

WELCOME TO TWINFIELD UNION SCHOOL!

We are happy to have your student join us!

All forms in the packet are required and must be returned in order to enroll your student. Please drop off or mail to:

Twinfield Union School
Att: Mary Anne Allen
106 Nasmith Brook Road
Plainfield, VT 05667

In Addition, YOU MUST ALSO PROVIDE:

- A photocopy of your child's **birth certificate**.
- A copy of your child's **current immunization record**. You can have your doctor's office fax it to us at 802-426-4085.
- Twinfield serves families within the physical boundaries of Marshfield and Plainfield. Families new to Twinfield must provide **Proof of Residency** (tax bill, lease, utility bill that includes parent name and PHYSICAL address, not just mailing address.)

Questions?

Mary Anne Allen, Registrar
426-3213 x207
Maryanne.allen@ccsuvt.net

HEALTH INFORMATION

This information is **REQUIRED** for the Vermont State Health Department. Please complete all questions.

Child's Name _____ Grade _____

Please circle:

My child HAS / DOES NOT have health insurance
(Information on the availability of Student Insurance Plans is available in the office.)

My child HAS / HAS NOT had a well child/adolescent exam by a medical provider in the past year

My child HAS / HAS NOT had a dental check up exam by a dentist in the past year

Has a doctor, nurse or other health professional EVER said that your child has asthma? YES NO DON'T KNOW/NOT SURE

If YES, does your child STILL have asthma? YES NO DON'T KNOW/NOT SURE

Name of Doctor _____ Dentist _____ Eye Doctor _____

Phone # _____ Phone # _____ Phone # _____

Circle all that apply: Glasses Contacts New lenses in the past year Date of last eye exam _____

Medical Issues/Problems _____ Dental Issues _____

Any Allergies YES NO If yes, explain _____

ALL CURRENT MEDICATIONS:

Taken at home: _____ Needed at School: _____

I give permission for the school nurse to give and receive health information to/from my child's:

Primary Care Physician Eye Doctor Dentist Counselor Other _____

Signature of Parent/Guardian _____ Date _____

AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION

PERMISSION TO GIVE: (please circle)

TYLENOL IBUPROFEN BENADRYL COUGH DROPS OTHER _____

Signature of Parent/Guardian _____ Date _____

AUTHORIZATION FOR EMERGENCY TRANSPORTATION/TREATMENT:

Name of student: _____

In case of accident or illness, I request the school to contact me. If not able to reach me, I hereby authorize the school personnel to seek emergency medical care, including transportation to the emergency room. I hereby authorize the physician in charge to administer whatever emergency treatment is necessary at my expense.

Signature of Parent/Guardian _____ Date: _____

Twinfield Union School

106 Nasmith Brook Road

Plainfield, VT 05667

PHONE 802-426-3213

FAX 802-426-4085

Request for Student Records (if applicable)

School: _____

Address: _____

Phone: _____ FAX: _____

_____ in grade ____ has enrolled at Twinfield Union School.
(Student name)

Please fax shot records, birth certificate and report card/schedule.

Please send all records including transcripts, health, special education, test scores, and any other information that may be helpful. If necessary, please enclose an explanation of your marking system.

Please also include the student's Vermont State ID Number (if applicable)

I hereby give permission to send all records regarding my child named above to Twinfield Union School.

Parent/Guardian Signature

Date

Please mail to: Mary Anne Allen, Registrar
Twinfield Union School
106 Nasmith Brook Road
Plainfield, VT 05667
maryanne.allen@ccsuvt.net

OFFICE USE ONLY

Date of Fax _____
Date Records Received: _____
Health _____
Academic _____
Special Ed _____
Other: _____

Prescription Medication Order and Permission Form

**-To be renewed at the beginning of each school year only
for students who must be given prescription medications during the school day-**

-To be filled out by Physician AND Parent-

Student Name: _____ Grade: _____ Date: _____

I hereby give permission for the above-named student to take medication at school as prescribed below and to release information to the Twinfield Union School Nurse concerning the prescribed medication(s) from

Physician's Name

Phone #

Signature of Parent/Guardian _____ Date _____

PHYSICIAN'S ORDER FOR MEDICATION AT SCHOOL

MEDICATION NAME: _____

DOSAGE: _____

DIRECTIONS FOR GIVING: _____

BEGINNING DATE: _____ ENDING DATE: _____

REASON FOR GIVING: _____

POSSIBLE SIDE EFFECTS: _____

Signature of Physician _____ Date _____

Name of Physician, PLEASE PRINT: _____

Please Note: No medication will be given at school until the school nurse receives this completed form with the prescribed medication in a container labeled by the pharmacy or physician. All medicine brought to school must be kept in the health office during school hours.

Date Received: _____ Signature of School Nurse: _____

Twinfield Union School

Media Release Permission

Do you give your permission for your child to be photographed or videotaped and named during school-sponsored activities and for these photos and/or videos to be shared with media and educational publications?

Do you give your permission to release information regarding academic and extracurricular achievements? (Example: honor roll, sports, recognition lists and event programs?)

Yes _____ No _____

Field Trips

Do you give your permission for your child to attend school-sponsored field trips this year?

Yes _____ No _____

Emergency Dismissal

In the event of an **unscheduled early dismissal due to weather or an immediate emergency situation**, a robo-call and an email will be sent to you, and your children will follow their normal dismissal procedure unless alternative bus or pickup arrangements are indicated below. These dismissal plans **should not include a phone call to the school or your child at the time of the emergency** if at all possible. Please be sure your child(ren) are aware of the arrangements. This info will also be shared with your child's teacher.

Instructions for an unscheduled early dismissal due to weather or emergency: (choose one)

- My child is to go HOME on the bus **OR** I will pick up my child at school
- Go to _____ on the bus
- _____ will pick up my child at school

Student Name _____ Grade _____

Parent/Guardian Signature _____ Date _____

Primary/Home Language Survey for All Kindergarten and Incoming Students

Instruction for schools in completing the survey:

1. Interview the parents/guardians of **ALL** new Kindergarten and incoming students in grades K-12 and record all information requested.
2. Provide interpreting services whenever necessary.
3. Please check to see that **all questions** on the form are answered.
4. A copy of any survey with a language other than English should be referred to the ESL teacher for further screening to determine if the student is an **English Language Learner (ELL)**.
5. Surveys for students identified as ELLs should be faxed (802-479-1829) or mailed to:
Jim McCobb, ELL Program Coordinator, Vermont Agency of Education, 219 North Main Street, Suite 402, Barre, VT 05641.
6. Place the original survey form in the student's permanent file.
7. For questions contact Jim McCobb at (802) 479-1273.

Student Information (Parents/Guardians should complete this section.)			
First Name:	Last Name:	Date of Birth (Month/Day/Year)	Gender: F <input type="checkbox"/> M <input type="checkbox"/>
Country of Birth:	Date of Entry in U.S. (Month/Day/Year):	Date student first began Kindergarten (or higher grade) in any U.S. school (Month/Day/Year):	
Questions for Parents/Guardians		Response	
What is the native language of each parent/guardian?			
What language(s) are spoken in your home?			
Which language did your child learn first?			
Which language does your child use most frequently at home?			
Which language do you most frequently speak to your child?			
What other languages does your child know?			
School Information (School Staff should complete this last section based on information gathered from parent/guardian.)			
What school will the student attend?			
Beginning date in this school (Month/Day/Year):	What grade will the student enter?	Person Conducting Survey:	



Migrant Education Program
 UVM Ext 327 US Route 302
 Barre, Vermont 05641
 (802) 476-2003 ext. 226 or
 (866)-860-1382 ext. 226

VERMONT EMPLOYMENT SURVEY

Please complete this form and return it to your school's office. All information provided is confidential. The Vermont Migrant Education Program will contact you to determine if your family is eligible. An eligible student can be of any race and/or ethnicity and speak any language. Please call if you have any questions: 866-860-1382 ext. 226

Guardian/Parent Name(s) _____ **Date** _____

Address _____ **Town** _____

Cell phone(s) _____ **Land-line** _____

Has your family moved from one town or state to another town or state in the last three years?

- No**, You do not need to complete the rest of this form. Thank you!
- Yes**, If yes from where? _____ Please complete the rest of this form.
 (town, city, state, country)

In the past three years, have you or anyone in your family worked in agriculture or logging? _____
If yes, please check all that apply:

- Dairy Work;
- Hemp;
- Raising and tending to poultry including egg production;
- Raising cows, pigs and other livestock or work in a slaughterhouse or other meat processing facility;
- Planting, growing, harvesting, packing, cutting or preparing fruits, vegetables and flowers for sale;
- Working in a greenhouse or nursery (tree/plant/flower) or planting, tending or harvesting field crops;
- Working in the woods in logging, maple sugaring, planting trees, Christmas treeing, etc.;
- Working in the catching, raising, harvesting or initial processing of fish or shellfish.
- Other _____

Please list all children ages 0 to 22 in your household: (list additional names on bottom of form)

Child:	Grade:	School:
Child:	Grade:	School:
Child:	Grade:	School:
Child:	Grade:	School:

Updated on 10.17.2019



Cultivating Healthy Communities

University of Vermont Extension and U.S. Department of Agriculture, cooperating, offer education and employment to everyone without regard to race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, and marital or familial status



Migrant Education Program
UVM Ext 327 US Route 302
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MIGRANT EDUCATION ELIGIBILITY CRITERIA

An eligible student can be of any race and/or ethnicity and speak any language. Staff from the Vermont Migrant Education Program will help families determine whether a family or student meets the eligibility requirements described below:

Who qualifies for our program?

A child may qualify if the following apply:

- Child is under age of 22 has not graduated from high school or another accreditation program; and
- Child has moved across school district lines with a farmworker (parents, guardians, etc); and
- Parent/guardian has engaged in qualifying seasonal or temporary agricultural work.

Examples of Qualifying Work:

- ✓ Dairy;
- ✓ Hemp;
- ✓ Poultry and livestock;
- ✓ Slaughterhouse, meat processing;
- ✓ Fruit and vegetable production, harvesting, processing;
- ✓ Greenhouse or plant nursery work including trees, plants, flowers;
- ✓ Field crop work for animal feed or human consumption;
- ✓ Working in the woods logging, maple sugaring, planting trees, Christmas treeing, etc.
- ✓ Working in the catching, raising, harvesting or initial processing of fish or shellfish.



For eligible students enrolled in school, VMPEP offers:

- Parent and school communication support. (Includes ensuring interpretation/translation is available to student/family.)
- School supplies and books
- Support for school enrollment including PK
- Referrals to afterschool, summer and health programs and services
- Information on post-secondary opportunities