

***Madison Public Schools***  
***Student Enrollment Checklist - Pre - K***



**Step 1: Establish Residency**

Residency requirements must be met for all new or transferred students entering the Madison Public Schools. Please provide one of the following:

- A copy of a Purchase and Sales Agreement
- A copy of a rental lease
- Resident Affidavit
- Parent/Guardian Affidavit
- Pupil/Student Affidavit

**Step 2: Enrollment Forms**

Student Enrollment forms may be obtained online or at the Madison Public Schools Central Office, 10 Campus Drive, Madison, CT 06443

- Birth Certificate
- Student Enrollment Form
- Permissions Form
- Early Childhood Health Assessment Record (State of Connecticut)

**Step 3: School Visitation**

Typical peer students are required to participate in a preschool screening. Please call the Madison Town Campus Learning Center (TCLC) (203) 245-1078 to schedule an appointment.

Special Education Students – If your child currently has an Individualized Education Program (IEP), please forward a copy of the IEP, along with any evaluations, to the Madison Town Campus Learning Center, 2 Campus Drive, Madison, CT 06443.

Central Office receives all student enrollment forms. If you have any questions regarding this information or have circumstances that do not meet the above referenced criteria, please contact the Madison Public Schools Central Office 203.245.6300 or email questions directly to [residency@madison.k12.ct.us](mailto:residency@madison.k12.ct.us)

# STUDENT ENROLLMENT FORM

## STUDENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Present Grade \_\_\_\_\_ Gender \_\_\_\_\_  
Student ID \_\_\_\_\_ Enter Date \_\_\_\_\_ School \_\_\_\_\_  
Residence Address \_\_\_\_\_  
Home Telephone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Sec. # (optional) \_\_\_\_\_  
Place of Birth \_\_\_\_\_ Country of Citizenship \_\_\_\_\_ Ethnicity (not required) \_\_\_\_\_  
Student's Primary Language \_\_\_\_\_ Language Spoken in Home \_\_\_\_\_  
Student Lives With:  Both Parents  Mother Only  Father Only  Other (please describe) \_\_\_\_\_  
Daycare Provider \_\_\_\_\_ Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Name and Address of School Last Attended \_\_\_\_\_ Grade Last Attended \_\_\_\_\_  
(include pre-school) \_\_\_\_\_  
Address of Former Residence \_\_\_\_\_

## PARENT / GUARDIAN INFORMATION

MOTHER /  GUARDIAN 1 /  OTHER \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Residence Address \_\_\_\_\_ Mailing Address (if different than Residence) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Telephone \_\_\_\_\_ Cell / Other Phone \_\_\_\_\_ Email \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Hours \_\_\_\_\_  
Work Telephone \_\_\_\_\_ Extension \_\_\_\_\_  
U.S. Citizen  Yes  No Responsible for Student  Yes  No Student Resides with this Parent / Guardian  Yes  No

FATHER /  GUARDIAN 2 /  OTHER \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Residence Address \_\_\_\_\_ Mailing Address (if different than Residence) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Telephone \_\_\_\_\_ Cell / Other Phone \_\_\_\_\_ Email \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Hours \_\_\_\_\_  
Work Telephone \_\_\_\_\_ Extension \_\_\_\_\_  
U.S. Citizen  Yes  No Responsible for Student  Yes  No Student Resides with this Parent / Guardian  Yes  No

Parental / Custody arrangements the school should be made aware of: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please send extra mailings to non-custodial parent

Signature of:  Parent  Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_  
 Parent  Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

## SIBLING INFORMATION

Please List Other Children in Student's Household:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Age \_\_\_\_\_ Gender \_\_\_\_\_ Grade as of Now \_\_\_\_\_

Enrolled in Madison Public Schools?  Daycare / Preschool?  Not Yet Enrolled in Madison Public Schools

If enrolled in the Madison Public Schools, School Name: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Age \_\_\_\_\_ Gender \_\_\_\_\_ Grade as of Now \_\_\_\_\_

Enrolled in Madison Public Schools?  Daycare / Preschool?  Not Yet Enrolled in Madison Public Schools

If enrolled in the Madison Public Schools, School Name: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Age \_\_\_\_\_ Gender \_\_\_\_\_ Grade as of Now \_\_\_\_\_

Enrolled in Madison Public Schools?  Daycare / Preschool?  Not Yet Enrolled in Madison Public Schools

If enrolled in the Madison Public Schools, School Name: \_\_\_\_\_

PLEASE LIST ADDITIONAL CHILDREN ON SEPARATE SHEET

## PRELIMINARY ASSESSMENT OF DOMINANT LANGUAGE

Connecticut state law requires that each school district conduct a preliminary assessment of the dominant language of each student in its public schools. This assessment is made in order to ascertain English proficiency. If the assessment indicates limited proficiency, a required bilingual education program is provided.

What language did your child learn to speak first? \_\_\_\_\_

What language does your child speak at home? \_\_\_\_\_

What language is spoken to your child at home? \_\_\_\_\_

What language is spoken by adults at home? \_\_\_\_\_

## HEALTH INFORMATION

Physical examinations are required before entry if:

- Entering from another CT district and your child will be in grades **K, 7 or 11**.
- Entering from **out-of-state**. You may submit a new physical or a physical performed in the previous state within 12 months of enrollment in Madison. It should be documented on the blue CT form.

Specific immunizations are required at certain grade levels. Please consult with the school nurse who can review your child's record and advise you regarding compliance. You may also visit the Madison School Health Services webpage on *Immunizations Required* for guidance at <http://www.madison.k12.ct.us/>

**Madison Public Schools**  
**PARENT / GUARDIAN PERMISSIONS FORM**

*Please sign **each** of the boxed sections below to grant **individual** permissions for your child*

Student Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

**UNSCHEDULED EARLY DISMISSAL - Emergency or Inclement Weather**

*In the event of an unscheduled early dismissal, my child should:  
Please choose **ONE** option*

Ride his/her assigned bus home

Ride his/her scheduled day-care provider as previously filed in school office

Will be picked up by \_\_\_\_\_ Relationship to Student \_\_\_\_\_

*(Please Note: Information regarding the status of an early dismissal will be posted on Channel 19, the district website homepage, local radio and television stations. Parents are encouraged to subscribe to the district Infoline to receive email updates on school closings and early dismissals. Telephone service will be limited to emergency calls during early dismissals.*

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

**PARENTAL PERMISSION OF STUDENT MEDIA COVERAGE / VIDEOTAPING / PHOTOGRAPHS**

Madison Board of Education Policy #5180.4 provides guidelines for the inclusion of schools or students for publicity purposes. The policy requires that parents be given the opportunity to withhold permission for interviews, photographs, and videotaping of their child at school. For media coverage featuring specific students and / or potentially controversial issues, individual parental permission will be requested and obtained.

I **agree** to allow my son / daughter to be interviewed, photographed, or videotaped in conjunction with school related policy.

I **refuse** permission for my son / daughter to be interviewed, photographed, or videotaped in conjunction with school related policy.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date



# State of Connecticut Early Childhood Health Assessment Record



To Parent or Guardian:

In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunization and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse, a physician assistant or the school medical advisor prior to entering an early childhood program in Connecticut.

Please print

Name of Child (Last, First, Middle)		Social Security Number	Birth Date	Sex
Address (Street)		Race/Ethnicity		
(Town and ZIP code)		<input type="checkbox"/> American Indian	<input type="checkbox"/> White, not of Hispanic origin	
		<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic/Latino	
		<input type="checkbox"/> Black, not of Hispanic origin	<input type="checkbox"/> Other	
Parent/Guardian (Last, First, Middle)		Home Phone Number	Work/Cell Phone Number	
Early Childhood Program			Program Phone Number	
Primary Health Care Provider	Preferred Hospital	Health Insurance Company/Number* or Medicaid/Number*		

\* If applicable

If your child does not have health insurance, call 1-877-CT-HUSKY

## Part I — To be completed by parent

**Important: Complete Part I before your child is examined.  
Take this form with you to the health care provider's office.**

Please check answers to the following questions in columns on the left.

(Explain all "yes" answers in the space provided below.)

Yes No

- Do you have any concerns about your child's general health, development or behavior?
- Has your child been diagnosed with any chronic disease  asthma  diabetes  seizure disorder  other \_\_\_\_\_
- Does your child have any allergies (food, insects, medication, latex, etc.)? Please specify: \_\_\_\_\_
- Does your child take any medications (daily or occasionally)?
- Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?
- Has your child had any hospitalization, operation, major illness or injury, or significant accident?
- In the last 12 months, has your child experienced any difficulty with wheezing or excessive night coughing?
- In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination?
- Has your child had a dental examination in the last 12 months?
- Would you like to discuss anything about your child's health with the child care provider or health consultant/coordinator?

Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

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I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian

Date

## Part II — Health Evaluation

**To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.**

Child's Name Birth Date (mm/dd/yy) Date of History/Physical Exam (mm/dd/yy)

LENGTH/HEIGHT		WEIGHT		WT FOR HT/BMI	HEAD CIRCUMFERENCE <sup>1</sup>		BLOOD PRESSURE <sup>2</sup>
IN/CM	%ILE	LB/KG	%ILE	%ILE	IN/CM	%ILE	/

Screening/Test Results				Immunization Record									
Screening Test	Result	Date	Abnormal/Comments	Vaccine (Month/Day/Year)									
<b>Vision<sup>2</sup></b> Test type: _____				Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6				
<b>Hearing<sup>3</sup></b> Test type: _____				<b>DTP</b>									
<b>Lead<sup>4</sup></b> Risk: Yes/No				<b>DTP/Hib</b>									
<b>TB<sup>4</sup></b> Risk: Yes/No				<b>DTaP</b>									
<b>Urinalysis (UA)<sup>4</sup></b>				<b>DT/Td</b>									
<b>Anemia<sup>5</sup></b> (HGB/HCT) Risk: Yes/No				<b>OPV</b>									
<b>Developmental Assessment<sup>6</sup></b> Test type: _____				<b>IPV</b>									
<b>Has this child received dental care in the last 12 months?<sup>7</sup></b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				<b>MMR</b>									
<b>* Chronic Disease Assessment:</b> Yes No <span style="float: right;">Date of onset</span>				<b>Measles</b>									
<input type="checkbox"/> <input type="checkbox"/> Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified				<b>Mumps</b>									
<input type="checkbox"/> <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II				<b>Rubella</b>									
<input type="checkbox"/> <input type="checkbox"/> Anaphylaxis: <input type="checkbox"/> med. <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex				<b>HIB</b>									
<input type="checkbox"/> <input type="checkbox"/> Seizures: Type _____				<b>Hep B</b>									
<input type="checkbox"/> <input type="checkbox"/> Other: Please specify _____				<b>Varicella</b>									
<b>Minimum requirements:</b> <sup>1</sup> Up to 2 years; <sup>2</sup> annual at 3 years; <sup>3</sup> annual at 4 years; <sup>4</sup> as needed; <sup>5</sup> 9–12 months; <sup>6</sup> each visit through 5 years; <sup>7</sup> annual at 2–3 years. <b>Federal requirements (eg, Head Start, WIC) may vary.</b> <b>*Prior to Public School Entry: Same as above and Hgb/hct.</b>				<b>PCV</b>									Pneumococcal conjugate vaccine
				<b>Other Vaccines (Specify)</b>									
				<b>Disease Hx of above</b> _____ (Specify) (Date mm/yy) (Confirmed by)									
				<b>Exemption</b>									
				Religious _____ Medical: Permanent _____ Temporary _____ Date _____									
				Recertify Date _____ Recertify Date _____ Recertify Date _____									

This child has the following problems which may adversely affect his or her educational experience:

Vision     Auditory     Speech/Language     Physical Dysfunction     Emotional/Social     Behavior  
 The child has a health condition which may require intervention at the program, e.g., seizures, allergies, asthma, anaphylaxis, special diet, long-term medication. *Specify:* \_\_\_\_\_

- Yes  No This child has a medical or emotional illness/disorder that now poses a risk to other children or affects the child's ability to participate safely in the program.  
 Yes  No Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.  
 The child may fully participate in the program.  
 The child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.) \_\_\_\_\_

I would like to discuss information in this report with the early childhood provider and/or health consultant/coordinator.

Signature of health care provider	MD/DO NP PA	Name (Please type or print.)	Phone number
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Address: \_\_\_\_\_

Yes  No Is this the child's Medical Home?    Next Appointment (mm/yy): \_\_\_\_\_    Next Immunization Appointment (mm/yy): \_\_\_\_\_

**Madison Integrated Preschool  
Madison Town Campus Learning Center (TCLC)  
2011/2012 Typical Peer  
Fees and Program Selection**

**Student/Parent Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Mother    Guardian 1    Other \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #s   Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Emergency Contacts: (other than parent): \_\_\_\_\_

Tele No. \_\_\_\_\_ Relationship to student: \_\_\_\_\_

**FEE AND SESSION SELECTION**

**Select the 3 day or 5 day Program (Fee is \$20 per session)**

\_\_\_\_\_ **3 day Program is \$60 per week (Monday/Wednesday/Friday)**

\_\_\_\_\_ **5 day Program is \$100 per week (Monday – Friday)**

\_\_\_\_\_ **Other – Please circle days (M, T, W, Th, F)**

\_\_\_\_\_ **AM Session**      \_\_\_\_\_ **PM Session**

**A screening for typical peers is required. Please bring this completed form and your deposit check for \$50.00 (which will be deducted from your total) to TCLC to register and to schedule an appointment for screening.**

There is an AM and a PM session. Please indicate your preference. We will make every effort to honor your preference. If we are fully enrolled in AM or PM and cannot honor your preference, we will call you to check on your interest in the available session. If the AM/PM sessions are filled a waiting list will be maintained.

**PAYMENT**

Based on your selections above, Madison Public Schools will send you an invoice covering the 10-month school year and monthly reminders. The invoice will indicate monthly due dates and payment amounts.

***Please make all checks payable to Madison Public Schools (please do not include cash)***

TCLC, 2 Campus Drive, Madison, CT 06443

Attn: TCLC Secretary, 203-245-1078