

Westerly Public Schools
Central Registration
23 Highland Avenue, Babcock Hall
401-315-1502 (call for an appointment)
401-348-2707 (fax)
mbarber@westerly.k12.ri.us



Registration Packet Preschool & Kindergarten

Documents/Forms Required for Registration:

- Completed Student Registration Packet (Pre-K & Kindergarten registration must also complete Development Survey)
- Child's Original Birth Certificate or Passport
- Child's Immunization Records and Physical
- Proof of Residency (see below)
- Custody Papers (if applicable)
- Parent/Guardian Driver's License/State ID
- To make an appointment to register your child you must call the Student Registration Office at 401-315-1502.

If you are having difficulty presenting any of the required information, please let us know when scheduling your appointment.

Acceptable forms of Proof of Residency:

- Rental/Lease Agreement/Mortgage Statement
 - Current Utility Bill
 - Westerly Property Tax Bill
 - State Housing Letter
-

Are you a Military Family? Please check one of the following:

☐ **Active** ☐ **Guard** ☐ **Reserves**

It is the policy of Westerly Public Schools not to discriminate in its education programs, activities, or employment policies on the basis of age, color, gender, national origin, race, religion, sexual orientation, or disability. If special accommodations are needed, please call 401-315-1502, 48 hours in advance.

Westerly Public Schools

Student Registration Form (please complete one form for each child to be enrolled)

STUDENT INFORMATION

SASID#

LASID#

Student Name _____
First Middle Last

Preferred Name _____ Gender M/F Date of Birth: _____

Place of Birth: _____ Entering Grade _____ School Year _____

STUDENT RESIDENCE INFORMATION

Home Address _____
Street Address Apt# City State Zip

Mailing Address (if different from above) _____ Home Phone _____

Are you currently *sharing* your home with another family? Y N

If **yes**, does this family have children who attend Westerly Public Schools? Y N If yes, please list student/school below.

Student Name	School Name	Student Name	School Name

HEAD OF HOUSEHOLD INFORMATION

FAMILY#

Student lives with (circle one): Both Parents Mother Father Guardian Other (specify) _____

Status of parents (check one): Married Divorced Widowed Separated Single/Never Married

If divorced, who has legal custody? Mother Father **(PLEASE ATTACH COPIES OF LEGAL DOCUMENTS)**

Is there a custodial agreement in place? Yes Sole Joint

Current Restraining Order? Yes No Expiration Date: _____

Are you the biological/adoptive parent(s) of the child? Yes No If no, your relationship: _____

Father/Guardian

Mother/Guardian

Name: _____

Name: _____

Address: _____

Address: _____

Home Phone: _____ Home Phone: _____

Cell/Pager: _____ Cell/Pager: _____

Email: _____ Email: _____

Employer: _____ Employer: _____

Work Phone: _____ Work Phone: _____

Student Registration Form (Continued)

MILITARY: Are you or your spouse in active military? YES _____

Please indicate Branch of Military (if applicable) _____

SPECIAL SERVICES

Has your child received any of the following services? (Please circle all that apply)

Gifted Education

Individual Education Plan (IEP)

504 Individualized Accommodation Plan

SIBLINGS

Does your child have any siblings that attend Westerly Public Schools?

Name	Date of Birth	Grade	School

EMERGENCY CONTACT INFORMATION

LASID#

LOCAL DAYTIME CONTACT OTHER THAN PARENT/GUARDIAN:

ONLY the following **adults** may be notified and are authorized to accept responsibility for this child in case of illness/emergency or in the event the child is dismissed before the close of school.

Relationship	Name	Home Phone	Cell Phone
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Relationship	Name	Home Phone	Cell Phone
--------------	------	------------	------------

Relationship	Name	Home Phone	Cell Phone
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STUDENT TRANSPORTATION NEEDS

Does your child need wheelchair transportation? Y N Seatbelt/Harness (if stated in IEP) Y N

Circle one choice for AM and one choice for PM

AM:	Bus	Walker	Drop-Off	PM:	Bus	Walker	Pick-Up
-----	-----	--------	----------	-----	-----	--------	---------

In the event of early school closing (inclement weather) and in the event that no one is at home, my child has been instructed to follow this contingency plan:

IF NO CONTINGENCY PLAN IS IN PLACE, your child will be taken back to the school they attend to await pick up by parent or designated contact. PLEASE BE AWARE that police may be contacted.

I certify that I have completed this registration form to the best of my knowledge.

Printed Name:

Relationship:

Date:

Westerly Public Schools

Race/Ethnicity Identification Form

Student's Name:

First

Middle

Last

Gender: ____Male____Female

Date of Birth:_____

Grade: _____

Ethnicity/Race Information – Part A & B New Federally Mandated Questions

Please answer both questions.

Part A – Ethnicity:

Is the student Hispanic or Latino? (Choose one only)

____YES

____NO

Part B – Race:

What is the student's race? (*Choose one or more*)

____American Indian or Alaska Native

____Asian

____Black or African American

____Native Hawaiian or Other Pacific Islander

____White

Definition of Race and Ethnic Categories Used for Federal Reporting

Ethnicity

Hispanic

➤ A person of Cuban, Mexican, Puerto Rican, South Central American or other Spanish culture or origin, regardless of race.

Race Categories:

American Indian or Alaska Native

➤ A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian

➤ A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American

➤ A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander

➤ A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White

➤ A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Parent/Guardian Signature

Date

August 2009



Angélica Infante-Green
Commissioner

State of Rhode Island and Providence Plantations
DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Shepard Building
255 Westminster Street
Providence, Rhode Island 02903-3400

Home Language Survey (HLS)

Dear Parent or Guardian,

The information requested on this form is necessary for the most appropriate school placement of your child, and will not be used for any other purposes¹.

Thank you for your collaboration.

To be completed by Parent or Guardian

Student Name:		
First	Middle	Last
Date of Birth:		Place of Birth²:
Month	Day	Year
Parent or Guardian Relationship to student:		
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other		

Home Language Code:

Language Background

(Please check all that apply)

1. What is the primary language used in the home, regardless of the language spoken by the student?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____	<i>Specify</i>
2. What is the language most often spoken by the student?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____	<i>Specify</i>
3. What is the language that the student first acquired?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____	<i>Specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____	<i>Specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not speak	<i>Specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not read	<i>Specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not write	<i>Specify</i>

¹ Required by Rhode Island Law (R.I.G.L. § 16-54-2) and the Equal Educational Opportunity Act (20 U.S.C. §1703(f))

² Families are not required to provide the place of birth, but providing the information can help LEAs to better prepare to be culturally responsive.

Last Updated: 4/30/2020

Telephone (401)222-4600 Fax (401)222-6178 TTY (800)745-5555 Voice (800)745-6575 Website: www.ride.ri.gov
The R.I. Board of Education does not discriminate on the basis of age, sex, sexual orientation, gender identity/expression, race, color, religion, national origin, or disability.

Family Interview – Educational History	
1. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.	
Yes* <input type="checkbox"/>	No <input type="checkbox"/>
Not sure <input type="checkbox"/> *If yes, please explain: _____	
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe	
2a. Has your child ever been referred for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes*	
If referred for an evaluation, has your child been identified? <input type="checkbox"/> No <input type="checkbox"/> Yes	
*If referred for an evaluation, and identified has your child ever received any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____	
2b. Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)	
2c. Does your child have an Individualized Education Program (IEP), or 504 plan? <input type="checkbox"/> No <input type="checkbox"/> Yes	
3. In which language do you prefer to receive oral communications from the school or district?	<input type="checkbox"/> English <input type="checkbox"/> Other _____ Specify
4. In which language do you prefer to receive written communications from the school or district?	<input type="checkbox"/> English <input type="checkbox"/> Other _____ Specify
5. Indicate date first enrolled in ANY U.S. school _____ (mm/dd/yyyy)	
Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.) _____ _____	

Month: _____ Day: _____ Year: _____
Date

Signature of Parent or Guardian _____

Print Parent/Guardian Name _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLS		
Name: _____		Position: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS: _____		
NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLS AND CONDUCTING INDIVIDUAL INTERVIEW		
Name: _____		Position: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS: _____		
Oral Interview Necessary: <input type="checkbox"/> YES <input type="checkbox"/> NO		Date of Individual Interview: _____ Month Day Year
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING THE LANGUAGE SCREENING ASSESSMENT		
Name: _____		Position: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS: _____		
NAME/POSITION OF QUALIFIED PERSONNEL REPORTING THE LANGUAGE SCREENING SCORES		
Name: _____		Position: _____
Date of Screener: _____ Month Day Year	Name of the Language Screening Assessment: _____	Score achieved: _____
Proficiency Level Achieved: Entering 1 <input type="checkbox"/> / Beginning 2 <input type="checkbox"/> / Developing 3 <input type="checkbox"/> / Expanding 4 <input type="checkbox"/> / Bridging 5 <input type="checkbox"/> / Reaching 6 <input type="checkbox"/>		
FOR STUDENTS WITH AN IEP OR 504 PLAN, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED:		

Westerly Public Schools
23 Highland Avenue
Westerly, RI 02891

**AUTHORIZATION FOR RELEASE OF
CONFIDENTIAL INFORMATION AND RECORDS**

Records to be released to:

☐ Dunns Corners School
8 1/2 Plateau Road
Westerly, RI 02891
Phone 401-348-2320
Fax 401-348-2325

☐ Springbrook School
39 Springbrook Road
Westerly, RI 02891
Phone 401-348-2296
Fax 401-348-2305

☐ State Street School
35 State Street
Westerly, RI 02891
Phone 401-348-2340
Fax 401-348-2345

☐ Westerly Middle School
10 Sandy Hill Road
Westerly, RI 02891
Phone 401-315-1601
Fax 401-348-2752

☐ Westerly High School
23 Ward Avenue
Westerly, RI 02891
Phone 401-315-1501
Fax 401-315-1611

☐ Central Registration
23 Highland Avenue
Westerly, RI 02891
Phone 401-315-1502
Fax 401-348-2707

Dear Sir or Madam:

The below named student has registered in the Westerly Public Schools. We are requesting that all academic and health records be forwarded to the address indicated above. Thank you in advance for your immediate attention to this request.

Sincerely,
Dr. Mark Garceau
Superintendent

Student's Full Legal Name (maiden name if applicable)

Grade OR Date of Graduation

PREVIOUS SCHOOL INFORMATION
Please enclose a copy of this request with the records

School Name: _____

Street Address: _____

City/Town/Zip: _____

Attention: _____

Phone: _____ Fax: _____

In order to receive the necessary records from your son/daughter's previous school, it is required that a release form be signed. The following form, signed by the **parent or legal guardian** of the above named student, will grant the Westerly Public Schools the necessary permission to request and receive any and all previous school records.

I hereby authorize the release of records for the above named student to the Westerly Public Schools.

Date: _____ Signature: _____
Parent/Legal Guardian/Student if over 18 Relationship to Student

Westerly Public Schools
Special Education Office 23 Highland Avenue
Westerly, RI 02891

**Authorization for Release of Information
Special Education Records**

Date: _____

Regarding _____ DOB: _____
Student Name

I/We hereby authorize the Westerly School Department to: _____ release to and/or _____ obtain from:

Name: _____
(Name of School, Medical Facility, Person, Agency, Organization)

Address: _____ Phone: _____

Special Education Documentation

<input type="checkbox"/> All Special Education Records	<input type="checkbox"/> Evaluation Team Summary
<input type="checkbox"/> Eligibility Statement	<input type="checkbox"/> Meeting Minutes
<input type="checkbox"/> IEP	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Psychological Assessment	<input type="checkbox"/> Social History
<input type="checkbox"/> Neuropsychological Assessment	<input type="checkbox"/> Speech Language Assessment
<input type="checkbox"/> Educational Assessment	<input type="checkbox"/> Occupational Therapy Assessment
<input type="checkbox"/> Clinical Psychological Assessment	<input type="checkbox"/> Physical Therapy Assessment
<input type="checkbox"/> Psychiatric Evaluation Assessment	<input type="checkbox"/> Adaptive PE Assessment
<input type="checkbox"/> Neurological Assessment	<input type="checkbox"/> Vision and Mobility Assessments
<input type="checkbox"/> Medical Assessment	<input type="checkbox"/> Observations
<input type="checkbox"/> Assistive Technology Assessment	<input type="checkbox"/> Functional Behavior Assessments
<input type="checkbox"/> Consultation	<input type="checkbox"/> Other

This information is needed for the following purpose:

I/We understand information released/received by either party identified above cannot be released to any third party without my/our express written authorization. Further, I/We understand any of the records which involve alcohol, drug abuse, or HIV (AIDS) testing are processed under Federal Regulation 42 CFR, Confidentiality of Alcohol and Drug Abuse, and RI Public Law Ch. 88-405, Sec. 23.

This authorization shall be effective one year from date signed and can be withdrawn at any time.

Signed: _____	_____
Parent or Legal Guardian	Student if Age 18
_____	_____
Relationship	Date

Westerly Public Schools

Residency Policy

Residency Requirements

1. Policy

- 1.1 Only children who reside in Westerly, residency being defined by the Rhode Island General Laws 16-64-1, and who are legally under control of the adults with whom they reside shall be allowed to attend the Westerly Public Schools.
- 1.2 Parents of non-resident children may request, in writing, from the Superintendent of Schools, permission for a child or children to attend Westerly Public Schools at a tuition rate established by the School Committee. Transportation for non-resident students will not be provided.
- 1.3 Parents or guardians who will be leaving Westerly prior to the end of the school year may request, in writing, permission to allow their children to attend Westerly Public Schools in accordance with the provisions of Rhode Island General Law 16-64-8. When a student changes his/her residence during the course of a semester, the student shall be allowed to complete the semester in Westerly. If the student is a senior or about to enter his/her senior year, the student shall be allowed to complete his/her senior year in Westerly as long as the student has sufficient credits which will enable him/her to graduate upon completion of one additional year.

Parents or guardians who will be moving to Westerly soon after the school year begins may request, in writing, permission to allow their children to attend Westerly Public Schools. Said request must include any Purchase and Sale Agreement or Lease Agreement for the intended place of residence and a projected date of occupancy for the residence. Parents will be required to pay tuition beginning on the first day and must make, at a minimum, payment for the quarter. If the parents take up residency in the community within forty-five (45) school days from the start of school, the tuition will be refunded in full. If residency takes place after the forty-fifth (45th) school day, tuition will then be charged on a per diem rate for all days attended as a non-resident.

2. Procedure

- 2.1 Affidavit of Residence will be required to be completed by all enrolled students.
- 2.2 Each principal shall submit to the Superintendent of Schools the name of any student in his/her school whom he/she suspects may not be residents of Westerly.
- 2.3 The Superintendent shall investigate each referral to insure residence requirements are enforced.

Central Registration Office

23 Highland Avenue
Westerly, RI 02891
401-315-1509
Fax: 401-348-2707

AFFIDAVIT OF RESIDENCE

Must be completed within 48 hours (two business days)

Must be signed in the presence of a Westerly Public Schools Central Registration Notary.

The undersigned, being a parent or duly appointed guardian of _____,
an un-emancipated minor, hereby certifies that the following information is true, complete and accurate. It is understood that this
information is sought and will be called upon by the Westerly Public Schools for the purpose of determining the residence of the
named child for school purposes.

The School Committee requires proof of residency documents such as lease/rental agreement, electric bill, etc.

Name of child _____

Child's residence _____

Length of child's residence at this address _____

Name of child's parents(s) _____

Parent(s) address _____

If parents reside in a different city or town, which parent has actual custody of the child?

Name of legal guardian _____

Guardian's address _____

Guardian appointed by _____

Does child reside with parent or legal guardian? _____

If child does not reside with parent or legal guardian, with whom does child reside?

Please state relationship to child _____

Child's residence during last school year _____

If child does not reside with parent or legal guardian, please state reason(s) _____

I understand that only residents of the Town of Westerly who are otherwise eligible are entitled to be educated by the Town of
Westerly without charge.

Affiant

STATE OF RHODE ISLAND, COUNTY OF WASHINGTON

Subscribed and sworn to before me this _____ day of _____, _____ by the above named individual
to be his/her free act and deed.

Notary Public

Westerly Public Schools
**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL
INFORMATION AND REPORTS**

I hereby authorize the Westerly Public Schools to obtain/release the following information as marked for the purposes of student registration:

X	Check mark indicates requested forms
	Proof of immunizations
	Proof of physical
	Lead screening
	Vision screening
	PPD results
	Other:

Records are to be released from:

Name of Doctor: _____

Address: _____

Phone: _____ Fax: _____

I understand that the records are protected under the State Confidentiality of Health Care Information Act and Privacy Act as well as the Federal Family Education Rights and Privacy Act and other federal and state law; that I agree to indemnify you for any claims made concerning such release; and state that any information given or received shall not be further released to anyone without first obtaining my additional written consent.

This authorization may be withdrawn by written notice at any further time. This authorization will expire six (6) months from the date below. Mechanical reproduction of this authorization may be accepted as if an original.

Students Name: _____ DOB: _____

Current Address: _____

Consented by: _____
Print Name Date

Relationship to student: _____

Signature: _____

Refused: _____ Date: _____



Department of Health

Three Capitol Hill Providence, RI 02908-5097

TTY: 711

www.health.ri.gov

Permission to provide information to KIDSNET

KIDSNET is a Department of Health information system containing healthcare information, including immunization and lead screening records. The information is shared with authorized healthcare professionals like school nurses and doctors to help assure that children are up to date on immunizations and other preventive health services. Signing this form gives your school nurse permission to share your address and/or immunization information with KIDSNET to help coordinate your health care and assure you have met the immunization requirements for school entry.

I, _____, hereby consent and grant to
(name)

_____ permission to provide
(name of school)

Check all that apply:

_____ Address

_____ Immunization information

to the Rhode Island Department of Health, KIDSNET Program, 3 Capitol Hill, Providence, RI 02908 for the purpose of health care coordination, including correspondence with parents or guardians and assuring that all healthcare providers responsible for verifying immunization status have complete and accurate information:

Student Name: _____

Mailing Address: _____

In signing this consent form, the student and/or the student's parent or legal guardian agrees to permit the release of these records.

Signature of Parent/legal guardian
(for students under age 18)

Signature of student
(for students 18+ years of age)

Printed name of Parent/legal guardian

Printed name of student

Date: _____

Date: _____

Medical and Developmental History Form

Name of Child _____ Date of Birth _____ M _____ F _____

Address _____ Telephone Number _____

Mother's Name _____ Father's Name _____

Address _____ Address _____
(if different from above) (if different from above)

Physician _____ Date of last physical exam _____

Child's family includes:

Brothers (name and date of birth)

Sisters (names and date of birth)

The following medical and developmental history is confidential. Your responses will be shared with professional personnel only if the information learned will help in planning your child's educational program.

1. **GENERAL HEALTH HISTORY**

Please check any of the following problems that your child may have experienced:

_____ Allergy to insect stings	Epipen? _____
_____ Allergies (other than above)	Epipen? _____
_____ Asthma _____ Inhaler?	Other: _____
_____ Cerebral Palsy	_____ Diabetes
_____ Epilepsy	_____ Heart Condition
_____ Orthopedic	_____ Speech Defect
_____ Hearing Problem	_____ Vision Problem
_____ Urinary Problem	_____ Surgeries or Hospitalization?
_____ Other (please specify) _____	

If your child is currently under treatment or experiencing any medical conditions, please describe the current problem and include any information about current treatment including medication, restrictions, etc.

Please list any immunizations, communicable diseases, serious injuries and/or operations or hospitalizations your child has had in the **past year**:

REMINDER: Any medication that needs to be administered to your child by a school nurse/teacher during school hours requires a completed physician's form (WO-123) from the prescribing physician. A copy of the Administration of Medication Form (WO-123) and/or Westerly Public Schools Policy Relating to Administering Medication to Children in School is available upon request.

Signature _____ Relationship _____

Westerly Public Schools
Addendum to Medical and Developmental History Form

**TO BE FILLED OUT ONLY IF REGISTERING A STUDENT
FOR PRE-SCHOOL OR KINDERGARTEN.**

Name of Child _____

Date of Birth _____ M _____ F _____

Were there any unusual circumstances during pregnancy, labor, delivery or in the time immediately following birth (caesarian delivery, forceps, prematurity, oxygen required for the baby, jaundice, etc.)? _____

If yes, please explain _____

Child's Birth Weight _____

Language Development

At what age did your child first begin to speak? Give approximate age if you do not remember the exact age:

First words: _____

Two or three words together _____

Sentences _____

Does your child:	<u>YES</u>	<u>NO</u>
1. Stutter?	_____	_____
2. Have difficulty expressing ideas and concepts?	_____	_____
3. Have difficulty being understood by other people?	_____	_____
4. Participate in a speech or language therapy program?	_____	_____

What years? _____ Provider _____

Motor Development

This child began walking at age (if guess, label as such) Age _____

Do you feel your child has adequate large muscle coordination?	<u>YES</u>	<u>NO</u>
	_____	_____

Does your child:	<u>YES</u>	<u>NO</u>
1. Catch a ball thrown to him/her?	_____	_____
2. Enjoy physical activities?	_____	_____
3. Lose balance, trip and fall more often than normal?	_____	_____
4. Have difficulty running?	_____	_____
5. Usually walk on tiptoes?	_____	_____

Westerly Public Schools
Addendum to Medical and Developmental History Form

Visual Development

	YES	NO
Has your child ever been examined by an eye doctor?	_____	_____
When? _____ By whom? _____		
Results _____		
Glasses prescribed? _____	_____	_____
Does your child:	YES	NO
1. Squint?	_____	_____
2. Have eyes that turn in?	_____	_____
3. Have eyes that turn out?	_____	_____
4. Sit very close to the television?	_____	_____
5. Rub eyes a lot?	_____	_____ Turn head to use
primarily one eye?	_____	_____
6. Lower one side of head when looking at others?	_____	_____

Hearing Assessment

	YES	NO
Has your child ever had any ear/hearing examination/treatment?	_____	_____
When? _____ By whom? _____		
Results _____		
Tubes in ears? _____ Date _____		
	YES	NO
Do you suspect your child has any hearing problems?	_____	_____
Does your child:		
1. Seem to have difficulty hearing?	_____	_____
2. Turn up the TV louder than others?	_____	_____
3. Seem to favor one ear over the other?	_____	_____
4. Jump or appear to be more startled than others		
if there is a sudden noise?	_____	_____
5. Seem to hear you if you talk in a whisper?	_____	_____
6. Make you talk loudly or repeat frequently?	_____	_____
7. Become confused in following more than two verbal		
directions at a time?	_____	_____
8. Have difficulty remembering things for a long time?	_____	_____
9. Have difficulty remembering things for a short time?	_____	_____

Westerly Public Schools
Addendum to Medical and Developmental History Form

Social Development

Does your child:	YES	NO
1. Have regular playmates the same age?	_____	_____
2. Have difficulty getting along with other children?	_____	_____
3. Prefer to play with other children instead of alone?	_____	_____
4. Become easily frustrated?	_____	_____
5. Cry often?	_____	_____
6. Have frequent temper tantrums?	_____	_____
7. Become frequently irritated or moody?	_____	_____
8. Become upset by changes in routine?	_____	_____
9. Demand much individual adult attention?	_____	_____
10. Accept discipline and limits?	_____	_____

Is there any other information that will help us understand this child?

+++++

Previous School Experience (including Preschool)

Year

Name /Location of School

Would you like an individual conference with the school nurse?_____Social Worker?_____

Other (please specify) _____

Thank you for your patience in filling out this questionnaire.

Signature_____Relationship_____Date_____

