ELDRED CENTRAL SCHOOL DISTRICT

NEW STUDENT REGISTRATION

Dear Parent/Guardian:

Welcome to the Eldred Central School District! All students who have a legal residency within the Eldred Central School District are eligible for enrollment in the District.

Please fill in all the attached forms as soon as possible. For grades Pre-K through 6, please call Kezia Labuda at 845-456-1100 x 5143. For grades 7 through 12, please call Lia Martucci at 845-456-1100 ext. 5180 to make an appointment to finalize your child's registration. You will need the following:

- Completed registration packet attached
- Original birth certificate of the child
- Proof of residency – acceptable proofs being deed or rental agreement, utility bill, etc. If you do not have a deed or rental agreement for your residency, a signed and notarized affidavit of residency by the property owner can be submitted.
- Immunization record and current physical
- Last report card from previous district of attendance
- Custody agreement if applicable
- Parent/Guardian photo ID

After you have submitted the above information and all required forms, your child's information will be reviewed by the Building Principal. A request for records will be submitted to your child's previous school.

If your child is in grades 7 through 12, a guidance counselor will contact you to finalize your child's schedule. If your child is in PreK through 6, you will be notified of your child's classroom teacher. Transportation will also contact you regarding bus routes.

If you have any questions prior to calling for a registration finalization appointment, please do not hesitate to ask. Welcome to the Eldred Central School District.

Sincerely,

Kezia Labuda, Registrar/Grades Pre-K through 6

Lia Martucci, Registrar/Grades 7 through 12

ELDRED CENTRAL SCHOOL DISTRICT

STUDENT REGISTRATION INFORMATION

Student's Full Name: _____ Date: _____

Student's Gender: _____ Birth Date: _____ Place of Birth: _____

Physical Address: _____

Mailing Address (If different): _____

City: _____ State: New York Zip Code: _____

Home Telephone: (_____) _____

Parent/Guardian Name: _____

Cell Phone: (_____) _____

Employer: _____

Work Phone: (_____) _____

Work Hours: _____

Email Address: _____

Parent/Guardian Name: _____

Cell Phone: (_____) _____

Employer: _____

Work Phone: (_____) _____

Work Hours: _____

Email Address: _____

Language Spoken at Home: _____

Child Lives With (Check (✓) one): Both Parents One Parent

Other (Explain): _____

If Legal Custody Has Been Established (*Please provide a copy of court documents to support this):

Person with legal custody or guardianship: _____ Date Established: _____

List All Other Persons Living in Child's Household:

	Other	Other	Other	Other
Name				
Age				
Grade (If applicable)				
Gender				
Relationship				

PREVIOUS SCHOOL INFORMATION

Previous School: _____

Telephone: _____ Fax: _____

Dates Attended: _____ Grades Attended: _____

Did your child receive any Special Programs/Interventions? (Please Check (✓) all that apply)

IEP/504 ESL/LEP AIS Title I Reading/Math Early Intervention

Explain: _____

ELDRED CENTRAL SCHOOL DISTRICT
STUDENT CONTACT INFORMATION

Student's Full Name: _____

Student's Grade: _____ Teacher: _____

Physical Address: _____

Mailing Address (If different): _____

City: _____ State: New York Zip Code: _____

Home Telephone: (_____) _____

Parent/Guardian Name: _____ Parent/Guardian Name: _____

Cell Phone: (_____) _____ Cell Phone: (_____) _____

Employer: _____ Employer: _____

Work Phone: (_____) _____ Work Phone: (_____) _____

Work Hours: _____ Work Hours: _____

Email Address: _____ Email Address: _____

Child Lives With (Check (✓) one): Both Parents One Parent
Other (Explain): _____

If Legal Custody Has Been Established (*Please provide a copy of court documents to support this):

Person with legal custody or guardianship: _____ Date Established: _____

EMERGENCY CONTACTS

When listing emergency names please use someone who has agreed to be responsible for your child if you are unavailable.

1. Name: _____ Phone: (_____) _____
Address: _____ Alternate Phone: (_____) _____
Relationship to Student: _____

2. Name: _____ Phone: (_____) _____
Address: _____ Alternate Phone: (_____) _____
Relationship to Student: _____

3. Name: _____ Phone: (_____) _____
Address: _____ Alternate Phone: (_____) _____
Relationship to Student: _____

4. Name: _____ Phone: (_____) _____
Address: _____ Alternate Phone: (_____) _____
Relationship to Student: _____

_____ _____
Parent/Guardian Signature Date

Notify the office immediately of any changes that may occur during the school year.

ELDRED CENTRAL SCHOOL DISTRICT

EMERGENCY MEDICAL INFORMATION

Student Name: _____ Date of Birth: _____ Age: _____ Grade: _____

Address: _____ Phone #: _____

Parent/Guardian Name: _____

Cell Phone: (_____) _____

Employer: _____

Work Phone: (_____) _____

Work Hours: _____

Email Address: _____

Parent/Guardian Name: _____

Cell Phone: (_____) _____

Employer: _____

Work Phone: (_____) _____

Work Hours: _____

Email Address: _____

Who lives with the child in his/her primary household? _____
Does the child spend a significant amount of time in another household? Yes No
If yes, describe _____
Who has legal custody of the child? _____
Describe any custody arrangements _____

HISTORY:

Were there any issues during pregnancy, labor and/or delivery for this child? Yes No
If yes, describe _____

Does this child have an ongoing health concern? (Asthma, Diabetes, etc.) Yes No
If yes, describe _____

Does this child have any allergies? Yes No
If yes, list allergies _____
Has the allergy required emergency treatment? Yes No
If yes, explain _____

Does this child require an epi pen? Yes No

Is there a history of any hospitalizations, significant injuries or surgery? Yes No
If yes, explain _____

Are there any current medical concerns/injuries? Yes No

Head _____ Eyes _____ Nose _____
Ears _____ Throat _____ Neck _____
Chest _____ Respiratory _____
Cardiovascular _____ Gastrointestinal _____
Genitourinary _____ Neurological _____
Musculoskeletal (include any past fractures, etc.) _____
Other _____

Name of Physician:_____ Telephone #_____
Does this child take any medication regularly at home? Yes No
Does this child require medication at school? Yes No
If yes, describe_____
IF YES, your child needs a medication dispensing form completed by their doctor for each medication needed. Written orders from your physician must be presented to the school health office. Prescription medication shall have the pharmacy label indicating the physician's name, child's name, instructions, and name and strength of the medication.

List any significant medical concerns in your family:

Mother_____ Father_____
Siblings_____ Grandparents_____
Other_____

Please complete Emergency Contacts for Health Office:

When listing emergency names please use someone who has agreed to be responsible for your child if you are unavailable.

1. Name:_____ Phone: (_____) _____
Address:_____ Alternate Phone: (_____) _____
Relationship to Student: _____

2. Name:_____ Phone: (_____) _____
Address:_____ Alternate Phone: (_____) _____
Relationship to Student: _____

3. Name:_____ Phone: (_____) _____
Address:_____ Alternate Phone: (_____) _____
Relationship to Student: _____

4. Name:_____ Phone: (_____) _____
Address:_____ Alternate Phone: (_____) _____
Relationship to Student: _____

Parent Authorization:

I authorize the officials of the Eldred School District to contact the persons named on this form in the event a parent cannot be reached. If parents, or other persons named on this form cannot be reached, the school nurse / or school officials may take reasonable action they deem necessary for the health of my child.

In the event of an emergency, and I cannot be reached, I hereby give my permission to the Eldred Central School District to transport my child to _____ Hospital and allow the physician in the emergency room to treat my child in an emergency situation. In the event the emergency is life threatening your child will be transported to the nearest facility. I will not hold the School District financially responsible for the emergency care and / or transportation of my child.

Student's Name: _____ Date of Birth: _____

Parent/Guardian Signature: _____

Relationship to Student: _____ Date: _____

ELDRED CENTRAL SCHOOL DISTRICT

STUDENT RACIAL AND ETHNIC IDENTIFICATION

To School Staff: This form will be filed in the student's permanent record as confidential information

To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

DIRECTIONS:
PLEASE ANSWER QUESTIONS (1) AND (2). PLEASE READ THEM BEFORE YOU RESPOND.
For question (1) Check (✓) the box that best describes your child. Check (✓) only ONE box.

1. **Is the student Hispanic, Latino, or of Spanish origin?** Hispanic, Latino or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other culture or origin, regardless of race.

☐ **YES, Hispanic**

☐ **NO, not Hispanic**

2. **Select one or more races from the following five racial groups.** For question (2) Check (✓) all groups that apply to your child; Check (✓) at least ONE box:

☐ **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 people of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **BLACK OR AFRICAN AMERICAN:** A person having origins in any of the Black racial groups of Africa.

☐ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

ELDRED CENTRAL SCHOOL DISTRICT

REQUEST FOR RECORDS

Date: _____

Previous School: _____

Address: _____

Previous School Phone Number: (_____) _____

Previous School Fax Number: (_____) _____

Re: _____
Student Name – Last First Middle Initial

To Whom It May Concern:

The above named student enrolled in our district on _____ and will be entering grade _____.
Please forward, as soon as possible, the following information:

____ Academic records, including report cards
____ Standardized test results, including aptitude and achievement tests
____ All NYS Assessments: Math, ELA, Social Studies, Science, Regents Exams, NYSAA and NYSESLAT
____ Health/Dental Records
____ Discipline referrals
____ Birth Certificate
____ Immunization Record
____ Custodial document
____ Attendance Records

___ Special Education Records:
*Individualized Education Program (IEP)
*Psychological
*Evaluations – Speech, OT, PT, etc.
* 504 Accommodation Plan
* Social History
* Classroom Observations

****

PARENT AUTHORIZATION TO SEND RECORDS

I authorize you to send all school records regarding my child (named above) to the following school. (Please check appropriate box)

George Ross Mackenzie Elementary
Kezia Labuda, Registrar
PO Box 249/1049 Proctor Rd.
Glen Spey, NY 12737
Phone: 845-456-1100x 5143 Fax: 845-856-8579

Eldred Central Jr/Sr. High School
Lia Martucci, Registrar
PO Box 249/600 Rt 55
Eldred, NY 12737
Phone: 845-456-1100x5180 Fax: 845-557-0690

_____ _____
Parent/Guardian Signature Date

Dear Parent, Guardian, or Eligible Student:

This is to advise you of your rights with respect to student records pursuant to the Family Education Rights and Privacy Act (FERPA). FERPA is a federal law designed to protect the privacy of student records. The law gives parents and students over 18 years of age (referred to in the law as "eligible students") the following rights:

1. The right to inspect and review the student's education records within 45 days of the day the district receives a request for access. Parents or eligible students should submit to the Building Principal a written request that identifies the records they wish to inspect. The Principal will make arrangements for access and notify the parent or eligible student of the time and place where the records may be inspected.

2. The right to request the amendment of the student's education records that the parent or eligible student believes are inaccurate or misleading. Parents or eligible students may ask the district to amend a record that they believe is inaccurate or misleading by writing the Principal, clearly identifying the part of the record they want changed, and specifying why it is inaccurate or misleading. If the district decides not to amend the record as requested by the parent of eligible student, the district will notify the parent or eligible student of the decision and advise them of their right to a hearing regarding the request for amendment. Additional information regarding the hearing procedures will be provided to the parent or eligible student when notified of the right to a hearing.

3. The right to consent to disclosures of personally identifiable information contained in the student's education records, except to the extent that FERPA authorizes disclosure without consent.

One exception which permits disclosure without consent is disclosure to school officials with legitimate educational interests. A school official is a person employed by the district as an administrator, supervisor, instructor, or support staff member (including health or medical staff and law enforcement unit personnel); a person serving on the school board; a person or company with whom the district has contracted to perform a special task (such as an attorney, auditor, medical consultant, or therapist); or a parent or student serving on an official committee, such as a disciplinary or grievance committee, or assisting another school official in performing his or her tasks.

A school official has a legitimate educational interest if the official needs to review an education record in order to fulfill his or her professional responsibility. Upon request, the district discloses education records without consent to officials of another school district in which a student seeks or intends to enroll.

4. The right to file a complaint with the U.S. Department of Education concerning alleged failures by the district to comply with the requirements of FERPA. The Office that administers FERPA is:

Family Policy Compliance Office
U.S. Department of Education
600 Independence Avenue SW
Washington, DC 20202-4605

NOTIFICATION OF DIRECTORY INFORMATION DESIGNATIONS

In addition to the rights outlined above, FERPA also gives the school district the option of designating certain categories of student information as "directory information". Directory information includes a student's name, address, telephone number, date and place of birth, major course of study, participation in school activities or sports, weight and height if a member of an athletic team, dates of attendance, degrees and awards received, most recent school attended, class schedule, digital image, e-mail address, and class roster.

You may object to the release of any or all of this "directory information"; however, you must do so in writing within 10 business days of receiving this notice. If we do not receive a written objection, we will be authorized to release this information without your consent. For your convenience, you may note your objections to the release of directory information on the enclosed form and return it to the Building Principal.

Sincerely,

Robert Dufour, Superintendent of Schools

ELDRED CENTRAL SCHOOL DISTRICT

***Disclaimer: BY SIGNING THIS FORM, YOU ARE OPTING OUT OF YOUR CHILD'S PARTICIPATION IN ACTIVITIES INCLUDING BUT NOT LIMITED TO: THE SCHOOL YEARBOOK, SCHOOL AWARD CEREMONIES (IN WHICH THE PUBLIC IS INVITED), AND NEWSPAPER ARTICES ABOUT THE SCHOOL**

5500-E2 OBJECTION TO RELEASE OF DIRECTORY INFORMATION DESIGNATION

The school district has designated certain categories of student information as "directory information". Directory information includes a student's name, address, telephone number, date and place of birth, major course of study, participation in school activities or sports, weight and height if a member of an athletic team, dates of attendance, degrees and awards received, most recent school attended, class schedule, digital image, email address and class roster.

If you object to the release of any or all of the directory information listed above, you must do so in writing within 10 business days of receiving this notice. For your convenience, you may note your objections to the release of directory information on this form and return it to the Building Principal.

Please do not release directory information without my prior consent.

_____
(Student Name)

_____
(Student Grade)

_____
(Parent, Guardian, or Eligible Student Signature)

_____
(Date)

Adoption: December 9, 1999

ELDRED CENTRAL SCHOOL DISTRICT
****

For Office Use Only:
Objection to release of directory information returned unsigned ____ Signed_____
Objection to release of directory information not returned _____

Initial: _____ Date: _____

ELDRED CENTRAL SCHOOL DISTRICT

STUDENT RESIDENCY
MCKINNEY-VENTO QUESTIONNAIRE

Name of School : _____

Name of Student: _____ Sex: ☐ Male
Last First Middle ☐ Female

Birth Date: _____ Age: _____ Social Security #: _____

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? Yes No

2. Is this temporary living arrangement due to loss of housing or economic hardship? Yes No

If you answered YES to the above questions, please complete the rest of this form.
If you answered NO, you may stop here and sign below.

Where is the student presently living? (*Check one box.*)

- In a motel
- In a shelter
- With more than one family in a house or apartment
- Moving from place to place
- In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite
- Awaiting foster care

Name of Parent(s)/Legal Guardians(s): _____
Address: _____ Phone: _____

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002(3)(d).

I agree to the release of the above information to the Academic Support for Kids Program (ASK). I understand as a result of this referral a representative from ASK will be contacting me.

_____ _____
Parent/Guardian Signature **Date**

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

_____ _____
McKinney-Vento Liaison Signature Date

ELDRED CENTRAL SCHOOL DISTRICT

RESIDENCIA PARA ESTUDIANTES
MCKINNEY-VENTO QUESTIONNAIRE

Nombre de la Escuela _____

Nombre del Estudiante: _____ Sexo: ☐ Masculino
Apellido Nombre Segundo Nombre ☐ Femenino

Fecha de Nacimiento _____ Edad: _____ # de Seguro Social: _____

El propósito de este cuestionario es presentar los objetivos del Acta McKinney-Vento (42 U.S.C.11435). Las respuestas a estas preguntas ayudarán determinar los servicios que el estudiante debe recibir.

1. ¿Es su domicilio actual un arreglo de vivienda temporal (de poca duración)? Si No

2. ¿Es este arreglo de vivienda temporal debido a la pérdida de su casa, vivienda o habitación, o debido a algún problema económico (*ejemplo*: desempleo)? Si No

Si usted contestó SI a estas preguntas, por favor complete el resto de este formulario.
Si usted contestó NO a estas preguntas, no siga.

¿Dónde se encuentra viviendo el estudiante actualmente? (Marque una opción.)
- En un motel
- En un albergue o lugar de refugio
- Con más de una familia en una casa o apartamento
- Moviéndose de lugar en lugar
- En un lugar generalmente no designado para dormir (ejemplo: carro, parque, o campamento)

Nombre delPadre/Madre/Guardián: _____
Dirección: _____ Teléfono: _____

Presentar información falsa o la falsificación de documentos para uso escolar son ofensas bajo la Sección 37.10 del Código Penal, y la inscripción del estudiante usando documentos falsos traerá como consecuencia que los responsables estarán sujetos a pagar los gastos de instrucción u otros cargos. TEC Sec. 25.002(3)(d)

Autorizo que se entregue informacion al Programa de Apoyo Academico para Niños (ASK). Entiendo que como resultatdo de esta referencia un representante de ASK se communicara conmigo.

.

_____ _____
Firma del Padre/Madre/Guardián **Fecha**

Yo certifico que el estudiante nombrado en este formulario califica para los programas de nutrición escolares bajo las provisiones del Acta McKinney-Vento.

_____ _____
Firma del oficial autorizado Fecha

ELDRED CENTRAL SCHOOL DISTRICT

TRANSPORTATION FORM

Please fill out the following information to help us locate your residence for the bus transportation department:

Student's Name: _____

Age: _____ Grade: _____

Physical Address: _____

Street/ driveway intersects with: _____

House Color and/or Landmarks: _____

Parent/Guardian Name_____Daytime Phone:_____

ELEMENTARY EARLY DISMISSAL
Only fill out this part of the form if you have a child in PreK through 6th grade)

In the event of an early dismissal at the **ELEMENTARY** school, please fill out the following information so that your child and your particular family situation can be accommodated:

In the event of an early dismissal, my child_____

_____ will go home on the bus he/she always travels on.

_____ should go home with _____ on Bus # _____

_____ will be picked up by _____

_____ _____

Parent/Guardian Signature Date

ELDRED CENTRAL SCHOOL DISTRICT

AFFIDAVIT OF RESIDENCY OF PARENT

STATE OF NEW YORK)
COUNTY OF _____)

_____, being duly sworn, deposes and says:
(Full name of Parent)

1. I am the natural parent of_____
(Full name(s) of child/children)

2. I understand that in order to enroll my child/children as students in the Eldred Central School District ("District") that I and my child/children must reside within the boundaries of the District.

3. I hereby attest that I reside, with my child/children at _____ which is a residence within the boundaries of the Eldred Central School District.

4. I make this affidavit to induce the District to allow my child/children to enroll in or to continue to attend school in the Eldred Central School District and acknowledge that if I do not actually live at this address or any address within the District, that my child/children will not be allowed to continue attendance in the Eldred Central School District and that I may owe monies as tuition for their attendance.

5 **I understand that statements made in this affidavit will be relied upon by the Eldred Central School District. I swear/affirm that these statements are true under the penalties of perjury, and I understand that the filing of a false instrument and the theft of services from a governmental agency such as a school district may be crimes punishable under New York State Law. I further acknowledge that making false statements in this affidavit may subject me to criminal prosecution. False statements will be turned over to New York State Police Department.**

_____
Signature of Parent

_____
Print Name of Parent

Sworn to before me this

_____day of _____, _____

_____
Notary Public – State of New York

11/24/08

ELDRED CENTRAL SCHOOL DISTRICT

CUSTODY AFFIDAVIT
Not applicable if child lives with both biological parents OR Custody Agreement provided

State of New York)
) SS:
County of Sullivan)

_____being duly sworn, deposes and says:
Name of Custodian

1. I, _____, am the sole custodial parent
   Name of Custodian

   of my son/daughter _____.
   Name of Minor Child

2. To my knowledge, there are no known claims of custody for my

   son/daughter _____.
   Name of Minor Child

_____
Signature of Custodial Parent

STATE OF NEW YORK)
) SS:
COUNTY OF SULLIVAN)

On the ____day of _____, in the year ____, before me, the undersigned, personally appeared. _____ personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** ☐ M ☐ F **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: _____
PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____
Dental Referral ☐ Yes ☐ No ☐ Not done Date: _____

Significant Medical/Surgical History: ☐ See attached _____

Allergies: ☐ **LIFE THREATENING** ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____
☐ Seasonal ☐ Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Body Mass Index: _____ _____ . _____

Weight Status Category (BMI Percentile):
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ☐ Yes ☐ No Student may self carry and self administer medication ☐ Yes ☐ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school:** _____ ☐ None

☐ **Known or suspected disability:** _____ ☐ Please monitor

☐ **Restrictions:** _____ ☐ Please monitor

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.

Rev. 2/08

DENTAL HEALTH CERTIFICATE

New York State law (chapter 281 permits schools to request a dental examination in the following grades: school entry, K 2, 4, 7, & 10. Your child may have a dental check up during this school year to assess his/her fitness to attend school. Please complete section 1 and take the form to your dentist for an assessment. If your child had a dental check up before he/she started school, ask your dentist to fill out section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1: To be completed by Parent/Guardian (please print)

Child's Name: Last	First	Middle
Birth Date: / / Month Day Year	Sex: Male Female	Will this be your child's first visit to a dentist? Yes No
School:		Grade:

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak, or focus on school activities? Yes No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-ray if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations below.

Parent's Signature: Date:

Section 2: To be completed by the Dentist (please print)

I. The Dental Health condition of _____ on _____ (Date of exam – Date of exam need to be within 12 months of the start of the school year in which it is requested)
Check one:

Yes, the student listed above is in fit condition of dental health to permit his/her attendance at public schools.
No, the student listed above is NOT in fit condition of dental health to permit his/her attendance at public schools.

NOTE: Not in fit condition of dental health mean that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's Name and Address (Please print or stamp)	Dentist's Signature

Optional Sections – If you agree to release this information to your child's school, please initial here:

II. Oral Health Status (check all that apply):

Yes No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary or permanent) OR a tooth that is missing because it was a result of caries OR an open cavity.]

Yes No **Untreated Caries** – Does this child have an open cavity? [At least 1 mm of tooth structure lost at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings are considered sound unless a cavitated lesion is also present.]

Yes No **Dental Sealants Present**

Other Problems (Specify): _____

III. Treatment Needs (check all that apply):

No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

ELDRED CENTRAL SCHOOL DISTRICT

PARENT AND PRESCRIBER AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

I. To be completed by Parent/Guardian:

I request that my child _____, grade _____ receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or the designated person in the case of absence of the school nurse, will administer the medication. I do hereby release, discharge and hold harmless the Eldred Central School from any and all liability and claim whatsoever for administration of the medication to my child should there develop any allergic reaction from the medication.

NOTE: THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION/ILLNESS MAY NOT BE GIVEN AT SCHOOL.

Signature of Parent/Guardian: _____ Date: _____

Address: _____

Telephone: Home: _____ Alternate: _____

II. To be completed by licensed Health Care Professional:

I request that my patient, as listed below, receive the following medication(s):

Student Name: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication(s): _____

Prescribed Dosage: _____ Frequency: _____

Route: _____ Times to be taken during school hours: _____

This student has been instructed on the use of this medication and has permission to carry and take this medication on his/her own as listed above? (Especially in the case of any life threatening allergy or health condition)

Yes No

Possible side effects and adverse reactions (if any): _____

Other recommendations: _____

Name of licensed Health Care Professional and Title (please print):

_____

Provider Signature: _____ Date: _____

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH: *Month* *Day* *Year*

GENDER: ❑ Male ❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other	*specify*	
2. What was the first language your child learned?	❑ English	❑ Other	*specify*	
3. What is the Home Language of each parent/guardian?	❑ Mother *specify*	❑ Father *specify*	❑ Guardian(s) *specify*	
4. What language(s) does your child understand?	❑ English	❑ Other	*specify*	
5. What language(s) does your child speak?	❑ English	❑ Other *specify*	❑ Does not speak	
6. What language(s) does your child read?	❑ English	❑ Other *specify*	❑ Does not read	
7. What language(s) does your child write?	❑ English	❑ Other *specify*	❑ Does not write	

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	**STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:**
District Name (Number) & School *Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** ☐ *No* ☐ *Not sure* ☐ ***If yes**, please explain:_____

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ☐ **No** ☐ **Yes*** ****Please complete 10b below***

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
☐ **No** ☐ **Yes – Type of services received:**_____

Age at which services received *(Please check all that apply)*:
☐ **Birth to 3 years (Early Intervention)** ☐ **3 to 5 years (Special Education)** ☐ **6 years or older (Special Education)**

10c. Does your child have an Individualized Education Program (IEP)? ☐ **No** ☐ **Yes**

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year: _____
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ☐ **Mother** ☐ **Father** ☐ **Other:**_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ NO ☐ YES

**DATE OF INDIVIDUAL INTERVIEW: _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
☐ ADMINISTER NYSITELL
☐ ENGLISH PROFICIENT
☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
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Cuestionario de Idioma del Hogar ("HLQ" por sus siglas en inglés)

Estimados padres o tutores:
Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura, escritura y comprensión en el inglés, así como conocer su educación previa e historial personal. Por favor, llene con su información las secciones "Conocimientos de idiomas" e "Historial educativo". Apreciamos mucho su colaboración respondiendo a estas preguntas.
Gracias.

Por favor escriba con claridad al completar esta sección.

NOMBRE DEL ESTUDIANTE:

Nombre *Segundo nombre* *Apellido*

FECHA DE NACIMIENTO:

Mes *Día* *Año*

GÉNERO:

❑ Masculino
❑ Femenino

INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL

Apellido *Primer Nombre* *Relación con el estudiante*

CÓDIGO DEL IDIOMA DEL HOGAR

Conocimientos de idiomas

(Por favor, marque todas las opciones que sean aplicables)

1. ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante?	❑ Inglés	❑ Otro _____ *especifique*	
2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?	❑ Inglés	❑ Otro _____ *especifique*	
3. ¿Cuál es el idioma primario de cada padre / tutor?	❑ Madre _____ *especifique*	❑ Padre _____ *especifique*	❑ Tutor(es) _____ *especifique*
4. ¿Qué idioma o idiomas entiende su hijo(a)?	❑ Inglés	❑ Otro _____ *especifique*	
5. ¿Qué idioma o idiomas habla su hijo(a)?	❑ Inglés	❑ Otro _____ *especifique*	❑ No sabe hablar
6. ¿Qué idioma o idiomas lee su hijo(a)?	❑ Inglés	❑ Otro _____ *especifique*	❑ No sabe leer
7. ¿Qué idioma o idiomas escribe su hijo(a)?	❑ Inglés	❑ Otro _____ *especifique*	❑ No sabe escribir

TO BE COMPLETED BY THE DISTRICT IN WHICH THE STUDENT IS REGISTERED

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

PARA LLENAR POR EL DISTRITO EN EL QUE EL ESTUDIANTE SE HA INSCRITO

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

8. Indique con un número el total de años que su hijo(a) lleva inscrito en una escuela: _____

9. ¿Cree usted que su hijo(a) pueda tener dificultades, interferencias o problemas educacionales que le afecten su capacidad para entender, hablar, leer o escribir en inglés o en cualquier otro idioma? En caso afirmativo, por favor descríbalos.

*Sí** ☐ *No* ☐ *No se sabe* ☐ * En caso afirmativo, por favor explique :_____

¿Qué gravedad considera usted que tienen estas dificultades educacionales? ☐ Poca gravedad ☐ Algo grave ☐ Muy grave

10a. ¿Alguna vez se ha recomendado a su hijo(a) a tener una evaluación de educación especial? ☐ **No** ☐ **Sí*** * *Por favor, llene 10b.*

10b. *Si se le ha recomendado alguna vez una evaluación, ¿ha recibido su hijo(a) alguna vez alguna forma de educación especial?

☐ **No** ☐ **Sí – Explique, que forma o formas de educación especial recibió:**

_____

Edad en la que recibió la intervención o forma de educación especial *(favor de marcar todas las opciones que sean aplicables)*

☐ **De nacimiento a 3 años (Intervención Temprana)** ☐ **3 a 5 años (Educación Especial)** ☐ **6 años o mayor (Educación Especial)**

10c. ¿Tiene su hijo(a) un Programa de Educación Individualizada ("IEP" por sus siglas en inglés)? ☐ **No** ☐ **Sí**

11. ¿Considera que hay alguna otra información importante que la escuela deba saber sobre su hijo(a)?
(Por ejemplo, talentos especiales, problemas de salud, etc.)

12. ¿En qué idioma(s) quiere usted recibir la información de la escuela? _____

_____ Mes: Día: Año: _____

Firma del padre/madre o de la persona en relación paternal *Date*

Relación con el estudiante: ☐ **Madre** ☐ **Padre** ☐ **Otra:**_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

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NAME: _____ **POSITION:** _____

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****DATE OF INDIVIDUAL INTERVIEW:** _____ (MO / DAY / YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
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☐ ENGLISH PROFICIENT
☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:** _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. / DAY / YR.)

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FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: