

Glen Lake School
A Great Place to Start
251 Elm Street
Goffstown, NH 03045
(603) 497-3550

Dear Parents and/or Guardians:

Welcome to Glen Lake School! We look forward to sharing the beginning of your child's educational journey.

Registering for kindergarten requires specific immunizations and documentation. Please read the following information carefully. Your child is officially registered for kindergarten once all paperwork has been returned to the school.

PHYSICAL EXAMINATION

A physical examination is required by law and must have taken place after September 1, 2011. All immunizations must be up-to-date. The doctor must complete and sign the enclosed Physician's Report form or provide us with their signed computer generated report. We urge you to make an exam appointment now, as the doctors' offices are usually booked quite far ahead. Please return your child's Physician's Report to the school as soon as the physical exam has been completed. Children without proper immunizations or a physical will be excluded from school in September.

BY LAW, CHILDREN WILL BE DENIED ENTRANCE TO SCHOOL WITHOUT THE FOLLOWING IMMUNIZATIONS:

1. A minimum of four (4) doses of DTP, DT, or Td
2. A minimum of three (3) doses of OPV (Polio Vaccine)
3. 2 Doses of MMR (Measles, Mumps, Rubella).
4. Three (3) doses of Hepatitis B.
5. 2 doses of Chickenpox vaccine, or history of disease.
6. Haemophilus Influenzae Type B (HIB) one dose after 15 months of age.

BIRTH CERTIFICATE

Our office must verify your child's **ORIGINAL BIRTH CERTIFICATE** before entrance to kindergarten. We will make a copy and return the original to you.

LEGAL DOCUMENTS

Our office must have copies of any legal documents that prohibit any person from seeing or dismissing your child during or at the end of the school day (i.e. Custody or Restraining Orders).

RESIDENCY

Two (2) Proofs of Residency are required for entrance into the Goffstown schools. Below is a list of documents that are acceptable proof. In the unusual case that you have none of these available, a signed and notarized statement of residence must be submitted.

- **Purchase and Sales Agreement**
- **Utility bill or deposit indicating address**
- **Driver's License**
- **Lease Agreement**
- **Voter Registration**
- **Social Services Paper—Social Security, AFDC**
- **If purchase of house has not been completed, a copy of the Purchase & Sales Agreement and a letter of intent must be submitted to the Superintendent of Schools.**

ALL KINDERGARTEN REGISTRATION FORMS LISTED ON THE NEXT PAGE MUST BE RECEIVED BY MARCH 23, 2012 TO GLEN LAKE SCHOOL IN ORDER FOR YOUR CHILD TO BE CONSIDERED FOR YOUR PREFERRED SESSION (AM or PM). STUDENTS WITH INCOMPLETE REGISTRATION PACKETS WILL NOT BE ASSIGNED A SESSION. YOUR CHILD MAY ENTER SCHOOL ONLY AFTER ALL REQUIRED DOCUMENTATION IS SUBMITTED.

- 1) Enrollment Record
- 2) Parent Observation Form
- 3) Signed Physician's Report (if exam is scheduled for after 3/23/2012 please provide copy of previous year exam along with date of upcoming physical)
- 4) Health History Form
- 5) Original Birth Certificate
- 6) Copies of any legal documents (IF APPLICABLE)
- 7) Two (2) Proofs of Residency

Bus routes are determined in late August and will be posted on the school district web site www.goffstown.k12.nh.us at that time. Just a reminder, busing is available to school in the morning for AM students and home from school in the afternoon for PM students. Parents/guardians are responsible for mid-day transportation. **There is no mid-day busing provided by the school district.**

In an effort to assist parents with their childcare needs we have been in contact with the Goffstown private care providers. The following providers (listed alphabetically) may offer something that fits your needs. Parents/guardians will need to contact the private provider directly to see what they are offering. Any arrangements for extended care are between parents/guardians and the private provider.

Allard Center YMCA

(7:00 am – 12:00 pm) or (11:30 am – 6:00 pm) Transportation provided by the YMCA to or from Glen Lake School
Laura Sinning 497-4663

Educare

Will provide care from 3:15 until 5:30 pm
School bus transportation between Glen Lake School and Educare
Janice Thomas-Aubin 627-3392

Kid University

Morning or afternoon program – Transportation provided by Kid University to or from Glen Lake School.
Bonnie Gorman 497-8358

Learn As We Play

Before school care at Learn As We Play 7:00 – 8:00
After school care at Learn As We Play 3:15 – 6:00
(School bus transportation between buildings) 668-3674

Little Leapers & Knowledge Keepers

Will provide care from 3:15 until 5:30 pm
School bus transportation between Glen Lake School and Little Leapers & Knowledge Keepers
Jennifer Lever 647-2273

Main Street Kids' Connection

Morning or afternoon program – Mid-day transportation provided by Main Street Kids' Connection.
Janet Luddy, Director 497-4014

If you have any questions, please feel free to contact the school at 497-3550.

Sincerely,

Leslie T. Doster

Leslie T. Doster
Principal

Office Use Only

LASID: _____ Enrollment date | code: _____ | _____ SASID: _____

Goffstown School District Student Registration

School Entering: **Glen Lake School** Town of Residence: _____

Date of Entrance: _____ Grade Entering: _____ Physical Exam Date: _____

Session Preference: _____ AM _____ PM _____ Either

Last School Attended: _____

Has the student ever previously attended school in Goffstown, New Boston or Dunbarton? *Yes or No*

If yes, which school(s)? _____ Grades _____ thru _____

STUDENT INFORMATION:

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

Physical Address: _____
(Street) (City/Town) (State) (Zip Code)

Mailing Address: _____
(Street) (City/Town) (State) (Zip Code)

Gender: *M or F* Date of Birth: _____ Place of Birth: _____
(City, State or Country if outside the U.S.)

U.S. Citizen? *Yes or No* Date of Citizenship: _____ Date of entry in U.S.: _____
Date first enrolled in a U.S. school: Month _____ Year _____

PARENT/GUARDIAN INFORMATION: (Do not include step parents here - list on Emergency Form)

Mother: _____ Home phone: _____
PHYSICAL _____ MAILING _____
ADDRESS: _____ ADDRESS: _____

Employer: _____ Work phone: _____
E-mail Address: _____ Cell phone: _____

Father: _____ Home phone: _____
PHYSICAL _____ MAILING _____
ADDRESS: _____ ADDRESS: _____

Employer: _____ Work phone: _____
E-mail Address: _____ Cell phone: _____

Student lives with: _____ Both Parents _____ Mother/Step-Father _____ Father/Step-Mother
_____ Mother Only _____ Father Only _____ Other Guardian: *See below*

Other Guardian Name(s): _____
Relationship: _____ Work phone: _____ Cell phone: _____

Goffstown School District Student Registration

Please complete the following questions:

Who has legal custody of the student? _____

Are there currently custody/visitation rights/restrictions, including restraining orders? *Yes or No*
If yes, please provide copies of legal documentation.

Does the student have an Individual Education Plan? *Yes or No*

Does the student have a 504 Accommodation Plan? *Yes or No*

Ethnicity & Race: *(This information is required by the NH Dept. of Education)*

Answer BOTH parts:

Part A. **Is this student Hispanic/Latino?** *(Choose only one)*

- No, not Hispanic/Latino
- Yes, Hispanic/Latino

Part B. **What is the student's race?** *(Choose one or more)*

- American Indian or Alaska Native
- Asian
- Black or African American
- White
- Native Hawaiian or Other Pacific Islander

Home Language Survey	Response
Please list all languages spoken in your home.	
Which language did your child first hear or speak?	
If English is the only language listed, stop here. If another language is listed, please answer the rest of the questions.	
Which language(s) do you speak to your child?	
Which language(s) does your child speak at home with adults?	
Which language(s) does your child speak at home with other children?	

For parents and guardians: If a language other than English is listed above, an ESOL teacher will test your child to find out if he or she can speak, understand, read, and write well in English. The results will be sent to you within 30 days. Based on the results of the test, your child may be eligible to enroll in an English language (ESOL) program at school. Parents/guardians may accept or decline ESOL program services for their child.

Instructions for survey administrator:

1. Please provide an interpreter when necessary.
2. If responses indicate a language other than English, please contact the ESOL teacher and provide her/him with a copy of this survey. Date of referral to ESOL teacher: _____
3. File original Home Language Survey in student's cumulative folder.

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

Goffstown School District
Emergency & Medical Information - New Registration

Please provide us with your student's medical information and emergency contacts to assist us in the event of an emergency, or if medical care is needed. If there are changes to this information during the school year, please contact the school to update your student's information as soon as possible. This information will be resent every year for your verification.

STUDENT INFORMATION:

Name: _____ Date of Birth: _____

School: _____ Entering Grade: _____

EMERGENCY CONTACT INFORMATION

If parents/guardian cannot be reached, the school should contact:

FIRST CONTACT:

Name: _____ Relationship to student: _____

Home #: _____ Work #: _____ Cell #: _____

SECOND CONTACT:

Name: _____ Relationship to student: _____

Home #: _____ Work #: _____ Cell #: _____

THIRD CONTACT:

Name: _____ Relationship to student: _____

Home #: _____ Work #: _____ Cell #: _____

MEDICAL INFORMATION:

Physician Name: _____ Phone Number: _____

Dentist Name: _____ Phone Number: _____

Conditions: _____

Allergies: _____

If emergency treatment is required, and the parents or legal guardian cannot be reached immediately, your signature in the space provided below empowers the school authorities to exercise their own judgment in calling the physician indicated above, or if not available, to transport the child to a hospital emergency room. Likewise, your signature below is not sufficient for the release of confidential information protected by Federal Law.

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

Glen Lake School

PARENT OBSERVATION FORM

Child's Name _____ Date of Birth _____
Last First Middle (Certificate
Required)

Name of Person Completing Form: _____

_____ Mother _____ Father _____ Other(Please identify) _____

1. Do you feel your child is ready for a kindergarten experience?

_____ Yes _____ No _____ Not Sure

Please explain: _____

2. Has your child attended preschool? _____ Yes _____ No

If yes, which school? _____

3. If yes, what difficulties, if any, did your child have in preschool? _____

4. Does your child get along well with other children?

_____ Yes _____ No If no, please explain _____

5. When your child plays with other children does he/she tend to be:

_____ The Leader _____ The Follower _____ Not Sure

6. Would your child rather play alone or with other children?

_____ Alone _____ Other Children _____ Not Sure

7. **Do you feel your child handles routine changes well?**

_____ Yes _____ No _____ Not Sure

If no, please explain: _____

8. **Does your child tend to cry easily?**

_____ Yes _____ No _____ Not Sure

9. **Do others experience difficulty understanding your child when he/she speaks?**

_____ Yes _____ No _____ Not Sure

10. **Does your child like to read or be read to?**

_____ Yes _____ No _____ Not Sure

11. **Which hand does your child use to eat, draw or write, and cut (with scissors)?**

12. **Who are the members of your child's household:**

Name DOB Relationship to student School (if Applicable)

Please feel free to write about anything you feel could have a bearing on how your child will adjust to school, classmates, and teachers.

Glen Lake School SCHOOL HEALTH HISTORY

(to be completed by Parent/Guardian)

Child's Name _____ Age _____ Sex M F

Please Check Any Of The Following Illnesses Your Child Has Had and Indicate Date:

	DATE		DATE		DATE
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Measles		<input type="checkbox"/> Kidney Disease		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> German Measles		<input type="checkbox"/> Scarlet Fever		<input type="checkbox"/> AIDS	
<input type="checkbox"/> Mumps		<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Serious Injury	
<input type="checkbox"/> Whooping Cough		<input type="checkbox"/> Ear Infection		<input type="checkbox"/> Operations	
<input type="checkbox"/> Meningitis		<input type="checkbox"/> Pneumonia		<input type="checkbox"/> Other	
<input type="checkbox"/> Varicella (Chicken Pox)					

Please answer the following questions as accurately as possible.

<p>Has your child ever had a convulsion? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/></p> <p>Does your child have allergic reactions to bee stings? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/></p> <p>Has your child had as many as three bouts of ear trouble? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/></p>	<p>Has your child had hearing problems? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/></p> <p>Has your child had vision problems? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/></p> <p>Has your child had an eye exam by an eye doctor? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/></p> <p>Does your child wear glasses? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/></p>
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Has your child ever had asthma? Yes No

If yes, please **specify** treatment: _____

Is your child currently taking prescribed medication(s)? Yes No

If yes, please **specify** name of medication: _____

Why medication is taken: _____

Time medication is taken: _____

Does your child have allergies to any medications or food? Yes No

If yes, please **specify**: _____

Treatment: _____

Has your child ever been hospitalized? Yes No

If yes, please **specify** when and why: _____

What is the date of your child's last physical exam? _____

Physician's Name: _____ Telephone No. _____

Physician's Address: _____

Were there any recommendations? _____

Please check any of the following health problems that may have a family history:

- | | | | |
|-----------------------------------|---------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer | <input type="checkbox"/> Allergies | |

Are both of the child's natural parents in good health? yes no

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Was your child an unusually quiet or inactive baby?	<input type="checkbox"/>	<input type="checkbox"/>	Does your child dress him/herself completely?	<input type="checkbox"/>	<input type="checkbox"/>
Was feeding your child a problem?	<input type="checkbox"/>	<input type="checkbox"/>	Does your child tie his/her own shoes?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child a fussy eater now?	<input type="checkbox"/>	<input type="checkbox"/>	Does your child fall frequently?	<input type="checkbox"/>	<input type="checkbox"/>
At present, does he/she seem to have difficulty chewing or swallowing?	<input type="checkbox"/>	<input type="checkbox"/>	Does your child have difficulty playing ball?	<input type="checkbox"/>	<input type="checkbox"/>
Was toilet training a problem?	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel that your child demonstrates any other coordination difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child wet the bed at night now?	<input type="checkbox"/>	<input type="checkbox"/>			
If you answered yes to any of the above, please explain: _____					

Birth Weight: _____
 lbs. oz.

Were there any unusual circumstances during pregnancy, labor, or delivery? yes no
 If yes, please explain: _____

At what age did he/she sit alone? _____

At what age did he/she crawl? _____

At what age did he/she walk? _____

At what age did he/she begin to use single words? _____ phrases? _____

When was your child completely toilet trained? _____

With which hand does your child eat, draw, throw, or hit a ball? _____

Please check any of the following which describes your child:

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Nail Biter | <input type="checkbox"/> Thumb Sucker | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Bed Wetter | <input type="checkbox"/> Jealous |
| <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Won't Mind |

Have you noticed any problems for which an adjustment could be needed, such as:

- | | | |
|----------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Emotional | <input type="checkbox"/> Physical |
| <input type="checkbox"/> Speech | <input type="checkbox"/> Behavioral | <input type="checkbox"/> Other |

Has your child been receiving Special Education services? yes no

If yes, please specify: _____

Glen Lake School
251 Elm Street
Goffstown, NH 03045
(Tel: 603-497-3550) (Fax: 603-497-3660)
PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION
(to be completed by Physician)

Child's Name _____ Date of Birth ___ / ___ / ___

THIS REPORT MUST BE COMPLETED AND GIVEN TO THE SCHOOL BEFORE CHILD ENTERS

Immunizations and Tests Performed

Dates of Immunizations / Tests (Must include day, month & year)						
	d/m/y	d/m/y	d/m/y	d/m/y	d/m/y	Date of Illness/Test
DPT						
Polio						
MMR						
Hib						
Hep B						
Chicken Pox						
TB Test						
Other						

Physical Examination

Height _____ Eyes _____ Ears _____ Vision _____

Weight _____ Nose _____ Skin _____ Tonsils _____

Blood Pressure _____ Glands _____ Speech _____ Nutrition _____

Heart _____ Lungs _____ Orthopedic _____ Hernia _____

Nervous System (*Specify epilepsy or hyperactive*) _____

Treatment _____

Diabetes _____ Treatment _____

Asthma _____ Treatment _____

Please **specify** if child has allergies (bee sting, food, etc.) or other condition that requires special medication or attention:

Previous diseases and operations: _____

Is the child capable of carrying a full program of school work including gymnastics and athletics? Yes ___ No ___

Must the school program be modified to meet the needs of this child? Yes ___ No ___

By restriction of use of stairs? Yes ___ No ___ By special seating accommodations? Yes ___ No ___

Other _____

Date of Examination _____ **Physician's Signature** _____

Please return completed form to:

Glen Lake School
251 Elm Street
Goffstown, NH 03045
Phone: (603) 497-3550 Fax: (603) 497-3660