
NEW STUDENT REGISTRATION FORM

On behalf of the School Counseling Department

WELCOME TO SPAULDING HIGH SCHOOL!

Please be advised that the following documents **MUST** be completed and/or received by the Guidance Secretary **BEFORE** your student's schedule is generated:

1. Completed Student Registration Packet
 2. Record Release Form (in registration packet)
 - 3. Birth Certificate**
 - 4. Immunization Records**
 - 5. Proof of Residency required (Per School Board Policy).**
Please fill out Residency Form
 6. Proof of guardianship or court paperwork
 7. Individual Education Plan (IEP or 504 plan) **If qualified*
-

When all of the necessary documentation is received by the guidance secretary, an appointment will be made with the appropriate guidance counselor with whom the student's schedule will be generated.

Please note that students will not start on the same day as their appointments.

Please reach out to the SHS Guidance Department with any questions.

SHS Counseling Secretary: (603)332-0757 ext. *2118

SHS Counseling Fax: (603)335-7377

SHS Counseling Email: brown.k@sau54.org

City of Rochester School Department



Office of the Superintendent
150 Wakefield Street
Suite #8
Rochester, NH 03867-1348
(603) 332-3678
FAX: (603) 335-7367

If you need assistance in reviewing this letter, please ask the person from our office who is meeting with you. We can provide you translations of the information, or contact an interpreter to speak with you, if necessary.

Si necesita ayuda para revisar esta carta, pregúntele a la persona de nuestra oficina que se reunirá con usted. Podemos proporcionarle traducciones de la información o contactar a un intérprete para que hable con usted, si es necesario.

Jika Anda memerlukan bantuan untuk meninjau surat ini, tanyakan kepada orang di kantor kami yang akan bertemu dengan Anda. Kami dapat menyediakan Anda dengan terjemahan informasi atau mengatur juru bahasa untuk berbicara dengan Anda, jika perlu.

यदि तपाईंलाई यो पत्र समीक्षा गर्न मद्दत चादिन्छ भन्ने, तिम्रो कार्यालयमा तपाईंलाई भेट्ने व्यक्तिलाई सोध्नुहोस्। तिम्रो तपाईंलाई अनुवादित जानकारी उपलब्ध गराउनु सक्छ वा आवश्यक भएमा तपाईंसँग कुनै रा गर्न आवश्यक व्यवस्था गर्न सक्छ।

Dear Parent/Guardian,

Welcome to the Rochester School District.

Attached to this letter is the *Home Language Survey* developed by the New Hampshire Department of Education (NH DOE) that we ask you to complete. The information in the survey ensures that we have the most accurate demographic information about students enrolling in our schools. We also need this information in order to understand a student's background in using and understanding English, and to determine how best to communicate with you as their parent or guardian.

The Survey is a two-page document that calls for information about your child's background in using English or other languages, and in attending school or receiving educational services. It is important that this survey be completed in full, or that you include as much responsive information as is possible.

Please be sure to respond to *Question 12* of the Survey by stating your preferred language that your child's school should use when sending you information or communicating directly with you.

If you have questions about completing the Survey, please ask the person from our office who is meeting with you. The survey is also available in several languages, including Spanish, Arabic,

Bosnian, French, Nepali, Portuguese, Swahili, and Vietnamese. If you do not speak one of these languages, we can contact a translator to assist you in completing the Survey.

If you answer Question 12 of the Survey by listing a language other than English, then your child's school will work to communicate with you in your preferred language. As part of that responsibility, the school will send you translations of certain "essential" school records when applicable to your child. Examples of those records include: academic progress reports, disciplinary information, permission forms, announcements of parent-teacher conferences, and health and safety information. In addition, we ask that you inform your child's school if you wish to receive a translated version of the school's full Student Handbook.

Please note that in the event of an emergency, the district will initially communicate with all parents in English. Additional communications with parents in their preferred language will follow as soon as practicable.

If you have any further questions regarding this letter, educational services for your child, or your access to school information, please contact the Rochester School Department Superintendent's office.

We look forward to working with your child and with you.

Sincerely,

The Rochester School
Department



Home Language Survey (HLS)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.		
STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
Month	Day	Year
		<input type="checkbox"/> Male <input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to Student

Language Background (Please check all that apply.)		
1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother _____ <i>specify</i>	<input type="checkbox"/> Father _____ <i>specify</i>
	<input type="checkbox"/> Guardian(s) _____ <i>specify</i>	
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:	
SCHOOL DISTRICT INFORMATION:	Student SASID
School Name	Address

Home Language Survey (HLS)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes* No Not sure

☐ ☐ ☐ *If yes, please explain: _____

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

10a. Has your child ever been referred for a special education evaluation in the past? ☐ No ☐ Yes* *Please complete 10b below

10b. *If referred for an evaluation, has your child ever received any special education services in the past?

☐ No ☐ Yes – Type of services received: _____

Age at which services received (Please check all that apply):

☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ☐ No ☐ Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

12. In what language(s) would you like to receive information from the school? _____

Signature of Parent or Guardian

Month: Day: Year:

Date

Relationship to student: ☐ Mother ☐ Father ☐ Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLS

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLS AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ No ☐ Yes

**DATE OF INDIVIDUAL
INTERVIEW:

MO. DAY YR.

OUTCOME OF
INDIVIDUAL
INTERVIEW:

☐ ADMINISTER STATE APPROVED WIDA Screener
☐ NOT ELIGIBLE FOR EL SERVICES

NAME/POSITION OF NH ESOL AND WIDA CERTIFIED PERSONNEL ADMINISTERING WIDA SCREENER

NAME: _____ POSITION: _____

DATE OF WIDA
SCREENER
ADMINISTRATION:

MO. DAY YR.

PROFICIENCY
LEVEL ACHIEVED
ON WIDA
SCREENER:

Overall Composite Score: _____

Does the student qualify for EL support? ☐ No ☐ Yes

Please attach a copy of the student's WIDA screener score report and file in student's cumulative folder.

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP:

Rochester School Department – Student Registration Form



Pupil Information: (please print, using black or blue ink)

Name: _____
(Last) (First) (Middle)

M/F _____ Date of Birth _____ City/State of Birth _____

Street Address _____ City _____ State _____ ZIP _____

Home Phone _____ Cell _____

Mailing Address (if different from above) _____

<p>Ethnicity: (circle one) Is your child Hispanic/Latino? Yes or No</p> <p>Race: (check all that apply) _____ American Indian/Alaskan Native _____ Asian _____ Black/African American _____ Native Hawaiian/Other Pacific Islander _____ White</p>	<p>Student resides with (check one):</p> <p>_____ Both Parents _____ Mother _____ Father _____ Legal Guardian</p> <p>_____ Joint Shared Custody _____ Foster Parent _____ Other</p> <p>Do you have any court orders? If yes, a complete original copy of any legal documents/court orders must be presented (i.e. divorce decree/parenting plan pertinent to custody & registration for school, custody, restraining order, etc.)</p>
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Date of Withdrawal: _____ **Grade now entering** _____

Last School Attended: _____ Grade: _____
(School) (City) (State)

Has your child ever registered or been evaluated by Rochester Public Schools before? If yes, when, or how long ago?

Does your child receive Special Services now? If yes, check all that apply: IEP _____ 504 _____ Other _____

Does your child have health issues? Yes _____ No _____

Please list all children who reside in the primary household between the ages of 0-18. (name, date of birth, school-if applicable)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Primary Household (Parents/Guardians/Legal Custodians Names(s) with whom the student primarily resides)

1. Name: _____ Relationship to student _____
 Work Phone: _____ Cell Phone: _____ Email Address: _____
2. Name: _____ Relationship to student _____
 Work Phone: _____ Cell Phone: _____ Email Address: _____

Secondary Household (Parent/Guardian/Legal Custodian Name with whom the student **does not** primarily reside)

Name: _____ Relationship to student _____
 Home Phone: _____ Cell #: _____ Work #: _____ Email Address: _____
 Secondary Address (no PO Boxes) _____
 Number/Street City/Town State/Zip

(Parent / Guardian Signature) _____

Date _____

FOR OFFICE USE ONLY

School _____ Bus # _____ D.E. _____ R.N. _____ D.B. _____ ESL _____ US D.E. _____
 ID # _____ Notified School _____ Rec Request _____ Entry Code _____ SASID _____
 Locker _____ HR _____ HR Teacher _____ Team _____ Other _____

Proof of Residency: Date Residency Affidavit Signed:

Lease _____ Closing Statement _____ Telephone _____ Electricity _____ Cable _____ FIT _____
 Address on Postal Forwarding Sticker _____ Dr. Billing _____ Bank Statement _____ Payroll Check _____

Student Name _____

Optional

**McKinney-Vento Residency Form
2023-24 School Year**

The answers you give below will help determine your child's eligibility for services under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school, even if they do not have the documents needed, such as proof of residency, immunization records or birth certificate.

Are you temporarily staying in one of the following places due to loss of housing or economic hardship?

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

____ Homeless Shelter ____ Doubled up (living/staying with another family member/others)

____ Hotel / Motel ____ Other location (e.g. in a car/park/campsite)

____ Other temporary living arrangement (please describe) _____

Names of children in household if above applies to you:

You only need to fill out ONE form per family

First Name	Last Name	Grade/Age	School

Parent/Guardian Name _____

Address _____ Phone _____

City _____ State _____ Zip _____

Email address _____

Please read: Presenting false information, false records or falsifying records is an offense punishable by federal and state law. By signing below, you attest that all information on this form is true and acute.

Parent/Legal Guardian Signature: _____ Date _____

For School Use Only: I certify the above named student is eligible to receive services under McKinney Vento Law Including the Child Nutrition Program

McKinney Vento Liaison: _____ Date _____

Rochester School Department

RESIDENCY AFFIDAVIT

New Hampshire law requires that your child be a legal resident of the Rochester School District in order to attend its schools. The legal residency of a minor child is defined in RSA 193:12 as follows:

1. Parents live together. The legal residence of a minor child is where his or her parents reside.
2. Parents live apart but are not divorced. Legal residence is the residence of the parent with whom the child resides.
3. Parents are divorced with joint legal custody or joint decision-making authority. Residence of the minor child is the residence of the parent with whom the child resides.
4. Parents are divorced and one parent has been given sole or primary physical custody or sole or primary residential responsibility by a court. Legal residence of the minor child is the residence of the parent who has sole or primary custody or sole or primary residential responsibility.
5. Parents are divorced and court order is for equal or approximately equal periods of residential responsibility. The child's legal residence is as stated in the court order/parenting plan.
6. The minor child is in the custody of a legal guardian appointed by a court of competent jurisdiction. Legal residence for the minor child is where the guardian resides.

Student Name _____ D.O.B. _____

The student's physical home address is:

Mailing address if different _____

The student lives with _____ who is

(CHECK ONE) a _____ parent or _____ guardian appointed by a court.

If you have checked off parent, please check off which one applies: Married Separated Divorced.

CATEGORY I (one document required) Homeowner/Renters:

Homeowners: Mortgage papers Certificate of Occupancy on a newly built home	Renter: Signed and dated lease	Other Notarized letter from landlord Notarized letter with explanation of living arrangements of property containing contact information for verification of the SAU.
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CATEGORY II (one document showing proper address is required)

Most recent cable bill Most recent gas or electric bill Doctor's bill, bank statement, or payroll check

The following additional documents are also required to be submitted:

Any court ordered, judgements, decrees, parenting plan or other documents (joint agreements) awarding primary physical custody or granting guardianship of the student to any person.

I (We) certify and acknowledge that the truth of the information contained in this Affidavit will be relied upon by the School District in determining the legal residence of the student in accordance with the educational laws of the State of New Hampshire. I (We) certify that the information contained herein is true, accurate and complete under pains and penalties of New Hampshire law. I (We) understand that providing misleading or false information about a student's residency is a criminal offense under RSA 641:3 and RSA 641:7. In addition, if this Affidavit is untrue, I (We) agree to pay tuition for my (our) child/ children to the district.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Adopted: October 12, 2023

SPAULDING HIGH SCHOOL

GUIDANCE DEPARTMENT

130 Wakefield Street

Rochester, NH 03867

TEL. (603)332-0757, ext. 5 FAX. (603)335-7377

REQUEST FOR RELEASE OF ACADEMIC/MEDICAL RECORDS

Requesting Records From/Releasing Records To (CIRCLE ONE):

SCHOOL

ADDRESS

CITY/STATE/ZIP

NAME OF STUDENT (PRINTED)

GRADE: _____ D.O.B. _____

I grant permission to obtain or release the requested information.

(If student is under 18, parent or legal guardian must sign)

Signature of Parent or Legal Guardian

Date:

Address: _____ Telephone (Home) _____

(Work) _____

For Office Use Only

REQUESTED INFORMATION

____ Copy of high school transcript (Official)	____ Withdrawal grades (Numerical)
____ Attendance record	____ Immunization/Health records
____ Explanation of Grading Values & School Profile	____ Special ED/IEP records & testing
____ Psychological testing	____ Discipline records
____ SASID#	____ Birth Certificate & appropriate court work
____ OTHER _____	

Request Sent By and Date _____

According to the Buckley Amendment, an educational institution may release student records to officials of another school system without the written consent of the parent.

4/2022 CC

City of Rochester School Department

Office of the Superintendent
150 Wakefield Street, Suite #8
Rochester, NH 03867-1348
Phone: (603) 332-3678
Fax: (603) 335-7367



TO: All Parents and Guardians
RE: **Medicaid to Schools Program**

In 1990, New Hampshire passed legislation to allow School Districts to access Medicaid funds to provide for children's health related services delivered in educational settings. This federal funding support is very important to your child's school in order to help offset the expense of providing these essential services.

If your child is covered by Medicaid Health Insurance, the Federal Medicaid Program will pay 50% of the cost of providing the health-related services prescribed in your child's Individualized Education Plan (IEP). The Rochester School District contracts with the "Medicaid for NH Schools Program" which handles the billing for reimbursement and is bound by a strict confidentiality agreement.

Please complete the section below (***whether or not your child is covered by Medicaid***), and return it to the school that your child attends; they will forward it to my attention at the Office of the Superintendent. The Medicaid number that you provide will be held in the strictest of confidence and will only be used to bill for services that your child receives.

☐

My child is covered by Medicaid.

☐

My child is NOT covered by Medicaid.

Parent/Guardian Name: _____
Please print: First Name MI Last Name

Student Name: _____
Please print: First Name MI Last Name

Student Medicaid Number: _____ **Date of Birth** ____/____/____

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

Should you have any questions or concerns regarding the Rochester School District's Medicaid Program, please contact SAU #54, 603-332-3678. Thank you very much for your assistance.

Rochester School Department
School Year 2023-2024
Parent Guardian Military Status Form

The State of New Hampshire is asking to provide military data as part of their annual enrollment reports. Please check off any of the criteria below if it applies to either parent/legal guardian. **Please note to only return this form if the criteria below applies and you wish to disclose your status.**

Student Name: _____ **Grade:** _____ **Date:** _____

Parent/ Guardian Name (1): _____

Military Status (check one)

- ☐ 1 Parents or Legal Guardians' Military Status does not apply for this student.
- ☐ 2 Active Duty in Armed Forces (not including National Guard)
- ☐ 3 Full Time National Guard
- ☐ 4 Student has parent or legal guardians in both 2 and 3.

Parent/ Guardian Name (2): _____

Military Status (check one)

- ☐ 1 Parents or Legal Guardians' Military Status does not apply for this student.
- ☐ 2 Active Duty in Armed Forces (not including National Guard)
- ☐ 3 Full Time National Guard
- ☐ 4 Student has parent or legal guardians in both 2 and 3.

Following are federal definitions that should help determine which status is appropriate for a given student.

Federal Definitions:

“Armed Forces” means the Army, Navy, Air Force, Marine Corps, and Coast Guard.

“Active duty” means full-time duty in the active military service of the United States, including full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned. **Such term does not include full-time National Guard duty.**

“Full-time National Guard duty” means training or other duty, other than inactive duty, performed by a member of the Army National Guard of the United States or the Air National Guard of the United States in the member's status as a member of the National Guard of a State or territory, the Commonwealth of Puerto Rico, or the District of Columbia under section 316, 502, 503, 504, or 505 of title 32 for which the member is entitled to pay from the United States or for which the member has waived pay from the United States.

ROCHESTER HEALTH POLICIES

1. Injuries occurring at home are the responsibility of the family and should be treated at home
2. Employees have a duty to provide emergency first aid treatment to students who are injured or have a condition requiring immediate attention. (See RSA 508:12 for statement of immunity from liability).
3. In cases of emergency, 911 will be activated and immediate medical attention will be sought. A parent/guardian and Central Office will be notified as soon as possible.
4. Follow-up treatment ace wraps, dressing changes, eye patching, will only be given upon written instruction from the physician and at the request of the parent. The use of crutches in school requires a medical note from a doctor and directives as to activity (excusal from PE, recess and building mobility along with evacuation planning are required.)
5. An emergency form will be completed for each student, listing the name, address, and **telephone number of parents or guardian and other persons authorized to assume responsibility**. The name of the physician and any present medical concerns may be listed on the form or communicated to the school nurse. Parents are responsible for informing the school as to changes in this information.
6. Students who are unable to participate in the total program shall present a letter from their physician stating the reasons and the approximate duration of limitation.
7. When other arrangements can be made medication should not be taken during school hours. Most prescriptions can be regulated around the school day. When medication has to be taken during school hours it must be a prescribed medication. Any over the counter medication including cough syrups, , pain relievers, etc. should be taken before and after school. In accordance with ED 311.02, if a prescribed medication must be taken during school hours, the school nurse is responsible for administering or delegating the administration of medication. The school nurse must have the following three items before medication can be given:
 - A. A prescription written by the licensed practitioner stating the name of the medication, the dosage and time as well as a diagnosis, if not in violation of confidentiality.
 - B. All medication shall be delivered and stored in the original pharmacy or manufactured labeled container. This shall be no more than a 30 day supply. The medication must be delivered to the school nurse or designee by a parent/guardian or designated responsible adult. A single dose of medication may be transferred from this container to a newly labeled container for the purpose of field trips or school sponsored activities.
 - C. Signed permission from the parent/guardian allowing the school nurse, or her designee, to observe and/or assist the child in taking his/her medication.
8. Students in grades 6 through 12 may be administered acetaminophen (Tylenol) for pain relief at the discretion of the nurse between the hours of 10:30 and 1:30 and only with written parent permission.
9. The school nurse will be responsible for the determination and appropriateness of delegation of medication administration, when necessary, to employees of the Rochester School District. Employees may not further delegate such administration to other staff members, outside agencies or volunteers.

10. In accordance with RSA 200:42-RSA200:47, a student will be allowed to carry and self administer prescription epi pens and rescue inhalers provided that the prescribing practitioner and parent complete the appropriate medication forms for self administration. The Nursing Supervisor, working with the School Nurse may be required, by necessity, to delegate to a student the self administration of a medication as required by a physician. The appropriate self administration medication forms must be completed and signed by the practitioner and the parent/guardian. A discussion with the parent/guardian and a plan of care and parameters from the medical provider to the school nurse must be furnished so that determination of necessity, management of care and emergency assist can occur. Communication between all parties, as medical needs change, would be the most prudent practice and an expectation within the school environment.
11. The School Health Services will follow the recommendations of the New Hampshire Bureau of Communicable Disease. If necessary, a note from his/her physician will be reviewed before the student may return to school.
12. Questions regarding school health policies should be directed to the school nurse.

Adopted:	April 8, 1993
Amended:	November 9, 1995
Amended:	January 13, 2009
Amended:	January 5, 2012
Amended:	October 11, 2018

ROCHESTER SCHOOL HEALTH SERVICES
150 Wakefield Street, Suite 8 ~ Rochester, NH 03867-1348
Tel. (603) 332-4090 ext. *4107 FAX (603) 332-4800

New Hampshire State Law requires documented proof of the following before a student can be permitted to attend school:

RSA 200:38 All children shall be **immunized prior to school entrance** in accordance with RSA 141-C:20-a and the doses and age requirements in He-P301.14.

RSA 200:32 A **complete medical examination** by a licensed physician shall be provided prior to entrance into the school system and thereafter as often as deemed necessary by the local school authority.

He-P301.14 **Immunization Requirements for entry to school:**

***Immunization requirements for Preschool, 3-5 years old, are listed on the back side of the Blue Form in this packet.**

DTaP, DT/DTP, Tdap/Td:

***For Children 6 years and under**, a minimum of 4 or 5 doses of a DTaP vaccine with the last dose given on or after the 4th birthday shall be deemed acceptable at the intervals indicated in He-P301.13 (4)c. **Also, for children 6 years and under**, the 5th dose is not necessary if the 4th dose was administered at age 4 years or older and is at least 6 months after the previous dose

***For children 7 years and older**, 3, 4 or 5 doses of DTaP, Tdap or Td vaccine with the last dose given on or after the 4th birthday.

***For Grades 7-12**, 1 dose of Tdap is required for entry into 7th grade. A Tdap vaccine given on or after the 7th birthday meets the school requirement for Grade 7.

POLIO:

***A minimum of 3 doses of Polio is acceptable**, if the last dose was after the age of 4 and the vaccine doses are all IPV or all OPV.

***If a combined IPV/OPV polio schedule was used**, 4 doses are always required, even if the 3rd dose was after the 4th birthday. Any OPV dose given on/after April 1, 2016 does not count toward the polio vaccine requirement and the series must be completed with IPV

***Kindergarteners through 9th graders** – must have 3 to 4 doses of polio vaccine, with one dose on or after the 4th birthday, and the last two doses separated by 6 months.

***10th grade through 12th grade** - needs 3 doses of polio vaccine with the last dose given on or after the 4th birthday, or 4 doses regardless of age at administration.

MMR:

***Kindergartners through 12th graders** - 2 doses required; the first dose must be on or after the 1st birthday.

Hepatitis B:

***Children born on or after 1/1/1993** are required to have 3 doses of Hepatitis B

Varicella:

***All children entering Kindergarten through 12th grades** shall have two doses of Varicella. Documentation of immunity by confirming laboratory test results is required for **incoming Kindergarten through 12th grade students** if student has not received Varicella vaccine. History of disease as reported by health care provider, or parent, is acceptable. **In all grades**, the first dose of varicella must be on or after the 1st birthday.

***In younger preschool children**, Haemophilus Vaccine is required. The number of doses is dependent upon the type of vaccine given.

***Other rules may apply depending upon the age of the student and the intervals in which the vaccines were given.**

***A child may be admitted or enrolled under "Conditional Enrollment"** with documentation of at least one dose of each required vaccine and **documentation of an appointment date** for the next dose(s) of required vaccine(s) consistent with an accelerated immunization schedule. **This appointment date shall serve as the exclusion date if the scheduled appointment is not kept.**

The reverse side is to be completed by physician

PHYSICIAN FORM
ROCHESTER SCHOOL HEALTH SERVICES
150 Wakefield Street, Suite 8 ~ Rochester, NH 03867-1348 ~ Tel. (603) 332-4090 ext. *4107 Fax (603) 332-4800

This section to be completed by a parent/guardian

Student's Name: _____ Date of Birth: ____/____/____ Sex: _____

Doctor/Practice Name: _____ Phone: _____

You must bring immunization record with you to register your child - it may not be faxed. Once initial immunizations have been presented for registration, a physical and any subsequent immunizations needed may be faxed to the secured Nursing line, 332-4800. If necessary, I give permission for the physician to fax or mail this health form to the Rochester School District.

Parent/Guardian Signature: _____

This section to be completed by a physician

Results of a Vision Screening: _____ Results of a Hearing Screening: _____

Weight: _____ Height: _____ Blood Pressure: _____

Lead Level #1: _____ Date: _____ Lead Level #2: _____ Date: _____

The following information is part of a health history or was noted during the physical exam and should be included on the student's school health record: _____

Please check history/present concern regarding any of the following:

<input type="checkbox"/> RAD	<input type="checkbox"/> Asthma	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Orthopedic Problems	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Behavioral Issues
<input type="checkbox"/> Serious Illness/Injuries	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Skin Disorder
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Surgery	<input type="checkbox"/> Nutritional Concerns
<input type="checkbox"/> Hospitalizations		

If required please provide more information about any of the items you have checked above: _____

Are there any other concerns or chronic health conditions you would like to mention? _____

Is this student physically capable of carrying a full program of school activities? _____

***** PLEASE PROVIDE A COPY OF THE CURRENT IMMUNIZATION RECORD *****

I hereby certify the above named student has received the required immunizations and medical exam in accordance with New Hampshire State Law.

MD's Signature: _____ **Date of Exam:** _____ **Today's Date:** _____

Rochester School Health Services
Health History
(To Be Completed By Parent/Legal Guardian)

Student's Name: _____ Date of Birth: _____ Sex: _____

Doctor/Practice Name: _____ Phone: _____

Please answer all of the following questions. If you have other confidential information you do not wish to list here but may affect your child's health care, please contact your child's school nurse.

Does your child have any allergies? No ☐ Yes ☐ If yes, explain to what, how they react and how it is treated.

Does your child have now (or in the past) any ear/hearing problems? No ☐ Yes ☐ If yes, explain: _____

Has your child had Chickenpox? No ☐ Yes ☐ If **Yes**, give age, date, **or lab test results (required for grades K-12)**

Is your child on any medications? No ☐ Yes ☐ If yes, give the name of medication, when taken & reason: _____

Is your child presently under medical care? No ☐ Yes ☐ If yes, explain: _____

Has your child experienced any emotional trauma? No ☐ Yes ☐ If yes, explain: _____

Is there any reason your child cannot participate in a full program of activities at school? No ☐ Yes ☐ If yes, explain:

Please check any of the following your child has/had:

- | | | |
|--|---|---|
| <input type="checkbox"/> RAD (Reactive Airway Disease) | <input type="checkbox"/> Asthma | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Seizure Disorder/convulsions | <input type="checkbox"/> Behavioral Issues |
| <input type="checkbox"/> Serious Illness/Injuries | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Surgery (operations) | <input type="checkbox"/> Nutritional Concerns |
| <input type="checkbox"/> Hospitalizations | | |

Please give us more information about any of the items you have checked above: _____

Are there any other concerns or chronic health conditions you would like to mention? _____

Health history completed by: _____ **Date completed:** _____

ROCHESTER SCHOOL HEALTH SERVICES
150 Wakefield Street, Suite 8
Rochester, New Hampshire 03867-1348
Phone: (603) 332-4090 ext. 4107 Fax: (603) 332-4800

Dear Parent/Guardian:

Welcome to the Rochester School System. The health of your child is of concern to us since it greatly influences his/her ability to learn. Please feel free to contact us about your child's health.

New Hampshire State Law Requires documented proof of the following before a student can be permitted to attend school:

- RSA 200:38 All children shall be **immunized prior to school entrance** in accordance with RSA 141-C20-a and the doses and age requirements in He-P 301.14.
- RSA200:32 A **complete medical examination** by a licensed physician upon or prior to entrance into the school system and thereafter as often as deemed necessary by the local school authority.

He-P301.14 Immunization Requirements for Entry to School:

***Immunization Requirements for Pre-school Students, 3-5 years old, is listed on the back side of this form.**

DTaP, DT/DTP, Tdap/Td:

- *For Children 6 years and under**, a minimum of 4 or 5 doses of a DTaP vaccine with the last dose given on or after the 4th birthday shall be deemed acceptable at the intervals indicated in He-P301.13 (4)c. **Also, for children 6 years and under**, the 5th dose is not necessary if the 4th dose was administered at age 4 years or older and is at least 6 months after the previous date.
- *For children 7 years and older**, 3,4, or 5 doses of DTaP, Tdap or Td vaccine with the last dose given on or after the 4th birthday.
- *For Grades 7-12**, 1 dose of Tdap is required for entry into 7th grade. A Tdap vaccine given on or after the 7th birthday meets the school requirement for Grade 7.

POLIO:

- *A minimum of 3 doses of Polio is acceptable**, if the last dose was after the age of 4 and the vaccine doses are all IPV or all OPV.
- *If a combined IPV/OPV polio schedule was used**, 4 doses are always required, even if the 3rd dose was after the 4th birthday. Any OPV doses given on/after April 1, 2016 does not count toward the polio vaccine requirements and the series must be completed with IPV
- *Kindergartners through 9th graders** – must have 3 to 4 doses of polio vaccine, with one dose on or after the 4th birthday, and the last two doses separated by 6 months.
- *10th grade through 12th grade** - needs 3 doses of polio vaccine with the last dose given on or after the 4th birthday, or 4 doses regardless of age at administration.

MMR:

- *Kindergartners through 12th graders** - 2 doses required; the first dose must be on or after the 1st birthday.

Hepatitis B:

- *Children born on or after 1/1/1993** are required to have 3 doses of Hepatitis B

Varicella:

- *All children entering Kindergarten through 12th grades** shall have two doses of Varicella. Documentation of immunity by confirming laboratory test results is required for **incoming Kindergarten through 12th grade students** if student has not received Varicella vaccine. History of disease as reported by health care provider, or parent, is acceptable. **In all grades**, the first dose of varicella must be on or after the 1st birthday.
- *In younger preschool children, Haemophilus Vaccine is required.** The number of doses is dependent upon the type of vaccine given.
- *Other rules may apply depending upon the age of the student and the intervals in which the vaccines were given.**

I have read the state requirements for entrance to school. I understand that my child, _____, cannot attend school unless his/her immunizations are up to date.

If you have other confidential information you do not wish to list here but may affect your child's health care, please contact your child's school nurse.

Does your child have any medical concerns? Yes _____ No _____ **If yes, please explain:** _____

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

Pre-school Students 3-5 Years Old

New Hampshire Immunization Requirements 2023-2024

Refer to page 2 for minimum ages and intervals

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

3-5 years	Four doses. The 3 rd and 4 th 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.
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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 ≥ 5 years of age.
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HEPATITIS B

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

JLCDA-R

Parent/Guardian Consent for School Health Services-Medical

Student First Name	Last Name	M.I.	Birth Date
Parent/Guardian First Name	Last Name	Phone Number	Relationship to Student

For each service choose Yes or No:

1. Basic school based health care services including care and treatment for illness and injury:

YES

NO

YES- response will authorize such treatments including, but not limited to, major or minor injury or illness reported or observed while the student is at school. Failure to respond will result in an indication of "no" for healthcare treatment.

NO- response will result in calls to the parent or guardian for the student to be picked up for all medical concerns. This will be for all instances where students are feeling ill, present with bodily fluids, injuries such as cuts, scrapes, bumps, or bruises. EMS will be called for any situation deemed serious.

2. Hearing Screening:

YES

NO

3. Vision Screening:

YES

NO

4. Do you give permission for health information to be shared with your child's teacher(s)?

YES

NO

Note: This form, in addition to a physician's authorization, will be required for the school nurse to administer daily or as-needed prescribed or over-the-counter medications.

When necessary, emergency health services such as first aid, CPR, or use of an automated external defibrillator (AED) will be performed until emergency medical services arrive on campus.

I understand that this consent will remain in effect until the above named student transfers to another school district, graduates, or I indicate in writing that I wish to rescind this consent for school health services.

Parent/Guardian Signature

Parent/Guardian Printed Name

Date

Rochester School District Medical Authorization & Student Household Contact Form

Rochester Middle School, BCA & Spaulding High School

Grade _____

Teacher/Team _____

Bus # _____ Walk _____ Other _____

Please **PRINT** Neatly

Student's Legal Name: _____
Last First Middle

Date of Birth: ____/____/____
MM DD YYYY

Gender (Circle One): Male / Female

Nickname (Optional): _____

Address Where Student is **Living**: _____ Apt # (If Applicable) _____
Number Street City State Zip

Mailing Address (if different) _____ Apt # (If Applicable) _____
Number Street City State Zip

Student E-Mail Address: _____

Parent/ Legal Guardian who student lives with:

Home Ph# _____

Name: _____
Last First Middle Relationship Cell Ph# Work Ph#

Name: _____
Last First Middle Relationship Cell Ph# Work Ph#

Address: _____ Apt # (If Applicable) _____
Number Street City State Zip

Parent E-Mail Address: _____

Parent/ Legal Guardian who student does not live with (if applicable):

Home Ph# _____

Name: _____
Last First Middle Relationship Cell Ph# Work Ph#

Name: _____
Last First Middle Relationship Cell Ph# Work Ph#

Address: _____ Apt # (If Applicable) _____
Number Street City State Zip

Parent E-Mail Address: _____

Emergency and Dismissal Contact

Please list two readily available people you would like for us to have on file related to your child who will assume temporary care of your child if you cannot be reached first for permission to dismiss.

1. _____
Last First M Gender Relationship to the student Phone Number #1 Phone Number #2

2. _____
Last First M Gender Relationship to the student Phone Number #1 Phone Number #2

Medical Information

I consent for my child (grades 6 – 12) to be administered Acetaminophen (Tylenol) between the hours of 10:30am & 1:30pm for pain relief only.
____ Yes ____ No

In case of an accident or serious illness and I cannot be reached, I hereby authorize the school personnel to secure medical help for my child.

Name of Student's Physician: _____ Tel.# _____

Please list any health conditions/treatments including allergies (be specific), medications, chronic health conditions (asthma, seizures, etc.), glasses/vision concerns, hearing concerns, significant injuries etc.

If you have other confidential information you do not wish to list here but may affect your child's health care, please contact your child's school nurse.

Parent/Guardian Signature _____ Date _____

***Special circumstance – Please attach current legal documentation/information (custody issues, history, family circumstances, etc.)