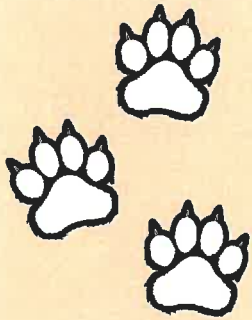


Valley View Community School

We Inspire Confident, Creative, and Compassionate Learners and Leaders



Paul Roberts

Principal

proberts@sau61.org

Blake McGurty

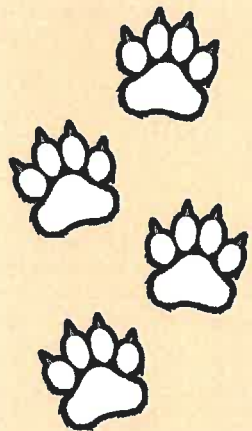
Assistant Principal

bmcgurty@sau61.org

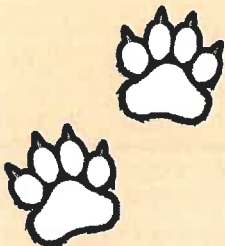
Alison Williams

Guidance Counselor

awilliams@sau61.org



79 Thayer Drive
Farmington, NH 03835
603.755.4757
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Dear Parents/Guardian,

Welcome to Valley View Community School, to make the registration process run smoothly, please have all forms in this packet completed, as well as the birth certificate, shot record and custodial papers (if applicable) and dropped off to the office as soon as possible.

1. Student Information Form
2. Parent Information Form
3. Home Language Survey
4. Student Health History Form
5. Proof of Residency (tax bill, mortgage/rental agreement, and/or utility bill)
6. Parent Residency Affidavit (to be completed on screening day)
7. Physical Form, to be completed by the child's physician
8. Health Immunization Form
9. Child's Birth Certificate
10. Child's Shot Record, completed by physician
11. Custodial Papers, if applicable

Please note that it is mandated that all children shall be immunized prior to school entrance in accordance with RSA#141-C:20-a. In addition, all children shall have a complete physical examination prior to school entrance in accordance with RSA#200:32. School district Policy #5111.1 and 5141 require a copy of your child's birth certificate. Any child who has not satisfied these stated requirements, will not be allowed to enter school.

We look forward to seeing you and your child.

Sincerely,

Paul Roberts
Principal

The mission of the Farmington School District is to develop and prepare every individual for lifelong learning and participation in a global society through quality education. The Farmington School District is a supportive learning environment for students, school staff, families, and the greater community.

Valley View Community School

Student Information

Student Name: _____ Date of Birth: _____ Grade: _____
Home Address: _____ Mailing Address: Same as Home Address Homeroom: _____
City, State, Zip: _____ Different: _____ Place of Birth: _____
Home Phone: _____
Email Addresses: _____ Court Orders Filed: yes / no Gender: _____
Please Notify the School with Written Restrictions or Court Orders

Home Language **Circle all the numbers that pertain to your child**
English (00) French (01) Spanish (02) Chinese (03) Greek (04) Finnish (05) Italian (06)
Portuguese (07) Polish (08) Japanese (09) American Sign (10) Vietnamese (11)
German (12) Other (99)

Ethnicity **Circle all numbers that pertain to your child**
(1)-American Indian/Alaskan Native (2)-Asian (3)-Hispanic/Latino
(4)-Black (5)-White (6)-Native Hawaiian or other Pacific Islander (7)-Black/White

Parent/Guardian Information

Mothers Name: _____ Custodial Parent
Mailing Address: _____ check if the same as above
if different: _____
Home Phone: _____
Cell Phone: _____
Employer Name: _____ **Employer Phone:** _____

Fathers Name: _____ Custodial Parent
Mailing Address: _____ check if the same as above
if different: _____
Home Phone: _____
Cell Phone: _____
Employer Name: _____ **Employer Phone:** _____

Guardians Name: _____
Mailing address: _____ check if same as above
if different: _____
Home Phone: _____
Cell Phone: _____
Employer Name: _____ **Employer Phone:** _____

Step Parent's Name: _____
Mailing Address: _____ check if same as above
if different: _____
Home Phone: _____
Cell Phone: _____
Employer Name: _____ **Employer Phone:** _____

Emergency Contact Information:

Please list three other adults who would be willing to assume temporary care of your child and/or be contacted in case of our inability to contact a parent or guardian.

Contact 1 Name	Relationship	Daytime Phone Number	Cell Phone
_____	_____	_____	_____
Contact 2 Name	Relationship	Daytime Phone Number	Cell Phone
_____	_____	_____	_____
Contact 3 Name	Relationship	Daytime Phone Number	Cell Phone
_____	_____	_____	_____

Notes:

Student Name: _____

In case of an unexpected early dismissal due to an emergency situation (i.e.: snow storm) my child should:

___ Follow regular end of day procedure

___ Walk to the home of: _____ Phone: _____

___ Take bus _____ to the home of: _____ Phone: _____

___ Be picked up by: _____ Phone: _____

___ My child has been instructed in the procedure to follow if there is an emergency dismissal from school. In the event of an area of school emergency, all SAU 61 students will follow their school's emergency guidelines.

In case of accident or serious illness, I request that the school call me. If the school is unable to reach me, I authorize the school to call the emergency contacts listed on the previous page. The school may also make whatever arrangements seem necessary, including calling an ambulance and transporting my child to the nearest hospital, unless otherwise instructed.

Parent Signature: _____ Date: _____

Please indicate YES or NO on the following with your initials on the appropriate line.

	YES	NO
HANDBOOK: I/We have read the Student Handbook with my/our student.	___	___
INTERNET PERMISSION: I/We have read and signed the technology form with my/our student.	___	___
VIDEO RELEASE: Permission is hereby granted for my student to participate in photographed and videotaped school activities. I understand that such photographs and videotaped productions are being used for educational and/or school related purposes only, and that as such, these photos and programs may be printed in local newspapers and/or shown on local cable television stations or the district website. I also understand that these photos and programs will not be duplicated or sold for profit.	___	___
WEBSITE PERMISSION: I will allow my child's writing, picture, movie or sound recording to be published on the school website.	___	___
NEWSPAPER: I grant permission for my child's photo to appear in the newspaper.	___	___
HOME COMPUTER ACCESS: Does your child have access to a computer at home?	___	___
HOME COMPUTER INTERNET ACCESS: Does your home computer have internet access?	___	___
PARENT IN MILITARY: Does your child have a parent or guardian that is actively enlisted and/or deployed? If yes please circle: mother, father, step-mom, step-dad, guardian, other: _____	___	___
SOCIAL DIRECTORY: We would like to offer a social directory which can be used by families to make contact with other families in their class and will be given to the whole class. This would be helpful in setting up play dates, planning birthday parties etc. Would you like to be part of this network?	___	___
SCHOOLWIDE TITLE 1: I have read the Title 1 letter and understand my rights as a parent of a student attending a schoolwide Title 1 school.	___	___

Parent Signature: _____ Date: _____

Previous School Information:

Name of School: _____

Town: _____ City: _____

Does your child have an IEP or 504? _____

Parent Information Form

Child's Full Name _____ Date _____

Date of Birth _____ Phone _____

Form filled out by (name) _____ Relationship _____

*We have found the following information important in helping the school understand and work with your child. Please answer the questions with as much detail and as objectively as you can. Please list, in order, (oldest first) the first and last names of all the children and adults in your family. **State ages next to each child's name.** Please include step-children and step parents and any other people living in your household. Include the child who you are registering today so that we may see where he/she fits in the family. If a child is not living at home, please indicate.*

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

1. Please explain your child's living situation (i.e. spends weekends at father's house; spends school week at mother's house; lives with both parents 7 days a week, etc.)

2. Age child crawled _____ walked _____ talked _____ completely toilet trained _____

3. Were there any difficulties during pregnancy or at birth? Birth weight? _____
(i.e. was child premature?)

4. Is child a bed wetter or do they wet/soil their pants during the day? _____

5. Can child dress unassisted? _____ Tie own shoes? _____

6. Has your child ever received any special services/support? (i.e., speech, OT, PT, counseling, neurological exam) _____

(over)

If there has been a death, a divorce, or an emotional/behavioral issue, please specify.

Please list 3-5 strengths that you feel your child has.

-
-
-
-
-

Please write down any concerns you have about your child (i.e. has a quick temper; very shy; has difficulties with transition; depends on others to tell them what to do; needs help in the bathroom, etc.)

Please share any additional comments below that you would want our school to know. (i.e. your child received tutoring at their previous school; your child was involved in an enrichment program; your child thrives when given leadership opportunities)

Home Language Survey

School: _____ District: _____ Date: _____

Student Information			
First name:	Last name:	Date of Birth:	Gender: <input type="checkbox"/> female <input type="checkbox"/> male
Country of Birth:	Date of entry in U.S.:	Date first enrolled in a U.S. school: Month Year	Current grade:

Family Information	
Name of parent/legal guardian:	Phone number:
Address:	<input type="checkbox"/> Please translate school notices. Language _____

Questions for Parents/Guardians	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) class 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.

Valley View Community School

Health Information and Medication Sheet

Student: _____ Date of Birth _____

Parent: _____

Doctor Name and Phone Number _____

Does your child have any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Ear Tubes |
| <input type="checkbox"/> Behavioral issues | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Nutritional Concerns |
| <input type="checkbox"/> Stomach/Bowel Problems | | |
| <input type="checkbox"/> Orthopedic (bone or muscle) Problems | | |
| <input type="checkbox"/> Kidney/Urinary Tract Problems | | |

Please list and explain any allergies to food, medication or insects. _____

Does your child take any medications on a regular schedule? Yes No

If yes, list any prescription or over the counter medications your child takes and why.

***A doctor's note is needed for all prescription medications.

Will medication need to be given at school? _____ What time? _____

If your child has asthma, what inhalers are used at home? _____

At school? _____

Does your child have any history of serious illness, surgery or injury? Yes No

If yes, explain. _____

Please turn this paper over.

Over the Counter Medication (OTC) Authorization Form

Before any child can receive an OTC medication at school, the parent/guardian must sign this form giving permission. Please put your initials on the following OTC medications you would like your child to receive at the discretion of the school nurse. If you do not want your child to receive any of these, please initial the last one.

***Please note: If your child needs chewable Tylenol, please send it in.**

Antibiotic ointment [cuts] (Bacitracin) _____

Anti itch gel [rashes] (Calagel) _____

Chewable Tylenol _____

Acetaminophen [headaches] (Tylenol) _____

Ibuprofen [muscle/joint pain] (Advil) _____

Cough drops _____

Antacid tablets [stomach] (Tums) _____

Benadryl [allergy, rash or swelling] _____

ALL OF THE ABOVE! _____

I DO NOT want my child to receive any of the above OTC medications at this time. _____

(initial)

Parent Signature _____ Date _____

A phone call will be attempted for any significant symptoms that your child may present. **Please keep the nurse informed of any phone number changes.** If unable to reach a parent by phone, a note will be written regarding any important or unusual issues.

All medications sent to the nurse's office must be in the original container with the child's name on it!

Is there anything that we need to know about your child or family that would help us to understand them better?

FARMINGTON SCHOOL DISTRICT
PARENT RESIDENCY AFFIDAVIT

STATE OF NEW HAMPSHIRE
COUNTY OF STRAFFORD

_____, being duly sworn under the pain and penalty of perjury,
hereby states the following under oath:*

1. I am the parent of _____, a student in the Farmington School District.
2. I have joint legal custody with _____, the child's _____ and have not surrendered the custody or control of said child to another person.
3. I also have primary physical custody of said child and I have not surrendered care, custody or control of said child to any other person.
4. I continue to be the primary provider of financial support and day-to-day care for the said child.
5. My permanent domicile and principal residence is located at _____ within the Farmington School District. _____ lives with me at that Farmington address.
6. Documentation in support of the statements contained in this affidavit is annexed hereto and intended to be incorporated herein.
7. I make this affidavit with knowledge that the Farmington School District will rely upon the truth of the statements set forth herein in determining the legal residence of the aforementioned child within the Farmington School District and his or her right to be provided with a tuition-free education in accordance with the Education Law of the State of New Hampshire

*** IT IS A CRIME IN THE STATE OF NEW HAMPSHIRE TO MAKE A SWORN FALSE STATEMENT. (See attached).**

Signed under the pains and penalty of perjury this _____ day of _____, 20__.

PARENT

STATE OF NEW HAMPSHIRE
STRAFFORD, SS.

The above-named _____ personally appeared before me on this _____ day of _____, 20__ executed the foregoing, acknowledged that the contents of same are true and correct to the best of his or her knowledge, and acknowledged that he/she executed the same as his/her free act and deed.

Notary Public/Justice of the Peace
My Commission Expires: _____

**SAU #61 FARMINGTON
PHYSICAL EXAMINATION**

NAME: _____ DOB: _____ SEX: M F GRADE: _____

PHYSICIAN'S NAME: _____

WT: _____ HT: _____ ALLERGIES: _____

LEAD LEVEL _____

HEARING: R ear _____ L ear _____ VISION: R eye _____ L eye _____

Eyes _____ Ears _____ Nose _____ Throat _____ Teeth _____

Lungs _____ Heart _____ Chest _____ Liver _____ Spleen _____

Abdominal masses or problems: _____

Bowels: _____ Bladder: _____

Joint Function:

Neck _____ Shoulder _____ Elbows _____ Wrists _____ Hands _____

Hips _____ Knees _____ Ankles _____ Feet _____

Neurological _____ Seizures _____ Medication _____

Diabetes _____ Asthma _____ ADD/ADHD _____ Medication _____

Description of any abnormal findings that would impact upon learning:

Is the child taking any prescription medications? _____ Name of medication: _____

PLEASE ATTACH A COPY OF THE IMMUNIZATION RECORD

I certify that I have examined this student and he/she may compete in all supervised, school athletic and physical education activities.

Date of Exam: _____ Physician Signature: _____