

# Proof of Residency Instructions

Dear Parents/Guardians of Incoming New Students,

Welcome to Dunbarton Elementary School where learning, diversity, and personal best are celebrated. We look forward to having your child(ren) join us. DES students enjoy many opportunities to learn, ask questions, problem solve and make new friends. They also work with teachers and staff members who are dedicated and committed to a high standard of excellence. We are pleased to extend a warm welcome to you!

Along with your registration packet we will need:

- Copy of your child's birth certificate
- Completed physical with required immunization documentation
- Proof of residency supported by two of the following documents:
  - a) Purchase and Sale agreement or lease agreement
  - b) Utility bill or deposit receipt indicating Dunbarton address
  - c) Driver's license with Dunbarton address
  - d) Social Services papers
  - e) Welfare card

NOTE: In the unusual case that none of these proofs of residency are available, a signed and notarized statement of residency must be completed.

NO CHILD WILL BE ENROLLED IN DUNBARTON ELEMENTARY SCHOOL UNTIL PROOF OF RESIDENCY HAS BEEN ESTABLISHED. FAILURE TO DO SO MAY RESULT IN FAMILIES OWING TUITION TO THE DUNBARTON SCHOOL DISTRICT.

Please return all forms as soon as possible. This will give the Dunbarton Elementary School Registration Team time to review all of the information that is essential to the proper placement of your child.

If your child has been diagnosed with a medical condition and/or will require medication during the school day, please call Mrs. Hast, the school nurse. She will be able to provide you with the necessary supplemental forms for your physician to complete. If you have any questions, please call the DES office at 774-3181.

Sincerely,

Owen Harrington, Principal

**Office of the Superintendent of Schools**  
**SAU#67**  
**Bow, New Hampshire**  
**TOWN OF RESIDENCE FORM**

Dear Parents/Guardians:

Proper allocation of district expenses makes it important that we determine the ***Town of Residence*** for each child as of September in an accurate manner. Therefore, we request that you complete this form and return it to the school with your signature.

**NOTE:** A separate form must be completed for each child.

My son/daughter \_\_\_\_\_,

Grade \_\_\_\_\_, resides in the Town of **Dunbarton**.

My child is attending Dunbarton Elementary School.

Date entering school \_\_\_\_\_

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

If at any time during the school year you move to another town within this school district, please be sure to notify the school and fill out a new Town of Residence Form.

DUNBARTON ELEMENTARY SCHOOL  
STUDENT INFORMATION SHEET  
2017-18

**STUDENT INFORMATION**

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

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

Date of Birth: \_\_\_\_\_ City and State of Birth: \_\_\_\_\_

Grade entering: \_\_\_\_\_ Gender (M or F): \_\_\_\_\_

**If transfer student - Previous School Attended:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**GUARDIAN INFORMATION**

**Primary**

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

E-mail: \_\_\_\_\_ Place of employment: \_\_\_\_\_

**Secondary**

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

E-mail: \_\_\_\_\_ Place of employment: \_\_\_\_\_

**EMERGENCY INFORMATION**

**Allergies:** \_\_\_\_\_

**\*\*\*If unable to contact parent, name a friend or relative who may be called upon if the child is ill.\*\*\***

**Emergency Contact #1:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**Emergency Contact # 2:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

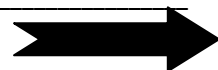
If none of the above can be contacted what do you wish the school to do if your child is sick or injured?

\_\_\_\_\_  
(The above recommendation of the parent will be respected as far as possible. However, in an emergency situation the final disposition will be the judgment of the school authorities.)

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

**SEE REVERSE SIDE**



**ADDITIONAL INFORMATION**

**Child lives with: (circle one):** Both Parents    Mother Only    Father Only    Grandparents

Father/Stepmother    Mother/Stepfather    Guardian    Other \_\_\_\_\_

Is there a joint custody or parenting plan in effect? **YES/NO** (If yes, plan must be on file with the school for enforcement)

Is there a restraining order in effect? **YES/NO** (If yes, legal papers must be on file with the school for enforcement)

Is there a second household that needs to receive mailings? **YES/NO** (If yes, please include name and address below)

Name: \_\_\_\_\_ Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

**Is the student Hispanic or Latino?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Race (circle one or more):**

American Indian/Alaska Native    Asian    Black/African American    White    Native Hawaiian/Pacific Islands

**ACADEMIC INFORMATION**

**1. Does your child have an Individual Education Plan (IEP) or a 504 Educational Plan? (circle one)**    IEP    504    NONE

**2. Is a language other than English spoken in your home? YES/NO**  
If so, what language? \_\_\_\_\_

**FUTURE ENROLLMENT**

**Names of siblings who are currently attending or will be attending DES in the future:**

Name:	D.O.B.	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PERMISSIONS**

**Photos of Dunbarton School District students are, on occasion, featured in the school newsletter, local newspaper and on the DSD website. Please complete the following:**

**Child's name:** \_\_\_\_\_ **has permission to be photographed.**

**Child's name:** \_\_\_\_\_ **does not have permission to be photographed.**

**PARENT/GUARDIAN SIGNATURE**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# MEDICAL REQUIREMENTS FOR ENTRANCE INTO SCHOOL

Welcome to Dunbarton Elementary School. We would like to be able to assist you and your child with adjusting quickly and comfortably into a new setting. Of special importance to us are your child's health and the prevention of communicable diseases. Documentation of physical exam and immunization record from a health care provider are required prior to start of school.

- New Hampshire State Law, RSA 200:32 requires all students to have a physical examination before entering school. Any information made available regarding allergies and physical challenges will become part of your child's confidential medical record at school. This exam must be within one year preceding first entry to this school district.
- New Hampshire State Law, RSA 141-C: 20-a requires all students in New Hampshire to be immunized against Diphtheria, Pertussis, Tetanus, Measles, Mumps, Rubella, Varicella(chicken pox), Polio, and Hepatitis B before entrance into school. Any child being admitted to the district must present proof of meeting immunization requirements. Failure to comply with this provision may result in exclusion from school for the child.

Note: This requirement may be waived for medical reasons if evidence is presented from your health care provider that immunization will be detrimental to the child's health or for religious reasons if a written notarized statement is presented to the school.

Check with your health care provider or the school nurse if you have any questions regarding immunization requirements. If your child is on a medication or starts a new medication, the school nurse MUST be notified. Please note this includes inhalers and rescue medications such as epipens.

If you have any further questions, please feel free to contact the school at 774-3181 ext. 205 for the school nurse.

Sincerely,

Virginia Hast, RN

Dunbarton Elementary, School Nurse

**DUNBARTON ELEMENTARY SCHOOL  
CONFIDENTIAL HEALTH HISTORY**

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Please attach a copy of the latest Physical and Immunization record from your child's Healthcare Provider**

**A. Family History:**

1. Check any of the following diseases that this student's parents, grandparents, aunts, uncles, brothers, or sisters have had:

- |                                        |                                         |                                             |                                   |
|----------------------------------------|-----------------------------------------|---------------------------------------------|-----------------------------------|
| <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Allergy            | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Inherited Diseases | <input type="checkbox"/> Cancer   |

2. Are the child's parents in good health? **YES/NO**

**B. Medical Information:**

1. Does your child have any allergies to food, medication, insect/bee bites, latex, etc.? **YES/NO**

a. If so, specify allergy and symptoms \_\_\_\_\_

b. What treatment is necessary? \_\_\_\_\_

2. If your child takes daily medication at home:

a. Name med/dosage/reason \_\_\_\_\_

3. If your child takes daily medication at school:

a. Name med/dosage/reason \_\_\_\_\_

4. Has your child had any operations, serious accidents, illnesses or hospitalizations? **YES/NO**

a. If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Please describe anything unusual about the pregnancy/delivery of this child:

\_\_\_\_\_

Describe any special medical care your child required during the first year:

\_\_\_\_\_

Does your child have any special health conditions?

- |                                                 |                                          |                                         |                                           |
|-------------------------------------------------|------------------------------------------|-----------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Frequent nosebleeds    | <input type="checkbox"/> Dry skin/eczema | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Heart conditions |
| <input type="checkbox"/> Frequent headaches     | <input type="checkbox"/> Overweight      | <input type="checkbox"/> Bronchitis     | <input type="checkbox"/> Constipation     |
| <input type="checkbox"/> Frequent stomach aches | <input type="checkbox"/> Anemia          | <input type="checkbox"/> Tonsillitis    | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Frequent sore throats  | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Incontinence     |
| <input type="checkbox"/> Frequent strep throats | <input type="checkbox"/> High lead level | <input type="checkbox"/> Other:         | _____                                     |

Does your child have health insurance? **YES/NO**

Please describe anything more about your child's health that you think it is important for us to know:

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List any school activities that your child **CANNOT** participate in and explain:

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### C. Additional Information:

1. Does he/she get along well with other children? **YES/NO**

2. Do any of the following apply to your child?

- |                                       |                                     |                                              |                                               |
|---------------------------------------|-------------------------------------|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Nail biting  | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Wets bed            | <input type="checkbox"/> Thumb sucking        |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Very shy   | <input type="checkbox"/> Speech difficulties | <input type="checkbox"/> Hearing difficulties |
| <input type="checkbox"/> Jealousy     | <input type="checkbox"/> Won't mind | <input type="checkbox"/> Breath holding      | <input type="checkbox"/> Very outgoing        |

### D. Please check any of the following illnesses your child has had and when:

- |                                      |                                         |                                          |                                        |
|--------------------------------------|-----------------------------------------|------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Mumps       | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Meningitis    |
| <input type="checkbox"/> Measles     | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Scarlet Fever  | <input type="checkbox"/> German Measles  |                                        |
| <input type="checkbox"/> Other:      | _____                                   |                                          |                                        |

Has your child ever had an eye exam by an eye doctor? **YES/NO**

Does he/she wear glasses? **YES/NO**

Is your child receiving any special services or in an early intervention program? **YES/NO**

Child's Doctor \_\_\_\_\_ Telephone # \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Telephone # \_\_\_\_\_

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(Parent/Guardian Signature)

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(Date)