

Mr. Thomas K. Ruscio, Principal

Jabish Brook Middle School

truscio@belchertownps.org

Ms. Sarah Strout, Assistant Principal

Jabish Brook Middle School

sstrout@belchertownps.org

JABISH BROOK MIDDLE SCHOOL **NEW STUDENT REGISTRATION**

Please submit the following records when registering your student. The school nurse will review all medical information and this information will be kept strictly confidential.

- Completed Registration Form
- Proof of Residency: 2 Forms Required (Please provide one from each category)
Mortgage Statement or Rental Agreement
Utility Bill at the address listed (electricity, heating, or phone)
- Birth Certificate
- Immunization Records / Recent Physical
- IEP (if applicable)
- Grades and Testing Scores from Previous School Attended
- Discipline Record from Previous School Attended

Please visit our website at www.belchertownps.org

Click on schools

Click on Jabish Brook Middle School

Mr. Thomas K. Ruscio, Principal

Jabish Brook Middle School

truscio@belchertownps.org

Ms. Sarah Strout, Assistant Principal

Jabish Brook Middle School

sstrout@belchertownps.org

RELEASE OF RECORDS CONSENT FORM

STUDENT NAME: _____ **DOB:** _____

In compliance with state and federal laws, permission is required of a parent, legal guardian or eligible student before any records can be released from/to an outside agency, school or college. In order to comply with this law, your signature is required.

I hereby grant permission for release of the following documents and communications:

Verbal Communication: _____

Standardized Tests/Transcript of Grades: _____

Health Records: _____

Transfer Card/Discipline Statement: _____

Special Education Records: _____

Other Contact Persons: _____

Other Evaluations: _____

RELEASED FROM/TO:

RELEASED TO/FROM:

**Belchertown Public Schools
Jabish Brook Middle School
62 N. Washington Street
Belchertown, MA 01007**

Parent/Advocate/Legal Guardian Signature

Date

BELCHERTOWN PUBLIC SCHOOLS

School Registration Form

For Office Use Only

- Cold Spring
- Swift River
- Chestnut Hill

- Jabish Brook
- Belchertown High

SASID: _____ Bus In: _____
Teacher: _____ Bus Out: _____
Grade: _____ Student ID: _____
Enroll Date: _____

STUDENT INFORMATION

Last Name: _____ First Name: _____ Middle Name (no initial): _____
Date of Birth: _____ Male/Female/Non-binary: _____ Home Phone: _____
Place of Birth (City/State/Country): _____ Has this student ever attended Belchertown Public Schools? Yes No

HOME ADDRESS (Do not list a PO Box)

Street Name / Apartment: _____ Town / Zip: _____

MAILING ADDRESS (if different from above)

Street Name / PO Box / Apartment: _____ Town / Zip: _____

ETHNICITY, RACE, and LANGUAGE

Under federal law, we must report this information to ensure that students are not denied any rights or benefits. If you choose, you may identify your child according to the following categories. If you do not choose to do so, we will use our best judgment.

- Choose **ONE** of the following: Hispanic or Latino NOT Hispanic or Latino
- Choose **ONE OR MORE**: American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

ADDITIONAL SERVICES

Please note any special services your child has received in the past.

- Special Education (IEP) 504 Accommodation Plan Title I
- Free or Reduced Lunch Sheltered English Immersion English as a Second Language

PARENT / GUARDIAN #1

Last Name: _____ First Name: _____ Relationship to Student: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ Occupation: _____ Place of Employment: _____
Does this person have legal custody of the student? Yes No Does this person live in the same house as the student? Yes No Address (if different): _____

PARENT / GUARDIAN #2

Last Name: _____ First Name: _____ Relationship to Student: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ Occupation: _____ Place of Employment: _____
Does this person have legal custody of the student? Yes No Does this person live in the same house as the student? Yes No Address (if different): _____

PARENT / GUARDIAN #3

Last Name: _____ First Name: _____ Relationship to Student: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ Occupation: _____ Place of Employment: _____
Does this person have legal custody of the student? Yes No Does this person live in the same house as the student? Yes No Address (if different): _____

EMERGENCY CONTACT (if parent/guardian cannot be reached)

Name (Last, First): _____ Relationship: _____ Address: _____ Phone: _____
Cell: _____

AUTOMATED NOTIFICATIONS

Belchertown Public Schools communicates with families using autodialed messages to telephones, including cellular phones. If you DO NOT wish to receive autodialed messages to certain numbers, you may opt out at any time by contacting the office of your child's school.

If you would like to receive text messages on your cellular phone, please text "Y" to 67587.

LEGAL AND CUSTODIAL INFORMATION

Do both parents have custody and parental rights with respect to this student? Yes No

If not, which of the following applies? Mother guardian with joint custody Father guardian with joint custody Other (specify): _____
 Mother guardian with sole custody Father guardian with sole custody

Are there any court orders in effect with respect to this student that should concern the school? Yes (explain) _____
 No

CHILDREN UNDER 18 IN HOUSEHOLD

Name (Last, First): Birthdate: Name (Last, First): Birthdate:
Name (Last, First): Birthdate: Name (Last, First): Birthdate:
Name (Last, First): Birthdate: Name (Last, First): Birthdate:

PREVIOUS SCHOOL

Name of School: Address:
Phone Number: Fax Number: Grade: Teacher's Name:

MILITARY FAMILY STATUS

Does this child have a parent/guardian for whom any of the following are true? On active military duty. Died on active duty in past 12 months.
 Retired or medically discharged in past 12 months. None of the above.

CHECKLIST AND SIGNATURE

In addition to this form, the school district requires copies of the following documents, which will be kept as part of the student's record according to state and federal records laws:

- Birth certificate
- Immunization records
- Physical examinations
- Complete school discipline records (if applicable)
- Special education records and/or ADA records (if applicable)
- Any court documents pertaining to custody, restraining orders, and/or guardianship (if applicable)
- Proof of residency: **2 forms required**
 - Mortgage statement or rental agreement/lease
 - Utility bill at the address listed (heating, electricity, or phone)

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

For office use only:

All forms received
 Some forms received. Forms still outstanding: _____

Signature of staff member receiving forms: _____ Date: _____

The Belchertown School District does not discriminate on the basis of age, sex, race, religion, color, national origin, sexual orientation, or disability in accordance with applicable laws and regulations.

Respect ~ Responsibility ~ Relationship ~ Rigor ~ Reflection ~ Resilience Revised 6/26/2017

Home Language Survey

Massachusetts Department of Elementary and Secondary Education regulations require that *all* schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. If a language other than English is spoken in the home, the District is required to do further assessment of your child. Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

Student Information		
First Name _____	Middle Name _____	Last Name _____
		Gender F <input type="checkbox"/> M <input type="checkbox"/>
Country of Birth _____	Date of Birth (mm/dd/yyyy) _____	Date first enrolled in ANY U.S. school (mm/dd/yyyy) _____
School Information		
Start Date in New School (mm/dd/yyyy) _____	Name of Former School and Town _____	Current Grade _____
Questions for Parents/Guardians		
What is the primary language used in the home, regardless of the language spoken by the student? _____	Which language(s) are spoken with your child? (include relatives -grandparents, uncles, aunts, etc. - and caregivers) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always	
What language did your child first understand and speak? _____	Which language do you use most with your child? _____	
How many years has the student been in U.S. Schools? (not including pre-kindergarten) _____	Which languages does your child use? (circle one) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always	
Will you require written information from school in your native language? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, what language? _____	Will you require an interpreter/translator at Parent-Teacher meetings? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, what language? _____	
Parent/Guardian Signature: X _____	Today's Date: _____ (mm/dd/yyyy)	

JABISH BROOK MIDDLE SCHOOL

GUIDANCE REGISTRATION

Student's Name: _____ Grade Entering: _____

Today's Date: _____ Planned Date of Entry: _____

Previous School: _____

Phone Number that You can be Reached at: _____

SCHEDULING INFORMATION

▶ Does your child have any special services/plans?

● DCAP

Yes No

● 504

Yes No

● IEP

Yes No

● Health Care

Yes No

● Other (*what kind*) _____

Yes No

If YES, have the current documents been forwarded?

Yes No

▶ Has your child ever received English Language Learner (ELL) instruction?

Yes No

Does your child currently receive ELL support?

Yes No

▶ Has your child had Band in the past?

Yes No

Has your child taken Music lessons?

Yes No

Would your child like to continue or begin Band?

Yes No

Which instrument does your child play? _____

If your child is interested in participating in Band, please contact the Band director, Ms. Smith, at your earliest convenience at (413) 323-0433 ext. 117.

▶ Has your child previously taken a Foreign Language (*Grade 8 students only*)?

Yes No

If YES, Which Language? _____

Which Language is your child interested in taking?

Latin French Spanish

(*Pending availability*)

▶ Would your child like a tour of the school (*pending availability*)?

Yes No

Massachusetts Parental Notice for One Time Consent to Allow the School District To Access MassHealth (Medicaid) Benefits

School District Name and Code: Belchertown Public Schools (0024)

School/District Contact: Student Support Services

Dear Parent/Guardian:

The purpose of this letter is to ask for your permission (also known as consent) to share information about your child with MassHealth. Local communities in Massachusetts have been approved to receive partial reimbursement from MassHealth for the costs of certain health-related services provided by the district to your child (or children). In order for your community to get back some of the money spent on services, the school district needs to share with MassHealth the following types of information about your child: name; date of birth; gender; type of services provided, when, and by whom; and MassHealth ID.

With your permission, the school district will be able to seek partial reimbursement for services provided by MassHealth, including, among others, a hearing test or eye exam; a school physical; occupational or speech or physical therapy; some school nurse visits; and counseling services with the school social worker or psychologist. Each year, the district will provide you with notification regarding your permission; you do not need to sign a form every year.

The school district cannot share with MassHealth information about your child without your permission. As you consider giving permission, please be advised of the following:

1. The school district cannot require you to sign up for MassHealth in order for your child to receive the health-related and/or special education services to which your child is entitled.
2. The school district cannot require you to pay anything towards the cost of your child's health-related and/or special education services. This means that the school district cannot require you to pay a co-pay or deductible so that it can charge MassHealth for services provided. The school district can agree to pay the co-pay or deductible if any such cost is expected.
3. If you give the school district permission to share information with and request reimbursement from MassHealth:
 - a. This will not affect your child's available lifetime coverage or other MassHealth benefit; nor will it in any way limit your own family's use of MassHealth benefits outside of school.
 - b. Your permission will not affect your child's special education services or IEP rights in any way, if your child is eligible to receive them.
 - c. Your permission will not lead to any changes in your child's MassHealth rights; and
 - d. Your permission will not lead to any risk of losing eligibility for other Medicaid or MassHealth funded programs.
4. If you give permission, you have the right to change your mind and withdraw your permission at any time.
5. If you withdraw your permission or refuse to allow the school district to share your child's records and information with MassHealth for the purpose of seeking reimbursement for the cost of services, the school district will continue to be responsible for providing your child with the services, at no cost to you.

I have read the notice and understand it. Any questions I had were answered. I give permission to the school district to share with MassHealth records and information concerning my child(ren) and their health-related services, as necessary. I understand that this will help our community seek partial reimbursement of MassHealth covered services.

Parent/Guardian Signature: _____ Date: _____

Child's Name:	Date of Birth:	SASID # (for district to add):
Child's Name:	Date of Birth:	SASID # (for district to add):
Child's Name:	Date of Birth:	SASID # (for district to add):

[Add more children](#)

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ Male Female Date of Birth: _____
Medical History _____

Pertinent Family History

Current Health Issues

Y **N**
 Allergies: Please list Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen®: Yes No
 Asthma: Asthma Action Plan Yes No (Please attach)
 Diabetes: Type I Type II
 Seizure disorder: _____
 Other (Please specify) _____

Current Medications (if relevant to the student's health and safety) Please circle those administered in school; a separate medication order form is needed for each medication administered in school.

Physical Examination

Date of Examination: _____

Hgt. _____ (____%) Wgt. _____ (____%) BMI: _____ (____%) BP: _____
(Check = Normal / If abnormal, please describe.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

Screening:

	(Pass) (Fail)		(Pass) (Fail)		(Pass) (Fail)
Vision: Right Eye	<input type="checkbox"/> <input type="checkbox"/>	Hearing: Right Ear	<input type="checkbox"/> <input type="checkbox"/>	Postural Screening:	<input type="checkbox"/> <input type="checkbox"/>
Left Eye	<input type="checkbox"/> <input type="checkbox"/>	Left Ear	<input type="checkbox"/> <input type="checkbox"/>	(Scoliosis/Kyphosis/Lordosis)	
Stereopsis	<input type="checkbox"/> <input type="checkbox"/>				

Laboratory Results: Lead _____ Date _____ Other _____

The entire examination was normal:

Targeted TB Skin Testing: Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):

Date of PPD: ____; Results: ____ mm.

Referred for evaluation to: _____ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> Other	

Comments/Recommendations:

Y N This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:

Y N Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record. See Other Side

Signature of Examiner Circle: MD, DO, NP, PA Date _____

Please print name of Examiner.

Group Practice _____ Telephone _____

Address _____ City _____ State _____ Zip Code _____

Please attach additional information as needed for the health and safety of the student.

MDPH 12/14/04

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / /

Sex: M F

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date	Vaccine Type	Vaccine		Date	Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1			Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
	2				2		
	3			Varicella (Var, MMRV)	1		
	4				2		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1			Meningococcal Quadrivalent MenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2				2		
	3			Meningococcal Serogroup B (Men B) MenB-FHbp MenB-4C	1		
	4				2		
	5				3		
	6			Seasonal Influenza Inactivated IIV4, IIV4-ID, IIV3, IIV3- ID, IIV3-HD, RIV3-IM, ccIIV3-IM	1		
	7				2		
	8				3		
Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP- IPV/Hib, Hib-MenCY)	1			Live Attenuated LAIV, LAIV4 (quadrivalent)	4		
	2				5		
	3				6		
	4				7		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP- IPV)	1			2009 H1N1 Influenza Inactivated or Live	1		
	2				2		
	3			Pneumococcal Polysaccharide (PPSV23)	1		
	4				2		
	5				Hepatitis A (HepA, HepA-HepB)	1	
			2				
Pneumococcal Conjugate (PCV13, PCV7)	1			Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1		
	2				2		
	3				3		
	4						
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1			Zoster (shingles)	1		
	2			Other:	1		
	3				2		

Please see next page ➡

CERTIFICATE OF IMMUNIZATION (continued)

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History	
<input type="checkbox"/>	Check the box if this person has a physician-certified reliable history of chickenpox.
Reliable history may be based on:	
<ul style="list-style-type: none"> • physician interpretation of parent/guardian description of chickenpox • physical diagnosis of chickenpox, or • serologic proof of immunity 	

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print): _____ Date: / /

Signature: _____

Facility name: _____