

Dear Parents of Incoming Kindergarten Students,

Children who turn five by December 1, 2024, are eligible to begin kindergarten at PQ in September, 2024. This year kindergarten registration will be by appointment only. The purpose of registering at this time of year is to help us identify all the children in our district who may attend kindergarten next fall. Holding kindergarten registration in December informs our budget recommendation for the number of kindergarten classes for the 2024-25 school year. It also begins the process of introducing you to Pequenaconk Elementary. Registering your child does not obligate your child to attend.

To register your child:

We will be holding in-person registration by appointment only. Registration will take place December 4, 2023 through December 7, 2023 from 3:30 pm to 6:30 pm at Pequenaconk Elementary School. Please call Jean Jerussi, 914-669-5317 x3056 or email jjerusi@northsalemschools.org to request an appointment. Appointments will start at 3:30 pm with the last appointment being 6:00 pm. We are asking that you complete the attached packet of information, which can also be found on our website (<https://www.northsalemschools.org/studentregistration>). Have your completed registration packet and all necessary supporting documents available at your registration appointment.

Your school contact for kindergarten registration is Jean Jerussi at 914-669-5317 ext. 3056. Her email address is jjerusi@northsalemschools.org. She is available to answer questions and help you through the process. Please call or email if you have questions about the registration process.

Parents must include all of the following in order to register; your packet will be considered incomplete for your child if any of these are incomplete:

- a copy of an original birth certificate or other proof of birth (passport, baptismal certificate);
- current record of immunizations, signed by your child's doctor, (even if incomplete);
- copy of photo identification of parent registering the student (driver's license with district address, etc.);
- copy of proof of residence of parent (tax bill or mortgage statement with address of property; if renting, lease/rental agreement with proof of ownership of the landlord of the property);
All families, new and existing, must show proof of residency;
- copy of proof of guardianship, if applicable;

Children entering kindergarten are required to provide proof of receiving the following immunizations prior to the start of school:

4-5 doses of Diphtheria and Tetanus Toxoid-Containing Vaccine and Pertussis Vaccine (one dose must be given after age 4)

3-5 doses of polio vaccine; (1 dose must be given after the age of 4)

2 doses of Measles/Mumps/Rubella-MMR;

3 Hepatitis B vaccine;

2 Varicella vaccine (chicken pox);

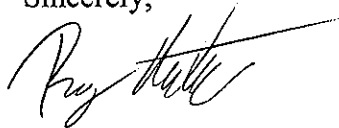
Our school nurse will check the required immunization and health services paperwork. If immunization of your child is not complete by registration time, we will still register your child, but do require that the immunization records be up-to-date before the start of school in September. If your child is not immunized or appropriate documentation is not provided to the nurse, your child may not be able to start school. If your child is not up-to-date with immunizations by the 14th calendar day, your child will be unenrolled. A physical examination is also required and must be dated after September 7, 2023. Physical forms must be received by the Health Office within 30 days of the start of school.

If you are unsure about your child's readiness for kindergarten:

Sometimes at this point in the year a parent will be concerned as to whether or not their child is "ready" to come to school. If your child attends nursery school or daycare, please confer with the person who knows your child. If you feel hesitant about your child's readiness and would like to talk with us at school in advance of the kindergarten screening, please contact us at 914-669-5317 ext. 3041. Please plan to register your child, but tell us you are unsure. We also advise you to register your child for nursery school so that your child will have a place should he or she not attend kindergarten.

We look forward to meeting you at PequenaKonck! Once you have registered, I will write to you about our plans for the spring. These include kindergarten student screening in April/May and our kindergarten student visitation/parent orientation in June – bus ride and all! Most of our communication is through email. Please make sure we have your correct email address. Please do not hesitate to call if you have any questions now or along the way.

Sincerely,



Roy Martin, Ed.D.
Principal

RM/jmj



Central School District
230 June Road · North Salem, New York 10560
(914) 669-5414 · Fax: (914) 669-8753
<http://www.northsalemschools.org>

Duncan Wilson, Ed.D.
Superintendent of Schools

Adam VanDerStuyf, Ed.D.
Deputy Superintendent

Dear Parents/Guardians:

Welcome to the North Salem Central School District. In accordance with the Individuals with Disabilities Education Act and New York State Education Law, I am writing to make you aware that the parent or person in parental relation of any student may refer such student to the District's Committee on Special Education for an evaluation to determine the student's eligibility for special education programs and services. Please know that the Pupil Personnel Services Department is here to support you and your child if he or she has, or is suspected of having, an educational disability.

Below is a link to the New York State Education Department's "*A Parent's Guide to Special Education*" in both English and Spanish. The parent guide provides an overview of a parent's rights regarding referral and evaluation of their child for the purposes of special education programs or services upon a student's enrollment in public school.

<http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm>

<http://www.p12.nysed.gov/specialed/publications/policy/spanishparentguide.htm>

In addition, you may contact the office of the Deputy Superintendent, Adam VanDerStuyf, at (914) 669-5414 ext. 1016 to make a referral to the Committee on Special Education, to obtain a copy of the Parent's Guide or to obtain further information concerning the referral process.

Sincerely

Adam VanDerStuyf

Adam VanDerStuyf
Deputy Superintendent

NORTH SALEM CENTRAL SCHOOL DISTRICT
ALTERNATE ACCEPTABLE DOCUMENTS
FOR ENROLLMENT

Documentation of age - In order to determine, for instance, the programming needs of your child/children, you will need to provide proof of age by providing one of the following:

- a. An original or certified transcript of a birth certificate or record of baptism (including an original or certified transcript of a foreign birth certificate or record of baptism) giving the date of birth; or
- b. passport (including foreign passport) giving the date of birth

Where the above are not available, the School District may consider certain other documents/records in existence two years or more to determine age. One or more of these documents may be necessary. The documents are the following:

- o official driver's license
- o state or other government issued identification
- o school photo identification with date of birth
- o consulate identification card
- o hospital or health records
- o military dependent identification card
- o documents issued by federal, state or local agencies (for instance, local social services agency, federal Office of Refugee Resettlement)
- o court orders or other court-issued documents
- o Native American tribal document
- o records from non-profit international aid agencies and voluntary agencies
- o Note: The School District may need to verify these documents/record

Proof of Residency is required. According to NY State Law, In order to register your child/children in the School District, you must be physically domiciled at your address within the School District's geographic boundaries.

Section A

- 1) *Copy of a residential lease or proof of ownership of a house or condominium, such as a deed or mortgage*
- 2) *a statement by a third-party landlord, owner or tenant from whom the parent(s) or person(s) in parental relation leases or with whom they share property within the district*
- 3) *such other statement by a third-party establishing parent(s) or person(s) in parental relation physical presence in the School District*
- 4) *other forms of documentation and/or information establishing parent(s) or person(s) in parental relation physical presence in the School District. For instance: current property tax bill, current homeowner's/renter's insurance policy statement, see also list from Section B*

Note: *The North Salem School District reserves the right to contact any individual who provides a statement attesting to the physical presence in the School District of the parent(s) or person(s) in parental relation to the student requesting enrollment.*

Section B

- 1) *pay stub*
- 2) *income tax form(s)*
- 3) *utility bill or other bills (e.g., power company, cable, etc.).*
- 4) *membership documents that are based upon residency (e.g., library cards)*
- 5) *voter registration document(s)*
- 6) *official driver's license, learner's permit or non-driver identification*
- 7) *documents issued by federal, state or local agencies (for instance, local social services agency, federal Office of Refugee Resettlement)*
- 8) *evidence of custody of the child/children, including, but not limited to judicial custody orders or guardianship papers*
- 9) *Other forms of documentation and/or information establishing parent(s) or person(s) in parental relation physical presence in the School District.*

NORTH SALEM CENTRAL SCHOOL DISTRICT STUDENT INFORMATION AND REGISTRATION FORM

Today's Date _____

Student's Last Name:		First Name:		Middle:	
Date of Birth:		Place of Birth:		Gender:	
Present Grade Level:		Currently attending (please indicate name of school):			
If student will be starting school in September, which grade did student just complete?					
If student is transferring from another school, has the "Release of Records" been completed and signed by the parent/guardian? <input type="checkbox"/> yes <input type="checkbox"/> no		Street Address:			
		City:		State/Zip	
		Telephone #		Fax #	
Has the student received any additional education services? If yes, please indicate:					
<input type="checkbox"/> reading room		<input type="checkbox"/> speech therapy		<input type="checkbox"/> physical therapy	
<input type="checkbox"/> math remediation		<input type="checkbox"/> occupational therapy		<input type="checkbox"/> language support	
<input type="checkbox"/> special education program					
<input type="checkbox"/> social service agencies who support family or child:					
<input type="checkbox"/> other:					
Sibling Information – please include first and last names					
Name:		M/F	Date of Birth	Current School and Grade:	
Has this family been previously registered in the North Salem Central School District? <input type="checkbox"/> yes <input type="checkbox"/> no					

Student's Last Name:			First Name:		Middle:
Student's Residence Address: Street:			Student's mailing address, if different:		
City	State	Zip	City	State	Zip
Student's home telephone number: (please include area code)					
With whom is the student living? (check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian <input type="checkbox"/> Other			If the parents are divorced, who has custody?		
			In addition to student's residence, to whom should mail be sent?		
Mother's Name:			US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mother's Residence Address Street:			Mother's Mailing Address, if different		
City	State	Zip	City	State	Zip
Home Telephone	Cellular		E-mail address		
Highest Level of Education:			Occupation:		
Employer Name/Address			Employer Telephone		
Father's Name:			US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Father's Residence Address Street:			Father's Mailing Address, if different		
City	State	Zip	City	State	Zip
Home Telephone	Cellular		E-mail address		
Highest Level of Education:			Occupation:		
Employer Name/Address			Employer Telephone:		
Stepparent/Guardian Information Name Address City Telephone			Stepparent/Guardian Information Name Address City Telephone		

Parent/Guardian Signature _____ Date: _____

For Office Use Only:			
Intake by: _____	Proof of Birth: _____	Proof of Residency _____	
Health registration complete? _____	Immunization record: _____	Request for Release of Records: _____	
Medical Alert? _____	Legal Alert? _____	Student Residency Questionnaire _____	

NORTH SALEM CENTRAL SCHOOL DISTRICT
STUDENT HEALTH HISTORY AND REGISTRATION FORM
(To be completed by parent of a student who did not attend North Salem Central School District last year)

Student's Last Name:	First Name:	Middle:
Date of Birth:	Gender:	Grade:

Please record approximate year child had any of the following:

Chicken Pox _____	Ulcers _____	Rheumatic Fever _____
Measles _____	Contact with Tuberculosis _____	Epilepsy _____
Mumps _____	Diabetes _____	Poliomyelitis _____
Whooping Cough _____	Major Fractures _____	High Blood Pressure _____
Heart Disease _____	Extended Illness _____	Ear Problems (tubes?) _____
Lyme Disease _____	Other: _____	

Please provide information about the entries selected above:

Has the child had any surgery, injuries or illnesses requiring hospitalization? ☐ No
☐ Yes: please explain _____

Is there any allergy to drugs, foods or stinging insects? ☐ No
☐ Yes: please explain _____

Does this child have asthma or hay fever? ☐ No
☐ Yes: please explain and include medication information _____

Does this child experience convulsive episodes or fainting spells? ☐ No
☐ Yes: please explain _____

Does this child wear glasses? ☐ No ☐ Yes
 If yes, are glasses to be worn at all times? ☐ No ☐ Yes For reading only? ☐ No ☐ Yes For distance? ☐ No ☐ Yes

Is this student under treatment or taking medication for any condition at the present time? ☐ No
☐ Yes: (please indicate the diagnosis and the name of the medication/dosage/frequency)

Is this student on medication that should be taken during school hours? ☐ No
☐ Yes: please explain _____

Is there any other condition for which the Health Office should be made aware? ☐ No
☐ Yes: please explain _____

Name of physician: _____ Telephone _____

Signature _____ Date : _____

Please use reverse for additional notes, and check here ☐

STUDENT HEALTH HISTORY AND REGISTRATION FORM

Additional Health Notes

[illegible]

KINDERGARTEN STUDENT INFORMATION SHEET

In order to gain a greater understanding of your child, we appreciate your completion of this sheet. If you have any concerns about a question or would like to talk to us in person, please let us know. Thank you.

CHILD'S FULL NAME: _____ BIRTHDATE: _____

FAMILY HISTORY: Name of Siblings Sex Age Grade Academic Adjustment _____

Other people living in your home: _____

BIRTH AND EARLY CHILDHOOD HISTORY:

Full Term: _____ Birth Weight: _____ Mother's Health at time of birth: _____

Delivery: Induced _____ Special circumstances (loss of oxygen, jaundice, prematurely, incubation, respiratory distress, early eating problems, cesarean section, additional comments: _____

Approximate age of sitting alone: _____ Walking: _____ Talking: _____

Speech development (underline): Stuttering, baby talk, lisping, can't think of words, faulty enunciation, loses thought, delayed, normal: other: _____

Any unusual occurrence in child's early life (underline and explain): Accident, fire, hospitalization, moving, separation from parent, death or illness of close family member, lived in a foreign country, other: _____

What language, other than English does your child speak or understand? _____

Does your child have any specific fears? Unusual eating habits or patterns, or problems with control, trouble separating from parents (baby-sitters, etc.), sleep problems; please explain: _____

MEDICAL HISTORY

Any major or chronic illnesses: (history of ear infections, allergies, convulsions, pneumonia?) _____

Accidents: (stitches, etc.) _____

Hospitalization: (include age of child, length of stay, reason for stay) _____

When your child is upset, in what way(s) might he/she respond or behave? _____

General Health: _____ Wears glasses? _____ Hearing loss? _____

over please....

KINDERGARTEN STUDENT INFORMATION SHEET

Did your child attend nursery school: _____ Where: _____
How long? _____

How did your child adjust to Nursery School? _____

Does your child enjoy being alone: _____ Does your child play with others: _____
How frequently? _____

Does he/she prefer same age _____, older, _____ or younger children _____.

Does he/she share: _____ How does he/she settle differences of opinion with playmates? _____

How many hours daily does your child watch TV? _____

How does your child react in new situations? _____

Is your child shy with adults? _____

Do you feel your child is advanced, at age level, or needs growth in these areas?

Language Development: _____

Creative and Imaginative Play: _____

Athletic Skills: _____

Social Interaction: _____

Academic Skills, Reading Readiness: _____

Math: _____

Printing: _____

Artistic - Musical Ability: _____

Does your child read? Please explain (books/words): _____

Has your child had any special testing or received any special help or intervention? Please explain: _____

Does your child have any special interest or take special lessons or attend special classes?
(Gymnastics, music, etc.) _____

Is there anything further you'd like us to know about your child? _____

Thank you for helping us get to know your child. We look forward to getting to know you both!

Roy Martin, Ed.D.
Principal

Jake Ross, Psy.D
School Psychologist

Person completing this form _____

Date _____

**NORTH SALEM CENTRAL SCHOOL DISTRICT
STUDENT RACIAL AND ETHNIC IDENTIFICATION**

Dear Parent/Guardian:

Beginning with the 2010-2011 school year, school districts and states are required to follow new standards in collecting and recording individual-level race and ethnicity data in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and Federal Education Departments
- Plan educational programs and make sure that they are readily available to all students
- Do statistical analysis

We need your help in order to accomplish this task. Please complete and return the enclosed forms using a separate form for each of your children who will be enrolled in the North Salem Central School District in the 2010-2011 school year. Please review the Racial/Ethnic definitions on the Student Racial and Ethnic Identification form, and return completed form(s) by September 27, 2010.

There are TWO areas that are needed to be checked off on the form:

- ✓ First, check YES or NO regarding whether or not the child is of Hispanic, Latino or Spanish origin.
- ✓ Second, check ONE OR MORE of the following choices that are true about the child's ethnicity/race. For example, you would check Asian *and* White for a child that was Asian and White.

North Salem Central School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If we are unable to get this information from you then, according to State and Federal regulations, we are required to use our own judgment to identify the race and ethnicity of the child. The form may not be blank.

Thank you for your cooperation. If you have any questions, please call your school's principal.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

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) and Regulations of the Chancellor A-820 prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number

**NORTH SALEM CENTRAL SCHOOL DISTRICT
STUDENT RACIAL AND ETHNIC IDENTIFICATION**

- All students between 5 and 21 years of age have the right to a free public education
- Children may not be refused admission to a public school because of race, color, creed, national origin, gender, gender identity, pregnancy, immigration/citizenship status, disability, sexual orientation, religion, or ethnicity.

Name of School:	
Student Identification Number:	Date of Birth (Month/Day/Year):
Student Name: Last, First, Middle:	Grade Level:

DIRECTIONS TO PARENT/GUARDIAN

PLEASE ANSWER BOTH QUESTIONS (1) AND (2). PLEASE READ THEM CAREFULLY BEFORE YOU RESPOND.

<p>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 Spanish culture or origin, regardless of race [Check (✓) <u>one</u> that best describes your child].</p> <p><input type="checkbox"/> YES, Hispanic <input type="checkbox"/> NO, not Hispanic</p>
<p>2. Check (✓) one or more races from the following five racial groups [Check (✓) all groups that apply to your child; check (✓) <u>at least ONE</u> box.]:</p> <p><input type="checkbox"/> AMERICAN INDIAN OR ALASKAN 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. E.g. Cherokee, Mohawk, Inuit.</p> <p><input type="checkbox"/> 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 Philippine Islands, Thailand and Vietnam.</p> <p><input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or Other Pacific Islands.</p> <p><input type="checkbox"/> BLACK: A person having origins in any of the Black racial groups of Africa.</p> <p><input type="checkbox"/> WHITE: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.</p>

Signature of Parent/Guardian/Other

Date

Relationship to Student:

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify) _____

See reverse letter for important message to Parent/Guardians and Confidentiality Procedures and Regulations.

Name of LEA: _____

Name of School: _____

Name of Student: _____

First

Middle

Gender: Male Date of Birth: ____ / ____ / ____ Grade: ____ ID#: ____
 Female Month Day Year (preschool-12) (optional)

Address: _____ Phone: _____

Where is the student currently living? (Please check *one* box.)

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____
- ☐ In permanent housing

Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

Date _____

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.



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

Elisa Alvarez, Associate 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 Person in Parental Relation:

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.

STUDENT NAME:

First Middle Last

DATE OF BIRTH:

GENDER:

Month Day Year

☐ Male
☐ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name First Name Relation to

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?

☐ Parent 1

☐ Parent 2

☐ Guardian(s)

specify

specify

specify

4. What language(s) does your child understand?

☐ English ☐ Other

specify

5. What language(s) does your child speak?

☐ English ☐ Other

☐ Does not speak

specify

6. What language(s) does your child read?

☐ English ☐ Other

☐ Does not read

specify

7. What language(s) does your child write?

☐ English ☐ Other

☐ Does not write

specify

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? _____

Signature of Parent or of Person in Parental Relation _____

Month: _____ Day: _____ Year: _____

Date

Relationship to student: ☐ Parent ☐ 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:

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.

BMI _____ kg/m²

Percentile (Weight Status Category): ☐ < 5th ☐ 5th- 49th ☐ 50th- 84th ☐ 85th- 94th ☐ 95th- 98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ Not Done

Hypertension: ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K <input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

☐ System Review Within Normal Limits

☐ Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list)

ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision Screening	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail					<input type="checkbox"/>
Notes					
Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done
Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> Other Restrictions:					
Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.					
Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> Other Accommodations*: Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
MEDICATIONS					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					