LISBON CENTRAL SCHOOL

15 Newent Road
Lisbon, CT 06351
P: 860.376.2403
F: 860.376.1102

Dear Parent/Guardian:

Enclosed are the forms to register your child at Lisbon Central School.

Please note there is a **Residency Affidavit** that a parent or guardian will need to complete and have notarized. A copy of verification of legal residency is required, which may include a lease, deed, homeowner's insurance declaration page, or rental agreement that includes your name, address and dates of lease. We no longer have a notary here at LCS.

If you have any questions, please feel free to call our office at (860) 376-2403.

Sincerely,

LCS Administration

Please complete and return:

- ☐ Student Registration Form
- ☐ Birth Certificate
- ☐ Residency Affidavit (notarized)
- ☐ Proof of Residency (see examples above)
- ☐ Race and Ethnicity Questionnaire
- ☐ Native Language Form (if not previously completed)
- ☐ Release of Information
- ☐ Yearly Health Form
- ☐ Administration of Medicine
- ☐ Health Assessment Record (blue form)
- ☐ Movie Permission Slip
- ☐ Handbook/Photos/Videos/Website Permission

STUDENT REGISTRATION FORM

Lisbon Central School

Child's Name _____ Registration Date _____
Last First Middle

Home Address _____

Primary Phone Number _____ Grade _____ Sex: M____ F____

Date of Birth _____ Place of Birth _____

If not born in USA; when did student first attend school in USA? _____

Student lives with: Both Parents____ Mother____ Father____ Other_____

Father (Guardian) _____ Cell Phone Number_____

Address if Non-custodial _____

Place of Work _____ Work Phone Number_____

Email address _____

Mother (Guardian) _____ Cell Phone Number_____

Address if Non-custodial_____

Place of Work _____ Work Phone Number _____

Email address _____

EMERGENCY CONTACTS

List in order who will assume temporary care of your child if Parents/Guardians cannot be reached:

	Name	Relationship	Phone
1.			
2.			
3.			
4.			
5.			

(Over)

Parent(s) in the Armed Forces Y _____N_____ : (on active duty or fulltime National Guard duty)

Migrant Y_____N_____: A child or parent who is migratory (agricultural, dairy or fisher) worker who moved within the past 36 months across state or district boundaries to obtain work.

OTHER CHILDREN LIVING IN HOUSEHOLD

Name _____ DOB _____ Name _____ DOB _____

_____

_____

School Student Last Attended _____

Address of School Last Attended _____

Did your child attend preschool? YES _____ NO _____

If Yes, Where _____

SPECIFIC INFORMATION (health - physical, social, special needs, etc...) _____

_____

_____

Is child in any type of special education program or does the child receive any special support of any kind?

Yes _____ No _____ If yes, what type? _____

Medical History/Concerns: _____

_____

Family Physician: _____ Phone: _____

Permission is given, if deemed medically urgent, to transport my child by ambulance/car to nearest hospital: Yes_____
If no, please advise: _____

Signature: _____ **Date**: _____

I, the undersigned, do hereby authorize officials of Lisbon School District to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

_____ _____

Parent/Guardian Signature **Date**

Lisbon Central School
15 Newent Road
Lisbon, CT 06351

Phone: (860) 376-2403
Fax: (860) 376-1102
www.lisbonschool.org

AFFIDAVIT OF RESIDENCE

☐ New Registration ☐ Moved Within Town of Lisbon

_____ _____ is seeking enrollment at
Name *D.O.B.*

_____ effective _____. This student currently resides
School *Date*

with _____ (___) _____
Name(s) *Telephone No.*

_____
Street *City* *State* *Zip Code*

who is (check one):

_____ Parent(s) _____ Legal Guardian _____ Foster home _____ Friend

_____ Family relative (indicate relationship): _____ _____ Other

if other, please explain _____

Please explain in detail the circumstances under which the student is residing permanently in Lisbon, including the relationship with the Lisbon resident in whose home the student will be residing.

_____

_____

Last school attended _____ Grade _____

I understand that if residency is not granted, I have the right to appeal and may submit my appeal in writing to the Superintendent of Schools.

A copy of verification of legal residency is required, which may include: lease, deed, homeowner's insurance receipt or rental agreement.

I attest that the above statements are accurate and true and that the student resides at the above address. If the student resides with anyone other than his/her parent(s), I attest that I am freely allowing the above named student to reside with me and that the residence indicated above is (1) permanent; (2) provided without pay; and (3) not for the sole purpose of obtaining school accommodations.

_____ _____
Parent / Legal Guardian Signature / Responsible Party *Date*

Subscribed and sworn to before me
this _____ day of _____ 20 ____

_____
(Notary Public/Seal)

Student Race and Ethnicity Questionnaire

Please answer the following questions about your child/children in the table below: 1) Is your child Hispanic/Latino, yes or no? and 2) What is your child's race? Check all that apply. Please note that you may refuse to answer these questions, but in this event a school district staff member will need to make the identification for you.

Child's Name	Is this child Hispanic/Latino? (check only one)		What is the child's race? (Check one or more, even if you answered "Yes" to the Hispanic/Latino question)				
	YES	NO	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White

Parent or Guardian Signature: _____

Definitions: Hispanic/Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippines Islands, Thailand and Vietnam. Black or African American: A person having origins in any of the black racial groups of Africa. Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands. White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

LISBON CENTRAL SCHOOL

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NATIVE LANGUAGE FORM

Dear Parent/Guardian:

Connecticut State law requires that each school district conduct a preliminary assessment of the native language of each student in its public schools.

Please complete the following form.

Thank you for your cooperation.

Sincerely,
Sally Keating
Superintendent

Student's Name: _____
Grade: _____
Teacher: _____

What is the primary language used in the home, regardless of the language spoken by the student?	
What is the language most often spoken by the student?	
What is the language that the student first acquired?	

_____ _____
Parent/Guardian Signature **Date**

LISBON CENTRAL SCHOOL

15 Newent Road
Lisbon, CT 06351
P: 860.376.2403
F: 860.376.1102

Release of Information
and
Authority to Obtain Information

I, the undersigned parent or guardian of _____
(**student name**)

do hereby give _____
(**name** of previous school attended)

_____
(**address** of previous school attended)

_____
(**phone** and **fax** number)

the authority to release educational, medical, psychological, special education, and any additional records to:

Lisbon Central School

15 Newent Road Lisbon CT 06351

Phone 860-376-2403 Fax 860-376-1102

_____

Signature of Parent/Guardian Date

LISBON CENTRAL SCHOOL

15 Newent Road
Lisbon, Connecticut
www.lisbonschool.org

Telephone #: (860) 376-2403
Fax #: (860) 376-1102

Dear Parents/Guardians:

The Yearly Health Form and the Authorization for the Administration of Medicine by School Personnel Forms are enclosed.

The **Yearly Health Form** must be filled out for each new student before entering Lisbon Central School. This form must be returned to the nurse's office ASAP.

The **Authorization for the Administration of Medicine by School Personnel Forms** must be filled out for students requiring **any** medication during school hours. Connecticut State Law and Regulations require a physician/dentist's written order and parent/guardian's authorization for a nurse or in her absence the principal/teacher to administer medications. Medications must be in pharmacy prepared containers and labeled with name of child, name of medication, strength, dosage, frequency, physician/dentist's name of original prescription and possible side effects. **PLEASE NOTE:** No loose medication will be accepted. All medication must be transported by an adult and must be in the prescription labeled bottle. The only medications that students may carry & self administer are rescue asthma inhalers and cartridge injectors for medically diagnosed allergies. Students need special permission (noted on the medication order form) to carry these items.

All students who have a food allergy are also required to have a **Food Allergy Action Plan Form** completed by their physician. It must include the student's allergy, action to be taken for minor and major reactions, and emergency contacts. This form can be obtained in the nurse's office, the main office or on the Lisbon Central School website.

I appreciate your support in returning these forms as soon as possible to promote and maintain the highest possible standard of health for each student within our school system. If you have any questions or concerns, please call (860) 376-6716.

Sincerely,

Theresa Svab
School Nurse, RN

TS 2024/2025 A

YEARLY HEALTH FORM

Student's Name _____ School Year _____ Grade/Teacher _____

Family Physician _____ Physician Phone _____

My child can participate in all activities including physical education. Yes _____ No _____

If, at any time during the school year, your child has any physical or other limitations that restrict him/her from participating in school activities, including gym, please provide medical documentation from your child's licensed care provider stating the specific restrictions and the reason for the limitations.

ASTHMA AND ALLERGIES

Asthma _____ Uses inhaler/nebulizer _____ Needs Medication at School (Yes/No) _____
Food Allergy _____ Requires Epipen/Benadryl _____
Bee Sting Allergy _____ Requires Epipen/Benadryl _____
Drug Allergy _____

List any medications taken at home or will need to take at school on a daily basis: _____
_____

- **NOTE: All medications to be taken at school require an <u>Authorization for the Administration of Medicine by School Personnel</u> order signed by a medical provider and parent/guardian.**

OTHER MEDICAL CONDITIONS

Please notify the school nurse if your child has any of the following medical conditions:

ADHD/ADD	_____	Hearing Problem	_____	Skin Disorder	_____
Cerebral Palsy	_____	Heart Condition	_____	Speech Defect	_____
Diabetes	_____	Physical Handicaps	_____	Surgery	_____
Ear Infections	_____	Scoliosis	_____	Urinary Problem	_____
Epilepsy	_____	Seizures	_____	Vision Problem	_____

If you answer "yes" to any of the above, please explain_____
_____

Please list any other medical conditions or other problems that you feel the school nurse should be aware of.

_____
_____

List dates and types of any communicable disease your child has had during the past year (ex: Rheumatic fever, Poliomyelitis, Scarlet Fever, Pneumonia, Mumps, Measles, Chicken Pox, German Measles)

_____

Does your child have health insurance? Yes _____ No _____

Name of Insurance Company _____

Would you like the above information shared with the bus company? Yes _____ No _____
Would you like the above information shared with appropriate school staff? Yes _____ No _____
I give permission for the school nurse to contact my child's physician as needed to obtain medical information. Yes _____ No _____

When your child is **ABSENT**, please call the school anytime at (860) 376-2403, ext. 203 and leave a message, including your child's name, teacher and reason why child will be out (sick, injured, family emergency, etc.). You may also email the attendance secretary at tgolas@lisbonschool.org. Otherwise, you will be called at home, cell or at work.

SCOLIOSIS SCREENINGS will be done for female students in grades 5 and 7 and male students in grade 8. The screenings will be performed in the spring. If you **DO NOT** want your child to participate in this screening at school, please check the reason below:

_____ His/Her health care provider will conduct the screening at their physical this school year.
_____ He/She is under the care of a doctor for scoliosis.

I, the undersigned, do hereby authorize officials of Lisbon School District to contact directly the persons named as emergency contacts and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, emergency contacts, or parents cannot be reached, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent/Guardian: _____ Date: _____

BACK

Lisbon Central School

Authorization for the Administration of Medicine by School Personnel

The Connecticut State Law (General Statues, Sec. 10-212A) requires a written order of a physician licensed to practice medicine in this or another state and the written authorization of a parent or guardian of such child for a school nurse or, in the absence of such nurse, qualified personnel for schools to administer medications to any student.

Physician's Order:

Name of Child: _____ School Year: _____ Grade: _____ Date:_____

Address: _____ Date of Birth: _____

Condition for which drug is being administered during school hours: _____

_____

Name of Drug, Dose & Method of Administration: _____

_____

Is this a controlled drug? _____ DEA # _____

Time of Administration in school _____

Medication shall be administered from _____ to _____
Date Date

Relevant side effects/Plan for management _____

_____

_____ _____
Physicians Signature Date

_____ _____
Physicians Name and Address Telephone

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Prescriber's authorization for self administration: _____Yes _____No Signature _____Date_____
Parent/guardian authorization for self administration: _____Yes _____No Signature _____Date_____

****

Parent/Guardian Authorization

I hereby request that the above medication, ordered by the physician for my child _____, be administered by school personnel. To ensure the safe administration of such medication, I permit the exchange of information between the prescriber and the school nurse. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a three month supply of said medication. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one (1) week beyond the close of school.

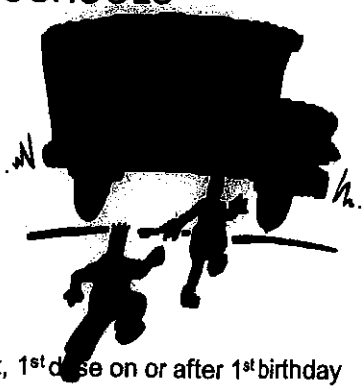
Parent/Guardian Signature _____ Date _____

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

IMMUNIZATION REQUIREMENTS FOR ENROLLED STUDENTS IN CONNECTICUT SCHOOLS

2024-2025 SCHOOL YEAR



PRESCHOOL

Hepatitis B:	3 doses, last one on or after 24 weeks of age
DTaP:	4 doses (by 18 months for programs with children 18 months of age)
Polio:	3 doses (by 18 months for programs with children 18 months of age)
MMR:	1 dose on or after 1st birthday
Varicella:	1 dose on or after 1st birthday or verification of disease
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday
Hib:	1 dose on or after 1st birthday
Pneumococcal:	1 dose on or after 1st birthday
Influenza:	1 dose administered each year between August 1st-December 31st (2 doses separated by at least 28 days required for those receiving flu for the first time)

KINDERGARTEN

Hepatitis B:	3 doses, last dose on or after 24 weeks of age
DTaP:	At least 4 doses. The last dose must be given on or after 4th birthday
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday
Hib:	1 dose on or after 1st birthday for children less than 5 years old
Pneumococcal:	1 dose on or after 1st birthday for children less than 5 years old

GRADES 1-6

Hepatitis B:	3 doses, last dose on or after 24 weeks of age
DTaP/Td:	At least 4 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses.
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday

GRADE 7-12

Hepatitis B:	3 doses, last dose on or after 24 weeks of age
Tdap/Td:	1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday
Meningococcal:	1 dose

Revised 1/3/2024

- DTaP vaccine is not administered on or after the 7th birthday.
- Tdap can be given in lieu of Td vaccine for children 7 years and older unless contraindicated.
- Hib is NOT required once a student turns 5 years of age.
- Pneumococcal conjugate is NOT required once a student turns 5 years of age.
- Influenza is NOT required once a student turns 5 years of age.
- HepA requirement for school year 2024–2025 applies to all Pre-K through 12th graders born 1/1/07 or later.
- HepB requirement for school year 2024–2025 applies to all students in grades K–12. Spacing intervals for a valid HepB series: at least 4 weeks between doses 1 and 2; 8 weeks between doses 2 and 3; at least 16 weeks between doses 1 and 3; dose 3 must be administered at 24 weeks of age or later.
- Second MMR for school year 2024–2025 applies to all students in grades K–12.
- Meningococcal conjugate requirement for school year 2024–25 applies to all students in grades 7–12.
- Tdap requirement for school year 2024–2025 applies to all students in grades 7–12.
- If two live virus vaccines (MMR, varicella, MMRV, intranasal influenza) are not administered on the same day, they must be separated by at least 28 days (there is no 4 day grace period for live virus vaccines). If they are not separated by at least 28 days, the vaccine administered second must be repeated.
- Lab confirmation of immunity is **only** acceptable for HepA, HepB, measles, mumps, rubella, and varicella.
- **VERIFICATION OF VARICELLA DISEASE:** confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

For the full legal requirements for school entry visit: Laws and Regulations (ct.gov)

If you are unsure if a child is in compliance, please call the Immunization Program at (860) 509-7929.

New Entrant Definition:

*New entrants are any students who are new to the school district, including **all** preschoolers and all students coming in from Connecticut private, parochial and charter schools located in the same or another community. **All preschoolers, as well as all students entering kindergarten**, including those repeating kindergarten, and those moving from any public or private pre-school program, even in the same school district, **are considered new entrants**. The one exception is students returning from private approved special education placements–they are not considered new entrants.

Vaccines supplied by the State of Connecticut are listed here, along with brand names.

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

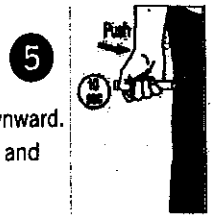
1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

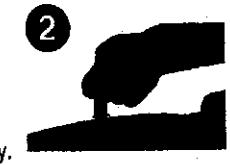


HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

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

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

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

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take in school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian _____ Date _____

To be maintained in the student's Cumulative School Health Record

HAR-3 REV. 1/2022

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height**_____in. /_____% ***Weight**_____lbs. /_____% **BMI**_____/_____% **Pulse** _____ ***Blood Pressure**_____/_____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**			***Auditory Screening**			History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	Date
Type:	Right	Left	Type:	Right	Left		
With glasses	20/	20/		❑ Pass	❑ Pass	***HCT/HGB:**	
Without glasses	20/	20/		❑ Fail	❑ Fail	***Speech** (school entry only)	
❑ Referral made			❑ Referral made			Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
*Explain:*_____
Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____
Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No

Risk Assessment	**Describe Risk Factors**	
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other _____

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian — Date

_____

Signature of health care provider — DMD / DDS / MD / DO / APRN / PA/ RDH — Date Signed — Printed/Stamped ***Provider*** Name and Phone Number

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 1/2022

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Religious Exemption: _____

Religious exemptions must meet the criteria established in Public Act 21-6: https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance—Immunizations.pdf.

Medical Exemption: _____

Must have signed and completed medical exemption form attached. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/Immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

_____

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

LISBON CENTRAL SCHOOL

15 Newent Road
Lisbon, CT 06351
P: 860.376.2403
F: 860.376.1102

To: Parents of children in grades 1-8

From: Superintendent of Schools

Re: Permission to watch PG movies (PG-13 in grades 7 & 8 only)

My son/daughter has permission to watch movies when necessary to enhance curriculum throughout the school year. In most circumstances, movies are only shown as part of the approved curriculum. All movies have been reviewed before viewing by the teaching staff and have been deemed appropriate for school use. This signed note will be effective for this school year only.

Please fill out the bottom portion of this paper and have your child return it to their teacher during the first week of school. If the completed form is not returned, your child will not be allowed to view movies.

_____ I give my child permission to view movies.

_____ I do not give my child permission to view movies.

Child's Name: _____

Child's Homeroom: _____

Parent's Signature: _____

Date: _____

Lisbon Central School

Student & Family Handbook

The Lisbon Central School Student & Family Handbook for the school year 2021-2022 is available online at our school's website: http://www.lisbonschool.org/student_handbook. A hard copy of the Student & Family Handbook is available upon request.

☐ ***We have read, as a family, the Lisbon Central School Student & Family Handbook and understand that it can be accessed at any time at the URL above or on the school website.***

Photos/Videos/Website

Lisbon staff has used children's photographs, videos, artwork, etc. as a means of acknowledging the child's efforts and recognizing excellent programs. The school has published children's photographs through "yearbooks". These are only some of the ways we have used photos and videos in constructive, positive ways.

The State Department of Education has advised us that, due to "privacy laws", the Lisbon School System should seek parental/guardian permission to photograph/videotape children.

We would appreciate your cooperation in signing the form below in order to indicate that you have read this letter. Thank you.

Photograph/Video Release: The Lisbon Board of Education retains the absolute right and permission to copyright and use, reuse and publish portraits, pictures, or videotapes of my child or in which my child may be included, in whole or part, without restrictions as to changes or alterations in composite of photograph/video.

The Lisbon School System will use these photographs/videotapes and no fees will be collected or profits made from these photographs/videotapes.

I give permission for my child's photo/video/artwork (without names) to be used on the website. ☐ ***Yes*** ☐ ***No***

I give permission for my child's photo/video (with names) to be used in school. ☐ ***Yes*** ☐ ***No***

I give permission for my child's photo (with names) to be used in the yearbook. ☐ ***Yes*** ☐ ***No***

STUDENT NAME (Printed) _____ STUDENT'S HOMEROOM _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____