Registration Checklist

2022-2023

To register your child, along with the completed paperwork, please provide the following:

BIRTH CERTIFICATE ☐

SOCIAL SECURITY CARD ☐

PROOF OF RESIDENCY
(LEASE OR MORTGAGE AGREEMENT OR A UTILITY BILL: *MUST SHOW YOUR PHYSICAL ADDRESS*) ☐

THE DOCUMENTS BELOW MUST BE FAXED FROM YOUR CHILD'S DOCTOR TO THE SCHOOL DIRECTLY
Fax:(603)869-2482

IMMUNIZATIONS RECORD ☐

RECENT (WITHIN THE LAST YEAR) PHYSICAL/ WELL CHILD CHECKUP ☐

If you have any question regarding immunizations or a well child check up for school
please contact the school nurse.
By phone: (603)869-5842
By email: treardon@bethlehem.k12.nh.us

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IMPORTANT CONTACT INFORMATION

For busing information, please contact **WW Berry Bus Company**: (603)636-6100

For the **Rec Department**, please contact 603-869-3351, ex. 19

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BES INFORMATION

FIRST DAY OF SCHOOL—Monday, August 29th, 2021

Check the BES website for additional information and updates throughout the year: bethlehem.k12.nh.us

Please be on the lookout for an invitation to our dismissal program, ***School Dismissal Manager***, which will allow you to set defaults for dismissal and make daily changes if needed for your child at the end of the day. Please contact the school with any questions regarding this program as we are happy to help get you successfully set up.

White Mountain School Administrative Unit 35
STUDENT REGISTRATION FORM
BETHLEHEM ELEMENTARY SCHOOL

TOWN CODE: BETH

TUITION STUDENT: YES NO

ENTRY DATE: ______________

ENTRY CODE: ______________

☐ **Birth Certificate** ☐ **Proof of Residency**

SASID # **POWERSCHOOL#** **MEALTIME#**

STUDENT NAME:	____________________ **LAST NAME (enter legal name)** **FIRST NAME** **MIDDLE NAME**
Social Security #:	____________________ **Date of Birth:** ____________________
Gender: (circle)	**Male** **Female** **Birthplace: (City, State)** ____________________
Student's Mailing Address:	____________________ Street/PO Box Number Town State Zipcode
Student's Physical Address:	____________________ Street Town State Zipcode
Student's Home Phone:	____________________ Will student be bussed: YES NO
Living with: (Circle)	PARENTS (One Household) MOTHER FATHER SHARED CUSTODY (Two Households) GUARDIAN OTHER: __________
MOTHER GUARDIAN OTHER __________	Name: ____________________ Home/Cell Phone: __________ ____________________ Address (if different from student's address above) Email ____________________ Place of employment Work Phone
FATHER GUARDIAN OTHER __________	Name: ____________________ Home/Cell Phone: __________ ____________________ Address (if different from student's address above) Email ____________________ Place of employment Work Phone
EMERGENCY CONTACT	Name: ____________________ Relationship: __________ ____________________ Address Home Phone ____________________ Cell Phone Work Phone
DOCTOR:	Name: ____________________ ____________________ Address Phone
Last School Attended:	____________________ Withdrawal Date: __________ ____________________ Address City, State, Zip Phone/Fax Number
Services: (circle all that apply)	Has student received any of the following supplemental services: (circle all that apply) Title I Special Ed. E.S.L. 504 Speech & Language Other: __________
Parent Military Status: (check off all that apply)	☐ No Active Duty for Parents or Legal Guardians. ☐ Active Duty in Armed Forces (not including National Guard) ☐ Full Time National Guard
Student's Ethnicity: (circle one - optional)	Hispanic or Latino Not-Hispanic or Latino
Student's Race: (circle all that apply – optional)	American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White

Form completed by: ______________________________ Date: ____________________
Parent/Guardian Signature

PLEASE COMPLETE LANGUAGE SURVEY ON BACK.

New Hampshire
Department of Education
Serving New Hampshire's Education Community

Home Language Survey

School: ______________________ District: ____________________ Date: _______

Instructions for survey administrator:

1. Please ensure this survey is in a language which is comprehensible to the parent/guardian who is completing it, and provide an interpreter to translate the survey when necessary.
2. If responses indicate a language other than English, contact the Student Services Coordinator or ESOL/ELL Program Coordinator in your school or district immediately.
3. Note the date of referral to Student Services/ESOL Program: *Month:* _____ *Day:* ______ *Year:* _____ (*initial*)
4. File the original *Home Language Survey* in the student's cumulative folder.

Information for parents and guardians:
All public school districts in the United States are required to provide language assistance to the parents and guardians of students in their local schools. In addition, it is the school's responsibility to identify any and all students who may have a language influence other than English. This is in order to determine whether the school is obligated to provide additional academic language services. In New Hampshire, these services are usually called ESOL or ELL Services.

Student Information: Please complete this general information about your son or daughter.			
First name:	Last name:	Date of Birth:	Gender: □ female □ male
Country of Birth:		Date first enrolled in a U.S. school: Month _____ Year _______	Current grade:

Family Information: Please complete this information about your family.	
Name of parent/legal guardian:	Phone number:
Address:	Would you like school notices translated? If yes, in which language: ______________

Questions about Language: Please answer the following questions about the languages that you and your family use.
What language(s) does your child hear or speak in your home?
Which language(s) did your child first hear or speak?
If English is the only language listed above, you may skip over the next questions. *If another language is listed, please answer the following questions.*
What language(s) do you use with your child?
What language(s) does your child hear or use at home with relatives and friends?
What language(s) does your child use with people in your community?

Parent/Guardian Signature: ______________________________ Date: ____________

Revised 10.7.16

BETHLEHEM ELEMENTARY SCHOOL EMERGENCY FORM

This form will be used by the school nurse and school staff when a student is released to go home.

Parent Information: Please fill out completely and sign where indicated. Please complete electronically or print clearly and return completed form to school.

HR

STUDENT'S LAST NAME		FIRST NAME		M.I.
BIRTH DATE	☐ MALE ☐ FEMALE	GRADE/TEACHER	HOME LANGUAGE	
STUDENT'S HOME ADDRESS		APT #	CITY, STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)		APT #	CITY, STATE	ZIP CODE
MOTHER'S/ LEGAL GUARDIAN'S LAST NAME	FIRST NAME	PLACE OF EMPLOYMENT		LIVES WITH? ☐ Yes ☐ No
ADDRESS		CITY, STATE		ZIP CODE

CONTACT NUMBERS		Indicate which phone to call for each message type:*				EMAIL ADDRESS:
HOME		EMERGENCY	☐ Home	☐ Cell	☐ Work	
CELL		ATTENDANCE	☐ Home	☐ Cell	☐ Work	
WORK		GENERAL INFO	☐ Home	☐ Cell	☐ Work	

FATHER'S / LEGAL GUARDIAN'S LAST NAME	FIRST NAME	PLACE OF EMPLOYMENT	LIVES WITH? ☐ Yes ☐ No
ADDRESS		CITY, STATE	ZIP CODE

CONTACT NUMBERS		Indicate which phone to call for each message type:*				EMAIL ADDRESS:
HOME		EMERGENCY	☐ Home	☐ Cell	☐ Work	
CELL		ATTENDANCE	☐ Home	☐ Cell	☐ Work	
WORK		GENERAL INFO	☐ Home	☐ Cell	☐ Work	

In case you are unable to reach me during any emergency, you are authorized to contact and, if necessary, release my child to any of the following:

NAME - CALL FIRST	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE
NAME - CALL SECOND	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE
NAME - CALL THIRD	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE

List all other family members (siblings in school or not) below. Please use back of sheet if necessary.

LAST NAME	FIRST NAME	HOME ROOM	GRADE	RELATIONSHIP
LAST NAME	FIRST NAME	HOME ROOM	GRADE	RELATIONSHIP

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I, the undersigned, as parent/legal guardian of, ______________________________ a minor,

(Print name of the student here)

give my permission for the information on this card to be shared with teaching staff as necessary. I hereby authorize the school to obtain medical care in case of emergency including transportation by ambulance to a medical facility. I hereby authorize the school to allow my child to be picked up by the above listed individuals if I cannot be reached. I will not hold the school district financially responsible for the emergency care and/or transportation of said child. Listed below are any restrictions on calling or pick up for my child for illness or injury and/or any legal custody concerns that the school should be aware of.

Restrictions

HEALTH ALERTS -- *List any medical condition which restricts physical activity or requires special attention. Include conditions such as asthma and allergies such as peanut and bee stings. If none, please indicate "none".*

DOES THE STUDENT HAVE HEALTH INSURANCE? (Check One) ☐ YES ☐ NO* If "Yes": ☐ Private Health Insurance ☐ Medicaid ☐ Healthy Kids

POLICY NUMBER:	GROUP NUMBER:
1. PRIVATE HEALTH INSURANCE NAME	Any changes in home or family that may affect your child's work at school? If yes, explain below.
NAME OF DOCTOR / MEDICAL OFFICE	PHONE NUMBER OF DOCTOR / MEDICAL OFFICE

MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS:	
MY CHILD CURRENTLY TAKES THE FOLLOWING MEDICATIONS:	

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THIS FORM AND DO HEREBY GIVE MY AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT, AND THAT ALL OF THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND CORRECT.

X

SIGNATURE OF: (CHECK ONE) ☐ PARENT ☐ LEGAL GUARDIAN DATE

STUDENT'S LAST NAME

FIRST NAME

MIDDLE INITIAL

BETHLEHEM ELEMENTARY SCHOOL

2297 Main Street
Bethlehem, New Hampshire 03574
Telephone (603) 869-5842 Fax (603) 869-2482
bethlehem.k12.nh.us
Sue Greenlaw, Principal

PERMISSION FOR SCHOOLS AND AGENCIES TO RELEASE INFORMATION OF A CHILD TO THE SCHOOL DISTRICT

Please forward to the above address all scholastic, psychological, and/or medical records and any other pertinent information on the following student(s).

STUDENT'S NAME **GRADE**

____

____

____

____

Sincerely,

Sue Greenlaw, Principal

AUTHORIZATION TO RELEASE STUDENT RECORDS

New Hampshire statute requires that any release of information from student records be with the prior approval of the parent or guardian. A copy of this permission shall have the same force as the original.

I hereby agree to the release of all records and pertinent information on my child/children from the

____

SCHOOL/AGENCY ADDRESS

and I request that they be transferred to the Bethlehem Elementary School.

____

PARENT/GUARDIAN SIGNATURE DATE

<*><*><*><*><*><*><*><*><*><*><*><*><*><*><*><*><*><*><*<*><*><*><*><*><*><*><*><*>

Office Use Only

Date Permission Form Sent	Date Records Received

"CHILDHOOD SHOULD BE A JOURNEY – NOT A RACE."

Pre-school Students 3-5 Years Old

New Hampshire Immunization Requirements 2022-2023

Refer to page 2 for minimum ages and intervals

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

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

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.

MEASLES, MUMPS, and RUBELLA (MMR)

3-5 years	One dose. This dose must be administered on or after age 12 months.

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.

HEPATITIS B

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

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.

*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)
Vaxelis™	Diphtheria, Tetanus, Pertussis (DTaP), Polio (IPV), Haemophilus influenzae type b (Hib), & Hepatitis B (Hep B).

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

Child & Family Experiences Questionnaire
Bethlehem Elementary School

At BES, we believe that all aspects of a child's well-being contribute to their success academically. We know that a child's parents/caregivers are the ones who know them best and are responsible for their welfare. Therefore, we are asking for you to partner with us in fully understanding your child's history. We ask about this so we can know if there are experiences that have been challenging or potentially upsetting for your child that you believe may contribute to how he/she is developing and/or behaving. Please share your thoughts about your child so that we can better help him/her to learn here at school.

1. With whom does your child have a close relationship/attachment? ______________________

   ____

2. Has your child lived with the same caregivers for his/her whole life? Yes No
   If not, who has your child been separated from and when? ______________________

____

3. Before age 3 years, did anything happen in his/her life that were scary or upsetting? Yes No
4. Has anything ever happened that was emotionally harmful to your child? Yes No
5. Is there anything that ever happened to your child that caused him/her physical harm? Yes No
6. Are there people in your child's life that you have concerns about? Yes No
7. Are there any people in your child's life that you have concerns about? Yes No
   If so, what was the event/experience? (examples: car accident, natural disaster, having someone close die, being attacked by an animal, being threatened, or hurt by someone, witnessing domestic violence, etc.) ______________________

8. Does your child
   a. have any behaviors that you find concerning? Yes No
   b. seem keyed up, on edge, or easily spooked or angered? Yes No
   c. talk or play (or have nightmares) about scary or upsetting events that have happened? Yes No
   d. have any problems with sleep, toileting, or eating? (circle all that apply) Yes No
   e. seem to be in a bad mood a lot, seem to see things in a negative way, or have trouble enjoying things? Yes No
   f. have times when he/she can't seem to calm down? Yes No
   g. have problems with concentration/attention? Yes No

9. Is there anything else you think is important for us to know about your child? Yes No
   If so, what? ______________________

   ____

10. Would you like to come in and speak with your child's teacher about any of your answers? Yes No

Thank you!

Section 1: ______/6 Section 2: ______/8

Adapted from Cassie Yackley, Psy.D
Child & Family Experiences Questionaire

Bethlehem Elementary School
Health History

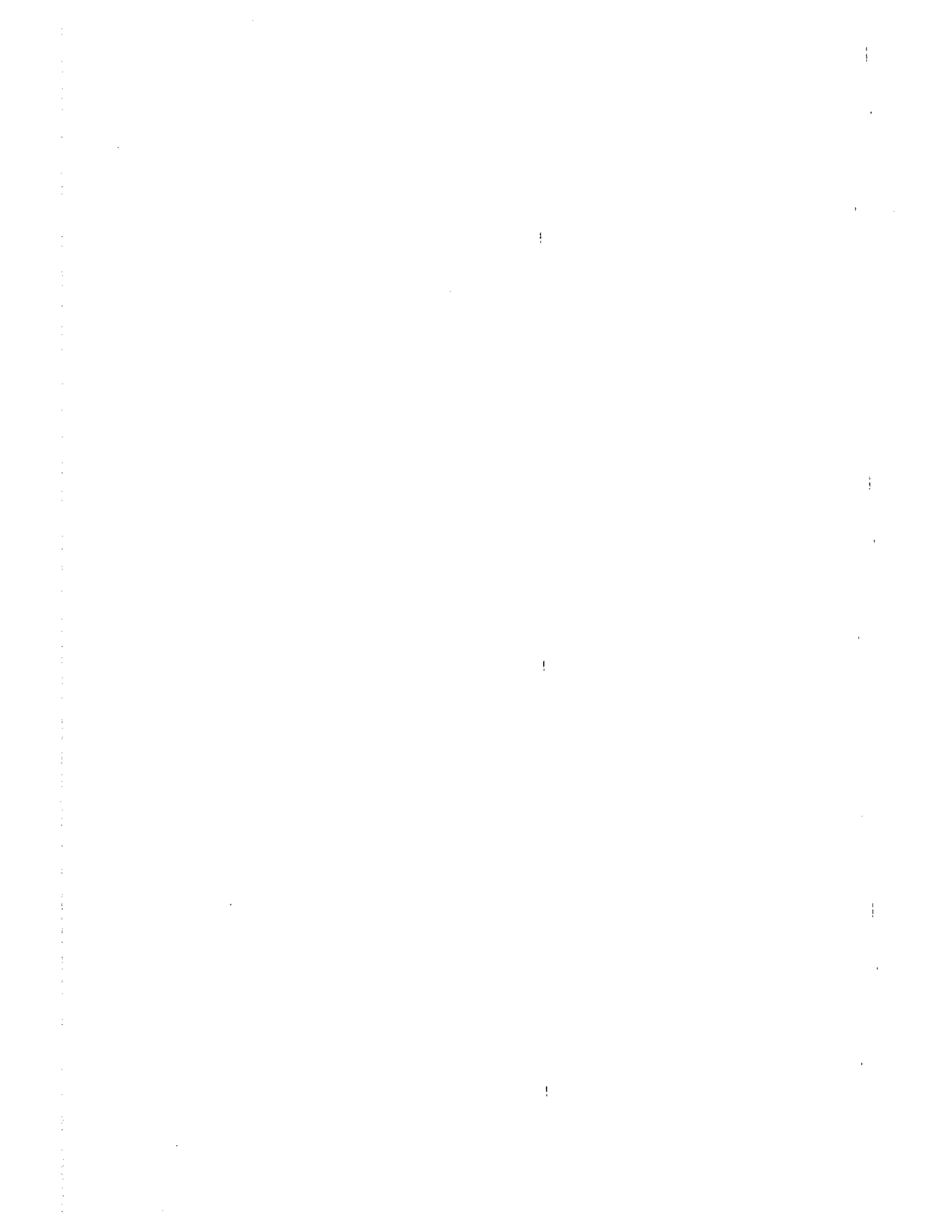
Name: ______________________ Birth Date: ____________ Grade: ____________

1. Does your child have any **severe / live threatening allergies?** No Yes Explain: ______________
____
Specify treatment needed at school: ______________________________
____
2. Does your child have any **mild / moderate allergies?** ? No Yes Explain allergy and symptons:
Food? ______________________________________
Seasonal / environmental? ______________________________
Other? ______________________________________
Specify treatment needed at school: ______________________________
3. Does your child have **asthma?** ? No Yes How often: ____________ Triggers: ____________
Specify treatment needed at school: ______________________________
4. Does your child have a history of **seizures?** No Yes What Type? ____________ How often: ________
Actions to be taken at school: ______________________________
5. Does your child have any **cardiac / heart history?** No Yes Explain: ______________________
Actions to be taken at school: ______________________________
6. Does your child take any **medications** regularly? No Yes **Where?** at Home at School*
Specify the medication, its purpose, dosage, frequency & other pertinent information: ____________
____
*NOTE Before any medication can be given at school (Rx & OTC) a medication permission form must be completed by PCP & Parent
7. Does your child have any **vision problems?** No Yes Glasses? No Yes Contacts No Yes
Specify problem(s) and treatment (s): ______________________________
8. Does your child have any **hearing problems** or frequent ear infections? No Yes Which ear? Right Left Both
9. Does your child have any **emotional / psychological** concerns? No Yes
Explain: ______________________________________
List any medications/drugs: ______________________________
Actions to be taken at school: ______________________________
10. Is there **anything else** about your child's medical, physical or emotions health that you would like staff to know?
____
____

Please note during this pandemic BES will require a doctor's note to clarify any ongoing known symptoms that your child may have that are similar to COVID-19 symptoms.

Any staff, students and families should stay home if they have COVID-19 symptoms, have been diagnosed with COVID-19, are waiting for test results, or have been exposed to someone with symptoms or a confirmed or suspected case and notify the school nurse

______________________________ ____________
Parent/guardian signature Date



Bethlehem Elementary School
2297 Main Street
Bethlehem, New Hampshire 03574

HEALTH HISTORY

The health of each student greatly influences his/her ability to learn.

Date: ________________ Grade: __________

Name of Child (full): ______________________________ Home phone: ______________

Date of Birth: __________________ M__ F__ Place of Birth: ______________________

Home Address: ____

Name of Father: ________________________ Work phone # ___________________

Name of Mother: ________________________ Work phone # ___________________

DISEASE RECORD

	Yes	No		Yes	No
Asthma	___	___	Kidney Disease	___	___
Chicken Pox	___	___	Measles	___	___
Deformities	___	___	Mononucleosis	___	___
Diabetes	___	___	Mumps	___	___
Eczema	___	___	Otitis Media (ear infection)	___	___
Epilepsy (seizures)	___	___	Pneumonia	___	___
Eyes – wears glasses	___	___	Rheumatic Fever	___	___
German Measles (Rubella)	___	___	Scarlet Fever	___	___
Heart Disease	___	___	Tuberculosis (self/family)	___	___
			Whooping Cough	___	___

Explain "Yes" answers here: ____

____

____

Allergies to pollen, medicine, food, insect sting, other? ______________________

____

Any current skin problems (itching, rashes, acne, warts, fungus, other)? ___________

____

Has your child ever been hospitalized? Explain: __________________________

____

OVER →

Has your child ever had surgery? Explain: ______________________________
____

Do you believe your child has any of the following concerns?

	Yes	No
Difficulty Hearing	___	___
Difficulty seeing	___	___
Gets short of breath easily	___	___
Falls frequently	___	___
Under weight / Over weight	___	___
Wet self during day / night	___	___
Burning with urination	___	___
Temper Tantrums	___	___
Good eating habits	___	___

Are there behaviors or personality problems, which you think, might affect your child's progress in school? If yes, explain: ______________________________
____

Does your child have unusual fears, phobias, or frequent nightmares, which concern you? If yes, explain:
____
____
____

Are there personal or family problems at home, which you would like to discuss with the School Nurse or Guidance counselor? Yes ____ No ____

When was the last time your child was seen by the Dentist? ______________

Seen by Dentist regularly? Every six months ____ Yearly ____ Once in a while ____ Never ____

Has your child ever been seen by an Optometrist (eye doctor)? Yes ___ No ___

Does your child take any medication(s)? Explain: ______________________________
____

Any other health information: ______________________________
____
____
____
____