JABISH BROOK MIDDLE SCHOOL
62 NORTH WASHINGTON ST.
BELCHERTOWN, MA 01007
PHONE: 413-323-0433
FAX: 413-323-0450

New Student Registration Packet

JBMS needs the following records on new students:

- Birth Certificate
- Immunizations/Recent Physical
- IEP (if applies)
- Grades and Testing Scores
- 2 forms of Proof of Residency
- Discipline Record from Previous School

Please visit our website at www.belchertownps.org
Click on **schools**
Click on **Jabish Brook Middle School.**

BELCHERTOWN Public Schools TRADITION AND INNOVATION – TOGETHER

Jabish Brook Middle School
62 North Washington Street
Belchertown, MA 01007
P (413) 323-0433 F (413) 323-0450

Mr. Thomas K. Ruscio, Principal
Principal
Jabish Brook Middle School
truscio@belchertownps.org

RELEASE OF RECORDS CONSENT FORM

STUDENT NAME: _____ **DOB:** _____

In compliance with state and federal laws, permission is required of parent, legal guardian or eligible student before any records can be released from/to an outside agency, school or college. In order to comply with this law, your signature is required.

I hereby grant permission for release of the following documents and communications:

Verbal Communication: _____

Standardized Tests/Transcript of Grades: _____

Health Records: _____

Transfer Card/Discipline Statement: _____

Special Education Records: _____

Other Contact Persons: _____

Other Evaluations: _____

RELEASED FROM/TO:

_____

_____

_____

_____

RELEASED TO/FROM:
Belchertown Public Schools
Jabish Brook Middle School
62 N. Washington Street
Belchertown, MA 01007

_____ _____

Parent/Advocate/Legal Guardian Signature **Date**

BELCHERTOWN PUBLIC SCHOOLS

School Registration Form

For Office Use Only

SASID: _____ Bus In: _____

Teacher: _____ Bus Out: _____

Grade: _____ Student ID: _____

Enroll Date: _____

☐ Cold Spring
☐ Swift River
☐ Chestnut Hill
☐ Jabish Brook
☐ Belchertown High

STUDENT INFORMATION

Last Name: | First Name: | Middle Name (no initial):

Date of Birth: | Male/Female/Non-binary: | Home Phone:

Place of Birth (City/State/Country): | Has this student ever attended Belchertown Public Schools? ☐ Yes ☐ No

HOME ADDRESS (Do not list a PO Box)

Street Name / Apartment: | Town / Zip:

MAILING ADDRESS (if different from above)

Street Name / PO Box / Apartment: | Town / Zip:

ETHNICITY, RACE, and LANGUAGE

Under federal law, we must report this information to ensure that students are not denied any rights or benefits. If you choose, you may identify your child according to the following categories. If you do not choose to do so, we will use our best judgment.

Choose **ONE** of the following: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino

Choose **ONE OR MORE**: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

ADDITIONAL SERVICES

Please note any special services your child has received in the past.

☐ Special Education (IEP) ☐ 504 Accommodation Plan ☐ Title I

☐ Free or Reduced Lunch ☐ Sheltered English Immersion ☐ English as a Second Language

PARENT / GUARDIAN #1

Last Name: | First Name: | Relationship to Student:

Home Phone: | Cell Phone: | Work Phone:

Email: | Occupation: | Place of Employment:

Does this person have legal custody of the student? ☐ Yes ☐ No | Does this person live in the same house as the student? ☐ Yes ☐ No | Address (if different):

PARENT / GUARDIAN #2

Last Name: | First Name: | Relationship to Student:

Home Phone: | Cell Phone: | Work Phone:

Email: | Occupation: | Place of Employment:

Does this person have legal custody of the student? ☐ Yes ☐ No | Does this person live in the same house as the student? ☐ Yes ☐ No | Address (if different):

PARENT / GUARDIAN #3

Last Name: | First Name: | Relationship to Student:

Home Phone: | Cell Phone: | Work Phone:

Email: | Occupation: | Place of Employment:

Does this person have legal custody of the student? ☐ Yes ☐ No | Does this person live in the same house as the student? ☐ Yes ☐ No | Address (if different):

EMERGENCY CONTACT (if parent/guardian cannot be reached)

Name (Last, First): | Relationship: | Address: | Phone: | Cell:

AUTOMATED NOTIFICATIONS

Belchertown Public Schools communicates with families using autodialed messages to telephones, including cellular phones. If you DO NOT wish to receive autodialed messages to certain numbers, you may opt out at any time by contacting the office of your child's school.

If you would like to receive text messages on your cellular phone, please text "Y" to 67587.

LEGAL AND CUSTODIAL INFORMATION

Do both parents have custody and parental rights with respect to this student? ☐ Yes ☐ No

If not, which of the following applies? ☐ Mother guardian with joint custody ☐ Mother guardian with sole custody ☐ Father guardian with joint custody ☐ Father guardian with sole custody Other (specify): _____

Are there any court orders in effect with respect to this student that should concern the school? ☐ Yes (explain) ☐ No _____

CHILDREN UNDER 18 IN HOUSEHOLD

Name (Last, First):	Birthdate:	Name (Last, First):	Birthdate:
Name (Last, First):	Birthdate:	Name (Last, First):	Birthdate:
Name (Last, First):	Birthdate:	Name (Last, First):	Birthdate:

PREVIOUS SCHOOL

Name of School: Address:

Phone Number: Fax Number: Grade: Teacher's Name:

MILITARY FAMILY STATUS

Does this child have a parent/guardian for whom any of the following are true? ☐ On active military duty. ☐ Retired or medically discharged in past 12 months. ☐ Died on active duty in past 12 months. ☐ None of the above.

CHECKLIST AND SIGNATURE

In addition to this form, the school district requires copies of the following documents, which will be kept as part of the student's record according to state and federal records laws:

- ☐ Birth certificate
- ☐ Immunization records
- ☐ Physical examinations
- ☐ Complete school discipline records (if applicable)
- ☐ Special education records and/or ADA records (if applicable)
- ☐ Any court documents pertaining to custody, restraining orders, and/or guardianship (if applicable)
- ☐ Proof of residency: **2 forms required**
  - ☐ Mortgage statement or rental agreement/lease
  - ☐ Utility bill at the address listed (heating, electricity, or phone)

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

For office use only:

☐ All forms received

☐ Some forms received. Forms still outstanding: _____

Signature of staff member receiving forms: _____ Date: _____

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. This 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 Information

First Name _____ Middle Name _____ Last Name _____ F ☐ M ☐ Gender

Country of Birth _____ Date of Birth (mm/dd/yyyy) ___/___/___ Date first enrolled in ANY U.S. school (mm/dd/yyyy) ___/___/___

School Information

Start Date in New School (mm/dd/yyyy) ___/___/20___ Name of Former School and Town _____ Current Grade _____

Questions for Parents/Guardians

What is the native language(s) of each parent/guardian? (circle one) _____ (mother / father / guardian) _____ (mother / father / 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 languages does your child know? (circle all that apply) _____ speak / read / write _____ speak / read / write	Which languages does your child use? (circle one) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always
Will you require written information from school in your native language? Y ☐ N ☐	Will you require an interpreter/translator at Parent-Teacher meetings? Y ☐ N ☐
Parent/Guardian Signature: X	___/___/20___ Today's Date: (mm/dd/yyyy)

JABISH BROOK MIDDLE SCHOOL
GUIDANCE REGISTRATION

Student's Name: _____ Grade Entering: ___

Today's Date: _____ Planned Date of Entry: _____

Previous School: _____

Phone Number that You can be Reached at: _____

SCHEDULING INFORMATION

- Does your child have any special services/plans?
  - DCAP ☐ Yes ☐ No
  - 504 ☐ Yes ☐ No
  - IEP ☐ Yes ☐ No
  - Health Care ☐ Yes ☐ No
  - Other *(what kind)* _____ ☐ Yes ☐ No

  If YES, have the current documents been forwarded? ☐ Yes ☐ No

- Has your child ever received English Language Learner (ELL) instruction? ☐ Yes ☐ No

  Does your child currently receive ELL support? ☐ Yes ☐ No

- Has your child had Band in the past? ☐ Yes ☐ No

  Has your child taken Music lessons? ☐ Yes ☐ No

  Would your child like to continue or begin Band? ☐ Yes ☐ No

  Which instrument does your child play? _____

  If your child is interested in participating in Band, please contact the Band director, Ms. Smith, at your earliest convenience at (413) 323-0433 ext. 117.

- Has your child previously taken a Foreign Language *(Grade 8 students only)*? ☐ Yes ☐ No

  If YES, Which Language? _____

  Which Language is your child interested in taking? ☐ Latin ☐ French ☐ Spanish

  (Pending availability)

- Would your child like a tour of the school *(pending availability)*? ☐ Yes ☐ No

Massachusetts Parental Notice for One Time Consent to Allow the School District To Access MassHealth (Medicaid) Benefits

School District Name and Code: Belchertown Public Schools (0024)

School/District Contact: Student Support Services

Dear Parent/Guardian:

The purpose of this letter is to ask for your permission (also known as consent) to share information about your child with MassHealth. Local communities in Massachusetts have been approved to receive partial reimbursement from MassHealth for the costs of certain health-related services provided by the district to your child (or children). In order for your community to get back some of the money spent on services, the school district needs to share with MassHealth the following types of information about your child: name; date of birth; gender; type of services provided, when, and by whom; and MassHealth ID.

With your permission, the school district will be able to seek partial reimbursement for services provided by MassHealth, including, among others, a hearing test or eye exam; a school physical; occupational or speech or physical therapy; some school nurse visits; and counseling services with the school social worker or psychologist. Each year, the district will provide you with notification regarding your permission; you do not need to sign a form every year.

The school district cannot share with MassHealth information about your child without your permission. As you consider giving permission, please be advised of the following:

1. The school district cannot require you to sign up for MassHealth in order for your child to receive the health-related and/or special education services to which your child is entitled.

2. The school district cannot require you to pay anything towards the cost of your child's health-related and/or special education services. This means that the school district cannot require you to pay a co-pay or deductible so that it can charge MassHealth for services provided. The school district can agree to pay the co-pay or deductible if any such cost is expected.

3. If you give the school district permission to share information with and request reimbursement from MassHealth:
   a. This will not affect your child's available lifetime coverage or other MassHealth benefit; nor will it in any way limit your own family's use of MassHealth benefits outside of school.
   b. Your permission will not affect your child's special education services or IEP rights in any way, if your child is eligible to receive them.
   c. Your permission will not lead to any changes in your child's MassHealth rights; and
   d. Your permission will not lead to any risk of losing eligibility for other Medicaid or MassHealth funded programs.

4. If you give permission, you have the right to change your mind and withdraw your permission at any time.

5. If you withdraw your permission or refuse to allow the school district to share your child's records and information with MassHealth for the purpose of seeking reimbursement for the cost of services, the school district will continue to be responsible for providing your child with the services, at no cost to you.

I have read the notice and understand it. Any questions I had were answered. I give permission to the school district to share with MassHealth records and information concerning my child(ren) and their health-related services, as necessary. I understand that this will help our community seek partial reimbursement of MassHealth covered services.

Parent/Guardian Signature: _____ Date: _____

Child's Name:	**Date of Birth:**	**SASID # (for district to add):**
Child's Name:	**Date of Birth:**	**SASID # (for district to add):**
Child's Name:	**Date of Birth:**	**SASID # (for district to add):**

Add more children

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth: _____

Medical History

Pertinent Family History

Current Health Issues

Y N

☐ ☐ Allergies: Please list: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: _____

☐ ☐ Other (*Please specify*) _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination

Date of Examination: _____

Hgt. _____ (____%) Wgt. _____ (____%) BMI: _____ (____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General _____
☐ Skin _____
☐ HEENT _____
☐ Dental/Oral _____
☐ Lungs _____
☐ Heart _____
☐ Abdomen _____
☐ Genitalia _____
☐ Extremities _____
☐ Neurologic _____
☐ Other _____

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐

	(Pass)	(Fail)
Hearing: Right Ear	☐	☐
Left Ear	☐	☐

	(Pass)	(Fail)
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other _____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
Date of PPD: ____; Results: ____ mm
Referred for evaluation to: _____ ☐ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:
☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations:

☐ Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:**

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.** See Other Side

_____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____ _____
Group Practice Telephone

_____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. MDPH 12/14/04

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / / Sex: ☐ female ☐ male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		*Haemophilus influenzae* type b (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV,) Td Tdap	1			4	
	2		Measles, Mumps, Rubella (MMR)	1	
	3			2	
	4		Varicella (Var)	1	
	5			2	
	6		Hepatitis A (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		Pneumococcal Polysaccharide (PPVZ3)	1	
	2			2	
	3		Influenza Inactivated (intramuscular) or Live (intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		Other:		
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)* Date: / /

Signature: _____

Facility name: _____