Foster Public School District
Captain Isaac Paine School
160 Foster Center Road
Foster, RI 02825
Telephone 401-647-5100

Michael S. Barnes, Ph. D.
Superintendent

Marcella Terranova Clark
Principal

STUDENT ENROLLMENT REQUIREMENTS

Please abide by the following enrollment requirements:

1. Foster requires **proof of residency.*** *A PO BOX is **not** an acceptable address.* We require **one** of the following:

   a) Current tax bill showing the home owner's name and address of house on which taxes are levied.

   b) Current mortgage statement or insurance bill home owner's name and street address of house.

   c) Valid Rental Agreement for the address of house.

   AND a copy of a valid license, state, or military ID.

2. Foster requires a valid **original** birth certificate and immunizations for the student.

3. R.I.G.L. 16-2-27, ***Kindergarten Grade Eligibility Requirement:*** will have completed 5 years of life on or before September 1 of any school year (FSD Policy #1201**)

4. R.I.G.L. 16-2-25, ***First Grade Eligibility Requirement:*** will have completed 6 years of life on or before September 1 of any school year (FSD Policy #1200**)

5. Foster requires that ***all*** requested information must be provided before any student may start classes.

*Residency will need to be verified.
**Policy can be provided upon written request.

The Foster School Department does not discriminate in accordance with applicable laws and regulations.

Foster Public Schools
Captain Isaac Paine Elementary School
160 Foster Center Rd, Foster, RI 02825
Registration Form

School: _____

School Year: _____

Enrollment Date: _____

Last Name			
First Name			
Middle Name			
Gender			
Grade		YOG	
Date of Birth			
SASID (Office use only)			

Has student been enrolled in a RI School? Yes or No If yes, which district? _____

Former School/School Address: _____

Has student ever been enrolled in Glocester Schools? Yes or No If yes, which school? _____

Student's Physical Home Address:

_____ Street _____ Town _____ Zip Code

Student's Mailing Home Address:

_____ Street _____ Town _____ Zip Code

Is Student Homeless? Yes ☐ No ☐

Parent 1/ Guardian 1 _____ Lives with? Yes or No Address: _____ If different from student

Place of Work: _____ Work Phone: _____

Work Phone: _____ Home/Cell Phone: _____ Email: _____

Parent 2/ Guardian 2 _____ Lives with? Yes or No Address: _____ If different from student

Place of Work: _____ Work Phone: _____

Work Phone: _____ Home/Cell Phone: _____ Email: _____

Are there any Legal issues or dismissal restrictions that the school should be aware of: ☐ Yes ☐ No If yes, a copy MUST be on file in the school

Priority 1 In an emergency Notify/Dismiss to:
Name: _____
Phone: _____
Relationship: _____

Priority 2 In an emergency Notify/Dismiss to:
Name: _____
Phone: _____
Relationship: _____

Priority 3 In an emergency Notify/Dismiss to:
Name: _____
Phone: _____
Relationship: _____

Priority 4 In an emergency Notify/Dismiss to:
Name: _____
Phone: _____
Relationship: _____

Phone numbers to be used for our School-to-Home Alert Calling System.

Phone Alert 1: _____
Email Alert 1: _____

Phone Alert 2: _____
Email Alert 2: _____

Phone Alert 3: _____
Email Alert 3: _____

Information below is required by the Rhode Island Department of Education (Please check each appropriate answer)

Is English the first native language of the student?	☐ Yes	☐ No
Is the student capable of performing ordinary classwork in English? If not, which language? _____	☐ Yes	☐ No
Is the student currently on an Individual Education Plan? IEP	☐ Yes	☐ No
Is the student currently on a 504 Plan?	☐ Yes	☐ No
Are there any court actions pending for this student?	☐ Yes	☐ No
Is the student either Hispanic or Latino?	☐ Yes	☐ No

Race (Please choose one or more.)

☐ White
☐ Black or African American
☐ Pacific Islander
☐ American Indian or Alaskan Indian
☐ Asian

Signature of Parent/Guardian: _____ **Date:** _____

Foster School Department
Captain Isaac Paine School
160 Foster Center Road
Foster, Rhode Island 02825
(401) 647-5100
Fax: (401) 647-3750

AUTHORIZATION FOR RELEASE OF INFORMATION FORM

School District and /or School Name _____

Address _____

City/State _____ Zip Code _____

Phone # _____ Fax # _____

Student's Name _____
First Middle Last

Home Address _____

Home Phone # _____ Current Grade _____

Student Information Authorized for Release (please check)

Health Records _____

All Student Records _____

I.E.P. (if applicable) _____

Authorized Signature _____ Date _____

School Name & Address:

Grade: _____

STATE OF RHODE ISLAND
SCHOOL PHYSICAL FORM

Health Care Provider Name and Address:

Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex
Address: Street	Apt #	City	State / Zip Code	Home Phone

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS	Please enter dates in MM/DD/YYYY format				
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTaP < 7 years					
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella			☐ Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis Tdap/Td ≥ 7 years					
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					
Influenza					

Medical Exemption:

☐ Hep B ☐ DTaP ☐ PCV ☐ Polio ☐ Hib ☐ MMR ☐ Varicella ☐ Td/Tdap ☐ Rotavirus ☐ Hep A ☐ Mening ☐ HPV ☐ Influenza

PHYSICAL EXAMINATION

Date of PE ___/___/___ Height _____ Weight _____ BP _____

PLEASE NOTE ANY HEALTH PROBLEM, CHRONIC HEALTH CONDITION OR DISABILITY THAT MAY AFFECT BEHAVIOR OR HEALTH AT SCHOOL:

1. ASTHMA: No ☐ Yes ☐ If yes, complete an *Asthma Action Plan* (www.health.ri.gov/publications/actionplans/2012Asthma.pdf)
2. ALLERGIES: No ☐ Yes ☐ (Please explain) _____ EPINEPHRINE AUTO-INJECTOR REQUIRED: No ☐ Yes ☐
   If student has a severe allergy (food, insect, other) complete a *Food Allergy& Anaphylaxis Emergency Care Plan* (www.foodallergy.org/document.doc?id=234)
3. DIABETES: No ☐ Yes ☐ If yes, complete a *Physicians Order Form For Students With Diabetes* (www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf)
4. OTHER: _____

Treatment Plan: _____

RESTRICTIONS: Can participate in physical education/sports: Fully☐ With limitation ☐ _____

MEDICATION (REQUIRED AT SCHOOL): No ☐ Yes ☐ (Please list) _____

Other medication(s) that may affect behavior or health at school: _____

LEAD SCREENING (Required for children < 6 years old) Student is in compliance with lead screening requirements: Yes ☐ No ☐	SCOLIOSIS SCREENING Yes ☐ No ☐	VISION SCREENING (Children entering Kindergarten) ☐Passed Screening ☐Screened & referred for comprehensive exam ☐Referred for comprehensive exam, but not screened
TUBERCULOSIS (If required by school district) Date of TB test:		Screening / Referral Date: Comprehensive Exam Date:

HEALTH CARE PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____

1-2015

Captain Isaac Paine Elementary School
160 Foster Center Road RI 02825
Phone: 401-647-5100
Fax: 401-647-3750

Dear Parent/Guardian,

We are required to have a physical exam within 1 year and proof of the required immunizations for your child to enter school. A current health history will help us meet your child's health needs and recognize anything significant that can affect their education.

If your child has any medical conditions, please make an appointment to meet with the School Nurse so she may discuss any questions or individualized medical care for your child during the school day. Communication is the key to your child's health and education. Please call 401-647-5100 to schedule an appointment with the School Nurse.

Student's Name_____ Date of birth_____

Does your child have any allergies?

Food_____ Insect_____ Animal_____

Type of reaction?_____Epi pen needed?_____

Please have your pediatrician send us medication orders and provide us with an epipen and/or medication to be used to treat the reaction.

Medical / Surgical History

_____ _____

_____ _____

Is your child prone to any of these conditions?

Seasonal allergies_____

Asthma_____ triggers_____ Inhailer_____

Stomach or gastrointestinal conditions_____ triggers_____

Eczema_____ triggers/ location_____

Ear infections_____

Nosebleeds_____

Headaches_____ triggers_____

Orthopedic conditions_____

Does your child wear glasses?_____ Hearing aids?_____

Other_____

_____

Medication

Does your child take any medications?_____
Please list _____

_____

Are there any medications to be given during school?_____
This includes inhalers, epipens, and PRN medications.

_____

_____

_____

Any medication needed to be given at school will require a physician's order and parent/ guardian's permission which is updated yearly. All medication must be transported to the school nurse by an adult only. Please ask for the medication administration paperwork and policy.

Does the Certified School Nurse Teacher have your permission to inform the school staff of health issues on a need to know basis?_____

Please note: It is your responsibility to inform the school nurse of any changes in the above information.

_____ _____

Parent/ Guardian Signature Date