MALDEN PUBLIC SCHOOLS
Parent Information Center
Registration Application

Student Information State ID # _____ Student ID # _____

Last: _____ First: _____ Middle: _____

Address: _____ Telephone: _____

Date of Birth: (mm/dd/yyyy) ____/____/____ ☐ Male ☐ Female

Birthplace: City: _____ State: _____ Country: _____

Home Language: _____ First Language: _____

Language parent/guardian prefers to receive school information: _____

Ethnicity: (choose only one) ☐ Yes, Hispanic or Latino (Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)
☐ No, not Hispanic or Latino

Race: (choose one or more)
☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

Family Information

Parent 1: _____ Address: _____

Email: _____ Cell Phone: _____ Work Phone: _____

Parent 2: _____ Address: _____

Email: _____ Cell Phone: _____ Work Phone: _____

Guardian's Name: _____ Address: _____

Email: _____ Cell Phone: _____ Work Phone: _____

Siblings (Brothers/Sisters)

Name	Age	Relationship	Grade	School

Medical Information

Doctor to be called: _____ **Telephone:** _____

Emergency Contacts (In case of emergency when parents/guardians are not available)

Name: _____ **Relationship:** _____ **Telephone:** _____

Name: _____ **Relationship:** _____ **Telephone:** _____

Previous School Information

Last school attended: _____

Location: _____ Last grade completed: _____ Grade(s) repeated: _____

When did your child start school in the United States.? _____

Has your child attended a public school in Malden before? ☐ Yes ☐ No Grade: _____ School: _____

Did your child receive any ELL program services before? ☐ Yes ☐ No

If yes, please check one: ☐ SEI ☐ ESL When did those services begin? _____

Does your child have an Individual Education Program (I.E.P.) ? ☐ Yes ☐ No

Kindergarten Students Only

Has your child attended preschool? ☐ **Yes** ☐ **No**

Name and address of preschool: _____

_____

How many hours a week does your child attend preschool? _____

Military Family Status

PLEASE CHECK ONE

	ACTIVE DUTY - Active duty members of the uniformed services, National Guard and Reserve on Active duty orders.
	DECEASED - Members who die on active duty.
	DISCHARGED - Members or veterans who are medically discharged or retired for one year.
	N/A - Not applicable.

Parent's Signature: Date:

School Assignment *(for office use only)*

School assigned: _____ Grade: _____ Program.: _____

School Proximity: Beebe _____ Ferryway _____ Forestdale _____ Linden _____ Salemwood _____

Intake Language: _____ Initials of PIC Interviewer: _____

PIC Authorized Signature: _____ Date: _____

CITY OF MALDEN, MASSACHUSETTS

THE PUBLIC SCHOOLS

529 Salem St., Malden, MA 02148 Tel. (781) 397-7271 Fax (781) 397-1547

MR. JOHN OTERI
Superintendent of Schools

JOAN FEDERICO
Manager, PIC

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** _____ **Gender** F ☐ M ☐

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)

Home Language forms are available in the following languages:

Arabic	Farsi	Hmong	Russian
Albanian	French	Japanese	Swahili
Bengali	Greek	Khmer	Telugu
Burmese	Gujarati	Korean	Thai
Simplified Chinese	Haitian	Polish	Urdu
Traditional Chinese	Hebrew	Portuguese	Vietnamese
Cape Verdean Creole	Hindi		

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

Malden Public Schools (0165)

Dear Parent/Guardian:

The purpose of this letter is to ask your permission to bill MassHealth for the cost of special education services that the district provides your child under the IEP that we developed with you. If you agree, MassHealth will reimburse the cost of services that they cover, such as therapy services as well as the cost of time spent by providers of such services to participate in Team meetings. We cannot send records and information about your child and your child's IEP services to MassHealth to ask for reimbursement without your consent and without first notifying you of the following:

1. The school district cannot require you to sign up for MassHealth in order for your child to receive the 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 special education services. This means that the school district cannot require you to pay a co-pay or deductible so that it can bill MassHealth. The school district can agree to pay the co-pay or deductible if any such cost is expected.

3. If the school district receives your consent:
   a. Your consent will not decrease 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 consent does not affect your child's special education services or IEP rights in any way.
   c. Your consent will not lead to any changes in your child's MassHealth rights; and
   d. Your consent will not lead to any risk of losing eligibility for other Medicaid or MassHealth funded programs.

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

5. If you withdraw your consent, or refuse to agree to allow the school district to share your child's records and information with MassHealth for the purpose of billing the cost of his/her IEP services, the school district will continue to be responsible for providing your child the special education services in his/her IEP at no cost to you.

I have read the notice and understand it. I have had my questions, if any, answered. I agree to give my consent to the school district to share records and information concerning my child and his/her IEP services as necessary to bill MassHealth to obtain federal reimbursement for the cost of the IEP services that MassHealth covers.

Parent/Guardian Signature: _____ _____

Date

Student Name:	**DOB:**	**SASID:**

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Mr. John Oteri
Superintendent of Schools

Patricia Tramondozzi, RN
Director of Nursing

MEDICAL RELEASE OF RECORDS

I give permission to: _____
Name of Health Agency/Doctor/Hospital

To release all medical information concerning my child:

_____ **Date of Birth:** _____
Name

to the Malden Public Schools for the school year _____

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Address _____

_____

_____

_____

FOR OFFICE USE ONLY

Send Records to:

_____

_____

_____

_____

Dedicated Fax # _____

Malden Public Schools Student Health Information

Student's Name _____ DOB _____ Gender ____ Grade _____ HR_____

Address_____ Is English spoken at home? _____ If NO, _____

Parent/Guardian #1_____ Home/Cell _____ Work # _____

Parent/Guardian #2 _____ Home/Cell _____ Work # _____

In case of an emergency or illness and we are unable to reach the contacts listed above, please provide 2 alternative contacts who will assume responsibility and transportation:

1. Name _____Relationship_____ Phone_____

2. Name _____Relationship_____ Phone_____

Please indicate if your child has any of the following health conditions:

Anxiety/Depression	YES	NO	Daily Medication	YES	NO	Orthopedic/Joint issues	YES	NO
ADD/ADHD	YES	NO	Diabetes	YES	NO	Seizures	YES	NO
Asthma/Inhaler	YES	NO	Eating Disorder	YES	NO	Speech Problems	YES	NO
Bathroom/Toileting	YES	NO	Hearing Problems	YES	NO	Tuberculosis	YES	NO
Blood Disorder	YES	NO	Heart Condition	YES	NO	Vision Problems	YES	NO
Concussion	YES	NO	Headaches	YES	NO	EpiPEN	YES	NO
Allergy to Food	YES	NO	Allergy to Medicine	YES	NO	Allergy to other	YES	NO
Any Surgeries	YES	NO	MEDICAL Condition	YES	NO	Accidents/Injuries	YES	NO

If you answered YES, please explain: _____

_____

_____**ALLERGY to** _____

Does your child have health insurance? YES or NO Private or Public _____

Doctor/Pediatrician _____ **Phone** _____

****DO NOT LEAVE BLANK****

PARENT/GUARDIAN AUTHORIZATION (Written Consent is required before any medication is given to your child)

YES NO 1. I give permission for the school nurse to administer **TYLENOL/ACETAMINOPHEN** to my child.
YES NO 2. I give permission for the school nurse to administer **IBUPROFEN/MOTRIN/ADVIL** to my child
YES NO 3. I give permission for the school nurse to administer **TUMS** (antacid tablets) to my child.
Yes NO 4. I give permission for the school nurse to administer **BENADRYL/DIPHENHYDRAMINE HCL** to my child

Medication dosage will be determined by child's weight and age
*****Children's chewable and liquid Tylenol/Ibuprofen MUST BE PROVIDED BY PARENT Not kept in stock***

I give permission for the school nurse to share information relevant to my child's health with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary physician for the purpose of referral and diagnosis and treatment. YES NO

PARENT/GUARDIAN SIGNATURE_____**DATE**_____

For office use only: Nurse Review _____ (2020)

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Mr. John Oteri.
Superintendent of Schools

Joan Federico, Manager
Parent Information Center

REQUEST FOR STUDENT RECORDS

In accordance with the provision of Public Law 93-380 and Massachusetts Law H R 16900, I, as parent/guardian, hereby authorize the transfer of school records as indicated below, as soon as this request is received. Thank You.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give permission to release school records for the following child(ren:)

Student's name	***Grade***	***D.O.B.***

New Address: _____ Phone: _____

_____

_____ Parent/Guardian's Signature

_____ Date

PLEASE FAX THE FOLLOWING RECORDS TO THE PARENT INFORMATION CENTER AT 781-397-1547:

❑ Transfer Card ❑ Transcript of Grades ❑ Health Records ❑ I.E.P. ❑ Discipline Report
❑ Standardized Test Scores ❑ ELL Testing/Folder

PLEASE SEND THE COMPLETE RECORDS TO THE FOLLOWING ☑ SCHOOL:

- ❑ Beebe School, 403 Pleasant St., Malden, MA 02148
- ❑ Ferryway School, 150 Cross St., Malden, MA 02148
- ❑ Forestdale School, 74 Sylvan St., Malden, MA 02148
- ❑ Linden School, 29 Wescott St., Malden, MA 02148
- ❑ Salemwood School, 529 Salem St., Malden, MA 02148
- ❑ Malden High School, 77 Salem St., Malden, MA 02148

Thank you for your cooperation.

Sincerely,

Joan Federico

Joan Federico, Manager
Parent Information Center

IMPORTANT LEGAL DOCUMENT

ANNUAL STREET LISTING

IMPORTANT: General Laws of Massachusetts mandate an annual street listing of residents as of January 1 each year. Update the information provided by adding, deleting, or making changes below the printed information. Please sign and respond within ten (10) days, even if no changes are necessary. For assistance, call at

← **If this address is incorrect, make corrections below**

_____

_____

✔ If there is no party information next to your name, you are not registered to vote. If you wish to register to vote, you may register in-person or by mail.

WARNING: Failure to respond to this mailing shall result in removal from the active voting list and may result in removal from the voter registration rolls.

INSTRUCTIONS: Please print. Update the information provided by adding, deleting, or making changes below the printed information. Designate the head of your household by marking an "X" in the second column next to the name. The ninth column labelled M/D asks if the person(s) listed have moved or are deceased. Enter an "M" or a "D" if appropriate. **The following fields are optional and are denoted as such by an asterisk: mail to, sex, party, number of cats, and telephone number.**

NAME Last First Middle	Mail to*	Previous Address If at the above address for less than one year	Sex* M/F	Date of Birth mm/dd/yyyy	Occupation	Party*	Nationality If non-U.S. citizen	M/D	# Dogs	# Cats*

Telephone Number* _____ ☐ Unlisted

_____

Signature of Respondent Date

Signed under the Penalties of Perjury as prescribed by M.G.L. Ch. 56, §4.

1	2	3	4	5
6	7	8	9	10