Residency Requirement(s) and Verification Notice

In accordance with Sections 10-186, 10-220 and 10-253(d) of the Connecticut General Statutes, the Ledyard Board of Education requires proof of residency in Ledyard during the school enrollment process. Individuals seeking enrollment in Ledyard Public Schools are required to provide such proof. All residency documents submitted are subject to verification by the Ledyard Board of Education. Proof of residency is also required for a change of address within the town.

Pursuant to Section 10-253 (d) of the Connecticut General Statutes, a child living with any individual other than the child's parent/legal guardian can attend school in the district only if such residence is (1) permanent; (2) provided without pay; and (3) not solely for the purpose of gaining school accommodations. In accordance with the statute, the district has the right to require proof that all three requirements have been satisfied.

In accordance with Section 10-186(b) (4) of the Connecticut General Statutes, if it is determined a student has been enrolled in Ledyard Public Schools in violation of the statutes referenced above, the Ledyard Board of Education has the right to assess tuition. Such tuition will be based on the district's per diem net current local education expenditure (as defined in section 10-261), multiplied by the number of days the student was improperly enrolled in Ledyard Public Schools. In addition, the statute provides that the Board of Education may seek to recover the amount of the assessment through available civil remedies.

By signing below, you acknowledge you have read and understand the residency requirements of enrollment in Ledyard Public Schools. You understand the Ledyard Board of Education has the authority to impose tuition as outlined above if the student being enrolled is not a resident of Ledyard. You also understand the Ledyard Board of Education has the right to pursue any and all legal remedies in the event that a student is enrolled improperly.

You hereby give consent to the Ledyard Board of Education to verify any information pertaining to the permanent residency of all pertinent parties involved in this registration.

_____ _____

Parent/Guardian Name (Print) Student Name (Print)

_____ _____

Parent/Guardian Signature Date

LEDYARD PUBLIC SCHOOLS RESIDENCY QUESTIONNAIRE

(All sections must be completed for form to be valid)

Replies are kept confidential and are intended to be used only to certify that a student is entitled to attend Ledyard Public Schools

List Student's Names (Last, First, Middle)	**DOB**	**Grade**

Address prior to moving to Ledyard: _____
No. and Street City State Zip Code

Father's Name _____ Mother's Name _____
Last First Middle Last First Middle

Which parents are living at the residence? _____ Mother _____ Father _____ Neither

Father's Info. _____
No. and Street City State Zip Code Phone

Mother's Info. _____
No. and Street City State Zip Code Phone

Primary family email _____

Host name (s) _____ Relationship to student _____

Host info. _____
No. and Street City State Zip Code Phone

Date student moved to the residence _____ How long will the student be residing at this address? _____

Reason family moved to this address _____
(Continue on back of form if additional space is needed)

If the student is not living with his/her family, will the student return to live with his/her family during school vacations, weekends, and/or the summer? _____ Yes _____ No _____ Not Applicable If yes, please explain on back of form.

Will the student be staying at the host's home seven (7) days a week? _____ Yes _____ No
If no, please explain on back of form.

Will any fees be paid for living at the residence? _____ Yes _____ No If yes, please explain on back of form.

Signature _____ Date _____
Parent/Guardian (or student if over age 18)

***** TO BE COMPLETED BY LEDYARD PUBLIC SCHOOLS RESIDENCY PERSONNEL *****

Address Verification Date: _____ Signature of Residency Personnel: _____

District Stamp: _____

LEDYARD PUBLIC SCHOOLS
4 Blonders Blvd, Ledyard, CT 06339
Telephone: 860-464-9255

RELEASE OF INFORMATION AUTHORIZATION
(HIPAA COMPLIANT AUTHORIZATION)

Student's Name: _____ Date of Birth: _____

I hereby authorize _____

(**name of Medical, Educational, or other Authority in possession of records**)
to release my child's health information, medical, psychological and/or educational records for the purpose listed below to be sent to the individual school checked off below.

The health care provider should fax medical records only to the school nurse fax number checked off below.

The information to be disclosed consists of **ALL** of the following:

Academic Testing **Special Education** **Health** **Discipline** **Attendance**

The information will be used for: **Academic Placement**

This authorization is valid for one calendar year. It will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school district, may no longer be protected by the HIPAA Privacy Act, but will become educational records protected by the Family Educational Rights to Privacy Act ("FERPA"). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

☑ **Two way communication**

Parent's Signature_____ Date:_____

Student's Signature *_____ Date:_____

*(If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. A competent minor, depending on their age, can consent to outpatient mental health care, alcohol and drug abuse treatment, testing for HIV/AIDS and reproductive health care services)

☐ Gales Ferry School
1858 Route 12
Gales Ferry, CT 063 35
Phone: 860-464-766 4
Fax: 860-464-513 8

Authorized Recipient:
Nurse'sfax:860-464-3021

☐ Gallup Hill School
169 Gallup Hill Road
Ledyard, CT 06339
Phone: 860-536-9477
Fax: 860-572-2788

Authorized Recipient:
Nurse's fax: 860-536-7231

☐ Juliet Long School
1854 Route 12
Gales Ferry, CT 06335
Phone: 860-464-2780
Fax: 860-464-5139

Authorized Recipient:
Nurse's fax: 860-464-3021

☐ Ledyard Middle School
1860 Route 12
Gales Ferry, CT 06335
Phone: 860-464-0200
Fax: 860-464-2155

Authorized Recipient:
Nurse's fax:860-464-6439

☐ Ledyard High School
24 Gallup Hill Road
Ledyard, CT 06339
Phone: 860-464-9600
Fax: 860-464-1990

Authorized Recipient
Nurse's fax: 860-464-2081

☐

_____
_____
_____
_____

Authorized Recipient: _____

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height**_____in. /_____% ***Weight**_____lbs. /_____% **BMI**_____/_____% **Pulse** _____ ***Blood Pressure**_____/ _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
*Explain:*_____
Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____
Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No
Risk Assessment	**Describe Risk Factors**		
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____		❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other _____

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian Date

_____

Signature of health care provider DMD / DDS / MD / DO / APRN / PA/ RDH Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 1/2022

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Religious Exemption: _____

Religious exemptions must meet the criteria established in Public Act 21-6: https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf.

Medical Exemption: _____

Must have signed and completed medical exemption form attached.
https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number