January 2019

Dear Families of Incoming Webster Kindergarten Students:

Kindergarten registration for students zoned to Webster School will begin in January. Registration packets are to be completed and handed in to Webster School by Friday, January 18th. Once residency has been verified, you will be contacted and given an appointment to bring your child to Webster School for a screening with our kindergarten teachers. While your child meets with the kindergarten teachers, you will meet with the nurse. Current medical information and immunization forms are required. Screenings will take place from Monday, March 4th to Friday, March 8th.

Registration packets can be downloaded from our website http://webster.nred.org. You can also pick-up a registration packet at Webster weekdays, between 8:00 AM and 2:30 PM.

If you plan on applying to Webster School through our Magnet Lottery, please make note of the following dates:

- Magnet Open House: February 28th at 6:00 PM at Webster School
- Magnet Application Due: Friday, March 15th City Hall Magnet Office
- Magnet Lottery: Thursday, March 21st at 9:00 City Hall Board Room

Children will be accepted from the Magnet Lottery list after all Webster home zoned kindergarten students have been registered and screened. The number of seats available for students applying through the lottery is determined based on the number of home zoned students registering for kindergarten.

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
Kindergarten Registration at Daniel Webster Elementary School

Please complete the Kindergarten Registration Packet. Drop off your completed packet to Daniel Webster School by January 18, 2019. After residency has been verified, an appointment will be set for your child to meet with the kindergarten teachers.

To be submitted to Webster School by January 18, 2019:

Proofs of Residency – 3 Required.
If you pay your bills on line, paper copies must be provided as proofs of residency. Documents you provide must be dated within 60 Days of January 18, 2019.

- Three documents are required.
- Sample documents are as follows:
  Landline Telephone Bill in Your Name
  Con Edison Bill in Your Name
  Cable Television Bill in Your Name
  Water Bill in Your Name
  Deed in Your Name
  Mortgage Statement in Your Name
  Section 8 Certificate Letter in Your Name

- Bank Statements and Credit Card Bills are NOT acceptable proofs of residency.

Child’s Birth Certificate

Emergency Contact Information Form

City School District of New Rochelle Registration Information Form

Daniel Webster Magnet School Screening Information Packet

Release for Records Consent

Home Language Survey

Pediatric and Adolescent School Health History - To be completed by parents/guardians.

Health Appraisal Form, including all immunizations - To be completed by your child’s health care provider.

Dental Certificate - To be completed by your child’s dentist.

Daniel Webster Magnet School
We Educate the Whole Child

Award-Winning School District • United States Department of Education • New York State Department of Education
CITY SCHOOL DISTRICT OF NEW ROCHELLE
DANIEL WEBSTER ELEMENTARY SCHOOL

Registration Information

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

PLEASE PRINT:

Reg. Date: ____________________________
Start Date: ____________________________

Student’s Name ____________________________

Date of Birth: ____________________________ Male Female

Student; First Language: ____________________________

Did Child attend School outside the U.S.? ________ If yes, which Grade(s): ____________________________

Language(s) Spoken at Home: ____________________________

Student’s Current Grade: ___________ Last Grade Attended: ___________ When?: ___________

Name & Address of Last School: ____________________________

Telephone (Name of Contact Person, if Known): ____________________________

Has this Child attended school in New Rochelle?: When?: ___________ Where?: ____________________________

Home Address: ____________________________ (Street Address) ____________________________ (Apt #:) ____________________________ (Zip code:)

Home telephone number(s): ____________________________

Parent’s Name: ____________________________ Birthplace: ____________________________

Home Address: ____________________________ (Street Address) ____________________________ (Apt #:) ____________________________ (Zip code:)

Home/Cellphone: ____________________________ Work telephone: ____________________________

Email(s): ____________________________

Occupation: ____________________________ Employer: ____________________________


Parent’s Name: ____________________________ Birthplace: ____________________________

Home Address: ____________________________ (Street Address) ____________________________ (Apt #:) ____________________________ (Zip code:)

Home/Cellphone: ____________________________ Work telephone: ____________________________

Email(s): ____________________________

Occupation: ____________________________ Employer: ____________________________


(Please continue to page 2)
Guardian/Custodian Name: ________________________________
(Other than parent)

Relationship to the student: ________________________________

Home/Cellphone: ___________________________ Work telephone: _______________________

Email(s): ____________________________________________

Occupation: _________________________________________ Employer: ________________________

**List below the FULL names of all other children in the family**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Date of Birth</th>
<th>School child is attending</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Previous Home address: ____________________________________________
(Save Address Apt # (City and State))

Previous telephone #s: ____________________________________________

Does your child have an I.E.P. from Special Education: Yes: [ ] No: [ ]

**Please list where and when your child has attended school:**

<table>
<thead>
<tr>
<th>GRADE:</th>
<th>SCHOOL ATTENDED</th>
<th>LOCATION</th>
<th>DATES OF ATTENDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Kindergarten</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Grade 1</td>
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<td>Grade 2</td>
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<td>Grade 3</td>
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<td>Grade 9</td>
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<td>Grade 10</td>
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<td></td>
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<tr>
<td>Grade 11</td>
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<td></td>
</tr>
<tr>
<td>Grade 12</td>
<td></td>
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</tbody>
</table>

(Please continue to page 3)
### Has your child ever received the following services in any school:

<table>
<thead>
<tr>
<th>SUPPORT SERVICES</th>
<th>CHECK ALL THAT APPLY</th>
<th>GRADE(S) IN WHICH SERVICES WERE RECEIVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>English as a Second Language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bilingual Class</td>
<td></td>
<td></td>
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<tr>
<td>Reading Help/Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource Room</td>
<td></td>
<td></td>
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<tr>
<td>Speech/Language</td>
<td></td>
<td></td>
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<tr>
<td>PT/OT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Education</td>
<td></td>
<td></td>
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<tr>
<td>Counseling/Social Skills Group</td>
<td></td>
<td></td>
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<tr>
<td>Repeated a Grade</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommended to Repeat Grade</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (explain)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Optional – Please check the appropriate box:

Parent 1
- American Indian
- Asian/Pacific Isl.
- Hispanic
- Black
- White

Parent 2

<table>
<thead>
<tr>
<th>Child's Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Contact:</td>
<td></td>
</tr>
<tr>
<td>Relationship to child:</td>
<td></td>
</tr>
<tr>
<td>Telephone Number(s):</td>
<td></td>
</tr>
<tr>
<td>Email(s):</td>
<td></td>
</tr>
<tr>
<td>Print Name of Parent or Guardian Completing Form:</td>
<td></td>
</tr>
<tr>
<td>Signature of Parent or Guardian Completing Form:</td>
<td></td>
</tr>
</tbody>
</table>

Today's Date: ______________
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 ____________
I hereby authorize:

__________________________ Former School

__________________________ Address

__________________________ City, State, Zip Code

To release all scholastic and health records, tests, evaluations, or any other pertinent information concerning my child __________________________ (child's name). It is understood that the privileged and confidential nature of such records will be preserved.

__________________________ Signature of Parent/Guardian

__________________________ Date

*Daniel Webster Magnet School  
*WE EDUCATE THE WHOLE CHILD  
*AWARD-WINNING SCHOOL DISTRICT • UNITED STATES DEPARTMENT OF EDUCATION • NEW YORK STATE DEPARTMENT OF EDUCATION*
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 # _______ Address: ___________________________ 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: ______________
WEBSTER SCHOOL DENTAL FORM

To: All Parents  
From: Robin Kaphan, Webster 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 three, 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.
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 when you register your child for school.**

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 ____

_________________________________________  Date
DANIEL WEBSTER MAGNET SCHOOL
KINDERGARTEN SCREENING INFORMATION

Child's Name: __________________________________________
Person Filling Out Form: __________________________________
Relationship to Child: ____________________________________

PRENATAL HISTORY:
Were there any difficulties during pregnancy?

__________________________

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

__________________________

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:
Did your child meet his/her milestones (rolling over, sitting, crawling, walking, talking, toilet training) within normal limits? If not, please explain.

__________________________

Were any referrals to Early Intervention made?

__________________________

Did your child receive any services through Early Intervention? If so, please explain.

__________________________

Do you have any behavioral concerns for your child?

__________________________

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

Interactive Play _________________________________________

Peer Relationships ________________________________________
Activity Level

Shyness

Tantrums

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

**CHILD’S HEALTH HISTORY:**
Please indicate anything you feel is pertinent regarding your child’s health and wellness.

**SIBLINGS:**

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Learning Difficulties: Please explain</th>
<th>Speech/Lang Difficulties: Please explain</th>
<th>IEP classification</th>
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</table>
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.

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<th>STUDENT NAME:</th>
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<td>First</td>
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<tr>
<th>DATE OF BIRTH:</th>
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<tbody>
<tr>
<td>Month</td>
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<table>
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<tr>
<th>GENDER:</th>
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<tbody>
<tr>
<td>☐ Male</td>
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<tr>
<th>PARENT/PARENTAL RELATION INFO:</th>
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<tbody>
<tr>
<td>Last Name</td>
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</table>

<table>
<thead>
<tr>
<th>HOME LANGUAGE CODE</th>
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</table>

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
6. Indicate the total number of years that your child has been enrolled in school

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.
   - Yes*   - No   - Not sure
   - "If yes, please explain:"______

   How severe do you think these difficulties are?
   - Minor
   - Somewhat severe
   - Very severe

10a. Has your child ever been referred for a special education evaluation in the past?
   - No
   - Yes*  "Please complete 10b below"

10b. "If referred for an evaluation," has your child ever received any special education services in the past?
   - No
   - Yes – Type of services received:

   Age at which services received (Please check all that apply):
   - Birth to 3 years (Early Intervention)
   - 3 to 5 years (Special Education)
   - 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)?
   - No
   - Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

12. In what language(s) would you like to receive information from the school?

_________________________  ________________________________  ________________________________
Signature of Parent or of Person in Parental Relation  Month:  Day:  Year:  Date

Relationship to student:
   - Mother
   - Father
   - Other:

**OFFICIAL ENTRY ONLY - NAME/POSITION OF 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:

- ADMINISTER NYSITELL
- ENGLISH PROFICIENT
- REFER TO LANGUAGE PROFICIENCY TEAM

**DATE OF NYSITELL ADMINISTRATION:**

MO.  DAY  YR.  PROFICIENCY LEVEL ACHIEVED ON NYSITELL:

- ENTERING
- EMERGING
- TRANSITIONAL
- EXPANDING
- COMPELLING

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

<table>
<thead>
<tr>
<th>NOMBRE DEL ESTUDIANTE:</th>
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<tbody>
<tr>
<td>Nombre</td>
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<table>
<thead>
<tr>
<th>FECHA DE NACIMIENTO:</th>
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<tr>
<td>Mes</td>
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<tr>
<th>GÉNERO:</th>
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<tbody>
<tr>
<td>Masculino</td>
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<table>
<thead>
<tr>
<th>INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apellido</td>
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<td>----------</td>
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</tbody>
</table>

| 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

2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?
   □ Inglés □ Otro

3. ¿Cuál es el idioma primario de cada padre / tutor?
   □ Madre □ Padre
   □ Tutor(es)

4. ¿Qué idioma o idiomas entiende su hijo(a)?
   □ Inglés □ Otro

5. ¿Qué idioma o idiomas habla su hijo(a)?
   □ Inglés □ Otro

6. ¿Qué idioma o idiomas lee su hijo(a)?
   □ Inglés □ Otro

7. ¿Qué idioma o idiomas escribe su hijo(a)?
   □ Inglés □ Otro
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 descríbelos.
   - 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*

10b. *Si se 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?

---

**OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ**

<table>
<thead>
<tr>
<th>NAME:</th>
<th>POSITION:</th>
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**IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:**

**NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW**

<table>
<thead>
<tr>
<th>NAME:</th>
<th>POSITION:</th>
</tr>
</thead>
</table>

**ORAL INTERVIEW NECESSARY:**
- No
- Sí

**DATE OF INDIVIDUAL INTERVIEW:**
- NO
- DAY
- yr

**OUTCOME OF INDIVIDUAL INTERVIEW:**
- ADMINISTER NYSITELL
- ENGLISH PROFICIENT
- REFER TO LANGUAGE PROFICIENCY TEAM

**NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL**

<table>
<thead>
<tr>
<th>NAME:</th>
<th>POSITION:</th>
</tr>
</thead>
</table>

**DATE OF NYSITELL ADMINISTRATION:**
- NO
- 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:

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SPANISH
MEDICATION ADMINISTRATION FORM
Parent/Provider Authorization for Administration of Medication at School/School Sponsored Events

To Be Completed By Parent/Guardian

Student Name: ___________________________ DOB: ___________________________
Grade: ___________________ School: ___________________________

I request the school nurse give the medication listed on this plan; trained staff may assist my child to take their own medications; or after the nurse determines eligibility, my child can take their own medications in school. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

Parent/Guardian Name (Please Print) ___________________________
Parent/Guardian Signature ___________________________
Date ___________________________
Email ___________________________
Phone ___________________________
☐ Check if Cell

To Be Completed By Health Care Provider – Valid for 1 Year

Diagnosis ___________________________
Medication: ___________________________
ICD Code ___________________________
Dose: ___________________________
Route: ___________________________
Time(s)*: ___________________________

*Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

PERMISSION TO RECEIVE OVER THE COUNTER (OTC) MEDICATION

☐ Acetaminophen (Tylenol for pain, fever) Dose ___________________________
☐ ibuprofen (Advil or Motrin for pain, fever) Dose ___________________________
☐ Diphenhydramine (Benadryl for Allergic reaction) Dose ___________________________
☐ Antacid (Maalox, Tums for abdominal discomfort) Dose ___________________________
☐ Cough Drops/Throat Lozenges (sore throat) Dose ___________________________
☐ Antibiotic Cream (skin lesions) Dose ___________________________
☐ Freq. ___________________________
☐ Route ___________________________

ATTESTATION REQUIRED FOR INDEPENDENT CARRY AND USE

NYS Law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medications, epinephrine auto-injector, insulin, carry glucagon and diabetes supplies, or other medications that require rapid administration, along with parent/guardian permission to allow this in school.

☐ Check this box and attach the attestation to request this option.

Name/Title of Prescriber (Please Print) ___________________________
Date ___________________________
Prescriber’s Signature ___________________________
Phone ___________________________
Email ___________________________
Fax ___________________________

Stamp ___________________________

Please return to School Nurse:

School Nurse ________________ ________________
Robin Kaphan RN | Gail Conway RN
Phone #: 914 576-8411 | 914 6738-1264
Email: rkaphan@nredlearn.org

School: ________________
Daniel Webster
Email: gconway@nredlearn.org
# Student Health History

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>Age:</th>
<th>Gender:</th>
<th>Parent/Guardian Name:</th>
<th>Home Phone:</th>
<th>Cell:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

## Your Child’s Medical History

<table>
<thead>
<tr>
<th>Medical History</th>
<th>YES</th>
<th>NO</th>
<th>If Yes, please explain and include date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Born premature or had complications after birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has an ongoing medical or developmental condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sees a medical specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has severe allergies or anaphylaxis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has been hospitalized</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had an operation/required surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had an injury requiring an Emergency Room visit</td>
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</tr>
<tr>
<td>Missed 5 days of school in a row due to illness/injury</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Had a bone/muscle injury</td>
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<tr>
<td>Passed out, had a concussion or serious head injury</td>
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<tr>
<td>Had a convulsion, has a seizure disorder, or epilepsy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has a vision problem or condition</td>
<td></td>
<td></td>
<td>glasses □ contacts □</td>
</tr>
<tr>
<td>Has a hearing problem or condition</td>
<td></td>
<td></td>
<td>hearing aid □ cochlear implant □</td>
</tr>
<tr>
<td>Wears a dental bridge, braces or mouthpiece</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Have any family members under the age of 50 ever:</strong></td>
<td>YES</td>
<td>NO</td>
<td>If Yes, please specify:</td>
</tr>
<tr>
<td>Had a heart attack</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had other serious health problems</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## CHECK ALL THAT APPLY TO YOUR CHILD:

- ADHD
- Allergies
- Asthma
- Autism
- Diabetes
- Ear Infections
- GI Conditions (ulcer, reflux, IBS)
- Headaches/migraines
- Heart Condition
- High Blood Pressure
- Mental Health Condition (Depression, eating disorder, anxiety, OCD, ODD, etc.)
- Scoliosis/Orthopedic Impairment
- Single Organ (kidney, testicle)
- Skin Condition
- Speech Condition
- Urinary Condition
- EI/CPSE/CSE services

## CURRENT MEDICATIONS

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Please list name, dose, time(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

## ASSISTIVE EQUIPMENT

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Please check all that apply:

- Crutches
- Walker
- Wheelchair
- Other:

## TREATMENTS

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

During or outside of school:

- Insulin/blood glucose monitoring
- Inhaler/nebulizer/peak flow monitoring
- Special diet

Is there any condition that would prevent your child from participating in physical education or sports?

- No □
- Yes: ___________________________

Please list any additional concerns:

Parent/Guardian Signature: ___________________________ Date: ________________
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 □ Medication/Treatment Order Attached □ Anaphylaxis Care Plan Attached

☐ Yes, indicate type: □ Food □ Insects □ Latex □ Medication □ Environmental

Asthma □ No □ Medication/Treatment Order Attached □ Asthma Care Plan Attached

☐ Yes, indicate type: □ Intermittent □ Persistent □ Other: ___________________________

Seizures □ No □ Medication/Treatment Order Attached □ Seizure Care Plan Attached

☐ Yes, indicate type: □ Type: ___________________________ Date of last seizure: ___________________________

Diabetes □ No □ Medication/Treatment Order Attached □ Diabetes Medical Mgmt. Plan Attached

☐ Yes, indicate type: □ Type 1 □ Type 2 □ HbA1c results: ____________ Date Drawn: ____________

Risk Factors for Diabetes or Pre-Diabetes:

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

BMI ___________ kg/m2 Percentile (Weight Status Category): □ <5th □ 5th-49th □ 50th-84th □ 85th-94th □ 95th-98th □ 99th and>

Hyperlipidemia: □ No □ Yes Hypertension: □ No □ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: ___________________________ Weight: ___________________________ BP: ___________________________ Pulse: ___________________________ Respirations: ___________________________

TESTS | Positive | Negative | Date | One Functioning: □ Eye □ Kidney □ Testicle
PPD/PRN | □ | □ | | □ Concussion – Last Occurrence: ___________________________
Sickle Cell Screen/PRN | □ | □ | | □ Mental Health: ___________________________

Lead Level Required Grades Pre-K & K | □ Test Done | □ Lead Elevated > 10 μg/dL | | □ 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: ___________________________ ___________________________

Diagnoses/Problems (list) ___________________________ ICD-10 Code ___________________________

☐ Additional Information Attached

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## SCREENINGS

<table>
<thead>
<tr>
<th>Vision</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
<td>20/</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Distance Acuity With Lenses</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision – Near Vision</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision – Color</td>
<td>Pass</td>
<td>Fail</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>Right dB</td>
<td>Left dB</td>
<td>Referral</td>
<td></td>
</tr>
<tr>
<td>Pure Tone Screening</td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Scoliosis</td>
<td>Required for boys grade 9</td>
<td>Negative</td>
<td>Positive</td>
<td>Referral</td>
</tr>
<tr>
<td>And girls grades 5 &amp; 7</td>
<td>□</td>
<td>□</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

**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
    - □ 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: ____________________________
- Provider Address:______________________________
- Phone:__________________________
- Fax:______________________________

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