



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

MAGDA PARVEY, Ed.D.
INTERIM SUPERINTENDENT OF SCHOOLS

TEL: 914/576-4460
FAX: 914/576-4479

MELISSA A. PASSARELLI
PRINCIPAL

GREGORY A. MIDDLETON
ASSISTANT PRINCIPAL

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

Daniel Webster Magnet School
WE EDUCATE THE WHOLE CHILD



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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

ID# _____ Census # _____

Magnet: Y N District-wide Special Education: Y N Verified by: _____

ESL _____ REG _____

**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".

Reg. Date: _____

PLEASE PRINT:

Start Date: _____

Student's Name _____

Date of Birth: _____ Male Female
Crce.

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: _____

Marital Status: Single: Married: Separated: Divorced: Widowed:

Parent's Name: _____ Birthplace: _____

Home Address: _____
(Street Address) (Apt. #) (Zip code)

Home/Cellphone: _____ Work telephone: _____

Email(s): _____

Occupation: _____ Employer: _____

Marital Status: Single: Married: Separated: Divorced: Widowed:

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

<u>Name</u>	<u>Age</u>	<u>Date of Birth</u>	<u>School child is attending</u>	<u>Grade</u>

Previous Home address: _____
(Street 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:

<u>GRADE:</u>	<u>SCHOOL ATTENDED/LOCATION</u>	<u>DATES OF ATTENDANCE</u>
Preschool		
Kindergarten		
Grade 1		
Grade 2		
Grade 3		
Grade 4		
Grade 5		
Grade 6		
Grade 7		
Grade 8		
Grade 9		
Grade 10		
Grade 11		
Grade 12		

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

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

Optional – Please check the appropriate box:

Parent 1		Parent 2
_____	American Indian	_____
_____	Asian/Pacific Isl.	_____
_____	Hispanic	_____
_____	Black	_____
_____	White	_____

Child's Name: _____

Emergency Contact: _____
Print Full Name

Relationship to child: _____

Telephone Number(s): _____

Email(s): _____

Print Name of Parent or Guardian Completing Form: _____

Signature of Parent or Guardian Completing Form: _____

Today's Date: _____



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TEL: 914 / 576-4460

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PRINCIPAL

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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ASSISTANT PRINCIPAL

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

**DANIEL WEBSTER SCHOOL
STUDENT EMERGENCY CARD 2019-2020 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 # _____

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.
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 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 _____

Dentist's Signature

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:

<u>Name</u>	<u>DOB</u>	<u>Learning Difficulties:</u> Please explain	<u>Speech/Lang Difficulties:</u> Please explain	<u>IEP classification</u>



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.*

STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
Month	Day	Year
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to Student

HOME LANGUAGE CODE

Language Background

(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ 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	<input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School	Address

Home Language Questionnaire (HLQ)—Page Two

<i>Educational History</i>	
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? _____	

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: <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:	



Lissette Colon-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

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89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

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.*

NOMBRE DEL ESTUDIANTE:		
Nombre	Segundo nombre	Apellido
FECHA DE NACIMIENTO:		GÉNERO:
Mes	Día	Año
		<input type="checkbox"/> Masculino
		<input type="checkbox"/> 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?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro	_____
			<i>especifique</i>
2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro	_____
			<i>especifique</i>
3. ¿Cuál es el idioma primario de cada padre / tutor?	<input type="checkbox"/> Madre	<input type="checkbox"/> Padre	_____
	<input type="checkbox"/> Tutor(es)		_____
			<i>especifique</i>
4. ¿Qué idioma o idiomas entiende su hijo(a)?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro	_____
			<i>especifique</i>
5. ¿Qué idioma o idiomas habla su hijo(a)?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro	<input type="checkbox"/> No sabe hablar
			<i>especifique</i>
6. ¿Qué idioma o idiomas lee su hijo(a)?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro	<input type="checkbox"/> No sabe leer
			<i>especifique</i>
7. ¿Qué idioma o idiomas escribe su hijo(a)?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro	<input type="checkbox"/> No sabe escribir
			<i>especifique</i>

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School	Address

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: _____ PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING
 MO DAY YR.

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



CITY SCHOOL DISTRICT OF NEW ROCHELLE
HEALTH SERVICES DEPARTMENT

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 _____ ICD Code _____

Medication: _____

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

- | | | | |
|---|------------|-------------|-------------|
| <input type="checkbox"/> Acetaminophen (Tylenol for pain, fever) | Dose _____ | Freq. _____ | Route _____ |
| <input type="checkbox"/> Ibuprofen (Advil or Motrin for pain, fever) | Dose _____ | Freq. _____ | Route _____ |
| <input type="checkbox"/> Diphenhydramine (Benadryl for Allergic reaction) | Dose _____ | Freq. _____ | Route _____ |
| <input type="checkbox"/> Antacid (Maalox, Tums for abdominal discomfort) | Dose _____ | Freq. _____ | Route _____ |
| <input type="checkbox"/> Cough Drops/Throat Lozenges (sore throat) | Dose _____ | Freq. _____ | Route _____ |
| <input type="checkbox"/> Antibiotic Ointment (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.

Stamp

Name/Title of Prescriber (Please Print) _____ Date _____

Prescriber's Signature _____ Phone _____

Email _____ Fax _____

Please return to School Nurse:

School Nurse: <i>Robin Kaphan RN / Gail Conroy RN</i>	School: <i>Daniel Webster</i>
Phone #: <i>914 576-8411</i>	Fax: <i>914 738-1264</i>
	Email: <i>rkaphan@nredlearn.org</i> <i>gconroy@nredlearn.org</i>



CITY SCHOOL DISTRICT OF NEW ROCHELLE
HEALTH SERVICES DEPARTMENT

STUDENT HEALTH HISTORY

Name:	DOB:	Age:	Gender:
Parent/Guardian Name:	Grade:	Home Phone:	Cell:
	Email:		Date:

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

CHECK ALL THAT APPLY TO YOUR CHILD:

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

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other:
TREATMENTS	YES	NO	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> 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	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

Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list)

ICD-10 Code

_____	_____
_____	_____
_____	_____

Additional Information Attached

Name: _____ DOB: _____

SCREENINGS

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

- Full Activity** without restrictions including Physical Education and Athletics.
- Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications
 - No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
 - No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
 - Other Restrictions:**

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

- Accommodations:** Use additional space below to explain

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

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

Explain: _____

MEDICATIONS

- Order Form for Medication(s) Needed at School attached**

List medications taken at home:

IMMUNIZATIONS

- Record Attached
- Reported in NYSIS
- Received Today: Yes No

HEALTH CARE PROVIDER

Medical Provider Signature: _____ **Date:** _____

Provider Name: *(please print)* _____ **Stamp:** _____

Provider Address: _____

Phone: _____

Fax: _____

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