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

MAGDA PARVEY, ED.D.
INTERIM SUPERINTENDENT OF SCHOOLS

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

MELISSA A. PASSARELLI
PRINCIPAL

GREGORY A. MIDDLETON
ASSISTANT PRINCIPAL

Registration at Daniel Webster Elementary School

Please complete the Registration Packet. Drop off your **completed packet** to Daniel Webster School.

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

- Three documents are required.
- Sample documents are as follows:
  - Landline Telephone Bill in Your Name
  - Con Edison Bill in Your Name
  - Cable Television Bill in Your Name
  - Water Bill in Your Name
  - Mortgage Statement in Your Name
  - Section 8 Certificate Letter in Your Name
- Bank Statements and Credit Card Bills are **NOT** acceptable proofs of residency.

Child's Birth Certificate

Emergency Contact Information Form

City School District of New Rochelle Registration Information Form

Daniel Webster Magnet School Screening Information Packet

Release for Records Consent

Home Language Survey

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

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

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

ID# _____ Census # _____

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

ESL. ____ REG.

CITY SCHOOL DISTRICT OF NEW ROCHELLE

DANIEL WEBSTER ELEMENTARY SCHOOL

Registration Information

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

Reg. Date: _____

PLEASE PRINT:

Start Date: _____

Student's Name _____

Date of Birth: _____ Male Female (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)

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

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

Optional – Please check the appropriate box:

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

Child's Name: _____

Emergency Contact: _____
Print Full Name

Relationship to child: _____

Telephone Number(s): _____

Email(s): _____

Print Name of Parent or Guardian Completing Form: _____

Signature of Parent or Guardian Completing Form: _____

Today's Date: _____

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.

2019-2020 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

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MELISSA A. PASSARELLI
PRINCIPAL

GREGORY A. MIDDLETON
ASSISTANT PRINCIPAL

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

I hereby authorize:

_____Former School

_____Address

_____City, State, Zip Code

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

_____Signature of Parent/Guardian

_____Date

DANIEL WEBSTER SCHOOL
STUDENT EMERGENCY CARD 2019-2020 SCHOOL YEAR

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

☐ Magnet ☐ Neighborhood

Student Name:_____ Teacher:_____

Address:_____

Home Phone:_____ Date of Birth:_____

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

Home Address: _____

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

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

Family Physician: _____ Phone: _____

Allergies: _____

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

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

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

ILLNESS OR INJURY

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

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

WEBSTER SCHOOL DENTAL FORM

To: All Parents
From: Robin Kaphan, Webster School Nurse

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

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

What can parents do?

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

If your child has not had a dental exam within the past year, please call today and schedule an appointment. **Ask your dentist to fill out the bottom portion of this form and return it to the school nurse when you register your child for school.**

School: _____ Teacher: _____ Grade: _____

Child's Name: _____

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

Completed _____ In Process _____

Did you recommend orthodontia? Yes ____ No ____

_____

Dentist's Signature Date

DANIEL WEBSTER MAGNET SCHOOL
KINDERGARTEN SCREENING INFORMATION

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

PRENATAL HISTORY:
Were there any difficulties during pregnancy?

_____

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

_____

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

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

_____

Were any referrals to Early Intervention made? _____

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

_____

Do you have any behavioral concerns for your child?

_____

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

Interactive Play _____

Peer Relationships _____

Activity Level _____

Shyness _____

Tantrums _____

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

_____

CHILD'S HEALTH HISTORY:

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

_____

_____

_____

SIBLINGS:

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

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
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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:

Historial Educativo

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

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

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

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

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

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

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

_____

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

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

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

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

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

_____ Mes: Día: Año: _____

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

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

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

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

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

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ NO ☐ YES

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

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

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ MO DAY YR

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

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

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: Robin Kaplan RN / Gail Conroy RN		School: Daniel Webster
Phone #: 914 576-8411	Fax: 914 738-1264	Email: rkaplan@nredlearn.org gconroy@nredlearn.org

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:** _____

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:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

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	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ 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.