Dear Parent/Guardian(s):

Welcome to the Mahopac Central School District. Listed below and enclosed are the required registration documents for eligible students. If you have any questions or need to set up a registration appointment, please contact the Office of Central Registration.

Registration Requirements for PRE SCHOOL EVALUATIONS	
Student Registration with Emergency Information • **Proof of Birth – Original Birth Certificate**	
Registration Contact List	
Verification of Residency Information	
• Three (3) proofs of residency required	
• Landlord or Residency Affidavit, *UPON REQUEST IF APPLICABLE*	
• Care, Custody and Control Affidavit, *UPON REQUEST IF APPLICABLE*	
Country and Home Language Survey ESOL	
Health Appraisal Form (to be completed by Physician) **	
NYS Immunization Requirements for School Entry	
Health History (to be completed by Parent/Guardian)	
Developmental History from Parent/Guardian	
Request for Pre School Evaluation	
Request for Time Enrolled in a Regular Early Childhood Programs	
Electronic Mail Election Form	
Written Notification about your rights and protections under the Federal Individuals With Disabilities Act (IDEA)	
** The physical must be within the twelve months prior to registration and accompanied by a record of your child's immunizations.	
Is a translator needed to assist with the registration process: Yes ____ No _____	
To make an appointment to register your child for CPSE Evaluation, please contact Marie Micol in The Office of Central Registration at 845-621-0656, ext. 13905.	
For questions related to the CPSE Evaluation process, please contact Tina Stark in The CPSE Office at 845-621-0656, ext. 13641.	

Thank you.

MAHOPAC CENTRAL SCHOOL DISTRICT
REGISTRAR

Student Registration Form

Please print legibly with blue or black ink

LAST NAME _____ **FIRST NAME** _____ **MI** _____

Birth City _____ **Birth State** _____ **Birth Country if not the U.S.** _____

Birth Date _____ **Male / Female**

HOME ADDRESS _____ _____ **NEAREST CROSSROAD** _____
City

MAILING ADDRESS (if different) _____ **CUSTODY ISSUES [1]: Yes / No**

ARE SPECIAL SERVICES REQUIRED: **English Language Learner / ESOL: Yes / No** **Special Education / IEP: Yes / No**

ETHNICITY (*Optional*)

Is the child Hispanic, Latino, or of Spanish Origin? *(Hispanic, Latino, or 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***

Select one or more races from the following five racial groups *(Check all groups that apply to your child; check at least one box):*

___ **American Indian or Alaskan Native**	*A person having origins in any of the original peoples of North and South America, and who maintains cultural identification through tribal affiliation or community recognition.*
___ **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, Philippine Islands, Thailand and Vietnam*
___**Black or African American**	*A person having origins in any of the Black racial groups of Africa*
___**Native Hawaiian/Other Pacific Islander**	*A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands*
___**White**	*A person having origins in any of the original peoples of Europe, North Africa or the Middle East*

RESIDENT PARENT/GUARDIAN INFORMATION

If student resides with Foster Parents or Legal Guardian, supporting documentation will be required.

Name _____ ___**Parent** ___**Step Parent** ___**Legal Guardian** _____**Other** **Male / Female**

Employer/Occupation _____ _____ **E-Mail Address:** _____

Home Phone (**)**_____ **Business Phone (** **)**_____ **Cell (** **)**_____

Work Location: City & State _____ **Hours:** _____ **to** _____ **Work Days:** ___**Mon** ___**Tues** ___**Wed** ___**Thurs** ___**Fri**

Name _____ ___**Parent** ___**Step Parent** ___**Legal Guardian** _____**Other** **Male / Female**

Employer/Occupation _____ **E-Mail Address:** _____

Home Phone (**)**_____ **Business Phone (** **)**_____ **Cell (** **)**_____

Work Location: City & State _____ **Hours:** _____ **to** _____ **Work Days:** ___**Mon** ___**Tues** ___**Wed** ___**Thurs** ___**Fri**

IF APPLICABLE, NON-RESIDENT PARENT/GUARDIAN INFORMATION

Name _____ ___**Parent** ___**Step Parent** ___**Legal Guardian** _____**Other** **Male / Female**

Employer/Occupation _____ **E-Mail Address:** _____

Parent Mailing Address (if different from Student): _____

_____ **Parent requests extra mailings:** ___**Yes** ___**No**

Home Phone (**)**_____ **Business Phone (** **)**_____ **Cell (** **)**_____

Work Location: City & State _____ **Hours:** _____ **to** _____ **Work Days:** ___**Mon** ___**Tues** ___**Wed** ___**Thurs** ___**Fri**

HAS YOUR CHILD EVER ATTENDED THE MAHOPAC CSD: Yes / No **IF YES PLEASE GIVE DATES:** _____

TRANSFER FROM: School Name _____ **City & State** _____

FOR GRADE K REGISTRATION, PRE-SCHOOL ATTENDED _____

TO BE COMPLETED BY SCHOOL PERSONNEL **ENTER DATE** _____ **SCHOOL CODE** _____

STUDENT ID NO: _____ **GRADE** _____

PROOF OF AGE: _____ **RECORD OF IMMUNIZATIONS: Yes / No**

Mahopac Central School District – Student Registration Form

Is your child presently under an order of suspension/expulsion from another school district Yes _____ No _____
Is your child presently under consideration of suspension or expulsion from another school district Yes _____ No _____
Is your child currently involved in the Juvenile Justice System Yes _____ No _____

BROTHERS & SISTERS (Include All Children Living With Family):

NAME (First & last)	DATE OF BIRTH	CURRENT SCHOOL	GRADE	GENDER	EXPECTED TO ATTEND MCSD IF YES – START DATE	FOR MCSD USE	

ARE THERE ANY SIBLINGS UNDER THE AGE OF FIVE WITH SPECIAL NEEDS? ____ Yes ____ No

EMERGENCY CONTACT INFORMATION: *In case of an emergency, the parent/guardians listed on page one of this form are the first to be contacted. In the event you cannot be reached, please list below three additional contacts. Please include their city and state in order to assist us in determining the contact in closest proximity to the school. The individuals below have the authorization to pick up your child in the event you cannot be reached.*

	RELATIONHIP TO STUDENT (i.e., grandparent, neighbor, childcare provider)	TELEPHONE NUMBER	CIRCLE ONE
CONTACT(1): _____	_____	( ) _____	Home Cell Work
CONTACT(2): _____	_____	( ) _____	Home Cell Work
CONTACT(3): _____	_____	( ) _____	Home Cell Work

PHYSICIAN: _____ **TEL:** ( ) _____

DENTIST: _____ **TEL:** ( ) _____

IF I WISH TO CHANGE THE DOCTOR INDICATED ABOVE, IT IS MY RESPONSIBILITY TO NOTIFY THE SCHOOL NURSE OF THIS CHANGE.

I GIVE PERMISSION FOR HEALTH INFORMATION TO BE SHARED WITH SCHOOL PERSONNEL.

EMERGENCY MEDICAL CARE CONSENT

In the event of an accident, sudden illness, or other cause which, in the judgment of the school nurse or other person in charge, requires advice or treatment beyond general aid, I give permission for an ambulance to be called to transport my child to the nearest hospital. Furthermore, I give permission to the hospital to treat my child. I understand that every effort will be made to contact me if the above circumstances should occur. I recognize that when the school calls for assistance in this way, it is acting on my behalf, and that any medical care that my youngster receives is the financial obligation of myself and not the school.

_____ _____
Parent/Guardian Signature **Date**

Note: As a procedure the school will ask parents to keep their child(ren) home from school if they show any sign of significant infection. If your child has had a fever (100 F. or above) he/she should not return to school until his/her temperature has been normal for at least 24 hours. Please have any body rash or eye inflammation checked by your doctor to determine whether or not it is contagious.

If a child requires any medication during school hours, the medication should be brought to the School Nurse by the parent or a responsible adult. It must be in the original prescription bottle with a permission form completed by the parent and doctor and signed by the parent/guardian. Students are not to bring medication (including over the counter medications such as Tylenol) with them.

_____ _____
Parent/Guardian Signature **Date**

I (We) affirm that the information provided on this form is true and correct. I (We) understand that the District may investigate any allegation contained in this form and may ask for written proof of any statement. In order to verify the information or statements provided on this form (including any supporting documents and affidavits), I (we) give consent for the release of this form (including any supporting documents and affidavits) or any information contained in this form to Mahopac Central School District, the landlord, or any other third party in furtherance of the School District's investigation. I (We) understand that if the allegations contained in this form (including supporting documents and affidavits) are determined not to be true and accurate, I (we) will be held responsible for the payment of tuition to the District.

_____ _____
Parent/Guardian Signature **Date**

[1] See Registration procedures for Custody Issues.

Registration Contact Sheet

Mahopac Central School District Office
179 East Lake Boulevard, Mahopac, NY 10541
Phone: 845-628-3415 Fax: 845-628-0261
District Website: www.mahopac.k12.ny.us

Office of Central Registration
100 Myrtle Avenue, Mahopac, NY 10541

Registration for Grades K – 12 and Transportation: Elfriede Schober
Phone: 845-621-0656 x13902 Fax: 845-628-3034
Registration for Pre School Evaluations: Marie Micol
Phone: 845-621-0656 x13905 Fax: 845-628-3034

Parent Portal – Marie Micol
Phone: 845-621-0656, ext. 13905 - Email: pcxp@mahopac.k12.ny.us

Mahopac High School
421 Baldwin Place Road, Mahopac, NY 10541-4631
Phone: 845-628-3256 Fax: 845-628-4380
Registrar: Elfriede Schober (The Office of Central Registration – 845-621-0656, x13902)
Nurse: Lynn Karst – 845-628-3256, Ext. 11700

Mahopac Middle School
425 Baldwin Place Road, Mahopac, NY 10541-4631
Phone: 845-621-1330 Guidance Fax: 845-628-2012
Registrar: Lynne Mongon, Ext. 12600
Nurse: Alice Foley, Ext. 12700

Austin Road Elementary School
390 Austin Road, Mahopac, NY 10541-2777
Phone: 845-628-1346 Fax: 845-628-5521
Registrar: Donna Tritremmel, Ext. 15502
Nurse: Teresa Sedran – 845-628-4574

Fulmar Road Elementary School
55 Fulmar Road, Mahopac, NY 10541-4521
Phone: 845-628-0440 Fax: 845-628-5714
Registrar: Susan Cammarano, Ext. 14501
Nurse: Noreen Beichert – 845-628-3457

Lakeview Elementary School
112 Lakeview Drive, Mahopac, NY 10541-2316
Phone: 845-628-3331 Fax: 845-628-5849
Registrar: Lisa Cancel, 16503
Nurse: Mary Brunetti – 845-628-3777

Transportation - Bus Garage – Falls District Office
100 Myrtle Avenue, Mahopac, NY 10541 - Phone: 845-628-7447

Building and Grounds – Facilities –
23 Secor Road, Mahopac, NY 10541 - Phone: 845-628-3331 x16901

MAHOPAC CENTRAL SCHOOL DISTRICT

179 East Lake Boulevard, Mahopac, NY 10541-4645 (845) 628-3415 Fax (845) 628-0261

Dr. Greg Stowell
Assistant Superintendent for
Pupil Personnel Services

Anthony DiCarlo
Superintendent of Schools

Dear Parents/Guardians:

Welcome to the Mahopac Central School District. Parents/Guardians and the school district enter into an important partnership to ensure that every student in our schools acquire the skills, knowledge, attitudes and interpersonal skills that will permit him or her to operate effectively in the broader community and lead a successful productive life in a changing world. This is critically important when a child has an educational disability. Therefore, please know the Pupil Personnel Department is here to support you if your child has or is suspected of having an educational disability.

Below is the contact information for the special education administrators at each level and 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 services or programs upon a student's enrollment in public school.

- Meghan Febbie
  Administrator for Out of District Special Education – All Grade Levels
  febbiem@mahopac.k12.ny.us
  (845) 621-0656 - ext. 13704

- Jeffrey Finton
  Administrator for Preschool and Elementary Special Education
  fintonj@mahopac.k12.ny.us
  (845) 621-0656 - ext. 13710

- Catherine Sweeney
  Administrator for Secondary Special Education-Middle School & High School
  sweeneyc@mahopac.k12.ny.us
  (845) 628-3256 - ext. 11640

A Parent's Guide to Special Education

English
http://www.p12.nysed.gov/specialed/publications/policy/parentsguide.pdf
Spanish
http://www.p12.nysed.gov/specialed/publications/policy/spanishparentguide.htm

Sincerely,

Greg Stowell

Greg Stowell, D.P.S.
Assistant Superintendent for
Pupil Personnel and Educational Services
(845) 628-3415 – ext. 10710

Revised 04/04/18

MAHOPAC CENTRAL SCHOOL DISTRICT
OFFICE OF CENTRAL REGISTRATION

Verification of Residency & Custody
Parent/Guardian Information Sheet

INTRODUCTION

As part of the process of registering a child in the Mahopac School District, you are being asked to provide information that will allow the district to verify that this child is legally entitled to an education in Mahopac. The education of each child in our schools is a responsibility we take seriously. Each one requires space, staff time and supplies that are expenses borne by the district. We hope that you will understand the obligation we have to our taxpayers to be sure that we are enrolling only those children who have a right to that education.

Parents/guardians are responsible for tuition payment if the parents' PRIMARY residence in not within the Mahopac Central School District. If you move from the Mahopac Central School District and do not withdraw your children in accordance with district policy, you will also be responsible for tuition.

NOTE: Education Law (Section 3202.1) states that the residence of the *parent* is the official residence of the *student*.

PRIMARY LEGAL RESIDENCE

You will be required to present proof that you do reside within the Mahopac School District, as follows:

Section A (*one item requested*):

- Proof of Ownership of a House or Condominium, such as a copy of Deed or Mortgage Statement
- Copy of Residential Lease/Rental Agreement
- A sworn or unsworn statement by a third-party landlord, owner or tenant from whom the parent leases or shares property within the District establishing physical presence *
- Other forms of documentation/information to establish physical presence such as current property tax bill, current homeowner's/renter's insurance policy (also see Section B)

Section B (*two items requested*):

- Paystub
- Income Tax Forms
- Utility or other bills
- Member documents based upon residency (e.g., library card)
- Voter Registration documents
- Official driver's license, learner's permit or non-driver ID
- State or other government issued identification
- Documents issued by Federal, State or Local agencies (e.g. Local Social Service Agency, Federal Office of Refugee Resettlement
- Evidence of custody of the child
- Other forms of documentation/information establishing physical presence in the District

***The *Landlord Affidavit and Residency Affidavit are* available on our website or upon request from the Office of Central Registration.**

CARE, CUSTODY AND CONTROL

Under New York State law, a child is entitled to attend school in the district which he/she resides. Usually this will be with the parent(s) of the child. At times, however, the child is living with someone other than the parent. The child is then considered to reside with the person who has Care, Custody and Control.

If you are registering your own child and that child lives with you, it is assumed that as a parent you have care, custody and control. If this is not the case, you will be asked for further information at registration.

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:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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:

New York State Center for School Health

X	NYS Required	X	NYC Required	X	NYS Optional	X	NYC Optional

NYS and NYC Screening Guideline Overview

	New Entrant	Pre K or K*	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Grade 6	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
HEARING SCREENING:														
Pure Tone	X	X	X		X		X		X				X	
SCOLIOSIS SCREENING														
Boys											X			
Girls							X		X					
VISION SCREENING														
Color Perception	X													
	X													
Fusion		X	X											
Near Vision	X	X	X		X		X		X				X	
	X	X	X		X		X							
Distance Acuity	X	X	X		X		X		X				X	
	X	X	X		X		X							
Hyperopia	X													

*Determine if your Kindergarten or Pre K students are your district's new entrants..

Health Examination Overview

	New Entrant	Pre K or K	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Grade 6	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
Health Examination**	X	X	X		X		X		X		X		X	
	X													
Dental Certificate	X	X	X		X		X		X		X		X	

**HealthExaminations may be either a Health Appraisal (health exam performed by the School Medical Director) or Health Certificate (health exam performed by the student's primary medicalprovider). They must be dated no more than 12 months prior to the state of the school year in which they are required, or the date of entrance to the school for new entrants.

This sample resource was created by the New York State Center for School Health and is located at www.schoolhealthny.com in the Laws|Guidelines|Memos - Effective July 2018

Mahopac Central School District

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: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental
Asthma ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached ☐ Intermittent ☐ Persistent ☐ Other : _____
Seizures ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached ☐ Type: _____ Date of last seizure: _____
Diabetes ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached ☐ Type 1 ☐ Type 2 ☐ HgbA1c 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
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			Date
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ System Review and Exam Entirely Normal

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

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ 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**

☐ Brace*/Orthotic ☐ Colostomy Appliance* ☐ Hearing Aids

☐ Insulin Pump/Insulin Sensor* ☐ Medical/Prosthetic Device* ☐ Pacemaker/Defibrillator*

☐ Protective Equipment ☐ Sport Safety Goggles ☐ 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: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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

2018-19 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

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). For grades pre-k through 10, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: intervals between doses of polio vaccine DO NOT need to be reviewed for grades 5, 11 and 12.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 11 and 12. 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 and 4	Grade 5	Grades 6, 7, 8, 9 and 10	Grades 11 and 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 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	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**3 doses**
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**	**1 dose**	**2 doses**	**1 dose**
Meningococcal conjugate vaccine (MenACWY)[8]		**Not applicable**		**Grades 7, 8 and 9: 1 dose**	**Grade 12: 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**		

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday.
   b. If the fourth dose of DTaP was administered at 4 years or older, the fifth (booster) dose of DTaP vaccine is not required.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older. A Tdap vaccine (or incorrectly administered DTaP vaccine) received at 7 years or older will meet the 6th grade Tdap requirement.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap. A dose received at 7 years or older will meet this requirement.
   b. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. Intervals between the doses of polio vaccine do not need to be reviewed for grades 5, 11 and 12 in the 2018-19 school year.
   e. If both OPV and IPV were administered as part of a series, the total number of doses and intervals between doses is the same as that recommended for the U.S. IPV schedule. If only OPV was administered, and all doses were given before age 4 years, 1 dose of IPV should be given at 4 years or older and at least 6 months after the last OPV dose.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten and grades 11 and 12. Two doses are required for grades kindergarten through 10.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks.
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine. (Minimum age: 6 weeks)
   a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7, 8 and 9.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. Unvaccinated children ages 7 through 11 months of age are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

Mahopac Central School District

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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 or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: Name

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-rays 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 listed below.

Parent's Signature _____ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ on_____ (date of assessment) The date of the assessment needs 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 the public schools.

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

NOTE: Not in fit condition of dental health means, 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/ Dental Hygienist's name and address (please print or stamp)

Dentist's/Dental Hygienist'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/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No Untreated Caries – Does this child have an open cavity? [At least ½ mm of tooth structure loss 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):_____

II. 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.

MAHOPAC CENTRAL SCHOOL DISTRICT
HEALTH OFFICE

HEALTH HISTORY FORM
TO BE COMPLETED BY PARENT

STUDENT _____ DOB _____ GRADE _____

DISEASES: (*Give Dates*)

History	Date	Date	Date
Chicken Pox	Epilepsy	Asthma	
Whooping Cough	Heart Disease	Bronchitis	
Tuberculosis	Kidney Disease	Pneumonia	
Tbc. Contact	Lyme Disease	Freq. Ear Conditions	
Anemia	Rheumatic Fever	Strep Throat	
Diabetes	Fifth's Disease	Scarlet Fever	

Allergies: Foods: _____ Medications: _____
Insects: _____ Environmental (grass, dust, etc.): _____

OTHER PERTINENT HEALTH DATA

Vision Difficulties _____ Glasses: Yes _____ No _____
Any family history of Color Perception Abnormalities Yes _____ No _____
Hearing Difficulties _____ Hearing Aid: Yes _____ No _____
Physical Handicaps _____
High Fevers _____ With Convulsions: Yes _____ No _____
Operations: Tonsils _____ Appendectomy _____ Hernia _____
Tubes in Ears _____ Other _____
Fractures _____ Sutures or Serious Injuries _____
Hospitalization: Reason _____
_____ Date: _____
Medications: Taken at home Yes _____ No _____ How Often? _____
Taken at school Yes _____ No _____ How Often? _____
Name of medication _____
Name of physician _____
Address & Phone Number _____
Menstruation: Age began: _____
Regular: Yes _____ No _____ Painful: Yes _____ No _____

Is child capable of carrying a full program of school work? Yes ____ No ____
Is child able to participate in all physical education activities? Yes ____ No ____
If no, give reason _____
Does child have irremedial defects? Yes ____ No ____
Is there any need to alter child's school program? Yes ____ No ____
If yes, give reason _____

Note: As a procedure the school will ask parents to keep their child home from school if they show any sign of significant infection. If your child has had a fever (100F or above) he/she should not return to school until his/her temperature has been normal for at least 24 hours.

Please have any body rash or eye inflammation checked by your doctor to determine whether or not it is contagious.

If a child requires any medication during school hours, the medication should be brought to the school nurse in the original prescription bottle with a permission form completed by the parent and doctor. Students are not to carry any medication (including Tylenol) with them.

I give permission for health information to be shared with school personnel.

Date _____ Parent Signature _____

Developmental History Form
(GRADES PS & K-5 ONLY)

Dear Parents:

We request that this be completed to offer the staff more insight to your child's development. This will remain part of your child's health folder.

Child's Name_____ Birthdate_____

1. Developmental history:

   Pregnancy: Full Term _____ If no, how many weeks? _____
   Delivery: Normal _____ If no, what difficulties? _____
   Birth Weight: Pounds_____ Ounces_____
   Age of child when: Walking _____ Talking _____
   Age of child when: Toilet training: day _____ night _____

2. Did your child attend nursery/preschool? ☐ Yes ☐ No

   If yes, which one? _____

   How long? _____
   (years) (half days) (full days)

3. Has your child had any previous physical, developmental or educational difficulties or delays?
   ☐ Yes ☐ No Please specify _____

4. Has your child received any special services through the district, such as:

   ☐ Speech ☐ Occupational Therapy ☐ Physical Therapy

   ☐ Special Education ☐ Resource Room

   Does your child have any problems with their speech at this time?
   ☐ Yes ☐ No Please specify _____

5. What is the main language spoken in the home? _____

   Second language spoken in the home? _____

_____ _____
Parent Signature *Date*

MAHOPAC CENTRAL SCHOOOL DISTRICT

Request for Pre School Evaluation

Date: _____

Child's Name: _____

Child's DOB: _____

Address: _____

Parent Phone Number: _____

To The Committee on Pre School Special Education:

I am the Parent/Guardian of: _____

I would like to have my child evaluated for:

_____

Please provide a brief description of your concerns:

_____

_____

_____

_____

Thank you for your time and consideration of my request.

_____ _____

Parent/Guardian Name Parent/Guardian Signature

Mahopac Falls School PPS – CPSE
Committee on Preschool Special Education
100 Myrtle Avenue – Room 11
Mahopac, NY 10541
(845) 621-0656 x 13641

Request for Time Enrolled in a Regular Early Childhood Program Form

STUDENT NAME: _____

STUDENT DATE OF BIRTH: _____

Please enter the following information regarding Preschool/daycare

- o My child *does not* attend a Regular Early Childhood Program

OR

- o My child *does attend* a Regular Early Childhood Program as indicated below

Name of the Program(s): _____

Contact Person/Tel #: _____

My child typically attends the program(s) for the amount of time for each day indicated

Monday	Tuesday	Wednesday	Thursday	Friday	Total mins for the week

PARENT/GUARDIAN SIGNATURE _____ **DATE**

_____

MAHOPAC CENTRAL SCHOOL DISTRICT

Dear Parents,

As you are well aware, current New York State regulations require that the District send you many documents pertaining to your child's receipt of special education services on a regular basis. These communications take the form of prior written notices and other required notifications, meetings notices, the procedural safeguards notice, copies of IEPs, notices requesting permission to conduct evaluations, etc. While we remain willing to provide you with these documents in paper format, current technology allows us to communicate with you electronically, thereby reducing the many thousands of pieces of paper (and saving trees) while continuing to maintain the level of communication required by regulations. Therefore, we would like to send you these documents by electronic mail communications (email). If you agree with our efforts to be more environmentally responsible and reduce the amount of paper that is inherent in our business, please give us your permission in the appropriate space below. If you would prefer instead to continue to receive documents in paper format, please indicate that in the other space provided below.

Thank you for your cooperation!

Please send this completed form back to us. If you wish, and have the capability, you may scan this document to the following offices electronically:

For HS students: digregoriok@mahopac.k12.ny.us 421 Baldwin Place Road, Mahopac, NY 10541

For MS students: papanicolaoul@mahopac.k12.ny.us 425 Baldwin Place Road, Mahopac, NY 10541

For ES students: torresm@mahopac.k12.ny.us 100 Myrtle Avenue, Mahopac, NY 10541
argentom@mahopac.k12.ny.us

For Pre-School students: starkt@mahopac.k12.ny.us 100 Myrtle Ave., Mahopac, NY 10541

I DO ELECT to receive documents by electronic mail (email) communication from the Mahopac Central School District pertaining to my child's receipt of special education services.

My Child's Name: _____ My Child's School: _____

Parent Signature: _____ Date: _____

Parent Email Address' on file will be used for all correspondence.

I DO NOT wish to receive documents by electronic mail (email) communication from the Mahopac Central School District pertaining to my child's receipt of special education services. I prefer instead to continue to receive such documents from the District in paper format.

My Child's Name: _____ My Child's School: _____

Parent Signature _____ Date: _____

ALLEN BEALS, M.D., J.D.
Commissioner of Health

ROBERT MORRIS, P.E.
Director of Environmental Health

MARYELLEN ODELL
County Executive

DEPARTMENT OF HEALTH

Early Intervention and Preschool Programs
110 Old Route 6, Building #3, Carmel, NY 10512
Office (845) 808-1640 Fax (845) 808-4092

Written Notification Regarding Use of Public Benefits or Insurance to Pay for Certain Special Education and Related Services

You are receiving this written notification about your rights and protections under the federal Individuals with Disabilities Act (IDEA), so that you can make an informed decision about whether you should give your written consent to allow your school district/municipality to use your or your child's public benefits or insurance to pay for special education and related services that your school district/municipality is required to provide at no cost to you and your child under IDEA.

Funds from a public benefits or insurance program (for example, Medicaid funds) may be used by your school district/municipality to help pay for special education and related services, but only if you choose to provide your consent, as explained below.

Before your school district/municipality can ask you to provide your consent to access your or your child's public benefits or insurance for the first time, it must provide you with this notification of the rights and protections, including the type of consent your school district/municipality will ask you to provide. If you choose not to provide consent, or later decide to withdraw your consent, your school district/municipality has a continuing responsibility to ensure that your child is provided all required special education and related services under IDEA at no charge to you or your child.

PARENTAL CONSENT

34 CFR 300.154(d)(2)(iv)(A)-(B) and 8 NYCRR 200.5(b)(8)(i)

Beginning on July 3, 2013, before your school district/municipality can use your child's public benefits or insurance for the first time to pay for special education and related services under IDEA, it must obtain your signed and written consent. Your school district/municipality is only required to obtain your consent one time.

This consent requirement has two parts.

1. Consent to share records about your child: Your school district/municipality is required to obtain your written consent before disclosing (sharing) personally identifiable information about your child (such as your child's name, address, social security number, individualized education program (IEP), and evaluation results) from your child's education records. In asking for your consent, the district/municipality will (1) identify the records (or information) about your child that will need to be shared (for example, about the services that may be provided to your child); (2) tell you the purpose of sharing the records (for example, billing for special education and related services); and (3) identify the agency to which your school district/municipality may disclose the information (for example, the Medicaid agency).
2. Consent to bill your public insurance program (for example, Medicaid): Your consent must include a statement specifying that your understand and agree that your school district/municipality may use your child's public benefits or insurance (e.g., Medicaid) to pay for some of your child's special education services.

If your school district/municipality has on file your consent that your provided before July 3, 2013 to release your child's records and to use your or your child's public benefits or insurance to pay for special education and related services, your school district/municipality is required to request a new consent from

you only when there is a change in any of the following: the type of service to be provided to your child (for example, physical therapy, or speech therapy), the amount of services to be provided to your child (for example, hours per week lasting for the school year), or the cost of services (that is, the amount charged to the public benefits or insurance program).

If any of the changes occur, your school district/municipality must obtain from you a new one-time consent. Before you provide your school district/municipality the new, one-time consent, your school district/municipality must provide you with this notification. Once you provide this one-time consent, you will not be required to provide your school district/municipality with any additional consent in order for them to access your or your child's public benefits or insurance even if your child's services change in the future. However, your school district/municipality must continue to provide you with this notification annually.

You have the right to withdraw your consent at any time. If you withdraw your consent, the school district must still provide all of our child's IEP special education and related services at no cost to you. To withdraw your consent, you will need to submit your request in writing to your child's school district/municipality.

NO COST PROVISIONS

34 CFR 300.154(d)(2)(i)-(iii) and 8 NYCRR 200.5(b)(8)(ii)(b)-(d)

The IDEA (no cost) protections regarding the use of public benefits or insurance are as follows:

1. Your school district/municipality may not require you to sign up for, or enroll, in a public benefits or insurance program in order for your child to receive a free appropriate public education.
2. Your school district/municipality may not require you to pay any out-of-pocket expenses, such as the payment of a deductible or co-pay amount for filing a claim for services that your school district/municipality is otherwise to provide your child without charge.
3. Your school district/municipality may not use your or your child's public benefits or insurance if using those benefits or insurance would:
    a. decrease your available lifetime coverage or any other insured benefit, such as a decrease in your plan's allowable number of physical therapy sessions available to your child or a decrease in your plan's allowable number of session for mental health services;
    b. cause you to pay for services that would otherwise be covered by your public benefits or insurance program because your child requires those services outside of the time your child is in school;
    c. increase your premium or lead to the cancelation of your public benefits or insurance; or
    d. cause you to risk the loss of your child's eligibility for home and community-based waivers that are based on your total health-related expenditures.

We hope this information is helpful to you in making an informed decision regarding whether to allow your school district/municipality to use your child's public benefits or insurance to pay for special education and related services under IDEA.

Contact information: For additional information and guidance on the requirements governing the use of public benefits or insurance to pay for special education and related services see:
http://www.2.ed.gov/policy/speced/reg/idea/part-b/part-b-parental-consent.html

For the full Suggested Model Written Notification of Parental Rights regarding Use of Public Benefits or Insurance developed by the U.S. Department of Education, see:
http://www.2.ed.gov/policy/speced/guid/idea/memosdcltrs/accmodelwrittennotification-6-11-13.pdf