

INSTRUCTIONS: BASIC INFORMATION FOR PRE-SCHOOL REGISTRATION FORM

1. All Applicants **MUST** complete Numbers 1, 2, 3, 4 of the three page registration form and **sign and have notarized the bottom of page 3, by at least one parent.**
Attach the following:
 - Copy of Original Birth Certificate or Passport
 - Copy of Driver's License
 - Proof of residency
 - Child's physical and immunization record
2. **DIVORCED OR SEPARATED PARENTS with** current custody orders must submit the Court Order **or** divorce papers stating that registering parent has residential custody.
3. **FOSTER PARENTS** must complete Sections 1 through 6 and submit a copy of BSW-241 or DSS2999 form. The DDS social worker (legal guardian) **MUST SIGN THE APPLICATION.**
4. **LEGAL GUARDIANS OR LEGAL CUSTODIANS** must complete Sections 1 through 6 and attach a certified copy of the Court Order and Affidavit Forms C & D. (Persons other than natural parents claiming a custodial relationship without a Court Order, must complete Sections 1 through 6 and Affidavit Forms C & D). **Forms C and D must be requested.**
5. **RENTERS:** If you are renting a home, please sign and notarize the Renter's Affidavit and have the landlord sign and notarize the Owner's/Landlord's Affidavit. This would also apply if you are sharing a home or not paying rent.
6. If you own your home, you do **not** need to fill out the Landlord/Owner's Affidavit.
7. All applicants **MUST** complete the following forms: CPSE Referral Form, Housing Questionnaire, Home Language Questionnaire, Student Racial and Ethnic Identification form.
8. **Please read instructions carefully.** Not all forms will apply.

Once all is complete, you may drop the packet off at the middle school, attention Jackie Franke, Registrar or email the packet to jfranke@emoschools.org.

RESIDENCY INFORMATION:*

HOMEOWNERS: If you own a home, you must attach the following; recent mortgage statement or deed, or county or school tax receipt, **AND two utility bills. DO NOT COMPLETE FORMS A OR B.**

RENTERS/LESSEES: If you are **Renting** or **Leasing** an apartment or home, submit your lease or rental agreement if available and complete Affidavit **Forms A & B.** Submit a recent utility bill. Have landlord complete **Form B** and provide a tax bill or a deed. If you do not have written rental or lease agreement, complete **Affidavit Forms A & B,** and submit a utility bill.

*Individuals who cannot provide any of the above documents must submit a written and notarized explanation as to why the document is unavailable.

CHECKLIST

<u>HAVE YOU:</u>	<u>YES</u>	<u>NO</u>	<u>N/A</u>
Completed Sections 1, 2, 3 and 4? <u>ALL REGISTRANTS</u>	_____	_____	_____
Completed and had <u>NOTARIZED</u> all applicable Affidavit Forms A & B and/or C & D?	_____	_____	_____
Attached the lease if you are leasing or deed if you own?	_____	_____	_____
Obtained necessary <u>SIGNATURES AND NOTARIZATIONS</u> on <u>ALL</u> pertinent documents?	_____	_____	_____
Included a copy of your child's <u>ORIGINAL BIRTH CERTIFICATE WITH RAISED SEAL OR PASSPORT?</u>	_____	_____	_____
Provided Immunization records? Proof of a recent skin test (PPD) Mantoux for tuberculosis with a negative result within 2 years. Please note that all students will be required to comply with the regulations.	_____	_____	_____
Enclosed proof of residency documents (see requirements above) in the East Moriches School District?	_____	_____	_____
Enclosed a divorce decree or custody papers, if applicable?	_____	_____	_____
Completed child's physical examination? Physical must be performed by a New York State physician up to 12 months prior to the commencement of the school year in which the examination is required.	_____	_____	_____
Enclosed completed CPSE Referral Form, Housing Questionnaire, Home Language Questionnaire, and Student Racial and Ethnic Identification form?	_____	_____	_____

East Moriches Union Free School District

Special Education Office

523 Montauk Highway

East Moriches, NY 11940

631-878-0162 Fax 631-909-7515

CPSE REFERRAL

Child's Name: _____ DOB: _____ Date of Referral _____

Address: _____

Parent/Guardian Name: _____

Current School or Services: _____

Teacher/Therapist: _____

Reason/s for Referral _____

Attempts to Resolve the Situation: _____

Parent/Guardian Signature: _____ Date received by CPSE Chairperson _____

**PLEASE PRINT
USING BLACK INK**

**OFFICIAL USE
ONLY**
Application
issued.....
Complete
application
received.....

EAST MORICHES UNION FREE SCHOOL DISTRICT
9 Adelaide Avenue
East Moriches, NY 11940
Tel: 631-878-0162 Fax: 631-909-1379

REGISTRATION FORM

COPY OF ORIGINAL BIRTH CERTIFICATE WITH RAISED SEAL OR PASSPORT MUST BE SUBMITTED WITH THIS REGISTRATION FORM

1. Today, _____, I am requesting permission to have the following child admitted to:

East Moriches Union Free School District

Student's Name: (Last, First, Middle) Date of Birth Grade Sex

Country/State of Birth: _____

(Check one)

2. Are you: _____ Natural /Adoptive parent(s) (if there has been a divorce, refer to instruction sheet)
 _____ Legal guardian (Court Appointed)
 _____ Person in parental relationship
 _____ Foster parent(s)

Parent/Guardian/Person in Custodial Relationship (Circle One)

Last Name _____ First Name _____ Middle Initial _____
Address _____

Mailing Address, if different _____

Phone Number: Home() _____ Work() _____ Cell() _____

Date of Birth _____

Name of Employer _____

Address of Employer _____

Days Worked _____ Hours Worked: From _____ To _____

Parent/Guardian/Person in Custodial Relationship (Circle One)

Last Name _____ First Name _____ Middle Initial _____
Address _____

Phone Number: Home() _____ Work() _____ Cell() _____

Date of Birth _____

Name of Employer _____

Address of Employer _____

Days Worked _____ Hours Worked: From _____ To _____

3. If the student is living with someone other than a parent or legally appointed guardian, give the address and telephone number of any living natural parents/guardians in spaces below. If both parents are deceased, provide copies of death certificates.

NOT APPLICABLE _____(Check)

Name _____ Relationship _____
Address _____ Zip _____ Phone # () _____
Name _____ Relationship _____
Address _____ Zip _____ Phone# () _____

4. General Student Information:

Total years your child has been schooled in the United States _____
Last School attended _____ Last Date of Attendance _____
Address _____
Phone Number _____

Does/did your child have an IEP (Special Education) or a 504 Plan: Yes _____ No _____ (Check one)

If yes, please provide a copy of the current IEP (Individual Educational Program) or 504 Plan

Student's last home address when in attendance at the previous school:

Street _____ Town _____ Telephone# _____
Name of Parent/Guardian at that previous address _____

Parent is active duty in the Armed Forces: Yes _____ No _____ (Check one)

HAS THE STUDENT EVER ATTENDED EAST MORICHES UNION FREE SCHOOL DISTRICT?

YES _____ NO _____

List the names of all children who live with you, whether in or out of school.

	<u>Name</u>	<u>Date of Birth</u>	<u>School</u>	<u>Grade</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

THIS SECTION MUST BE COMPLETED BY ALL NEW ENTRANTS:

Has student participated in Interscholastic Athletics: Yes No (Circle one)

If YES, Level: JHS _____ JV _____ V _____ Intramural _____

Has the student participated in Band/Chorus? If so, circle either or both.

5. If the student is a FOSTER CHILD, foster parents must have a social worker sign this document. In addition, complete forms BSW-241 or DSS-2999.

Type of Education: Academic _____ Occupational _____
Special Education _____ School District of Origin _____

6. **THE FOLLOWING QUESTIONS MUST BE ANSWERED WHEN APPLICATION FOR ADMISSION IS FILED BY PERSONS OTHER THAN A NATURAL PARENT. NOTE: The school retains the right to temporarily delay completion of this registration pending evaluation of the facts presented in this or any other portion of this application.**

- a) Why is the child not living with his/her natural or adoptive parent? _____
- b) Does the student live in your home exclusively? Yes No (Circle One)
- c) Is this a temporary or permanent relationship? _____
- d) How often will the natural parents see the child? _____
- e) What percentage of financial support will be made by the natural parents? _____
- f) What percentage of financial support will be made by you? _____

The East Moriches School District is entitled to receive reimbursement of expenses for health-related services for children who are Medicaid eligible. To preserve confidentiality, we ask all parents to sign the following statement:

I hereby give permission for the East Moriches School District to disclose information from my child's educational records to local, state and federal representatives for the sole purpose of claiming Medicaid reimbursement should my child ever need health-related support services and should my child be receiving Medicaid at that time.

Signature of Parent/Guardian

Date

Under **PENALTIES OF PERJURY**, the statements contained in this application are true. I understand that the statements in this application are subject to verification by the School District and that false statements could subject me to transportation and/or tuition charges where applicable. I also understand that it is my responsibility to notify the school of any changes or circumstances affecting this application. **ANY FALSE STATEMENTS MADE IN THIS APPLICATION IS ALSO PUNISHABLE AS A CLASS "A" MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW.**

Date

Date

PRINT Name of Mother/Guardian

PRINT Name of Father/Guardian

Signature Mother/Guardian
Sworn to before me
this day of

Signature Father/Guardian
Sworn to before me
this day of

Notary Public

Notary Public

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at the top page of registration materials that the district shares with families. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the student is not required to submit proof of residency and other required documents that may be part of the registration packet.

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

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

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

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

If **ANY** box other than "In Permanent Housing" is checked, then the student/family should be immediately referred to the MV Liaison. In such cases, **proof of residency** and other documents normally needed for enrollment are **not required** and the student is to be **immediately enrolled**. **After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

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

THIS FORM MUST BE COMPLETED
STUDENT RACIAL AND ETHNIC IDENTIFICATION

To the Parent/Guardian: The *East Moriches Union Free School District* has adopted a policy which requires the collection and recording of the ethnic identity of students in the *East Moriches Union Free School District* 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.
- Study the movement of students in different ethnic groups as they move from school to school.
- Analyze differences in academic performance, attendance and completion of school.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the back of this page. Put a check (✓) in the box for the category or categories which best describe your child. The *East Moriches Union Free 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 the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

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

Please complete the form following this page.

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 because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Name of School:

School District Student Identification Number:

Date of Birth (Month/Day/Year):

Student Name: Last, First, Middle:

Grade Level:

DIRECTIONS TO PARENT/GUARDIAN

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 Spanish 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 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.
- 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.

Signature of Parent/Guardian/Other

Date

Relationship to Student (please check one box below):

- Mother Father Guardian Other (Specify): _____



Lissette Colon-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:		GENDER:
Month	Day	Year
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother _____ <i>specify</i>	<input type="checkbox"/> Father _____ <i>specify</i>
	<input type="checkbox"/> Guardian(s) _____ <i>specify</i>	
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> 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:
<input type="text"/>	<input type="text"/>
<i>District Name (Number) & School</i>	<i>Address</i>

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: Mother Father Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF QUALIFIED 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: _____ PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING

Mo. DAY YR.

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

RENTER'S/NON-OWNER'S AFFIDAVIT

FORM A-Page 1

STUDENT'S NAME (Print last name, first name)

STATE OF NEW YORK)

)ss:

COUNTY OF _____)

_____, being duly sworn, deposes and says:

(Name)

1. I understand that this statement is being made UNDER THE PENALTIES OF PERJURY in order that my Child/Ward may be admitted to the East Moriches School Union Free School District as a district resident. I further understand that if my Child/Ward is found not to be a legitimate resident of the East Moriches Union Free School District that I WILL BE LEGALLY RESPONSIBLE FOR AND WILL BE BILLED THE SCHOOL DISTRICT'S ANNUAL TUITION RATE PER CHILD, RETROACTIVE to the first day of admission. I also realize that theft of governmental services is a crime punishable under the State Penal Law and that a false statement made in connection with this application will make me liable to criminal prosecution. I have been informed that the school district will make unannounced home visits for purposes of residency verification.

2. I _____ am the (PARENT/GUARDIAN/CUSTODIAL PARENT) of the above named Child/Ward. I reside at (state address and specify the exact nature of the space: basement apartment, second floor apartment, number of rooms, etc.) _____

with my Child/Ward, and

1	_____	7	_____
2	_____	8	_____
3	_____	9	_____
4	_____	10	_____
5	_____	11	_____
6	_____	12	_____

(LIST EACH AND EVERY OTHER PERSON LIVING AT THE ABOVE ADDRESS).

This is my actual and only permanent residence. My Child/Ward lives with me and said address is his/her actual and only permanent residence.

3. My last address was _____

where I lived with

- | | |
|---|----|
| 1 | 7 |
| 2 | 8 |
| 3 | 9 |
| 4 | 10 |
| 5 | 11 |
| 6 | 12 |

(LIST EACH AND EVERY PERSON WHO LIVED AT THE ABOVE ADDRESS).

I began living at _____

(CURRENT ADDRESS) on _____ (DATE). My living arrangement is governed by

(CHECK APPROPRIATE BOX):

- a formal lease (attach copy of lease and Owner’s Affidavit – Form B)
- other (attach rental agreement or realtor’s statement and Owner’s Affidavit, - Form B).

The terms and conditions of my tenancy are as follows (specify rent, etc.):

MONTHLY RENT: _____

DURATION OF TENANCY: _____

Print Name

Sworn to before me
this _____ day of _____, 200_

SIGNATURE OF RENTER/NON-OWNER

NOTARY PUBLIC

ANY FALSE STATEMENT MADE IN THIS APPLICATION IS ALSO PUNISHABLE AS A CLASS “A” MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW.

LANDLORD'S/OWNER'S AFFIDAVIT

FORM B-Page 1

STUDENT'S NAME (Print last name, first name)

STATE OF NEW YORK)

)ss:

COUNTY OF _____)

Attach Deed or Mortgage
Statement (or Tax Bill)

_____, being duly sworn, deposes and says:
(Name)

1. I understand that this statement is being made UNDER THE PENALTIES OF PERJURY, in order that the above mentioned child/ward may be admitted to the East Moriches School Union Free School District as a district resident.

2. I am the legal owner of _____ (ADDRESS)

A COPY OF DEED, MORTGAGE STATEMENT OR TAX BILL MUST BE ATTACHED

The terms and conditions of said tenancy are as follows: (Specify Rent, etc.)

(Attach copy of Lease). _____

3. To the best of my knowledge the above mentioned property is the current residence of _____ (NAME OF PARENT/GUARDIAN) and the Child/Ward named above.

4. The following names include ALL other persons living at this address:

1	_____	7	_____
2	_____	8	_____
3	_____	9	_____
4	_____	10	_____
5	_____	11	_____
6	_____	12	_____

Print Name

Sworn to before me
this _____ day of _____, 200_

SIGNATURE OF OWNER

NOTARY PUBLIC

ANY FALSE STATEMENT MADE IN THIS APPLICATION IS ALSO PUNISHABLE AS A CLASS "A" MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW.

2020-21 School Year New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) ²	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older or 3 doses if 7 years or older and the series was started at 1 year or older		3 doses
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap) ³		Not applicable		1 dose
Polio vaccine (IPV/OPV) ⁴	3 doses		4 doses or 3 doses if the 3rd dose was received at 4 years or older	
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose		2 doses	
Hepatitis B vaccine ⁶	3 doses		3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years	
Varicella (Chickenpox) vaccine ⁷	1 dose		2 doses	
Meningococcal conjugate vaccine (MenACWY) ⁸		Not applicable	Grades 7, 8, 9, 10 and 11: 1 dose	2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) ⁹	1 to 4 doses		Not applicable	
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses		Not applicable	

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE 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:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Environmental

Asthma <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	

Seizures <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____	Date Drawn: _____

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: No Yes **Hypertension:** No Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated > 10 µg/dL				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

<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	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name:	DOB:
-------	------

SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis Required for boys grade 9 And girls grades 5 & 7	Negative <input type="checkbox"/>	Positive <input type="checkbox"/>	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

Full Activity without restrictions including Physical Education and Athletics.

Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications

No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

Other Restrictions:

Developmental Stage for Athletic Placement Process ONLY
Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports
Student is at **Tanner Stage:** I II III IV V

Accommodations: Use additional space below to explain

<input type="checkbox"/> Brace*/Orthotic	<input type="checkbox"/> Colostomy Appliance*	<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Insulin Pump/Insulin Sensor*	<input type="checkbox"/> Medical/Prosthetic Device*	<input type="checkbox"/> Pacemaker/Defibrillator*
<input type="checkbox"/> Protective Equipment	<input type="checkbox"/> Sport Safety Goggles	<input type="checkbox"/> Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

Order Form for Medication(s) Needed at School attached

List medications taken at home: _____

IMMUNIZATIONS

Record Attached Reported in NYSIIS Received Today: Yes No

HEALTH CARE PROVIDER

Medical Provider Signature:	Date:
Provider Name: <i>(please print)</i>	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.