WEBSTER ELEMENTARY SCHOOL
95 GLENMORE DRIVE
NEW ROCHELLE, NEW YORK 10801
(914) 576-4460; Fax : (914) 576-4479

Melissa A. Passarelli
Principal

Gregory A. Middleton
Assistant Principal

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

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DOCUMENTS TO SHOW RESIDENCY IN NEW ROCHELLE
MIIMUM 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

OFFICE USE ONLY: _____ Res. ____ Meds/Imm. ____ Lang. Surv. ____ Transport. ____ M ____ F ____

ID# _____ Census # _____

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

ESL. ☐ REG. ☐

CITY SCHOOL DISTRICT OF NEW ROCHELLE

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 (Circle)

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: ☐

(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

Name	*Age*	*Date of Birth*	*School child is attending*	*Grade*

Previous Home address: _____
(Street Address) (Apt. #) (City and Stated)

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:

GRADE:	*SCHOOL ATTENDED/LOCATION*	*DATES OF ATTENDANCE*
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		

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 office 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 office, 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.

New York Penal Law § 210.45. Making a punishable false written statement.

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: _____

c.c.: School of Attendance

OFFICE USE ONLY: B.C. ___ Res. ___ Meds/Imm. ___ Lang. Surv. ___ Transport. ___ M ___ F ___

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

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: _____ Masculino Femenino
(Circule uno)

Estudiante. Principal lenguaje _____

Fue a la escuela de su País?: _____ En caso afirmativo, que grado(s) curso?: _____

Idioma que se habla en casa: _____

Grado que cursa el estudiante: _____ Ultimo 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: _____
(si 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

Nombre	*Edad*	*Fecha de nacimiento*	*Escuela a la que asisten*	*Grado*

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

Teléfono(s) anterior(es) : _____

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

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

GRADO:	*ESCUELA/LOCALIDAD*	*FECHAS DE ASISTENCIA*
Prescolar		
Kínder		
1er Grado		
2do Grado		
3er Grado		
4to Grado		
5to Grado		
6to Grado		
7mo Grado		
8vo Grado		
9no Grado		
10mo Grado		
11vo Grado		
12vo Grado		

(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?

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

Opcional - Por favor marque la casilla correspondiente:

Parent 1		**Parent 2**
_____	Indio Americano de EE.UU.	_____
_____	Asiático/de las islas del pacifico	_____
_____	Hispano	_____
_____	Afroamericano	_____
_____	Caucásico	_____

Nombre del Estudiante: _____

Contacto de emergencia: _____
Escriba claramente el nombre completo

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: _____

HC 1/24/19

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

1. New Student:_____ **2**. Address Change:_____ **3**. School Change:_____

4. Magnet CILA Kaleidoscope (circle one) Previous School

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.** (print) **Other**_____

Mother_____ Father_____
Last name First name Last name First name

Primary Phone# _____ Mother Cell# _____ Father 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

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

Este formulario debe ser completado para todos los estudiantes

OFFICE USE ONLY ____Magnet ____CILA ____Kaleidoscope

AM BUS: _____ TIME: _____ AM STOP: _____

PM BUS: _____ TIME: _____ PM STOP: _____

BUS COMPANY: _____ START DATE: _____

Padre/Tutor: *Complete una solicitud para cada estudiante que está registrando. . El personal de la oficina de transporte identificará y notificará a los estudiantes por correo al final de agosto que cumplan con el requisito de 1.5 millas necesarias para recibir el autobús.*

POR FAVOR IMPRIMA CLARAMENTE. REPORTE LOS CAMBIOS DE NÚMEROS DE TELÉFONO A LA OFICINA DE TRANSPORTE

Solicitud de Transporte 2020-2021
Escuelas primarias públicas de New Rochelle

Por favor marque una de las cuatro opciones:

1. Estudiante Nuevo:____ **2**. Cambio de dirección:_____ **3**. Cambio de escuela:_____
Escuela previa

Escuela: _____ Grado (círcule 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.** (imprima) **Otro**_____

Madre_____ Padre_____
Apellido Primer Nombre Apellido Primer Nombre

Tutor legal/custodio (si no es la madre o padre)_____
Apellido Primer Nombre

Número Principal (____)_____ Celular de la Madre (____)_____ Celular de el Padre ( )_____

Correo electrónico_____

Firma de la madre o el padre o tutor legal/custodio _____ **Relación con el estudiante:**_____
(madrer, padre, otro)

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

Nombre de Contacto:_____ Relación con el estudiante: _____
Apellido Primer Nombre Preferiblemente residente de New Rochelle (amigo, vecino,otro)

Teléfono de casa: (___)_____ Teléfono celular/trabajo: (___)_____

Revised 2-4-15

DANIEL WEBSTER SCHOOL
STUDENT EMERGENCY CARD 2020-2021 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)

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:** _____

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Gregory A. Middleton
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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 _____

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

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

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

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

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated.
Thank you.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:
☐ Male
☐ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence? ☐ English ☐ Other _____ *specify*
2. What was the first language your child learned? ☐ English ☐ Other _____ *specify*
3. What is the Home Language of each parent/guardian? ☐ Mother _____ *specify* ☐ Father _____ *specify* ☐ Guardian(s) _____ *specify*
4. What language(s) does your child understand? ☐ English ☐ Other _____ *specify*
5. What language(s) does your child speak? ☐ English ☐ Other _____ *specify* ☐ Does not speak
6. What language(s) does your child read? ☐ English ☐ Other _____ *specify* ☐ Does not read
7. What language(s) does your child write? ☐ English ☐ Other _____ *specify* ☐ Does not write

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** ☐ *No* ☐ *Not sure* ☐ *If yes, please explain:_____

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

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

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

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

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

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

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

_____ Month: Day: Year: _____
Signature of Parent or of Person in Parental Relation *Date*

Relationship to student: ☐ Mother ☐ Father ☐ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

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

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ NO ☐ YES

**DATE OF INDIVIDUAL INTERVIEW: _____ (MO DAY YR.)

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

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

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

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

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

55 Hanson Place, Room 594
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Cuestionario de Idioma del Hogar ("HLQ" por sus siglas en inglés)

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

NOMBRE DEL ESTUDIANTE:

Nombre *Segundo nombre* *Apellido*

FECHA DE NACIMIENTO:

Mes *Día* *Año*

GÉNERO:
❑ Masculino
❑ Femenino

INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL

Apellido *Primer Nombre* *Relación con el estudiante*

CÓDIGO DEL IDIOMA DEL HOGAR

Conocimientos de idiomas

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

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

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

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

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

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

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

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

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

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

_____

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

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

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

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

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

_____ Mes: Día: Año: _____

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

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

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

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

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ NO ☐ YES

**DATE OF INDIVIDUAL INTERVIEW: _____ MO DAY YR.

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

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ MO. DAY YR.

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

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

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**
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	

Lead Level Required Grades Pre- K & K **Date**

☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL

Other Pertinent Medical Concerns

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

Name:			DOB:
SCREENINGS			
Vision	**Right**	**Left**	**Referral** / **Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No
Distance Acuity With Lenses	20/	20/	
Vision – Near Vision	20/	20/	
Vision – Color ☐ Pass ☐ Fail			
Hearing	**Right** dB	**Left** dB	**Referral**
Pure Tone Screening			☐ Yes ☐ No
Scoliosis Required for boys grade 9 And girls grades 5 & 7	**Negative** ☐	**Positive** ☐	**Referral** ☐ Yes ☐ 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

☐ 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: *(please print)* Stamp:

Provider Address:

Phone:

Fax:

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

Health Services Department

City School District of New Rochelle

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 _____

Health Services Department

City School District of New Rochelle

LA SALUD DENTAL

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

Las persnas pueden mantener sus dientes por todo la vida – si ponen de su parte le dan oportunidad al dentista de ayudaries. La mayoria de las enfermedades dentales se pueden evitar. Sin embargo, 98% de la poblacion de los Estados Unidos son victimas de caries dentales.

Empezando al trecer ano las visitas al dentist son recommendandol. Durante la vista el dentista le prestara lost siguentes servios:

1. **Examina los dientes y las encias**
2. **Le limpia los dientes**
3. **Examina sus dientes para averiguar si caries, en cuyo caso las mismas son llendas. Es major cuidarse de las cuando estas son pequenas.**
4. **Ayuda a prevenir mayors problemas de dentales.**
5. **Provee instrucciones para la salud dental.**

Los padres y guardians por su parte pueden hacer lo sigiente:

1. **Proveer una dieta balanceada a su familia.**
2. **Ayudar a que sus ninos limiten las comidas que contienen zucar.**
3. **Apoyar a sus ninos para que se cepillen los dientes immediatamente despues de comer y que hagan esto correctamenta usando una pasta dental que contenga fluoruro.**
4. **Lievar a sus ninos a examines cada ano y mas si es necessario.**
5. **Dar buen ejemplo a sus hijos, siguiendo ustedes buenas practices de salud dental.**

Si su nino o nina no ha sido examindado por el dentista durante el ano pasado, favor de llamar hoy hacer una cita para esta proposito. Pidale al dentista que completa la forma adjunta y devuela la misma a la enfermera escolar para que ella pueda mantener los recodos de salud de sus hijos al dia.

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 _____

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

☐ Acetaminophen (Tylenol for pain, fever)	Dose _____	Freq._____	Route_____
☐ Ibuprofen (Advil or Motrin for pain, fever)	Dose _____	Freq._____	Route_____
☐ Diphenhydramine (Benadryl for Allergic reaction)	Dose _____	Freq._____	Route_____
☐ Antacid (Maalox, Tums for abdominal discomfort)	Dose _____	Freq._____	Route_____
☐ Cough Drops/Throat Lozenges (sore throat)	Dose _____	Freq._____	Route_____
☐ 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:		School:
Phone #:	Fax:	Email:

CITY SCHOOL DISTRICT OF NEW ROCHELLE
HEALTH SERVICES DEPARTMENT

STUDENT HEALTH HISTORY

Name:	**DOB:** **Age:** **Grade:**	**Gender:**
Parent/Guardian Name:	**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	☐	☐	
Has an ongoing medical or developmental condition	☐	☐	
Sees a medical specialist	☐	☐	
Has severe **allergies** or **anaphylaxis**	☐	☐	☐Food ☐Environmental ☐Insect ☐Medication ☐Other Specify:
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	☐	☐	☐ glasses ☐ contacts
Has a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
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	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
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:** _____

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:

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

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

	Name	*Relationship*	*Phone*
1.			
2.			
3.			
4.			
5.			

*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

WEBSTER ELEMENTARY SCHOOL
95 GLENMORE DRIVE
NEW ROCHELLE, NEW YORK 10801
(914) 576-4460; Fax : (914) 576-4479

Melissa A. Passarelli
Principal

Gregory A. Middleton
Assistant Principal

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@nredlearn.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