever a petition for guardianship or legal custody is filed in a court of competent jurisdiction on behalf of a relative of a child, other than a parent, the child shall be permitted to attend school in the district in which the relative of the child resides pending a court determination relative to custody or legal guardianship."

Completion and Notarization of Parent or Guardian Residency Affidavit and proof of residency such as a utility bill, rent receipt, lease copy or mortgage statement in the Parent or legal guardian's name and address, is required.

It is a crime in the State of New Hampshire to make a sworn false statement.

Chapter 641:3 states "Unsworn Falsification – A person is guilty of a misdemeanor if:

- I. He or she makes a written or electronic false statement which he or she does not believe to be true, on or pursuant to a form bearing a notification by law to the effect that false statements made therein are punishable; or
- II. With a purpose to deceive a public servant in the performance of his or her official function, he or she:
 - a) Makes any written or electronic false statement which he or she does not believe to be true; or
 - b) Knowingly creates a false impression in a written application for any pecuniary or other benefit by omitting information necessary to prevent statements therein from being misleading; or
 - c) Submits or invites reliance on any writing which he or she knows to be lacking in authenticity; or
 - d) Submits or invites reliance on any sample, specimen, map, boundary mark, or other object which he or she knows to be false.
- III. No person shall be guilty under this section if he or she retracts the falsification before it becomes manifest that the falsification was or would be exposed. "

Chapter 643:7--Tampering with Public records or Information states: "A person is guilty of a misdemeanor if he:

- I. Knowingly makes a false entry in or false alteration of anything belonging to, received or kept by the government for information or record, or required by law to be kept for information for the government; or
- II. Presents or uses anything knowing it to be false, and with a purpose that it be taken as a genuine part of information or records referred to in paragraph I; or
- III. Purposely and unlawfully destroys, conceals, removes or otherwise impairs the verity or availability of any such thing.

Re-adopted by the Board: August 17, 2009

FARMINGTON SCHOOL DISTRICT
PARENT RESIDENCY AFFIDAVIT

STATE OF NEW HAMPSHIRE
COUNTY OF STRAFFORD

_____ being duly sworn under the pain and penalty of perjury,
hereby states the following under oath:*

1. I am the parent of _____, a student in the Farmington School District.
2. I have joint legal custody with _____, the child's _____ and have not surrendered the custody or control of said child to another person.
3. I also have primary physical custody of said child and I have not surrendered care, custody or control of said child to any other person.
4. I continue to be the primary provider of financial support and day-to-day care for the said child.
5. My permanent domicile and principal residence is located at _____ within the Farmington School District. _____ lives with me at that Farmington address.
6. Documentation in support of the statements contained in this affidavit is annexed hereto and intended to be incorporated herein.
7. I make this affidavit with knowledge that the Farmington School District will rely upon the truth of the statements set forth herein in determining the legal residence of the aforementioned child within the Farmington School District and his or her right to be provided with a tuition-free education in accordance with the Education Law of the State of New Hampshire

* IT IS A CRIME IN THE STATE OF NEW HAMPSHIRE TO MAKE A SWORN FALSE STATEMENT. (See attached).

Signed under the pains and penalty of perjury this _____ day of _____, 20__.

PARENT

STATE OF NEW HAMPSHIRE
STRAFFORD, SS.

The above-named _____ personally appeared before me on this _____ day of _____, 20__ executed the foregoing, acknowledged that the contents of same are true and correct to the best of his or her knowledge, and acknowledged that he/she executed the same as his/her free act and deed.

Notary Public/Justice of the Peace
My Commission Expires: _____