



Dear Families,

Welcome to the Gill-Montague Regional School District.

Please fill out all the sections of this packet to register your child in the following schools: Hillcrest Elementary School (PK-1st), Sheffield Elementary School (2nd-5th), Gill Elementary School (K-6th), Great Falls Middle School (6th-8th), or Turners Falls High School (9th- 12th). You will need to submit the following documents:

- Birth Certificate
- Proof of Residency
- Immunization Records

Central Registration is in the Office of Pupil Services located at 35 Crocker Ave., Turners Falls MA 01376. The office is open from 8:00 AM to 4:00 PM. If you have any questions about the registration process, please call 413.863.7508. You will be notified by the individual school when your child may begin. It is important that you do not send your child to school until you receive this notification.

Bienvenido al Distrito Escolar Regional Gill - Montague. Por favor, rellene todos los apartados de este paquete para inscribir a sus estudiantes en una de la siguiente escuela: Hillcrest Elementary School (PK-1st), Sheffield Elementary School (2nd-5th), Gill Elementary School (K-6th), Great Falls Middle School (6th-8th), or Turners Falls High School (9th- 12th). Tendrá que presentar los siguientes documentos:

- *Certificado de nacimiento*
- *Prueba de residencia*
- *Registros de inmunización*

Registro Central se encuentra en la Oficina de Servicios Estudiantiles ubicada en 35 Crocker Ave., Turners Falls, MA 01376. La oficina está abierta de 8:00 AM a 4:00 PM. Y si usted tiene alguna pregunta, por favor llame al 413.863.7508. Se le notificará por la misma escuela cuando su niño puede comenzar. Es importante que usted no envíe a su hijo a la escuela hasta que ha recibido esta notificación.

Nancy Parlakulas
Director of Pupil Services
GILL-MONTAGUE REGIONAL SCHOOL DISTRICT



NEW & RETURNING STUDENT REGISTRATION FORM

REQUIRED FORMS: Please submit the following forms with your registration form.

- Birth Certificate
- Proof of Residency (proof of home ownership, rental/lease agreement, or utility bill in parent/guardian's name)
- Immunization Records

Please check if any of the following applies to your child:

- Title 1 Services
- Individual Education Plan (IEP) and/or special education related services
- 504 Plan
- ELL Services

What grade level will your child be attending? _____ What school? _____

Has your child ever been enrolled in any of the schools of the Gill-Montague Regional School District? Yes No
When? _____ What school? _____

STUDENT INFORMATION: Please fill out the following with the student's legal information.

FIRST NAME:	MIDDLE NAME:	LAST NAME:
DATE OF BIRTH:	CITY OF BIRTH:	STATE OF BIRTH:
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		COUNTRY OF BIRTH:
STREET:		
CITY:	STATE:	ZIP CODE:

PARENT/GUARDIAN INFORMATION:

PARENT 1

RELATIONSHIP TO STUDENT:	<input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian If guardian, please specify:		
NAME:			
ADDRESS:			
CITY:	STATE:	ZIP CODE:	
HOME PHONE:	WORK PHONE:	CELL PHONE:	
EMAIL ADDRESS:			
Please check one...	<input type="checkbox"/> I live with the student <input type="checkbox"/> I do not live with the student		

PARENT 2

RELATIONSHIP TO STUDENT:	<input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian If guardian, please specify:		
NAME:			
ADDRESS:			
CITY:	STATE:	ZIP CODE:	
HOME PHONE:	WORK PHONE:	CELL PHONE:	
EMAIL ADDRESS:			
Please check one...	<input type="checkbox"/> I live with the student <input type="checkbox"/> I do not live with the student		

CUSTODIAL INFORMATION:

Who has legal custody of the child? Parent Grandparent Guardian If guardian, please specify:



MILITARY FAMILY STATUS: Please check all that applies to the student.

- Active duty members of the uniformed services, National Guard and Reserve on active duty orders
- Members of veterans who are medically discharged or retired within one year
- Members who die on active duty

PREVIOUS ADDRESS:

PREVIOUS STREET:		
PREVIOUS CITY:	PREVIOUS STATE:	PREVIOUS ZIP CODE:

The following questions are used to collect information about the housing status of students as required by the McKinney-Vento Act, 42 U.S.C. 111435. Your answers help to determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? Yes No
2. Is this temporary living arrangement due to loss of housing or economic hardship? Yes No

If you answered YES to both of the above questions, please answer the following:

Where is the student presently living? (Please check one)

- Sharing housing with others (friends or relatives) in a house or apartment
- Moving from place to place
- In a place not usually for sleeping such as a car, park, or campsite
- In a motel/hotel
- In shelter

Family with whom the student resides:

NAME:		TELEPHONE:
ADDRESS:		
CITY:	STATE:	ZIP CODE:
RELATIONSHIP TO STUDENT:		

Please be aware that M.G.L. c. 76, §5 allows the School Committee to obtain the full cost of any student's education from any adult who enrolled a student in the Gill-Montague Regional School District, knowing that the student was not a resident.

What is the student's race/ethnicity? Please check all that apply...	Is the student Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
What is the student's native language? (Specify language or dialect first learned by student or first used by parent/guardian with the child)	
Country of Origin: (Country from which immigrant children emigrated)	

Emergent Immigrant Status: Yes No

(An indication of whether a student is eligible for the Emergency Immigrant Education Program is that the student must not have been born in any State (and of the 50 states, Puerto Rico, District of Columbia, Guam, American Samoa, the Virgin Islands, the Northern Marian Islands, or the territory of the Pacific Islands) and must not have completed 3 full academic years of school in any state.)

Migrant Status: Yes No

An indication of whether an individual or a parent/guardian accompanying an individual maintains primary employment in one or more agricultural or fishing activities on a seasonal or other temporary basis and establishes a temporary residence for the purpose of such employment.



Is this the first time the child in a school in the USA? Yes No

If NO, where did the student go to school?

How long did the student attend school?

What language was used for instruction?

Has the child attended school in another country? Yes No

If YES, where did the student go to school?

How long did the student attend school?

What language was used for instruction?

Has the child studied English? Yes No How many years of English has the child studied? _____

For children enrolling in Kindergarten only:

Did the child participate in any group experience prior to entering school (i.e. daycare, preschool)? Yes No

Name of pre-school/daycare: _____

Please provide any additional information about your child that may help him/her receive appropriate English Language instruction:

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. The 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'S FULL NAME:		
COUNTRY OF BIRTH:	DATE OF BIRTH: (mm/dd/yyyy)	GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
DATE FIRST ENROLLED IN ANY U.S. SCHOOL: (mm/dd/yyyy)		
What is the native language of each parent/guardian? (circle one) _____ (parent(s)/guardian) _____ (parent(s)/guardian)	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?	
Which other language does your child know? (circle all that apply) _____ speak/read/write _____ speak/read/write	Which language does your child use? _____ (seldom/sometimes/often/always) _____ (seldom/sometimes/often/always)	
Will you require written information from school in your native language? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will you require an interpreter/translator at Parent-Teacher meetings? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent/Guardian Signature:	Today's Date:	



HEALTH/MEDICAL INFORMATION and Permission to treat

For School Nurse's Records

STUDENT'S NAME:

FIRST NAME:		MIDDLE NAME:		LAST NAME:	
GENDER:			DATE OF BIRTH:		
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other					
STREET:				HOME PHONE:	
CITY:		STATE:		ZIP CODE:	

Does your child have health insurance? Please circle: Yes / No

Health Insurance Company:

Physician's Information: Please provide your family physician's name and phone number.

Please list any medications that your child takes:

Please check all that your child has been diagnosed with:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Hearing problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraines	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Condition

Others: (specify) _____

Allergies: please specify (food, medications, environmental, insects)

If your child has allergies, do they require an EPI-PEN? Yes / No

NOTE: EPI-PENS are administered only to children with a known medically diagnosed life threatening allergy.

Does your child have any physical limitations that may require program modification or restrictions? If so, please explain.

Please add any other problems or comments you like to bring to the attention of the school nurse or physician. Please include any significant accidents, illnesses, and or losses (death in family, a move, divorce, etc.) in recent months that may affect your child's school experience.

I give permission for the school nurse to administer the following medication(s) to my child: (Please circle yes or no)

Yes / No Ibuprofen	Yes / No Benadryl	Yes / No Tums	Yes / No Cough Drops
Yes / No Tylenol	Yes / No Calamine	Yes / No Bacitracin	

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to the school nurse to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment. If emergency treatment is required, and the parents or legal guardians cannot be reached immediately, my signature in the space provided below empowers the school authorities to exercise their own judgment in calling the physician indicated above or to transport the child to a hospital emergency room.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____



EMERGENCY INFORMATION:

If my child becomes ill at school and neither parent can be reached, you are authorized to call the following individuals who will assume responsibility and arrange transportation.

NAME:	RELATIONSHIP:
PHONE:	MOBILE:
NAME:	RELATIONSHIP:
PHONE:	MOBILE:
NAME:	RELATIONSHIP:
PHONE:	MOBILE: