DANIEL WEBSTER ELEMENTARY SCHOOL
95 GLENMORE DRIVE
NEW ROCHELLE, NEW YORK 10801-3199

BRIAN G. OSBORNE, ED.D.
SUPERINTENDENT OF SCHOOLS

MAGDA PARVEY, ED.D.
ASSISTANT SUPERINTENDENT

TEL: 914/576-4460
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MELISSA A. PASSARELLI
PRINCIPAL

GREGORY A. MIDDLETON
ASSISTANT PRINCIPAL

February 2018

Dear Families of Incoming Webster Kindergarten Students:

Kindergarten registration at Webster School will be completed in two phases. Initial registration will take place from Tuesday, February 27th to Friday, March 2nd. Please call Webster School at 576-4462 to make an appointment for initial registration. You can also email Mrs. Fennell at jfennell@nredlearn.org to request an appointment. Include your name and phone number in the email.

Children should not attend the initial registration. During the initial registration, staff will collect forms and check residency. You will also meet with the nurse, Mrs. Robin Kaphan and with the social worker, Mrs. Rachel Long. This process will take approximately thirty minutes. Please complete all the registration forms BEFORE arriving for your initial registration appointment. Registration forms can be downloaded off our school website at http://webster.nred.org. If you do not have access to a printer, please pick up a registration packet at Webster School. Once again, all registration forms must be completed prior to your initial registration appointment.

During initial registration, you will need to present the following in order to establish residency and eligibility:

- Your child's original birth certificate (or a certified copy) or passport
- Your child's immunization records (vaccinations/shots)
- Three different proofs of residence (examples: utility bill, deed, mortgage statement, tax bill, lease agreement) If you are using a utility bill as one proof of residency and it is an online bill, please bring a COPY of the bill.
- Photo I.D. of parent/guardian

At the initial registration, an appointment will be made for your child to meet with the kindergarten teachers for a screening. If you have applied for Webster School through the Magnet Lottery, you have to register your child in your home zoned school. Children will be accepted from the Magnet Lottery list after all Webster home zoned kindergarten students have been registered and screened.

I look forward to meeting the incoming kindergarten students, and to these children becoming a part of the Daniel Webster School family!

Sincerely,
Melissa A. Passarelli

OFFICIAL USE ONLY: ID#:_____ Census #: _____ Verified by:_____

B.C. ____ Meds/Imm. ____ Lang. Sur. ____ Trans. Form ____ M/F Magnet: Y/N District-wide Special Education: Y/N

CITY SCHOOL DISTRICT OF NEW ROCHELLE

DANIEL WEBSTER MAGNET SCHOOL

Registration Information: *Only students whose parents or legal guardians reside in New Rochelle may be registered in our district schools.* Students attend the school according to their area of residence, except in the case of Magnet students. Proofs of residence must be provided in accordance with district policy. If the person registering is not listed as the parent of the child, he/she must provide a copy of the following at time of registration: Court Order naming "Parent by Adoption" or "Legal Guardian" or "Order of Custody."

PLEASE PRINT **TODAY'S DATE:**_____

STUDENT'S NAME: _____ **DATE OF BIRTH:** ___/___/_____ MALE/FEMALE

FIRST MD. INITIAL LAST CIRCLE ONE

City and Country of Birth: _____ Cultural Ethnicity (optional) _____

If Foreign Born: Date of entry into U.S. _____ Student's First Language: _____

Did Child attend school outside U.S. _____ If yes, which Grade(s):

Student's Current Grade: _____ Last Grade Attended: _____ When? _____

Name/Address of Last School: _____

Name/Telephone Number of Contact: _____

Has child attended school in New Rochelle? Yes/No _____ When? _____ Where? _____

HOME ADDRESS: _____

STREET ADDRESS APT. # ZIP CODE

HOME TELEPHONE NUMBER: _____

FATHER'S NAME: _____ Birthplace: _____

Home Address, if different: _____

Home number, if different: _____ CELL # _____ WORK # _____

Email address: _____ Occupation: _____ Employer: _____

Marital Status (please check): ____Married / _____ Separated/ _____Divorced/ _____Widowed/ _____ Single

MOTHER'S NAME: _____ Birthplace: _____

Home Address, if different: _____

Home number, if different: _____ CELL # _____ WORK # _____

Email address: _____ Occupation: _____ Employer: _____

Marital Status (please check): ____Married / _____ Separated/ _____Divorced/ _____Widowed/ _____ Single

GUARDIAN/CUSTODIAN NAME (other than parent): _____

Relationship to student: _____

Home number, if different: _____ CELL # _____ WORK # _____

Email address: _____ Occupation: _____ Employer: _____

EMERGENCY CONTACT (other than Parent/Guardian): _____

Relationship to student: _____

Home # _____ CELL # _____ WORK # _____

List below the FULL NAMES of all other children in the family

NAME	AGE	DATE OF BIRTH	SCHOOL CHILD ATTENDS	GRADE

PLEASE COMPLETE THE BACK OF THE FORM

Has your child ever received the following services in any school?

SUPPORT SERVICES	CHECK ALL THAT APPLY	GRADE(S) IN WHICH SERVICES WERE REC'D.
English as Second Language		
Bilingual Class		
Reading Help/Lab		
Resource Room		
Speech/Language		
PT/OT		
Special Education		
Counseling/Social Skills Group		
Repeated Grade (Retained)		
Recommended to Repeat Grade (Be Retained)		
Other (please explain)		

Does your child have an I.E.P. from Special Education? _____

(Please answer Yes or No)

Optional: Please check the appropriate box:

Father		Mother
	American Indian	
	Asian/Pacific Island	
	Hispanic	
	Black	
	White	

Print Name of Parent or Guardian Completing the Form: _____

Signature of Parent or Guardian Completing the Form: _____

Today's Date: _____

DANIEL WEBSTER SCHOOL
STUDENT EMERGENCY CARD 2018-2019 SCHOOL YEAR

It is mandated by state law that we have the following information on file. This information will allow us to contact you or your designee in the event of an accident or illness to your child.

☐ Magnet ☐ Neighborhood

Student Name:_____ **Teacher:**_____

Address:_____

Home Phone:_____ **Date of Birth:**_____

Mother/Guardian Full Name:_____ **Home Phone:**_____
Business Phone: _____
e-mail Address:_____ **Cell Phone:** _____

Home Address: _____

Father/Guardian Full Name: _____ **Home Phone:** _____
Business Phone: _____
e-mail Address: _____ **Cell Phone:** _____
Home Address: _____
HAVE PHONE NUMBERS CHANGED SINCE LAST YEAR? _____**(please check)**

IF THE ABOVE ADDRESS HAS CHANGED SINCE INITIAL REGISTRATION CHECK BOX ☐

Family Physician: _____ **Phone:** _____

Allergies: _____

If I cannot be contacted, I authorize the following people to pick up my child in an emergency situation:

Person:_____ **Relationship** _____ **Home #** _____
Address: _____ **Cell #**_____
Person:_____ **Relationship** _____ **Home #** _____
Adress: _____ **Cell #** _____
Person:_____ **Relationship** _____ **Home #** _____
Address:_____ **Cell #** _____

ARE ANY ORDERS OF PROTECTION, CUSTODY VISITATION RIGHTS, OR RESTRAINING ORDERS IN EXISTENCE? IF SO, THE MAIN OFFICE MUST HAVE A COPY OF COURT PAPERS.

ILLNESS OR INJURY

If the student becomes ill in school or is injured, the nurse will make every effort to contact you. If she cannot reach you by phone, she will contact your family physician or send the child to the hospital unless you give other instructions. The school in no way assumes financial responsibility.

Signature of parent/guardian completing this card: _____
Print Name _____ **Date:** _____

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GREGORY A. MIDDLETON
ASSISTANT PRINCIPAL

Request for Records

School Name _____
School Address _____
City,State,Zip Code _____
Phone Number _____
Fax Number _____
Student Name _____

The above pupil has entered our school as of _____from your school System.

Would you please forward to us all the records concerning this child along with any of the following:

- Transfer Card
- Scholastic Records
- Standardized Test Results including NYSESLAT
- Health Records
- Speech
- Remedial Reading
- Psychological Services
- Social Work

Authorization for Release of Information

I hereby grant permission for release of all school records including academic , psychological and health records pertaining to _____

Parent/Guardian
Signature_____**Date**_____

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GREGORY A. MIDDLETON
ASSISTANT PRINCIPAL

Release of Records Form

Student's Name _____

New School Attending _____

New School Address _____

City/State & Zip Code _____

New School Phone Number _____

New School Fax Number _____

I hereby grant persmission for release of all school records including academic, psychological and health records pertaining to:

_____

Parents/Guardian Signature _____Date_____
New Home Address _____
New Home Telephone #: _____
Last Day of Attendance at Webster School _____

DENTAL HEALTH

To: All Parents
From: Your School Nurse

People can keep their teeth throughout life if they do their part and allow the dentist to do his or her part. Most dental disease is preventable. Starting at age 3 regular visits to the dentist are essential. During a dental visit the dentist will:

1. Examine teeth and gums.
2. Clean teeth.
3. Check teeth for cavities and fill them while they are small.
4. Prevent major dental problems.
5. Provide dental health instructions.

What can parents do?

1. Provide a well-balanced diet for the family.
2. Help children limit eating sugar-containing foods. Offer healthy snacks.
3. Encourage children to brush promptly and properly after eating, using fluoride toothpaste.
4. Take children to the dentist yearly, more often if there are problems.
5. Set a good example by following good dental health practices.

If your child has not had a dental exam within the past year, please call today and schedule an appointment. Ask your dentist to fill out the bottom portion of this form and return it to the school nurse so she can keep an accurate record on your child's health status.

School: _____ Teacher: _____ Grade: _____

Child's Name: _____

The above child has had a dental examination and the necessary work is:

Completed _____ In Process _____

Did you recommend orthodontia? Yes ____ No ____

_____

Dentist's Signature Date

DANIEL WEBSTER MAGNET SCHOOL
SCREENING INFORMATION

Child's Name _____
Person Filling Out Form _____
Relationship to Child _____
Address _____

PRENATAL HISTORY

Were there any difficulties during pregnancy?

_____

Was medication used during pregnancy?

_____

Was your child born prematurely?
If so, at how many weeks was your child born?

_____

BIRTH HISTORY

Medication

_____

Delivery

_____

C-Section

_____

INFANCY – Please comment on your child's habits/behaviors in the following categories.

Feeding/Eating

_____

_____

Activity Level

_____

_____

Sleep

_____

_____

LANGUAGE DEVELOPMENT

Child's First Language _____
Primary Language Spoken in the Home _____
Other Language(s) Spoken in the Home _____
Dominant Language of Child _____
Other Language(s) Spoken by Child _____

DEVELOPMENTAL MILESTONES

	Average	Delayed	Not Achieved
Rolled Over			
Sat Alone			
Crawled			
Walked			
Toilet Trained			
Fed Self			
Buttoned Clothes			
Dressed Self			
Tied Shoes			
Washed Self			

SOCIAL DEVELOPMENT

Please describe your child's development as it relates to the topics below.

Interactive Play

_____

Peer Relations

_____

Activity Level

_____

Shyness

_____

Tantrums

_____

How would you describe your child as an infant?
What are some of the things your child enjoyed doing?

How would you describe your child now?
What does your child enjoy doing most?

CHILD'S HEALTH HISTORY

Please indicate anything you feel is pertinent regarding your child's health and wellness.

SIBLINGS

Name	DOB	Learning Difficulties Please explain if this applies.	Speech/Lang. Difficulties Please explain if this applies.	IEP Please check if this applies.

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:

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

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Cuestionario de Idioma del Hogar ("HLQ" por sus siglas en inglés)

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

Por favor escriba con claridad al completar esta sección

NOMBRE DEL ESTUDIANTE:

Nombre *Segundo nombre* *Apellido*

FECHA DE NACIMIENTO:

Mes *Día* *Año*

GÉNERO:
❑ Masculino
❑ Femenino

INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL

Apellido *Primer Nombre* *Relación con el estudiante*

CÓDIGO DEL IDIOMA DEL HOGAR

Conocimientos de idiomas

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

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

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

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

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

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

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

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

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

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

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

_____

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

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

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

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

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

_____ Mes: Día: Año: _____

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

Relación con el estudiante: ❑ Madre ❑ Padre ❑ Otra:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

HEALTH SERVICES

CITY SCHOOL DISTRICT OF NEW ROCHELLE
Brooke Balchan, DO. FAAP

Pediatric and Adolescent School Health History

Date form completed: _____ [ ]Parent Completed□ [ ]In Person Interview [ ]Telephone Interview

School: _____ Grade: _____

General Information:
Child's Name: _____ Sex: [ ]M [ ]F DOB: ___/___/___ Age_____

Address: _____
STREET CITY STATE ZIP CODE

Home Phone: _____(M)Cell Phone: _____(M)Wk Phone: _____ (M) email: _____

(F)Cell Phone: _____(F)Wk Phone: _____ (F) email: _____

Mother's Name: _____ Age: _____

Father's Name: _____ Age: _____

Brothers and Sisters Names:

1. _____ Sex: [ ]M [ ]F Date of Birth: ___/___/___
2. _____ Sex: [ ]M [ ]F Date of Birth: ___/___/___
3. _____ Sex: [ ]M [ ]F Date of Birth: ___/___/___
4. _____ Sex: [ ]M [ ]F Date of Birth: ___/___/___

Are parents: [ ]Married [ ]Divorced [ ]Separated [ ]Remarried [ ]Single
Who cares for the child after school: _____

Birth History:
Birth weight: ___ lbs. ___ oz. Weeks gestation: ____ Hospital born at: _____

Pregnancy: [ ] Normal [ ] Complications:
_____

Type of delivery: [ ] NSVD□□ [ ]C-Section [ ]Breech [ ]Forceps [ ]Other
Reason: _____

Problems during pregnancy: _____

Problems during delivery: _____

Problems after delivery: _____

(If NICU, describe course on separate paper)

Infancy/Toddlerhood/Early Childhood Developmental History:
At what age did this child?

Roll over	____ months	Talk (two words together)	____
Sit up without support	____ months	Bladder trained	____
Crawl	____ months	Bowel trained	____
Walk alone	____		

Feeding difficulties: [ ]Yes [ ]No
Sleeping problems [ ]Yes [ ]No

If yes to either, please describe:
_____

_____

Describe your child during infancy and toddlerhood: _____

How did your child adjust to Pre-K or childcare, i.e., separation issues: _____

_____

Check if your child had services from [ ] Early Intervention [ ] CPSE

Past Medical History:
Allergies to food or medicines? [ ]Yes [ ] No Name of allergens: _____

If yes, please describe: _____

_____

(If yes, complete allergy history for registration)
Immunizations up to date? If not, please elaborate: _____

_____

Medications (including name, dosage and frequency) taken:
1. _____

2. _____

3. _____

Hospitalizations, accidents or broken bones (note any ICU admissions)

Date	Child's Age	Name of hospital	Reason for hospitalization
____	_____	_____ _____	_____
____	_____	_____ _____	_____

Major or serious illnesses

Date	Child's Age	Illness	Physician	Treatment
____	____	_____ _____	_____	_____
____	____	_____ _____	_____	_____

Surgical procedures:

Date	Child's Age	Physician	Procedure
____	____	_____	_____
____	____	_____	_____

Review of Systems:
Indicate which of the following conditions or problems the child has had. Give details and dates for the problems checked:

[ ] Skin trouble	[ ] Asthma	[ ] Bedwetting
[ ] Eye or vision problems	[ ] Any other lung problems	[ ] Joint aches or pains
[ ] Eyeglasses	[ ] Heart murmur	[ ] Orthopedic or bony problems
[ ] Frequent ear infections	[ ] Any other heart problems	[ ] Seizures
[ ] Difficulty hearing	[ ] Jaundice	[ ] Frequent headaches
[ ] Frequent nose bleeds	[ ] Frequent stomach aches	[ ] Skin rashes
[ ] Nasal allergies	[ ] Frequent diarrhea	[ ] Insect bite reactions
[ ] Sinus problems	[ ] Frequent constipation	[ ] Anemia
[ ] Frequent sore throats	[ ] Black or tarry stools	[ ] Speech problems
[ ] Thyroid problems	[ ] Kidney or bladder infection	[ ] Increased lead levels
[ ] Pneumonia	[ ] Frequent or painful urination	[ ] Current health concerns/issues

Girls: Menstrual History Onset: _____ Frequency: _____
Cramps: [ ] Yes [ ] No Irritability: [ ]Yes [ ]No

Other: Note any important details in the space below.]

_____

_____

Behavioral History: Has your child ever been evaluated for, diagnosed with, or treated for:

1. ADHD	[ ]Yes [ ]No	4. Depression	[ ]Yes [ ]No
2. Anxiety Disorder	[ ]Yes [ ]No	5. OCD	[ ]Yes [ ]No
3. Tourette's Syndrome	[ ]Yes [ ]No	6. Other _____	

Details: (Including psychiatric hospitalizations) – If using separate sheet please check here [ ]

_____

_____

_____

_____

Name of Evaluating/Treating Physician\Psychiatrist\Psychologist

_____ _____ _____
Physician Name Telephone FAX

_____ _____ ____ ____
Street Address City ST Zip

Pediatrician/FP/NP: _____ Phone _____ Address _____

Specialist 1: _____ Phone _____ Address _____
[specify specialty]

Specialist 2: _____ Phone _____ Address _____
[specify specialty]

Family History:

Father's country of birth: _____
Father's occupation: _____
Father's Education: _____

Mother' country of birth: _____
Mother's occupation: _____
Mother's Education: _____

Does the child have any blood relatives (father, mother ,brother, sister, father's side or mother's side who have the following conditions? (mark with a check)

[ ] Birth deformity _____
[ ] Mental retardation _____
[ ] Convulsions, epilepsy _____
[ ] Mental illness _____
[ ] Family or inherited disease _____
[ ] Death in childhood _____
[ ] Eye problem _____
[ ] Hearing Problems _____
[ ] Asthma _____
[ ] Hay fever _____
[ ] Allergies _____
[ ] Severe Anemia _____
[ ] Sickle Cell disease _____
[ ] Bleeding tendencies _____

[ ] Tuberculosis _____
[ ] Diabetes _____
[ ] Heart Attack (under age 50) _____
[ ] Cancer _____
[ ] High blood pressure _____
[ ] Kidney problems _____
[ ] Obesity _____
[ ] Thyroid Problems _____
[ ] ADD/ADHD _____
[ ] Speech issues _____
[ ] Developmental delay _____
[ ] Learning disability _____
[ ] Autism _____
[ ] Other _____

For all conditions checked please describe: _____

_____

_____

Educational History:

Previous School: _____ Location: _____Length of Attendance: _____

If not in New Rochelle: Has your child ever attended school in New Rochelle? [ ]Yes [ ]No

If yes, please list the schools and circle the name of the last school your child attended in New Rochelle.

_____ _____

_____ _____

Did your child have an? IEP [ ]Yes [ ]No 504 Plan [ ]Yes [ ]No

Did your child receive any services at previous school? [ ]Yes [ ]No If yes please describe: _____

_____

Social History:

Living situation: [ ]Homeowner [ ]Home rental [ ]Apartment owner [ ]Apartment rental

Who lives in the home? _____

_____

Does child have: Own room [ ] Yes [ ] No
Own bed [ ] Yes [ ] No

Pets in the home? [ ] Yes [ ] No If yes, specify: _____

Does anyone smoke in the home? [ ] Yes [ ] No

First language of child: _____ Language spoken at home: _____

_____

Signature of School Nurse Date

[If form was completed by parent]

School Nurse Reviewed with parent [ ] Yes [ ] No

Annual & Program Reviews and Reevaluations for the Committee on Special Education (CSE)

*****PARENTS! PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM**

City School District of New Rochelle – Health Services Department

HEALTH APPRAISAL FORM

Date of Exam: ___/___/___

Name: _____ **Date of Birth:** ___/___/___ **Gender:** ☐ M ☐ F

School: _____ **Grade:** ____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal: (include dates)

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: _____
PPD: Please complete screening on reverse side of form
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____
Dental Referral ☐ Yes ☐ No ☐ Not done Date: _____

Significant Medical/Surgical History: ☐ See attached _____

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

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

PHYSICAL EXAM

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

Body Mass Index: _____ _____ . _____ (Required by NYS)

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

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

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: _____
For Girls: Age of onset of menses: _____ LMP: _____
Specify any abnormality (use separate paper if needed): _____

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

☐ Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.
☐ Specify medical accommodations needed for school: _____ ☐ None
☐ Known or suspected disability: _____ ☐ Please monitor
☐ Restrictions: _____ ☐ Please monitor
☐ Protective equipment required: ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

SPORTS CLEARANCE : By signing and submitting this form, the parent and physician attest that they have fully disclosed all of this student's health history, conditions, medications and relevant family history (e.g., early cardiac death.) Parent and physician assume liability for non-disclosures of such information. The School District Physician has final authority to medically clear students for interscholastic sports participation. Parental signature authorizes School Health personnel to communicate with your child's physician regarding medical clearance for sports.

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

***Parent Signature: _____ Date: _____

H-1 HEALTH APPRAISAL FORM (Revised 2/08)
This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.

***PARENTS! PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM

TUBERCULOSIS TESTING / SCREENING – EITHER A OR B MUST BE COMPLETED BY THE PHYSICIAN

A. PPD (Mantoux):

1. Date placed _____ Date read _____ Result in mm _____
2. If PPD is Positive: CXR: Date of exam: ___/___/___ Result: _____

Treatment: _____

_____

B. Tuberculin screening not indicated _____ (MD must initial)

PRESCRIPTION MEDICATIONS

Medications (list all): ☐ None

Medication: _____ Dosage/Time: _____

Medication: _____ Dosage/Time: _____

Medication: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ☐ Yes ☐ No *Student may self carry and self administer medication ☐ Yes ☐ No

Note: Nurse will also assess self-direction for the school setting. ***Students are not permitted to carry or self-administer USDEA controlled drugs.** Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PERMISSION TO RECEIVE PRESCRIPTION AND OVER THE COUNTER (OTC MEDICATION)

Health Care Provider and Parent signatures required

Parents must provide all medications.

☐ Tylenol (pain, fever)	Dose _____	Freq._____	Route_____
☐ Ibuprofen (Advil, Motrin) (pain, fever)	Dose _____	Freq._____	Route_____
☐ Benadryl (Allergic reaction/Allergy)	Dose _____	Freq._____	Route_____
☐ Antacid (Maalox, Tums) (abdominal discomfort)	Dose _____	Freq._____	Route_____
☐ Cough Drops/Throat Lozenges (sore throat)	Dose _____	Freq._____	Route_____
☐ Antibiotic Ointment (skin lesions)	Dose _____	Freq._____	Route_____

SIGNATURES ARE REQUIRED IN ORDER FOR SCHOOL NURSE TO DISPENSE PRESCRIPTION AND OTC MEDICATION

(Stamp below)

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

***Parent Signature: _____ Date: _____

Parental signature authorizes School Health personnel to communicate with your child's physician regarding prescription and OTC medication.