

TIVERTON SCHOOL DEPARTMENT

**100 North Brayton Road
Tiverton, RI 02878
401-624-8475
www.tivertonschools.org**

HEALTH INFORMATION

HIPAA RELEASE

Student health information is protected under the Health Insurance Portability and Accountability Act (HIPAA). These regulations require that our schools store health records in secure locations (locked file cabinets) with restricted access. This also applies to information stored on our computers, which is protected by several district passwords and accessible to only our school nurses.

Student health information is highly confidential and shared only with staff members who work directly with your child. Your written consent will be required in situations where it is necessary to share your child’s medical records with anyone other than school personnel. Please list your child’s specific medical concerns in the space provided below, as well as the name and account number of your medical insurance.

MEDICAL CONCERNS:

Please indicate below the school personnel you wish to be made aware of your child’s medical concerns so that we may provide care and services necessary to maintain the health and safety of you child.

MY CHILD’S HEALTH INFORMATION MAY BE SHARED WITH THE FOLLOWING:

- | | |
|--|---|
| <input type="checkbox"/> Classroom Teacher | <input type="checkbox"/> School Secretary |
| <input type="checkbox"/> All Building Teachers | <input type="checkbox"/> Teacher Assistants |
| <input type="checkbox"/> Building Administrators | <input type="checkbox"/> Bus Driver/ Monitors |

Medical Insurance Provider: _____ Acct. Number: _____

PLEASE SIGN BELOW TO INDICATE THAT YOU HAVE READ THE ABOVE INFORMATION:

Signature

date

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STUDENT HEALTH HISTORY AND RELEASE

Please fill out this health history form as completely as you can so that the school will have all of the necessary information to safe-guard your child's health and well-being during school hours. Thank you.

CHILD'S NAME: _____ DOB ____/____/____

ADDRESS: _____ PHONE: _____

DOCTOR'S NAME: _____ ADDRESS: _____

Does your child have any recurring health problems? YES ___ NO ___

Please Explain _____

Is Student Receiving outside services? YES ___ NO ___

SPEECH _____ COUNSELING _____ EDUCATIONAL _____

Do you believe your child has any speech, language, or hearing problems? YES ___ NO ___

Please Explain _____

BIRTH HISTORY

Mother's health during pregnancy _____

Length of pregnancy _____ Complications during delivery _____

PERINATAL HISTORY (first 28 days)

Birth weight _____ Length _____ Health at birth _____

SOCIAL HISTORY

Behavioral (thumb-sucking, nail-biting, etc.) _____

Activities of daily living (naps, toileting, appetite, etc.) _____

Parent Initials: _____

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STUDENT HEALTH HISTORY AND RELEASE (page 2)

Asthma _____ Known asthma triggers _____

Allergies (insects, medications, food, environmental, etc.) List type of reaction and date of last reaction.

ASTHMA _____
MANAGEMENT _____

EAR INFECTIONS _____ TONSILLITIS _____

STREP THROAT _____ RESPIRATORY INFECTIONS _____

HEART CONDITION _____ HEADACHES _____

SEIZURES _____ DIABETES _____

SPEECH PROBLEMS _____ HEARING PROBLEMS _____

VISION PROBLEMS _____ EMOTIONAL CONCERNS _____

LANGUAGE PROBLEMS _____

Is there a family history of: Diabetes? _____ Cancer? _____ Asthma? _____ Allergies? _____

Physical disabilities _____

Able to participate in full physical activities? YES _____ NO _____

ILLNESSES, INJURIES, OPERATIONS (include dates): _____

CHICKEN POX ___/___/___ BRONCHITIS ___/___/___ SCARLET FEVER ___/___/___

PNEUMONIA ___/___/___ PERTUSSIS ___/___/___ OTHER ___/___/___

Currently on Medication(s)? _____ NAME AND REASON: _____

Will your child require medication while at school? _____

PARENT'S SIGNATURE: _____ DATE: _____

School Name & Address:

HealthCare Provider Name and Address:

**STATE OF RHODE ISLAND
SCHOOL PHYSICAL FORM**

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 (R16-219-CHO 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/DTaP	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT
Pneumococcal/Conjugate PCV					
Polio					
Haemophilus influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella	<input type="checkbox"/> Student has history of varicella disease				
Tetanus-Diphtheria-Pertussis Tdap/Td	Check <input type="checkbox"/> if Td	Check <input type="checkbox"/> if Td	Check <input type="checkbox"/> if Td		
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					

Immunization Exemption: Medical Religious

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

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:

ASTHMA: No Yes DIABETES: No Yes OTHER: _____

Significant Systems Findings: _____

ALLERGIES: No Yes (Please explain) _____ EPINEPHRINE AUTO-INJECTOR REQUIRED: No Yes

Treatment Plan: _____

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

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

RESTRICTIONS: Can participate in physical education: Fully With limitation _____

Can participate in sports: Fully With limitation _____

LEAD SCREENING (Required for children <8 years of age only) Student is in compliance with lead screening requirements: Yes <input type="checkbox"/> No <input type="checkbox"/>	SCOLIOSIS SCREENING Yes <input type="checkbox"/> No <input type="checkbox"/>	VISION SCREENING (Children entering Kindergarten) <input type="checkbox"/> Passed screening <input type="checkbox"/> Screened and referred for comprehensive exam <input type="checkbox"/> Referred for comprehensive exam but not screened Screening Date: _____ Comprehensive Exam Date: _____
TUBERCULOSIS (If required by school district) Date of TB test: _____		

HEALTHCARE PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____

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MEDICATION ADMINISTRATION

PHYSICIAN AUTHORIZATION (FOR EPIPEN ORDERS FILL OUT SEVERE ALLERGY PROCEDURE FORM)

Student Name _____ DOB ____/____/____

Name of Medication _____ Daily _____ PRN _____

Dosage while in school _____ Route of Administration _____ Time to be Given _____

Diagnosis _____

Is this a new medication _____ Expected Duration _____

List of significant side effects _____

Self-carry/ self administer in the school setting:

Please circle the appropriate response below. (DOES NOT APPLY TO CONTROLLED SUBSTANCES)

- Do you authorize this child to self-carry the above ordered medication in the school setting? (Excludes elementary grade students) YES NO
- Do you authorize this child to self-administer the above medication in the school setting? YES NO

Field trip information:

Please circle the appropriate response below.

- On an off-site school sponsored activity without a nurse present, this student may self-carry the above medication? (Excludes elementary grade students) YES NO
- On an off-site school sponsored activity without a nurse present, this student may self-administer the above ordered medication? YES NO
- The above medication may be omitted. YES NO

Print Physician Name _____ Phone _____

Physician Signature _____ Date ____/____/____

Address _____

Parent/ Guardian Authorization

I authorize the above medication to be administered to my child under the direction of my health care provider. The school nurse may contact my health care provider regarding this medication if necessary.

- My child may self-carry the prescribed medication. (Excludes elementary grade students). YES NO
- My child may self-administer the prescribed medication. YES NO

Signature of Parent/ Guardian _____ Date ____/____/____

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SEVERE ALLERGY PROCEDURE

Student Name _____ **DOB** ___/___/___

Specific Allergy _____

Has this student had prior anaphylactic reaction? _____ **Date** ___/___/___

Reaction and treatment _____

The following procedure will be followed for an allergic reaction:

Please circle yes or no.

YES **NO** Give Benadryl _____ dose; Observe for allergic symptoms then give EIPEN ____ dose

YES **NO** Give EIPEN _____ dose immediately upon exposure.

Additional Orders

Note: Students treated with an EIPEN will be transported via rescue to the ER for medical evaluation.

Self-carry/ self administer in the school setting:

Please circle the appropriate response below. (DOES NOT APPLY TO CONTROLLED SUBSTANCES)

- Do you authorize this child to self-carry the above ordered medication in the school setting? (Excludes elementary grade students) **YES** **NO**
- Do you authorize this child to self-administer the above medication in the school setting? **YES** **NO**

Field trip information:

Please circle the appropriate response below.

- On an off-site school sponsored activity without a nurse present, this student may self-carry the above medication? (Excludes elementary grade students) **YES** **NO**
- On an off-site school sponsored activity without a nurse present, this student may self-administer the above ordered medication? **YES** **NO**
- The above medication may be omitted. **YES** **NO**

Print Physician Name _____ **Phone** _____

Physician Signature _____ **Date** ___/___/___

Address _____

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REPORT OF DENTAL EXAMINATION

THIS IS TO CERTIFY THAT I HAVE EXAMINED THE TEETH OF:

NAME _____ GRADE _____

___ NO DENTAL TREATMENT NECESSARY

___ TREATMENT IN PROGRESS

___ TREATMENT COMPLETED

DENTIST SIGNATURE _____ DATE ___/___/___

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STUDENT DIRECTORY INFORMATION

FERPA RELEASE

The Family Educational Right and Privacy Act (FERPA) requires that school districts designate certain types of student information as student "Directory Information" that can be disclosed with parents'/ guardians' prior consent. This information is considered to be general information that would not be harmful or invasive if disclosed in school publications, such as school and district newsletters, yearbooks, the Tiverton Public Schools website www.tivertonschools.org, and to newspaper and television media.

The Tiverton School Department has designated the following as student "Directory Information":

- | | |
|-------------------------|---|
| *Student Name | *Participation in School Activities and Sports |
| *Photograph | Weight and Height of students on high school sports teams |
| *School Student Attends | *Honors and Awards Received |
| *Grade Level | *Major Field of Study |
| *Dates of Attendance | *Date and Place of Birth |
| *Telephone Listing | *Address |
| *E-mail | *Other information considered directory |

In addition to the above information, names, addresses, and telephone listings of high school students may be provided to military recruiters if requested. If you do not want the Tiverton School Department to disclose any of the above Directory Information or information to military recruiters, without your prior consent you must sign one of the attached forms and return it to your child's school by within two weeks of your dated signature below. Please refer to your child's school handbook for additional information on student records.

PLEASE SIGN BELOW TO INDICATE THAT YOU HAVE READ THE ABOVE INFORMATION:

Signature

date

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STUDENT DIRECTORY INFORMATION REVOCATION

I am requesting that the Tiverton School Department withhold the release of "Directory Information" concerning my child.

Child/ Children _____ DOB ____/____/_____

Telephone _____ Address _____

Parent/ Guardian _____ Date ____/____/_____
signature

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STUDENT RECORDS RELEASE FORM

To Whom it May Concern:

The below mentioned student has been enrolled in the Tiverton Public Schools. Please release his/her scholastic, health, and discipline records, along with any other pertinent information that may be available. If the student has transferred between quarterly marking periods, please include the numerical average to date.

It would be most helpful if you would also provide an explanation of your grading policy and credit system if applicable.

Thank you for your prompt attention to this.

Yours truly,

William J. Rearick

Superintendent of Schools

Student Name: _____

Records to be released to:

Tiverton School Dept.
100 North Brayton Rd. (Rear)
Tiverton, RI 02878

Tiverton High School
100 North Brayton Rd.
Tiverton, RI 02878

Tiverton Middle School
10 Quintal Dr.
Tiverton, RI 02878

Ranger Elementary
278 North Brayton Rd.
Tiverton, RI 02878

Pocasset Elementary
242 Main Road
Tiverton, RI 02878

Ft. Barton Elementary
99 Lawton Avenue
Tiverton, RI 02878

I hereby give permission to the _____ Department to release all records for my child to the Tiverton Public Schools.

Date ___/___/___

Parent/ Guardian _____
signature



Deborah A. Gist
Commissioner

RI Department of Education Home Language Survey

The information requested on this form is necessary for the most appropriate placement for your child as required by Rhode Island Law (R.I.G.L. § 16-54-2) and the Equal Educational Opportunity Act (20 U.S.C. §1703(f)) and will not be used for any other purposes. Thank you for your cooperation.

To be completed by parent or guardian:

Student Name: _____

Registration _____ Date of _____

Date: _____ Birth: _____

1. What language do you use most often when speaking to your child?

2. What language did your child first learn to speak?

3. What language does your child use most often when speaking to you?

4. What language does your child use most often when speaking to other adults in the home or to their primary caretaker?

5. What language does your child use most often when speaking to siblings or other children in the home?

6. What language does your child use most often when speaking to friends or neighbors outside the home?

Signature of Parent or Guardian _____ Date _____

Print Parent/Guardian Name _____

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William J. Rearick
Superintendent of Schools

Douglas Fiore
Director of Administration

Diane Sanna
Director of Curriculum

Steven Fezette
Principal, Tiverton High School

Patricia Aull
Principal, Tiverton Middle School

Suzette Wordell
Principal, Ft. Barton Elementary

Thomas Gastall
Principal, Ranger Elementary

Fran Blaess
Principal, Pocasset Elementary

Dear Parent or Guardian,

Please be aware that Rhode Island Law requires that the Tiverton School Department provide a directory to the Tiverton Police Department containing the names and addresses of all parents' of students. The reason for the directory is to allow the police department to notify parent(s)/ guardian(s) if a convicted sex offender takes up residency in the Town of Tiverton. Pursuant to the Rhode Island Sex Offender Registration and Community Notification Act, it is the responsibility of the police department under the law to notify parents and community members of the registration of convicted sex offenders in certain circumstances.

If any parent/guardian does not want to be notified by the Tiverton Police Department, please call my office at (401) 624-8475. Please also complete the bottom of this page indicating the name of your child or children enrolled in the Tiverton School Department, and also include your signature and address.

You will continue to receive sex offender registration information from the Tiverton Police Department unless and until you notify the Tiverton School Department that you wish to remove your child/ children's' name from the directory or until your child or children no longer are enrolled in the Tiverton Schools, whichever occurs first.

Sincerely,

William J. Rearick
Superintendent of Schools

I am requesting that my child/ children be removed from the sex offender notification directory. I understand that by filling out this form I am directing the Tiverton School Department to withhold my contact information from the Tiverton Police Department.

Child/ Children _____

Telephone _____ Address _____

Parent/ Guardian _____ Date ____/____/____

signature

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STUDENT TRANSPORTATION PROCEDURE

Due to the fact that all school bus routes are structured during the summer months, and are based on providing transportation service from and to a student's home residency, any and all requests for altering the same will need to be submitted to the student's school of attendance no later than August 15th of each respective year for consideration.

- Any request received after August 15th will not be considered until the third week of September
- Exceptions being: New Registrations/ Residents

Upon consideration and approval of request, all requests will be considered effective for 5 days. Students shall have only one alternate designated pickup/ drop-off location to ensure safety and to monitor bus capacities.

My child _____ will have the following alternate pickup/ drop-off for the _____ school year.

Location of Alternate Pick-up: _____
For all 5 days

Location of Alternate Drop-off: _____
For all 5 days

Parent/ Guardian _____ Date ____/____/_____
signature

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LICENSED CHILD DAY CARE CENTER DROP-OFF REQUEST

Date of Request ____/____/____

Student Name _____ DOB ____/____/____

Student Residence: _____

Request for School Year: _____ Student will be in grade: _____

Assigned Elementary School: _____

Parent or Legal Guardian: _____

Parent or Legal Guardian Residence: _____

Child Day Care Center: _____

Address of Child Day Care Center: _____

Child Day Care Drop Off Location: _____

Parents Consent: I hereby authorize the Tiverton School Department to transport my son/ daughter to the day care center specified above and also certify that I have made arrangements for representatives of specified day care center to take responsibility for my child's welfare beginning at the time my son/ daughter arrives at the location designated herein.

Parent/ Guardian _____ Date ____/____/____
Signature

Day Care Provider Consent: I acknowledge that I have been designated as the day care provider for the above specified student and accept full responsibility for this child's welfare beginning at the time the child arrives at the location designated herein.

Day Care Provider _____ Date ____/____/____
Signature

Day care drop-off requests must be approved by the Superintendent of Schools. If approved, child day care drop-off requests are granted for a one-year period only and must be applied for annually.

Recommended by: _____ Date ____/____/____
Principal Signature

Approved by: _____ Date ____/____/____
Superintendent Signature