

**STUDENT REGISTRATION PACKET
FOR STUDENTS BEING ENROLLED IN GRADES K THROUGH 12**

Listed below and enclosed are the registration documents required for registration:

Welcome Letter from our Superintendent of Schools

Registration Forms

- Student Registration Form with Emergency Contact Information
- Registration Contact List
- Verification of Residency & Custody Information
- Request for Records
- 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 (Grades K-5 Only)
- Use of Pesticides Notification

In addition to the completed registration packet, you are also required to provide the following documentation in order to complete the registration process:

Additional Documentation:

- Proof of Age - Original Birth Certificate or, if not available, Record of Baptism (domestic or foreign), Passport (domestic or foreign) or any of the following documents if in existence for at least two years:
 - Official Driver's License
 - State or other Government-Issued identification
 - School photo identification with date of birth
 - Consulate identification card
 - Hospital or health records
 - Military dependent identification card
 - Documents issued by Federal, State or Local Agencies (i.e., local Social Service Agency or Federal Office of Refugee Resettlement)
 - Court Orders or Other court-issued documents
 - Native American Tribal document; or
 - Records from non-profit international aid agencies and voluntary agencies
- Recent Photo of Student
- Record of Immunizations
- Current Physical – no later than 12 months old

MAHOPAC CENTRAL SCHOOL DISTRICT

- Previous School Records if available – most recent Report Card, IEP, etc.
- 3 Proofs of Residency – see “Verification of Residency & Custody Information” Form
- Custody – If child is not living with both parents, legal custody documentation must be provided if available, or custody affidavits must be completed. *A Care, Custody and Control Affidavit is available upon request.*

When your paperwork is in order please contact us to schedule an appointment. The Office of Central Registration is located at The Falls District Office, 100 Myrtle Avenue, Mahopac, NY.

Primary Contact

Elfriede Schober, Registrar

Phone: 845-621-0656 x13902

E-mail: schobere@mahopac.k12.ny.us

Alternate Contact

Marie Micol, Registrar

Phone: 845-621-0656 x 13905

E-mail: micolm@mahopac.k12.ny.us



MAHOPAC CENTRAL SCHOOL DISTRICT

Anthony DiCarlo
Superintendent of Schools

Dear Parents/Guardians:

Welcome to the Mahopac Central School District (K-12).

At our school, we strive to meet the needs of all students by promoting opportunities for their academic, social and physical growth. We also believe that it is important for students to have a safe, positive and healthy environment.

The administration, faculty and I look forward to a long and productive relationship with your family and pledge our best efforts to serve you. I encourage you to work with our staff as a team to help give your child the best education.

The Mahopac Schools have a long-standing history of providing high quality education for all our students. All staff is committed to educating the whole child.

Again, I extend to you a warm welcome to the Mahopac Schools, a community of learning and friendship.

Sincerely,

Anthony DiCarlo
Superintendent of Schools



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 ISSUES¹: 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.*

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

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 is 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 required):

- 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 *
- Current property tax bill
- Current homeowner's or renter's insurance policy

Section B (two items required):

- 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-drive 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)
- 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.

REQUEST FOR RECORDS
Consent by Parent

Office of the Registrar and Office of Special Education

Former School Name & Address

Telephone No.

I hereby give consent for release of student information concerning my child:

Name of Student: _____ **Date of Birth:** _____
Name of Parent: _____ **Relationship:** _____

Signature of Parent: _____ **Date:** _____

CHECK INFORMATION BEING ENCLOSED:

General Student Information

Special Education Department (if applicable)

- ___ Cumulative Student Record
- ___ Achievement Data
- ___ Report of Grades
- ___ Standardized Test Scores
- ___ All Health Related Records
- ___ Other

- ___ Psychological/Psychiatric Reports
- ___ Speech/Language Reports
- ___ Special Ed & 504 Records
- ___ Social History
- ___ Other
- ___ Please transfer IEP on IEP Direct to Mahopac Central School District

THIS COMPLETED FORM, PLUS ATTACHMENTS, SHOULD BE SENT TO THE ATTENTION OF THE REGISTRAR/HOUSE SECRETARY AT THE SCHOOL INDICATED BELOW:

- ___ Mahopac High School, 421 Baldwin Place Road, Mahopac, NY 10541 Tel: 845-628-3256
- ___ Mahopac Middle School, 425 Baldwin Place Road, Mahopac, NY 10541 Tel: 845-621-1330
- ___ Austin Road School, 390 Austin Road, Mahopac, NY 10541 Tel: 845-628-1346
- ___ Fulmar Road School, 55 Fulmar Road, Mahopac, NY 10541 Tel: 845-628-0440
- ___ Lakeview Elementary, 112 Lakeview Drive, Mahopac, NY 10541 Tel: 845-628-3331

INFORMATION REGARDING SPECIAL EDUCATION ONLY SHOULD BE SENT TO THE ATTENTION OF PUPIL SERVICES AT THE SCHOOL INDICATED BELOW:

- Grades 10th, 11th & 12th**
___ Mahopac High School, 421 Baldwin Place Road, Mahopac, NY 10541 Tel: 845-628-3256, ext. 11640
- Grades 6th, 7th, 8th & 9th**
___ Mahopac Middle School, 425 Baldwin Place Road, Mahopac, NY 10541 Tel: 845-621-1330, ext. 12650
- Grades K through 5th**
___ Mahopac Falls School, 100 Myrtle Avenue, Mahopac, NY 10541 Tel: 845-621-0656, ext. 13704

MCSD Building Registrar: Check appropriate building above and provide your name and extension below.



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

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* <input type="checkbox"/>	No <input type="checkbox"/> Not sure <input type="checkbox"/>
*If yes, please explain: _____	
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe	
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below	
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past?	
<input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____	
Age at which services received (Please check all that apply):	
<input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)	
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <small>MO DAY YR.</small>	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <small>Mo. DAY YR.</small>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:	

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: <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 checked="" 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"/> 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	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 $\mu\text{g/dL}$				<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:	<table style="width: 100%;"> <tr> <td style="width: 70%;">Diagnoses/Problems (list)</td> <td style="width: 30%;">ICD-10 Code</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	Diagnoses/Problems (list)	ICD-10 Code	_____	_____	_____	_____	_____	_____
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	Positive	Referral	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics. <input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> No Contact Sports <input type="checkbox"/> No Non-Contact Sports <input type="checkbox"/> Other Restrictions: </div> <div style="width: 65%;"> <p>Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling</p> <p>Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field</p> </div> </div>				
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> Accommodations: Use additional space below to explain <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> Brace*/Orthotic</div> <div style="width: 33%;"><input type="checkbox"/> Colostomy Appliance*</div> <div style="width: 33%;"><input type="checkbox"/> Hearing Aids</div> <div style="width: 33%;"><input type="checkbox"/> Insulin Pump/Insulin Sensor*</div> <div style="width: 33%;"><input type="checkbox"/> Medical/Prosthetic Device*</div> <div style="width: 33%;"><input type="checkbox"/> Pacemaker/Defibrillator*</div> <div style="width: 33%;"><input type="checkbox"/> Protective Equipment</div> <div style="width: 33%;"><input type="checkbox"/> Sport Safety Goggles</div> <div style="width: 33%;"><input type="checkbox"/> Other:</div> </div> <p>*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.</p>				
Explain: _____				
MEDICATIONS				
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached				
List medications taken at home:				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIIS		Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> 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.				

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: / / Sex: Male Female Will this be your child's first oral health assessment? Yes No
Month Day Year

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 Dentist's/Dental Hygienist's Signature
(please print or stamp)

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 1/2 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.



NYS Required

NYC Required

NYS Optional

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 medical provider). 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.

2018-19 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). 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)²		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 vaccine⁶	3 doses		3 doses or 2 doses of adult hepatitis B vaccine (Recombvax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine⁷	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		

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

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

OTHER PERTINENT HEALTH DATA

Vision Difficulties _____
Any family history of Color Perception Abnormalities _____
Glasses: 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 School District
Lakeview Elementary School
112 Lakeview Drive
Mahopac, NY 10541-2316
Phone (845) 628-3331 x16910 Fax (845) 621-5470
email:prineg@mahopac.k12.ny.us**

George Prine
Director of Facilities III

Dear Parent, Guardian and School Staff:

Attached you will find details explaining the new pesticide notification law. This cover letter is to inform you that the Mahopac Central School District currently and will continue to use what is called an Integrated Pest Management System, whereby alternate methods are used to control any potential problems in our District (i.e. ants, bugs, bees etc.).

Please be assured the Mahopac Central School District has NO intention whatsoever of using any potentially harmful pesticide of any kind in our school buildings.

Feel free to call me with any questions you should have.

Sincerely,

George Prine

MAHOPAC CENTRAL SCHOOL DISTRICT

Initial notification to persons in parental relation and staff pursuant to Section 409-H of the State Education Law.

Dear Parent, Guardian, and School Staff:

New York State Education Law Section 409-H, effective July 1, 2001, requires all public and nonpublic elementary and secondary schools to provide written notification to all persons in parental relation, faculty and staff regarding the potential use of pesticides periodically throughout the school year.

The Mahopac Central School District is required to maintain a list of persons in parental relation, faculty, and staff who wish to receive 48-hour prior written notification of certain pesticide applications. The following pesticide applications are not subject to prior notification requirements:

- A school remains unoccupied for a continuous 72-hours following an application.
- Anti-microbial products.
- Nonvolatile rodenticides in tamper resistant bait stations in areas inaccessible to children.
- Silica gels and other nonvolatile ready-to-use pastes, foams, or gels in areas inaccessible to children.
- Boric acid and disodium octaborate tetrahydrate.
- The application of EPA designated biopesticides.
- The application of EPA designated exempt materials under 40CFR152.25.
- The use of aerosol products with a directed spray in containers of 18 fluid ounces or less when used to protect individuals from an imminent threat from stinging and biting insects including venomous spiders, bees, wasps, and hornets.

In the event of an emergency application necessary to protect against an imminent threat to human health, a good faith effort will be made to supply written notification to those on the 48-hour prior notification list.

If you would like to receive 48-hour prior notification of pesticide applications that are scheduled to occur in your school, please complete the form below and return to the Mahopac Central School District. For further information on these requirements the school pesticide representative is Mr. George Prine, Director of Facilities III, 112 Lakeview Drive, Mahopac, NY 10541 (845) 628-3331 Ex.16902, fax (845) 621-5470, or email at prineg@mahopac.k12.ny.us.

PLEASE PRINT

Date: _____

School building affiliated with: _____

Name of student: _____

Address: _____

Day Phone: _____ Evening Phone: _____

E-Mail: _____