Registration at Daniel Webster Elementary School

Please complete the Webster’s Registration Packet. Your completed registration packet should be dropped off or mailed to Webster School.

The following documents are required:

**Proof of Residency**
Attached is a list of acceptable proofs of residency. If you pay your bills online, paper copies must be provided as proof of residency. Documents you provide must be dated within 60 days of the registration date.

**Child’s Birth Certificate**

**Forms Specific to the Registration Process**
City School District of New Rochelle Registration Information Form
Transportation Form (This must be completed even if your child will not take the bus.)
Student Emergency Card
Webster Records Request Form
Home Language Questionnaire
Health Appraisal Form
Immunization Records (To be completed by your child’s doctor.)
Dental Form (To be completed by your child’s dentist.)
Medication Administration Form, if applicable
Student Health History
Kindergarten Screening Information
The City School District of New Rochelle Transportation
DOCUMENTS TO SHOW RESIDENCY IN NEW ROCHELLE
MINIMUM THREE (3) PROOFS OF RESIDENCY

Three documents are required:

Sample documents are as follow:

- Landline Telephone Bill in Your Name
- Con Edison Bill in Your Name
- Cable Television Bill in Your Name
- Water Bill 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
CITY SCHOOL DISTRICT OF NEW ROCHELLE

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:

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: ____________________________

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>
<td></td>
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</tr>
</tbody>
</table>

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:  

<table>
<thead>
<tr>
<th>GRADE</th>
<th>SCHOOL ATTENDED/LOCATION</th>
<th>DATES OF ATTENDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kindergarten</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 1</td>
<td></td>
<td></td>
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<tr>
<td>Grade 2</td>
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<td>Grade 3</td>
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<td>Grade 4</td>
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<td>Grade 5</td>
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<td>Grade 6</td>
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<td>Grade 7</td>
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<td>Grade 8</td>
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<tr>
<td>Grade 9</td>
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<tr>
<td>Grade 10</td>
<td></td>
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<tr>
<td>Grade 11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NATURE OF STUDENT RESIDENCY

- Does the student live in New Rochelle with the student’s parent or legal guardian? Yes [ ] No [ ]
  (Proof of residence will be required)

- Does the student live in New Rochelle with a non-parent who has assumed financial and decision-making responsibility for the student? Yes [ ] No [ ]
  (Proof of relationship will be required; see “Important Information for Applicants,” Paragraph 3)

- Does the student live in New Rochelle in a “Host Family” arrangement? Yes [ ] No [ ]
  (Proof of host family relationship will be required; see “Important Information for Applicants” Paragraph 4).

INFORMATION ABOUT THE PERSON COMPLETING THIS FORM

My name is: ________________________________

I live at: Street address: ________________________________
Apartment or unit number: ________________
Home phone number ________________ Cellphone number ________________
Email: ________________________________

My relationship to the student is (e.g. "parent: mother/father," “legal guardian,” “host,” “other”). If “Other,” please describe below:


I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE

Signature ________________________________ Date ________________
PLEASE READ THE IMPORTANT INFORMATION BELOW

New York Penal Law § 175.30. Offering a false instrument for filing in the second degree.
   A person is guilty of offering a false instrument for filing in the second degree when, knowing that a written instrument contains a false statement or false information, he offers or presents it to a public officer or public servant with the knowledge or belief that it will be filed with, registered or recorded in or otherwise become a part of the records of such public office or public servant.

   Offering a false instrument for filing in the second degree is a class A misdemeanor.

New York Penal Law § 175.35. Offering a false instrument for filing in the first degree.
   A person is guilty of offering a false instrument for filing in the first degree when, knowing that a written instrument contains a false statement or false information, and with intent to defraud the state or any political subdivision, public authority or public benefit corporation of the state, he offers or presents it to a public officer, public servant, public authority or public benefit corporation with the knowledge or belief that it will be filed with, registered or recorded in or otherwise become a part of the records of such public office, public servant, public authority or public benefit corporation.

   Offering a false instrument for filing in the first degree is a class E felony.

   A person is guilty of making a punishable false written statement when he knowingly makes a false statement, which he does not believe to be true, in a written instrument bearing a legally authorized form notice to the effect that false statements made therein are punishable.

   Making a punishable false written statement is a class A misdemeanor.

DEPARTMENT OF PUPIL SERVICES USE ONLY

Reviewed on ____________________________ By: ____________________________
   Date: ____________________________ Name of the person reviewing form

Name of Attendance teacher ____________________________________________ Date: ____________________________
   Time: ____________________________

New Resident of New Rochelle [ ]
Change of address within New Rochelle [ ]
Change of School within New Rochelle [ ]
Other: ____________________________________________

School Name: ____________________________________________

--------------------------------------------------------------------------------------------------------------------------

Verified [ ] Not verified [ ]

Name of Attendance Teacher ____________________________________________ Date: ____________________________

Student(s) name(s): ____________________________________________

School of Attendance: ____________________________________________

cc.: School of Attendance
CITY SCHOOL DISTRICT OF NEW ROCHELLE
DANIEL WEBSTER ELEMENTARY SCHOOL

Información de Registro

Solo podrán inscribirse en nuestro distrito escolar los estudiantes cuyos padres o tutores legales residen en New Rochelle. Los estudiantes asistirán a la escuela que corresponda a su área de residencia, excepto en el caso de los estudiantes que asistan a una Escuela "Magnet". Las pruebas de residencia deben proporcionarse de acuerdo con la política del Distrito. Si la persona que registra al estudiante no es el padre/madre, deberá presentar al momento de registrarlo: copia de la orden de la corte que lo nombra "Padre Adoptivo" o "Guardián/Tutor Legal" u "Orden de Custodia".

ESCRIBA CLARAMENTE Y CON LETRA IMPRENTA:

Fecha de Inscripción: __________________________
Fecha de Inicio: __________________________

Nombre del Estudiante: ____________________________________________________________
Fecha de nacimiento: ________________

Estudiante. Principal lenguaje __________________________

En caso afirmativo, que grado(s) curso?: __________________________

Idioma que se habla en casa: __________________________

Grado que cursa el estudiante: ________________ Último grado que curso: ________________ Cuando? ________________

Nombre y dirección de la última escuela:

Teléfono (Persona que pueda dar información, si la hubiese): __________________________

El estudiante asistió a la escuela en New Rochelle? ________________ Cuando? ________________ Donde? __________________________

Domicilio del Estudiante: ________________________________________________________

(Calle y numero) (Apto. #) (código postal)

Número de teléfono(s) casa/celular(es): ____________________________________________

Parent 1. Nombre: ______________________________________________________________

Lugar de nacimiento: __________________________

Domicilio: ________________________________________________________________

(calle y numero) (Apto. #) (código postal)

Teléfono casa/celular: __________________________

Teléfono del trabajo: __________________________

Email(s) __________________________________________________________

Ocupación: __________________________ Empleador: __________________________

Estado Civil: Soltero(a): ______ Casado(a): ______ Separado(a): ______ Divorciado(a): ______ Viudo(a): ______

Parent 2. Nombre: ______________________________________________________________

Lugar de nacimiento: __________________________

Domicilio: ________________________________________________________________

(calle y numero) (Apto. #) (código postal)

Teléfono casa/celular: __________________________

Teléfono del trabajo: __________________________

Email(s) __________________________________________________________

Ocupación: __________________________ Empleador: __________________________

Estado Civil: Soltero(a): ______ Casado(a): ______ Separado(a): ______ Divorciado(a): ______ Viudo(a): ______

(Por favor continúe en la pág. 2)
Nombre del Guardián/tutor/custodio: 
(sí no es uno de los padres)

Relación con el estudiante: 

Teléfono casa/celular: __________________________ Teléfono del trabajo: __________________________

Email(s) __________________________________________

Ocupación: __________________________ Empleador: __________________________

**Escriba en la lista abajo los nombres COMPLETOS de todos los demás niños de la familia**

<table>
<thead>
<tr>
<th>Nombre</th>
<th>Edad</th>
<th>Fecha de nacimiento</th>
<th>Escuela a la que asisten</th>
<th>Grado</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Domicilio anterior: __________________________
(Calle, numero) (Apto. #) (ciudad y país)

Teléfono(s) anterior(es): __________________________

Su hijo tiene un plan especial de enseñanza (I.E.P.) de Educación especial? Yes: ☐ No: ☐

**Por favor indique a qué escuela(s) asistió su hijo(a) y cuando:**

<table>
<thead>
<tr>
<th>GRADO:</th>
<th>ESCUELA OCALIDAD</th>
<th>FECHAS DE ASISTENCIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescolar</td>
<td></td>
<td></td>
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<tr>
<td>Kinder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1er Grado</td>
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<tr>
<td>2do Grado</td>
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<tr>
<td>3er Grado</td>
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<td>4to Grado</td>
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<td>5to Grado</td>
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<td>6to Grado</td>
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<td>7mo Grado</td>
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<td>8mo Grado</td>
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<td>9mo Grado</td>
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<td>10mo Grado</td>
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<tr>
<td>11mo Grado</td>
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<tr>
<td>12mo Grado</td>
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</tbody>
</table>

(Por favor continúe en la pág. 3)
**Su hijo(a) ha recibido alguno de estos servicios en la(s) escuela(s) en las que asistió?**

<table>
<thead>
<tr>
<th>SERVICIOS DE APOYO</th>
<th>MARQUE LO QUE CORRESPONDA</th>
<th>GRADO(S) EN LOS QUE SE RECIBIÓ/RECIBIERON ESOS SERVICIOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inglés como Segundo idioma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clase bilingüe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ayuda/Lab. de lectura</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aula de Recursos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Terapia del lenguaje</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Terapia física u ocupacional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enseñanza Especial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grupo de consejería y socialización</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repitió un grado</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recomendación de repetir un grado</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Otros servicios (explique)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Opcional** - Por favor marque la casilla correspondiente:

<table>
<thead>
<tr>
<th>Parent 1</th>
<th>Parent 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Indio Americano de EE.UU.</td>
</tr>
<tr>
<td></td>
<td>Asiático/de las islas del pacífico</td>
</tr>
<tr>
<td></td>
<td>Hispano</td>
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<tr>
<td></td>
<td>Afroamericano</td>
</tr>
<tr>
<td></td>
<td>Caucásico</td>
</tr>
</tbody>
</table>

Nombre del Estudiante: ____________________________________________________________

Contacto de emergencia: ________________________________________________________

Relación con el estudiante: ____________________________________________________

Número(s) de teléfono: _________________________________________________________

Email(s) ________________________________________________________________

Escriba Claramente el nombre del Padre/Madre/Guardián/Tutor/Custodio que llena este formato:

________________________________________________________________________

Firma del Padre/Madre/Guardián/Tutor/Custodio que llena este formato: __________________________________________

Fecha: __________________________
NEW ROCHELLE CITY SCHOOL DISTRICT
Office of Transportation
515 North Avenue, New Rochelle, NY 10801

AM BUS: _______ TIME: _______ AM STOP: _______
PM BUS: _______ TIME: _______ PM STOP: _______
BUS COMPANY: _______ START DATE: _______

Parent/Guardian: Complete one application for each student being registered. The transportation office staff will identify and notify students by mail at the end of August those who meet the 1.5 mileage requirement necessary to receive bussing.

PLEASE PRINT CLEARLY. REPORT PHONE NUMBER CHANGES TO THE TRANSPORTATION OFFICE IMMEDIATELY.

2020-2021 Transportation Application
New Rochelle Public Elementary Schools


4. Magnet CILA Kaleidoscope
(circle one)

School: ________________ Grade (circle one): PA PP K 01 02 03 04 05

Student ID#: (REQUIRED) ___________________________ Today's Date: ______________________

STUDENT DATA INFORMATION

Student Name: ________________
LAST Name
FIRST Name
Middle

Student Home Address:
Street: __________________________________________ Apt No.: ______________________

City: __________________________ State: __________ Zip: __________

Date of Birth: __________ Sex: __________

Parent OR Legal/Custodial Guardian Information

Title: (circle) Dr. Mr. Mrs. Ms. Mr. & Mrs. Other ________________

Mother __________________________ Father __________________________
Last name First name Last name First name

Primary Phone# ____________________ Cell# ____________________

E-Mail __________________________

Signature of Mother or Father
or Legal/Custodial Guardian __________________________________________

Relationship to Student: __________________________________________
(mother, father, other)

Emergency Contact (other than parent or legal/custodial guardian)

Mother __________________________ Phone # __________________________

Revised 2-4-15
Solicitud de Transporte 2020-2021
Escuelas primarias públicas de New Rochelle

Por favor marque una de las cuatro opciones:

Escuela: ____________  Grado (cercule uno): PA PP K 01 02 03 04 05

#ID de Estudiante: (NECESARIO) ______________ Fecha de hoy: ______________

INFORMACIÓN DE DATOS DEL ESTUDIANTE

Nombre del estudiante: __________________________

APellido  NOMBRE  SEGUNDO NOMBRE

Domicilio del estudiante:

Calle: __________________________ Apt No.: __________

Ciudad: __________________________ Estado: __________ Código postal: __________

Fecha de nacimiento: ___________  Género: M____ F____

Información del padre o tutor legal/custodio

Título: (círcule) Dr. Sr. Sra. Soltera Sr. y Sra. (imprime) Otro __________

Madre __________________________ Padre __________________________

Apellido __________________________ Primer Nombre __________________________

Tutor legal/custodio (si no es la madre o padre) __________________________

Apellido __________________________ Primer Nombre __________________________

Número Principal (____) __________________________ Celular de la Madre (____) __________________________

Correo electrónico __________________________

Firma de la madre o el padre __________________________ Relación con el estudiante: __________________________

o tutor legal/custodio

Contacto de emergencia (que no sea el padre o el tutor legal o de custodia)

Nombre de Contacto: __________________________

Apellido __________________________ Primer Nombre __________________________

Relación con el estudiante: __________________________

Teléfono de casa: (____) __________________________ Teléfono celular/trabajo: (____) __________________________

Revised 2-4-15
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.

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)

HAS THE ABOVE ADDRESS CHANGED SINCE LAST YEAR? IF YES, 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 Records Request Form

This form gives Webster School the ability to request school records from your child’s Preschool and any other school your child attended.

I hereby authorize:

________________________________________ Former School

________________________________________ Address

________________________________________ City, State, Zip Code

to release my child’s records to Webster School.

Student’s Name

Signature of Parent/Guardian

Date
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.

---

**Home Language Questionnaire (HLQ)**

<table>
<thead>
<tr>
<th>Student Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
</tr>
</tbody>
</table>

**Date of Birth:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**Gender:**

- [ ] Male
- [ ] Female

**Parent/Person in Parental Relation Info:**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Relation to Student</th>
</tr>
</thead>
</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
   - [ ] Father
   - Specify
   - 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

---

**School District Information:**

<table>
<thead>
<tr>
<th>District Name (Number) &amp; School</th>
<th>Address</th>
</tr>
</thead>
</table>

**Student ID Number in NYS Student Information System:**
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?

   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:**

   **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

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 histórico 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:

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

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

SCHOOL DISTRICT INFORMATION:

Student ID Number in NYS Student Information System:

District Name (Nombre) & School Address

SPANISH
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 describales.

Si* □ 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 □ Si* *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 □ Si – Explíque, 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?

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

Relación con el estudiante: □ Madre □ Padre □ Otra:

Date

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:

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: ________________________ POSITION: ________________________

DATE OF NYSITELL

ADMINISTRATION:

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

SPANISH
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

□ Yes, indicate type □ Intermittent □ Persistent □ Other: ____________________________

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: ___________________________ Respiration: ___________________________

TESTS Positive Negative Date
PPD/PRN ____________________________ ____________________________
Sickle Cell Screen/PRN ____________________________ ____________________________
Lead Level Required Grades Pre-K & K ____________________________
□ Test Done □ Lead Elevated >10 μg/dL ____________________________

One Functioning: □ Eye □ Kidney □ Testicle
□ Concussion – Last Occurrence: ____________________________
□ Mental Health: ____________________________
□ Other: ____________________________

□ System Review and Exam Entirely Normal

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

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

□ Assessment/Abnormalities Noted/Recommendations: ____________________________

Diagnoses/Problems (list) ICD-10 Code

□ Additional Information Attached

Rev. 5/4/2018 Page 1 of 2
Name: 

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>20/20</td>
<td>20/20</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Distance Acuity With Lenses</td>
<td>20/20</td>
<td>20/20</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Vision – Near Vision</td>
<td>20/20</td>
<td>20/20</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 80</td>
<td>Left 80</td>
<td>Referral</td>
<td></td>
</tr>
<tr>
<td>Pure Tone Screening</td>
<td></td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Scoliosis</td>
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<td></td>
<td>Referral</td>
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<tr>
<td>Required for boys grade 9</td>
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<tr>
<td>And girls grades 5 &amp; 7</td>
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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 NYSIS

Received Today: ✗ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature: ________________________________

Date: ________________________________

Provider Name: (please print)

Provider Address:

Phone: ________________________________

Fax: ________________________________

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

Rev. 5/4/2018 Page 2 of 2
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 visit the dentist will:

1. Examine teeth and gums
2. Clean teeth
3. Check teeth for cavities and fill them
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 food with sugar. Offer health 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.

________________________________________  ____________  ____________
Student Name                                   School                        Grade

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

[ ] Completed   [ ] In Process

Did you recommend orthodontia? [ ] Yes   [ ] No

Dentist Name ___________________________________ Dated: ____________

Telephone Number ________________________________

H-1B Dental Health Notice (Rev. 10/26/06) S:\HealthFORMS, HEALTH SERVICES DEPT\CURRENT FORMS HSD 2017 - 2018
updated H-1 B Dental Health Notice.doc
LA SALUD DENTAL

A: Todos Los Padres y Guardianes
De: Las Enfermeras Escolares

Las personas pueden mantener sus dientes por toda la vida – si ponen de su parte le dan oportunidad al dentista de ayudarles. La mayoría de las enfermedades dentales se pueden evitar. Sin embargo, 98% de la población de los Estados Unidos son víctimas de caries dentales.

Empezando al tercer año las visitas al dentista son recomendando. Durante la vista el dentista le prestara los siguientes servicios:
1. Examina los dientes y las encías
2. Le limpia los dientes
3. Examina sus dientes para averiguar si caries, en cuyo caso las mismas son llenadas. Es mayor cuidarse de las cuando estas son pequeñas.
4. Ayuda a prevenir mayores problemas de dentales.
5. Provee instrucciones para la salud dental.

Los padres y guardians por su parte pueden hacer lo siguiente:
1. Proveer una dieta balanceada a su familia.
2. Ayudar a que sus niños limiten las comidas que contienen zucar.
3. Apoyar a sus niños para que se cepillen los dientes inmediatamente después de comer y que hagan esto correctamente usando una pasta dental que contenga fluoruro.
4. Llevar a sus niños a examine cada año y mas si es necesario.
5. Dar buen ejemplo a sus hijos, siguiendo ustedes buenas practices de salud dental.

Si su niño o niña no ha sido examindado por el dentista durante el año pasado, favor de llamar hoy hacer una cita para esta proposito. Pidale al dentista que completa la forma adjunta y devuelva la misma a la enfermera escolar para que ella pueda mantener los recudos de salud de sus hijos al día.

_________________________________________  __________________________  __________
Student Name  School  Grade

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

[ ] Completed  [ ] In Process

Did you recommend orthodontia?  [ ]Yes  [ ]No

Dentist Name__________________________________  Dated: __________

Telephone Number ________________

H-1B Dental Health Notice (Rev. 10/26/06)S:\Health\FORMS, HEALTH SERVICES DEPT\CURRENT FORMS HSD 2017 - 2018 updated:\H-1 B Dental Health Notice.doc
# MEDICATION ADMINISTRATION FORM

**Parent/Provider Authorization for Administration of Medication at School/School Sponsored Events**

## To Be Completed By Parent/Guardian

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade: __________________________</td>
<td>School: ___________________</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Parent/Guardian Name (Please Print)</th>
<th>Parent/Guardian Signature</th>
<th>Date</th>
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</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Email</th>
<th>Phone</th>
<th>Check if Cell</th>
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</table>

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

<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>ICD Code:</th>
</tr>
</thead>
</table>

| Medication: | |
|-------------| |

<table>
<thead>
<tr>
<th>Dose:</th>
<th>Route:</th>
<th>Time(s)*:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

*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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Freq.</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen (Tylenol for pain, fever)</td>
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<tr>
<td>Ibuprofen (Advil or Motrin for pain, fever)</td>
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<tr>
<td>Diphenhydramine (Benadryl for Allergic reaction)</td>
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<tr>
<td>Antacid (Maalox, Tums for abdominal discomfort)</td>
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<tr>
<td>Cough Drops/Throat Lozenges (sore throat)</td>
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<tr>
<td>Antibiotic Ointment (skin lesions)</td>
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</table>

## 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.

<table>
<thead>
<tr>
<th>Name/Title of Prescriber (Please Print)</th>
<th>Date</th>
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<table>
<thead>
<tr>
<th>Prescriber’s Signature</th>
<th>Phone</th>
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Please return to School Nurse:

<table>
<thead>
<tr>
<th>School Nurse:</th>
<th>School:</th>
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</table>
## STUDENT HEALTH HISTORY

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

### Your Child's Medical History

- [ ] Born premature or had complications after birth
- [ ] Has an ongoing medical or developmental condition
- [ ] Sees a medical specialist
- [ ] Has severe allergies or anaphylaxis
- [ ] Has been hospitalized
- [ ] Had an operation/required surgery
- [ ] Had an injury requiring an Emergency Room visit
- [ ] Missed 5 days of school in a row due to illness/injury
- [ ] Had a bone/muscle injury
- [ ] Passed out, had a concussion or serious head injury
- [ ] Had a convulsion, has a seizure disorder, or epilepsy
- [ ] Has a vision problem or condition
- [ ] Has a hearing problem or condition
- [ ] Wears a dental bridge, braces or mouthpiece

### Have any family members under the age of 50 ever:

- [ ] YES
- [ ] NO

If Yes, please specify:

- [ ] Had a heart attack
- [ ] Had other serious health problems

### 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>Given at school</th>
<th>Taken at home</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] YES</td>
<td>[ ] NO</td>
</tr>
</tbody>
</table>

Please list name, dose, time(s):

### ASSISTIVE EQUIPMENT

<table>
<thead>
<tr>
<th>During or outside of school</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] YES</td>
</tr>
</tbody>
</table>

Please check all that apply:

- [ ] Crutches
- [ ] Walker
- [ ] Wheelchair
- [ ] Other:

### TREATMENTS

<table>
<thead>
<tr>
<th>During or outside of school</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] YES</td>
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</tbody>
</table>

- [ ] 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: ____________
DANIEL WEBSTER MAGNET SCHOOL
KINDERTAGEN 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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The City School District of New Rochelle Transportation

For the SAFETY OF OUR CHILDREN, Transportation Rules for KINDERGARTEN & 1st GRADE students include that a PARENT or DESIGNEE meet the child at the Bus Stop

My Child ________________________________

has permission in my absence at the Bus Stop to be released to the persons named below

PLEASE PRINT

***PHOTO I.D. REQUIRED FOR RELEASE OF YOUR CHILD***

<table>
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<tr>
<th>Name</th>
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With the Safety of My Child in mind, I realize that the Driver will return My Child to the School if ANY of the names listed above are not at the Bus Stop in my absence.

This rule applies to ALL Kindergarten & 1st Grade Students

Parent Signature ___________________________ Contact # __________ Date __________

Bus Stop: ________________________________

SCHOOL: ___________________________ Route: _________ Grade: _________

PLEASE RETURN SIGNED FORM TO DRIVER BY NEXT SCHOOL DAY
May 2020

Dear Kindergarten Parents:

Welcome to the Wonderful World of Webster School! We are hosting a welcome for our incoming kindergarten students and their parents on Wednesday, June 3rd from 9:15 am to 10:00 am.

Students will be able to meet other incoming kindergarten children and participate in activities with the kindergarten teachers. While the children are with the kindergarten teachers, there will be an informational session for parents. You will have the opportunity to meet Psychologist Rebecca McNaughton, Social Worker Rachel Long, and Assistant Principal Gregory Middleton.

If you have any questions regarding the Kindergarten Welcome, please email me at mpassarelli@nredllearn.org. We look forward to seeing you and your child on Wednesday, June 3rd at 9:15 am in Webster School’s cafeteria.

Very truly yours,

Melissa A. Passarelli