



GEORGE M. DAVIS JR. ELEMENTARY SCHOOL  
80 ISELIN DRIVE  
NEW ROCHELLE, NEW YORK 10804

**BRIAN OSBORNE, Ed.D.**  
SUPERINTENDENT OF SCHOOLS

**MAGDA PARVEY, Ed.D.**  
ASSISTANT SUPERINTENDENT AND CHIEF ACADEMIC OFFICER

**ANTHONY BAMBROLA**  
PRINCIPAL

**LAURIE MARINARO**  
ASSISTANT PRINCIPAL

PHONE 914-576-4421  
FAX 914-576-4325

February 1, 2018

Families of Incoming Davis Kindergarten Students:

Kindergarten registration at Davis School will be completed in March of 2018 between March 6<sup>th</sup> and March 29<sup>th</sup>. **Student interviews/evaluations will take place during these March registration dates.**

Beginning **February 26<sup>th</sup>**, you may call our main office @ (914) 576-4421 to schedule an appointment for registration. It is only necessary for one parent/guardian to attend this session. Children **will** attend the registration appointment, as children will be assessed by our kindergarten staff, while the attending parent will meet with our office and clinical staff.

During the initial registration, main office staff will collect forms and check residency. You will also meet with our school nurse, Ms. Nancy Pritz and our social worker, Ms. Heather Cayanan. The entire process should take 30-60 minutes.

***In order to speed the registration process and help us stick to our schedule, please complete all registration forms BEFORE arriving at school for your registration appointment. Registration forms can be downloaded off our school website—<http://davis.nred.org>.***

At the time of initial registration, you will need to present the following in order to establish residency and eligibility:

- Your child's original birth certificate (or a certified copy) or passport
- Your child's immunizations records (vaccinations/shots)
- Three (3) proofs of residence (utility bill, phone bill, water bill, tax bill, lease agreement, etc.) showing name and address
- Photo I.D. of parent/guardian

Along with the co-Presidents of the Davis PTA and our Kindergarten teachers, I'm thrilled to invite your family to attend an orientation meeting on **Wednesday, April 18<sup>th</sup>** at 9:30 a.m. in order to learn about our Kindergarten programs and the registration process in general. Our teachers will provide a quick overview of their work, and we will offer a student-led, guided walking tour of the school, as well.

If you know of other families joining Davis in Fall 2018, please remind them to engage with our office team to set up their appointment!

For years, Davis Elementary has proudly cherished each of our students and worked to adapt our instruction to meet every child's individual needs and strengths. Our teachers and staff care deeply about our school and their work. We look forward to meeting another group of eager kindergarteners shortly, and look forward to welcoming your family into our school community.

Sincerely,

*Anthony Bambrola*

Anthony Bambrola



GEORGE M. DAVIS JR. ELEMENTARY SCHOOL  
80 ISELIN DRIVE  
NEW ROCHELLE, NEW YORK 10804

**BRIAN OSBORNE, ED.D.**  
SUPERINTENDENT OF SCHOOLS

**MAGDA PARVEY, ED.D.**  
ASSISTANT SUPERINTENDENT AND CHIEF ACADEMIC OFFICER

**ANTHONY BAMBROLA**  
PRINCIPAL

**LAURIE MARINARO**  
ASSISTANT PRINCIPAL

PHONE 914-576-4421  
FAX 914-576-4225

February 1, 2018

To the Family of \_\_\_\_\_:

Welcome to Davis! Thank you for scheduling a registration appointment for your child. Your registration appointment has been scheduled for: \_\_\_\_\_

Please complete all the enclosed forms **PRIOR** to your appointment, so as to help us maintain an efficient and timely process each day. Also remember that at the time of initial registration, you will need to present the following in order to establish residency and eligibility:

- Your child's original birth certificate (or a certified copy) or passport
- Your child's immunizations records (vaccinations/shots)
- Three (3) proofs of residence (a utility bill, phone bill, water bill, tax bill, lease agreement, etc.) showing name and address
- Photo I.D. of parent/guardian

If a question concerning your residence arises, the School District will ask you to provide additional documentation of your residence. If, after supplying such evidence, verification remains unresolved, the School District will conduct a formal investigation into your residency. The District may ask you to provide further proof of residency, including the name and address of your employer, and/or may ask that you attend a conference. During such a conference, a District representative will present you with the evidence we have collected regarding your residency, and you will be given an opportunity to respond.

After the conference, the School District will reach its determination as to your actual residence. If our investigation reveals that you are not a District resident and that you have not relinquished custody and control of your child to a New Rochelle resident, your child will not be permitted to enroll in New Rochelle schools.

Please sign (below) to affirm that you have read and understand our residency requirements and processes outlined in this letter, and to affirm that your children are indeed residents of the City School District of New Rochelle.

Sincerely,

*Anthony Bambrola*

Anthony Bambrola  
Principal

Student's Name: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

CITY SCHOOL DISTRICT OF NEW ROCHELLE REGISTRATION FORM  
**GEORGE M. DAVIS 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 cast of Magnet students. Proofs of residence must be provided 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 by Adoption" or "Legal Guardian" or "Order of Custody."

PLEASE PRINT:

Today's Date: \_\_\_\_\_

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Male**  **Female**   
**City and Country of Birth:** \_\_\_\_\_ **Cultural Ethnicity (optional)** \_\_\_\_\_  
**Did Child attend school outside of U.S:** Yes  No  If yes, which \_\_\_\_\_  
**Grade(s) attended:** \_\_\_\_\_ **Language(s) Spoken at Home:** \_\_\_\_\_

**Child's Current Grade:** \_\_\_\_ **Last Grade Attended:** \_\_\_\_ **When?** \_\_\_\_\_  
**Name of Last School:** \_\_\_\_\_  
**Address of Last School:** \_\_\_\_\_  
**Telephone Number of Last School:** \_\_\_\_\_ **Name of Contact Person:** \_\_\_\_\_  
**Has this child attended school in New Rochelle:** **When?** \_\_\_\_\_ **Where?** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
Street City State Zip Code  
**Home Telephone Number (s):** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Birthplace:** \_\_\_\_\_  
**Home Address:** \_\_\_\_\_  
Street City State Zip Code  
**Email address:** \_\_\_\_\_  
**Telephone Numbers** Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_  
**Marital Status (Please Check One)** Single  Married  Separated  Divorced  Widowed

**Mother's Name (First and Maiden):** \_\_\_\_\_ **Birthplace:** \_\_\_\_\_  
**Home Address:** \_\_\_\_\_  
Street City State Zip Code  
**Email address:** \_\_\_\_\_  
**Telephone Numbers** Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_  
**Marital Status (Please Check One)** Single  Married  Separated  Divorced  Widowed

**Guardian/Custodian Name (other than parent):** \_\_\_\_\_  
**Home Address:** \_\_\_\_\_  
Street City State Zip Code  
**Relationship to Student:** \_\_\_\_\_ **Email address:** \_\_\_\_\_  
**Telephone Numbers** Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_  
(Please continue to page 2)

CITY SCHOOL DISTRICT OF NEW ROCHELLE REGISTRATION FORM  
DAVIS ELEMENTARY

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

Name	Age	Date of Birth	School Child attends	Grade

**Previous Home Address:** \_\_\_\_\_  
Street City State Zip Code

**Country if other than U.S.** \_\_\_\_\_ **Previous Home Telephone Number:** \_\_\_\_\_

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	Date 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		

Support Services	Check all that apply	Grade(s) in which Services were Received
English as a Second Language	<input type="checkbox"/>	
Bilingual Class	<input type="checkbox"/>	
Reading Help/Lab	<input type="checkbox"/>	
Resource Room	<input type="checkbox"/>	
Speech/Language	<input type="checkbox"/>	
PT/OT	<input type="checkbox"/>	
Special Education	<input type="checkbox"/>	
Counseling/Social Skills Group	<input type="checkbox"/>	
Repeated a Grade	<input type="checkbox"/>	
Recommended to Repeat a Grade	<input type="checkbox"/>	
Other: (explain)	<input type="checkbox"/>	

**Optional – Please check appropriate box(es)**

Father	Mother
<input type="checkbox"/> American Indian/Alaska	<input type="checkbox"/>
<input type="checkbox"/> Asian	<input type="checkbox"/>
<input type="checkbox"/> Black/African American	<input type="checkbox"/>
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/>
<input type="checkbox"/> Multiracial	<input type="checkbox"/>
<input type="checkbox"/> Native Hawaiian/Pac. Isl.	<input type="checkbox"/>
<input type="checkbox"/> White	<input type="checkbox"/>

CITY SCHOOL DISTRICT OF NEW ROCHELLE REGISTRATION FORM  
DAVIS ELEMENTARY

Child's Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Telephone Numbers Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Other Designated Adult (Include Relationship to child): \_\_\_\_\_

Telephone Numbers Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**PLEASE NOTE:**

**IT IS IMPORTANT FOR YOU TO PROVIDE THE SCHOOL WITH YOUR CURRENT PHONE NUMBERS IN ORDER THAT YOU CAN BE REACHED IN THE EVENT OF AN EMERGENCY. PLEASE NOTIFY THE SCHOOL WITH ANY CHANGES TO YOUR CONTACT INFORMATION, I.E., CHANGES TO PHONE NUMBERS, ADDRESS CHANGE, EMERGENCY CONTACT NAMES, ETC.**

SIGN FORM IN PRESENCE OF SCHOOL PERSONNEL AT THE SCHOOL REGISTRATION:

\_\_\_\_\_  
**Print Name of Parent or Guardian Completing Form**

\_\_\_\_\_  
**Signature of Parent or Guardian Completing Form**

\_\_\_\_\_  
**Today's Date**





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

Lisette 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.

<b>Please write clearly when completing this section:</b>		
<b>STUDENT NAME:</b>		
First	Middle	Last
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
Month	Day	Year
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
Last Name	First Name	Relation to Student

HOME LANGUAGE CODE

<b>Language Background</b> (Please check all that apply.)		
1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother _____ <i>specify</i>	<input type="checkbox"/> Father _____ <i>specify</i>
	<input type="checkbox"/> Guardian(s) _____ <i>specify</i>	
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not write

<b>THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:</b>	
<b>SCHOOL DISTRICT INFORMATION:</b>	<b>STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:</b>
District Name (Number) & School _____ Address _____	

## Home Language Questionnaire (HLQ)—Page Two

<b>Educational History</b>	
<b>8. Indicate the total number of years that your child has been enrolled in school</b> _____	
9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.	
Yes* <input type="checkbox"/>	No <input type="checkbox"/>
Not sure <input type="checkbox"/> *If yes, please explain: _____	
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe	
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below	
10b. <u>*If referred for an evaluation</u> , has your child ever <u>received</u> any special education services in the past?	
<input type="checkbox"/> No <input type="checkbox"/> Yes - Type of services received: _____	
Age at which services received (Please check all that apply):	
<input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)	
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> Yes	
11. Is there anything else you think is important for the school to know about your child? (e.g. special talents, health concerns, etc.)	
_____	
_____	
12. In what language(s) would you like to receive information from the school? _____	

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

Signature of Parent or of Person in Parental Relation \_\_\_\_\_ Date \_\_\_\_\_

Relationship to student:  Mother  Father  Other: \_\_\_\_\_

<b>OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ</b>							
NAME: _____	POSITION: _____						
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:							
_____							
<b>NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW</b>							
NAME: _____	POSITION: _____						
ORAL INTERVIEW NECESSARY: <input type="checkbox"/> No <input type="checkbox"/> Yes							
**DATE OF INDIVIDUAL INTERVIEW: _____ <small>MO DAY YR</small>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">OUTCOME OF INDIVIDUAL INTERVIEW:</td> <td style="padding: 2px;"><input type="checkbox"/> ADMINISTER NYSITELL</td> </tr> <tr> <td style="padding: 2px;"></td> <td style="padding: 2px;"><input type="checkbox"/> ENGLISH PROFICIENT</td> </tr> <tr> <td style="padding: 2px;"></td> <td style="padding: 2px;"><input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM</td> </tr> </table>	OUTCOME OF INDIVIDUAL INTERVIEW:	<input type="checkbox"/> ADMINISTER NYSITELL		<input type="checkbox"/> ENGLISH PROFICIENT		<input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
OUTCOME OF INDIVIDUAL INTERVIEW:	<input type="checkbox"/> ADMINISTER NYSITELL						
	<input type="checkbox"/> ENGLISH PROFICIENT						
	<input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM						
<b>NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL</b>							
NAME: _____	POSITION: _____						
DATE OF NYSITELL ADMINISTRATION: _____ <small>MO DAY YR</small>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">PROFICIENCY LEVEL ACHIEVED ON NYSITELL:</td> <td style="padding: 2px;"><input type="checkbox"/> ENTERING</td> <td style="padding: 2px;"><input type="checkbox"/> EMERGING</td> <td style="padding: 2px;"><input type="checkbox"/> TRANSITIONING</td> <td style="padding: 2px;"><input type="checkbox"/> EXPANDING</td> <td style="padding: 2px;"><input type="checkbox"/> COMMANDING</td> </tr> </table>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL:	<input type="checkbox"/> ENTERING	<input type="checkbox"/> EMERGING	<input type="checkbox"/> TRANSITIONING	<input type="checkbox"/> EXPANDING	<input type="checkbox"/> COMMANDING
PROFICIENCY LEVEL ACHIEVED ON NYSITELL:	<input type="checkbox"/> ENTERING	<input type="checkbox"/> EMERGING	<input type="checkbox"/> TRANSITIONING	<input type="checkbox"/> EXPANDING	<input type="checkbox"/> COMMANDING		
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:							
_____							



**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.

**2018-2019 Transportation Application  
New Rochelle Public Elementary Schools**

1. New Student: \_\_\_\_\_ 2. Address Change: \_\_\_\_\_ 3. School Change: \_\_\_\_\_

4. Magnet \_\_\_\_\_ CILA \_\_\_\_\_ Kaleidoscope \_\_\_\_\_ Previous School \_\_\_\_\_  
(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. (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 # \_\_\_\_\_



Dr. Brian Osborne, Superintendent of Schools  
 Dr. Magda Parvey, Assistant Superintendent

**City School District of New Rochelle**  
**Dismissal and Contact Form**  
**Despido y Contacto**



2017-2018

Please Print

ID:

Student's Name / Nombre del estudiante		Date of Birth / fecha de nacimiento	Teacher / Maestro(a)
Home Address / dirección		City / ciudad	State / estado Zip / código de zip

**Emergency Early Dismissal / Despido de Emergencia**

In the event of an early dismissal due to an emergency (weather, etc.), please indicate how you child should go home.

En caso de que las escuelas despachen los estudiantes temprano debido a una emergencia (clima, etc.), favor de indicar cómo niño(a) debe irse a su casa.

Please check ALL boxes that apply:

- Contact by phone any of the adults listed below in case of emergency / En caso de emergencia contacte a cualquier adulto nombrado en este documento abajo.
- My child who normally walks has my permission to walk home. / Mi niño(a) que usualmente camina puede caminar a casa.
- My child who normally is bused has my permission to be bused home. / Mi niño(a) que usualmente toma el autobús puede ir en autobús.
- My child may be dismissed to any one of the adults listed below. / Mi niño(a) puede ser recogido (a) por uno de los adultos nombrado abajo.
- My child may not be dismissed to anyone. / Mi niño (a) puede NO DEBE ser despachado con nadie.

All students dismissed to an adult must be met and signed out at the Principal's Office.

Todo estudiante despachado a un adulto se debe presentar al personal de la escuela ya tiene que firmar para recoger al estudiante en la oficina del director de la escuela.

	Name / Nombre	Telephone / Teléfono		
		Home / Casa	Work / Trabajo	Mobile / Móvil
Parent/Guardian #1 Padre/Tutor				
Parent/Guardian #2 Madre/Tutor				
Adult #1 / Adulto #1				
Adult #2 / Adulto #2				

**Emergency Contacts / Información de emergencia**

Two people we can notify in an emergency, if you are not available. Please list a neighbor or relative who lives nearby and who is generally at home  
 Dos personas que se pueda llamar por alguna emergencia y que estén en casa.

1	Name / Nombre	Telephone / Teléfono	Home:
	Address / dirección		Cell:
2	Name / Nombre	Telephone / Teléfono	Home:
	Address / dirección		Cell:
Doctor's Name / Nombre del Doctor		Telephone / Teléfono	Home:
Address / dirección			

**ATTENDANCE NOTIFICATION / NOTIFICACION DE ASISTENCIA**

The School District routinely announces school related information by telephone, and also notifies parents of student absences. Please provide your preferred contact information to receive absence notices. / El Distrito Escolar anuncia habitualmente por teléfono información relacionada a las escuelas, incluyendo información sobre falta de asistencia a clases. Le pedimos proporcione el modo en el que desea ser informado sobre las faltas de asistencia.

School Related Calls:

Home / Casa	Work / Trabajo	Mobile / Móvil	Text 9 Digits / Texto	eMail

**Regular Dismissal / Despido Normales**

At Regular Dismissal my child will / Al Despido Regular mi niño(a)

<input type="checkbox"/> Walk home alone / Caminar solo en casa	<input type="checkbox"/> Be picked-up / Va a ser recogido
Persons Authorized to pick-up my child / Personas autorizadas para recoger a mi niño(a)	
1.	2.
3.	4.



Davis School Health Office  
 Phone: 914-576-4422  
 Fax: 914-576-4225

**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: <input type="checkbox"/> M <input type="checkbox"/> 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):  <5<sup>th</sup>  5<sup>th</sup>-49<sup>th</sup>  50<sup>th</sup>-84<sup>th</sup>  85<sup>th</sup>-94<sup>th</sup>  95<sup>th</sup>-98<sup>th</sup>  99<sup>th</sup> and >

**Hyperlipidemia:**  No  Yes **Hypertension:**  No  Yes

**PHYSICAL EXAMINATION/ASSESSMENT**

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>TESTS</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Other Pertinent Medical Concerns</b>
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
<b>Lead Level Required Grades Pre-K &amp; K</b>			<b>Date</b>	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated > 10 µg/dL				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

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

- |                                 |                                         |                                        |                                       |                                           |
|---------------------------------|-----------------------------------------|----------------------------------------|---------------------------------------|-------------------------------------------|
| <input type="checkbox"/> HEENT  | <input type="checkbox"/> Lymph nodes    | <input type="checkbox"/> Abdomen       | <input type="checkbox"/> Extremities  | <input type="checkbox"/> Speech           |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Back/Spine    | <input type="checkbox"/> Skin         | <input type="checkbox"/> Social Emotional |
| <input type="checkbox"/> Neck   | <input type="checkbox"/> Lungs          | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Neurological | <input type="checkbox"/> Musculoskeletal  |

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	<b>Diagnoses/Problems (list)</b>	<b>ICD-10 Code</b>
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name:			DOB:	
<b>SCREENINGS</b>				
<b>Vision</b>	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Notes</b>
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
<b>Hearing</b>	<b>Right dB</b>	<b>Left dB</b>	<b>Referral</b>	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Scoliosis</b> Required for boys grade 9 And girls grades 5 & 7	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:	Trunk Rotation Angle:			
<b>Recommendations:</b>				
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>				
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics.				
<input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications				
<input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling				
<input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field				
<input type="checkbox"/> Other Restrictions:				
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> Accommodations: Use additional space below to explain				
<input type="checkbox"/> Brace*/Orthotic <input type="checkbox"/> Colostomy Appliance* <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Insulin Pump/Insulin Sensor* <input type="checkbox"/> Medical/Prosthetic Device* <input type="checkbox"/> Pacemaker/Defibrillator* <input type="checkbox"/> Protective Equipment <input type="checkbox"/> Sport Safety Goggles <input type="checkbox"/> Other:				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
<b>MEDICATIONS</b>				
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached				
List medications taken at home: _____				
<b>IMMUNIZATIONS</b>				
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>HEALTH CARE PROVIDER</b>				
Medical Provider Signature:			Date:	
Provider Name: <i>(please print)</i>			Stamp:	
Provider Address:				
Phone:				
Fax:				
<b>Please Return This Form To Your Child's School When Entirely Completed.</b>				



CITY SCHOOL DISTRICT OF NEW ROCHELLE  
HEALTH SERVICES DEPARTMENT

**STUDENT HEALTH HISTORY**

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

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

**CHECK ALL THAT APPLY TO YOUR CHILD:**

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

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

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

No  Yes: \_\_\_\_\_

Please list any additional concerns:

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

