



Chaplin Elementary School

Mr. Kevin J. Chavez, Principal

<http://chaplinschool.org>

240 Palmer Road
Chaplin, CT 06235
Phone: 860-455-9593
Fax: 860-455-0742

PROOF OF RESIDENCY

Student Name _____ DOB _____

Parent Name _____ Phone # _____

Item used for Proof of Residency

Please **check off** below and **attach** document provided as proof of residency.

Date on Item _____

- ☐ Telephone bill
- ☐ Electric bill
- ☐ Lease/Mortgage
- ☐ Rent check receipt
- ☐ Gas bill
- ☐ Notarized letter from landlord
- ☐ Cable bill

***We do not accept Post Office box as a Proof of Residency**

CHAPLIN ELEMENTARY SCHOOL STUDENT REGISTRATION FORM

240 Palmer Road, Chaplin, CT 06235
Tel. 860-455-9593 – Fax 860-455-0742

Student Grade: _____			New Teacher: _____			
STUDENT INFORMATION						
Last name: _____		First: _____	Middle: _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age _____	Date of Birth ____/____/____
Street address: _____		Home Phone: _____			Place of Birth: _____	
P.O. box: _____		City: _____		State: _____	ZIP Code: _____	
Child resides with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other/Relationship _____						
ACCEPTABLE PROOFS OF RESIDENCY – REQUIRED DOCUMENTS						
<input type="checkbox"/> Deed <input type="checkbox"/> Tax <input type="checkbox"/> Rental Agreement <input type="checkbox"/> Utility Bill <input type="checkbox"/> Other: _____						
<i>Do both parents/guardians listed below have the authority in all school and medical matters?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No						
Mother's Name: _____			Father's Name: _____			
Mother's Cell #: _____			Father's Cell #: _____			
Mother's Email: _____			Father's Email: _____			
Mother's Employer: _____			Father's Employer: _____			
Mother's work # ()			Father's work # ()			
Sibling Name	Age	Sex	Date of Birth	Grade		
_____	_____	_____	____/____/____	_____		
_____	_____	_____	____/____/____	_____		
_____	_____	_____	____/____/____	_____		
_____	_____	_____	____/____/____	_____		
Is English the primary language spoken at home? _____ If not, please indicate other language _____						
Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other _____						
Do you have any questions or concerns which would help us better understand your child (fears, behaviors, personality traits): _____ _____						
Has there been any major change in the family (such as moving, illness, death in family, new baby, divorce)? _____ _____						
If your child requires transportation other than from your home address either before or after school, please keep in mind that pick-up and drop-off location MUST be within the school district.						
Before School Pick-Up			After School Drop-Off			
Name: _____			Name: _____			
Address: _____			Address: _____			
Tel. # _____			Tel. # _____			
Signature of Parent / Guardian _____ Date _____						

~~~PLEASE FILL OUT BACK OF FORM~~~

**ALTERNATE EMERGENCY CONTACT INFORMATION**  
(If parents/guardians cannot be reached for transportation or illness)

|                   |                |                |  |
|-------------------|----------------|----------------|--|
| Emergency #1 Name |                | Relationship:  |  |
| #1 Daytime Phone: | #1 Cell Phone: | #1 Work Phone: |  |
| Emergency #2 Name |                | Relationship:  |  |
| #2 Daytime Phone: | #2 Cell Phone: | #2 Work Phone: |  |
| Emergency #3 Name |                | Relationship:  |  |
| #3 Daytime Phone: | #3 Cell Phone: | #3 Work Phone: |  |

**2nd MAILING INFORMATION**

(If a 2nd mailing is needed, please fill in the following information)

|                     |                  |
|---------------------|------------------|
| 2ND Mailing Name:   |                  |
| 2ND Mailing Street: |                  |
| 2ND Mailing City:   | 2ND Mailing Zip: |

**Chaplin Kids Before School Care does not operate on a late start. After School Care will only operate on early dismissal days for Parent-Teacher Conferences.**

# CHAPLIN ELEMENTARY SCHOOL

## Preschool Information Form

### ***General Information***

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Mother's Email: \_\_\_\_\_  
Daytime Phone \_\_\_\_\_ Cell \_\_\_\_\_ Home \_\_\_\_\_  
Father's Name: \_\_\_\_\_ Father's Email: \_\_\_\_\_  
Daytime Phone \_\_\_\_\_ Cell \_\_\_\_\_ Home \_\_\_\_\_  
Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Brothers and Sisters (include names and ages): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
What languages are spoken at home? \_\_\_\_\_

### ***Prenatal and Birth History***

Mother's general health during pregnancy (illnesses, accidents, medications, etc.) \_\_\_\_\_  
\_\_\_\_\_  
Length of pregnancy: \_\_\_\_\_ Length of Labor: \_\_\_\_\_  
General condition: \_\_\_\_\_ Birth weight: \_\_\_\_\_  
Were there any unusual conditions that may have affected the pregnancy or birth? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### ***Medical History***

Provide the approximate ages at which the child suffered the following illnesses and conditions:

|                    |                      |                   |
|--------------------|----------------------|-------------------|
| Allergies _____    | Ear Infections _____ | Meningitis _____  |
| Asthma _____       | Encephalitis _____   | Mumps _____       |
| Chicken Pox _____  | German Measles _____ | Pneumonia _____   |
| Colds _____        | Headaches _____      | Seizures _____    |
| Convulsions _____  | High Fever _____     | Sinusitis _____   |
| Croup _____        | Influenza _____      | Tinnitus _____    |
| Dizziness _____    | Mastoiditis _____    | Tonsillitis _____ |
| Draining Ear _____ | Measles _____        | Other _____       |

Other doctor(s) your child has seen in the past or sees currently. Please give name, address & reason:

Dentist\_\_\_\_\_

Cardiologist\_\_\_\_\_

Ophthalmologist\_\_\_\_\_

Naturopathic Physician\_\_\_\_\_

Orthopedist\_\_\_\_\_

Other\_\_\_\_\_

Is the child taking any medications (herbal, over-counter, prescribed)? If yes, identify.

Medication\_\_\_\_\_ Reason\_\_\_\_\_

Medication\_\_\_\_\_ Reason\_\_\_\_\_

Other\_\_\_\_\_

Has the child had any surgeries? If yes, what type and when (i.e. tonsillectomy, tube placement. etc.)?\_\_\_\_\_

\_\_\_\_\_

Describe any major accidents or hospitalizations:\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have there been any negative reactions to medications? If yes, identify:\_\_\_\_\_

\_\_\_\_\_

Does the child have any allergies (animals, medications, foods)? If yes, identify:\_\_\_\_\_

\_\_\_\_\_

Describe any neurological concerns and/or evaluations of your child:\_\_\_\_\_

\_\_\_\_\_

Describe any hearing and/or visual concerns and/or your child:\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Describe any factors that could affect your child's energy during the day:

Typical bedtime: \_\_\_\_\_ Typical wake time \_\_\_\_\_

Bedtime routine: \_\_\_\_\_

Nightmares: \_\_\_\_\_ Night terrors \_\_\_\_\_

Bedwetting: \_\_\_\_\_ Sleepwalking \_\_\_\_\_

Talking in sleep: \_\_\_\_\_

Other: \_\_\_\_\_

Describe significant medical conditions of other family members that may have had an impact on your child:

\_\_\_\_\_

\_\_\_\_\_

### ***Development History***

Provide the approximate age at which the child began to do the following activities:

Crawl \_\_\_\_\_ Sit \_\_\_\_\_ Stand \_\_\_\_\_

Walk \_\_\_\_\_ Feed self \_\_\_\_\_ Dress self \_\_\_\_\_

Toilet trained \_\_\_\_\_

Use single words (i.e. no, mom, doggie, etc.): \_\_\_\_\_

Combine words (i.e. me go, daddy shoe, etc.): \_\_\_\_\_

Talked in complete sentences: \_\_\_\_\_

Name simple objects (i.e. dog, car, tree, etc.): \_\_\_\_\_

Use simple questions (i.e. Where's doggie?): \_\_\_\_\_

Engage in a conversation: \_\_\_\_\_

Does the child have difficulty walking, running, or participating in other activities which require small or large muscle coordination?

\_\_\_\_\_

\_\_\_\_\_

Are there or have there ever been any feeding problems (i.e. problems with sucking, swallowing, drooling, chewing, etc.)? If yes, describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe the child's response to sound (i.e. responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### ***Previous Educational Experience***

Has your child ever attended?

Home daycare?      Yes\_\_\_\_      No\_\_\_\_

Daycare center?      Yes\_\_\_\_      No\_\_\_\_

Preschool?      Yes\_\_\_\_      No\_\_\_\_

Nursery school?      Yes\_\_\_\_      No\_\_\_\_

If daycare center, preschool or nursery school, please list name and address:

\_\_\_\_\_

### ***Services Received, if any:***

Birth-3, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### ***Strengths***

Describe your child's strengths. Consider things such as personality, interests, and educational strengths: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### ***Social/Emotional Development***

Describe any concerns with your child's social/emotional development from birth to present age. Consider things such as friendships, behavior, temperament, adjustment to new settings (i.e. school, child care, play groups, etc.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Family Assessment**

You are (circle):      Married      Separated      Divorced      Widowed      Remarried

How many children do you have?

1. Name: \_\_\_\_\_ Age: \_\_\_\_\_

Please circle:    Male    Female      biological child      Stepchild      adopted

2. Name: \_\_\_\_\_ Age: \_\_\_\_\_

Please circle:    Male    Female      biological child      Stepchild      adopted

3. Name: \_\_\_\_\_ Age: \_\_\_\_\_

Please circle:    Male    Female      biological child      Stepchild      adopted

Additional children: \_\_\_\_\_

\_\_\_\_\_

Do all your children live with you?      Yes      No

If not, where do they live? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you or your spouse work outside the home? **YOU:**    Yes    No      **SPOUSE:**    Yes    No

If yes, when do you work?      **YOU:**    Day    Evening    Night      **SPOUSE:**    Day    Evening    Night

Is there any family history of problems in learning, attention, behavior, and/or mental health? If so, please describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please feel free to list any additional information, comments or concerns that have not already been covered.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# Chaplin Elementary School

## SCHOOL READINESS / PRESCHOOL STUDENT ACCEPTANCE FORM

School year: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M F

Parent / Guardian Name (s): \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

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

Language spoken at home: \_\_\_\_\_

Health Insurance: ☐ Private ☐ Husky A ☐ Husky B

Physician's Name: \_\_\_\_\_ Dentist's Name: \_\_\_\_\_

Family Ethnicity: ☐ African American ☐ Asian / Pacific Islander ☐ Hispanic ☐ White

☐ other, please specify: \_\_\_\_\_

Household Annual Gross Income: \_\_\_\_\_ (Please mail or drop off copies of pay stubs for 4 weeks, W-2's or your 2023 Income Tax Return for verification.)

Family Size: \_\_\_\_\_ (Please include the total number of adults and children living in the home and eating together – regardless of relationship)

Please circle your family size in the left column and circle the income level in that row that is closer to your family's gross income amount.

### School Readiness Income Guidelines

| Family Size | Under 50%      | 51 – 75%             | Over 75%       |
|-------------|----------------|----------------------|----------------|
| 1 to 3      | \$0 - \$47,270 | \$47,271 - \$ 70,906 | Over \$ 70,906 |
| 4           | \$0 - \$56,274 | \$56,275 - \$ 84,412 | Over \$ 84,412 |
| 5           | \$0 - \$65,278 | \$65,279 - \$ 97,918 | Over \$ 97,918 |
| 6           | \$0 - \$74,283 | \$74,284 - \$111,424 | Over \$111,424 |
| 7           | \$0 - \$75,971 | \$75,972 - \$113,956 | Over \$113,956 |
| 8           | \$0 - \$77,659 | \$77,660 - \$116,488 | Over \$116,488 |

Did you receive Family Assistance Funds? Yes No

The Chaplin School Readiness Program is committed to building partnerships with families. We maintain collaborations with outside community agencies to support our families and staff.

Please let us know if you would like information on any of the following services or resources:  
(Please check all that you would be interested in learning about.)

☐ Parenting Classes

☐ Parent Advocacy

☐ Food Stamps (SNAP)

☐ Summer Feeding Sites

☐ Counseling Services

Other, Please specify \_\_\_\_\_

☐ Adult Education

☐ Chaplin Public Library

☐ WIC

☐ Fuel Assistance

☐ Health Services

☐ Parent Leadership Training

☐ Pay Groups

☐ Area Food Banks

☐ Support Groups

☐ Immunizations

Chaplin Elementary School  
240 Palmer Road  
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860-455-9593

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

Student ID#: \_\_\_\_\_

**No Income Attestation**

Dear Parent or Guardian,

Here at the Consolidated School District of New Britain, we believe that all children are entitled to equitable educational opportunities regardless of their socioeconomic and financial status.

I attest that I do not have any ongoing income that includes, but is not limited to:

- pensions
- annuities
- dividends
- interest (if more than \$50.00 per month)
- rental income
- income from boarders
- estate or trust income
- royalties
- social security or supplemental security income (SSI)
- tribal distributions
- veterans' benefits
- unemployment compensation
- workers' compensation
- alimony
- foster care payments
- cash gifts from friends and relatives
- lottery winnings

Based on your No Income status, your Parent Fees will be assessed at the lowest income level on the CT Office of Early Childhood Fee Schedule. Additionally, please note that this No Income Attestation must be resubmitted on a yearly (School Year) basis if the qualifying factors noted above continue to apply.

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

Parent/Guardian Name (Please Print): \_\_\_\_\_

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