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

Families of Incoming Davis Kindergarten Students:

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

Beginning **February 26th**, 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 18th** 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: ____________

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

______________________________ 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 telephone: ______________ Work telephone: ______________

Occupation: ______________ Employer: ______________

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

Parent's Name: ______________ Birthplace: ______________

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

Home telephone: ______________ Work telephone: ______________

Occupation: ______________ Employer: ______________

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

(Please continue to page 2)

Guardian/Custodian Name:
(other than parent): ______________________

Relationship to the student: ______________________

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 home telephone #: ______________________

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		

(Please continue to page 3)

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:

Father		Mother
______	American Indian	______
______	Asian/Pacific Isl.	______
______	Hispanic	______
______	Black	______
______	White	______

Child's Name: ______________________________

Emergency Contact: ______________________________
Print Full Name

Relationship to child: ______________________________

Telephone Number(s): ______________________________

Print Name of Parent or Guardian Completing Form: ______________________________

Signature of Parent or Guardian Completing Form: ______________________________

Today's Date: ______________

HC 12/13/17

FOR OFFICE USE ONLY: Birth Cert._____ Res._____ Medical forms_____ Lang. Survey____ Transportation________ M ☐ F ☐
ID#____________________________CENSUS#____________________________
Magnet Yes☐ No☐ District-wide Special Education: Yes☐ No☐ Verified by: ________

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)________
If **Foreign Born**: Date of entry into U.S. ____________
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	☐	
Bilingual Class	☐	
Reading Help/Lab	☐	
Resource Room	☐	
Speech/Language	☐	
PT/OT	☐	
Special Education	☐	
Counseling/Social Skills Group	☐	
Repeated a Grade	☐	
Recommended to Repeat a Grade	☐	
Other: (explain)	☐	

Optional – Please check appropriate box(es)		
Father		**Mother**
☐	American Indian/Alaska	☐
☐	Asian	☐
☐	Black/African American	☐
☐	Hispanic or Latino	☐
☐	Multiracial	☐
☐	Native Hawaiian/Pac. Isl.	☐
☐	White	☐

(Please continue to page 3)

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

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.

Please write clearly when completing this section:

STUDENT NAME:		
First	*Middle*	*Last*

DATE OF BIRTH:			GENDER:
Month	*Day*	*Year*	❑ 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.)

Question			
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

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

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

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:

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.

2018-2019 Transportation Application
New Rochelle Public Elementary Schools

1. New Student:________ **2**. Address Change:________ **3**. School Change:________________
Previous School

4. Magnet CILA Kaleidoscope
(circle one)

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

Student ID#: (REQUIRED)____________________ Today's Date: ____________________

STUDENT DATA INFORMATION

Student Name:____
LAST Name **FIRST** Name Middle

Student **Home** Address:

Street:____ Apt No.:____________

City:____________________________ State:______________ Zip:____________

Date of Birth:____________________ Sex:______________

Parent *OR* Legal/Custodial Guardian Information

Title: (circle) **Dr. Mr. Mrs. Ms. Mr. & Mrs.** (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

City School District of New Rochelle

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

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 ye tiene que firmar para recojer el estudiante en la oficina del director de la escuela.

		Telephone / Teléfono		
	Name / Nombre	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)

☐ **Walk home alone / Caminar solo en casa**	☐ **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.**

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and Annual & Program Reviews and Reevaluations for the Committee on Special Education (CSE)

*****PARENTS! PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM**

City School District of New Rochelle – Health Services Department

HEALTH APPRAISAL FORM   Date of Exam: ___/___/___

Name: ______________________ Date of Birth: ___/___/___ **Gender:** ☐ M ☐ F

School: ______________________ **Grade:** ____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal: (include dates)

Sickle Cell Screen: ☐ Positive ☐Negative ☐ Not done Date: ________
PPD: Please complete screening on reverse side of form
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: ________
Dental Referral ☐ Yes ☐ No ☐ Not done Date: ________

Significant Medical/Surgical History: ☐ See attached ______________________

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other: ______________________

Allergies: ☐ LIFE THREATENING ☐ Food: ________ ☐ Insect: ________ ☐ Other: ________
☐ Seasonal ☐ Medication: ________

PHYSICAL EXAM

Height: ________ Weight: ________ Blood Pressure: ________ Date of Exam: ________

Body Mass Index: ___ ___ . ___ (Required by NYS)	Vision - without glasses/contact lenses	R	L	Referral
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th	Vision - Near Point	R	L	
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher	Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: ________
For Girls: Age of onset of menses: ________ LMP: ________
Specify any abnormality (use separate paper if needed): ______________________

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.
☐ **Specify medical accommodations needed for school:** ________ ☐ None
☐ **Known or suspected disability:** ________ ☐ Please monitor
☐ **Restrictions:** ________ ☐ Please monitor
☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistent eyewear ☐ Other: ________

SPORTS CLEARANCE : By signing and submitting this form, the parent and physician attest that they have fully disclosed all of this student's health history, conditions, medications and relevant family history (e.g., early cardiac death.) Parent and physician assume liability for non-disclosures of such information. The School District Physician has final authority to medically clear students for interscholastic sports participation. Parental signature authorizes School Health personnel to communicate with your child's physician regarding medical clearance for sports.

Provider's Signature: ________ **Phone:** ________
Provider's Name/Address: ________ **Fax:** ________
*****Parent Signature:** ________ **Date:** ________

H-1 HEALTH APPRAISAL FORM (Revised 2/08)
This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.

*****PARENTS! PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM**

TUBERCULOSIS TESTING / SCREENING – EITHER A OR B MUST BE COMPLETED BY THE PHYSICIAN

A. PPD (Mantoux):

1. Date placed ______________ Date read ____________ Result in mm ____________
2. If PPD is Positive: CXR: Date of exam: ___/___/___ Result: ____________________

Treatment: ____

____

B. Tuberculin screening not indicated _________ (MD must initial)

PRESCRIPTION MEDICATIONS

Medications (list all): ☐ None

Medication: ______________________________ Dosage/Time: ______________________

Medication: ______________________________ Dosage/Time: ______________________

Medication: ______________________________ Dosage/Time: ______________________

If AM dose is missed at home: ____

I assess this student to be self-directed ☐ Yes ☐ No *Student may self carry and self administer medication ☐ Yes ☐ No

Note: Nurse will also assess self-direction for the school setting. ***Students are not permitted to carry or self-administer USDEA controlled drugs.** Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PERMISSION TO RECEIVE PRESCRIPTION AND OVER THE COUNTER (OTC MEDICATION)

Health Care Provider and Parent signatures required

Parents must provide all medications.

☐ Tylenol (pain, fever)	Dose _____	Freq._____	Route_____
☐ Ibuprofen (Advil, Motrin) (pain, fever)	Dose _____	Freq._____	Route_____
☐ Benadryl (Allergic reaction/Allergy)	Dose _____	Freq._____	Route_____
☐ Antacid (Maalox, Tums) (abdominal discomfort)	Dose _____	Freq._____	Route_____
☐ Cough Drops/Throat Lozenges (sore throat)	Dose _____	Freq._____	Route_____
☐ Antibiotic Ointment (skin lesions)	Dose _____	Freq._____	Route_____

SIGNATURES ARE REQUIRED IN ORDER FOR SCHOOL NURSE TO DISPENSE PRESCRIPTION AND OTC MEDICATION

(Stamp below)

Provider's Signature: ______________________ **Phone:** ______________

Provider's Name/Address: ______________________ **Fax:** ______________

*****Parent Signature:** ______________________ **Date:** ______________

Parental signature authorizes School Health personnel to communicate with your child's physician regarding prescription and OTC medication.

HEALTH SERVICES
CITY SCHOOL DISTRICT OF NEW ROCHELLE

Early Childhood School Health History

Date form completed: ______________________ [ ]Parent Completed [ ]In Person Interview [ ]Telephone Interview

School: ____________________________ Grade: ______

General Information:

Child's Name: ____________________________ Sex: ❒M ❒F DOB: ___/___/___ Age:______

Address: ____
STREET CITY STATE ZIP CODE

Home Phone: _________ Cell Phone: _________ Office Phone: ________ Parent email: ____________

Mother's Name: ______________________________ Age: __________

Father's Name: ______________________________ Age: __________

Brothers and Sisters Names:

1. ____________________________ Sex: ❒M ❒F Date of Birth: ___/___/___
2. ____________________________ Sex: ❒M ❒F Date of Birth: ___/___/___
3. ____________________________ Sex: ❒M ❒F Date of Birth: ___/___/___
4. ____________________________ Sex: ❒M ❒F Date of Birth: ___/___/___

Are parents: ❒Married ❒Divorced ❒Separated ❒Remarried ❒Single

Who cares for the child after school: ______________________________________

Birth History:

Birth weight: ___ lbs. ___ oz. Weeks gestation: ____ Hospital born at: ____________________

Pregnancy: ❒ Normal ❒ Complications: ________________________________

Type of delivery: ❒ NSVD ❒C-Section ❒Breech ❒Forceps ❒Other

Reason: _______________

Problems during pregnancy: ______________________________________

Problems during delivery: ______________________________________

Problems after delivery: ______________________________________

If NICU, add details:

Respiratory/Cardiac:

Ventilator: ❒No ❒ Yes If yes, # ________days ________weeks

Cardiac Surgery: ❒No ❒ Yes If yes, describe, including age at surgery: ____________

____

Other: ____

____

GI/GU:
Describe, including any feeding problems: ______________________________
____

Infection: ____

Neurology:
Intraventricular Hemorrhage: ❒No ❒ Yes If yes, Grade: [ ] I [ ] II [ ] III [ ] IV
____

Ophthalmology:
Retinopathy of Prematurity: ❒No ❒ Yes If yes, current vision/vision care: ______________
____

Neonatal Hearing Test (OAE): [ ] Normal [ ] Abnormal If abnormal, current hearing level and care: ____

Specialist and Subspecialist practitioners involved with child during neonatal/infancy period:
Specialist 1: ______________________ Phone ____________ Address ______________________
[specify specialty]
Specialist 2: ______________________ Phone ____________ Address ______________________
[specify specialty]

Developmental History:
At what age did this child?

Roll over	____________	months
Sit up without support	____________	months
Crawl	____________	months
Walk alone	____________	
Talk (two words together)	____________	
Bladder trained	____________	
Bowel trained	____________	

Did your child experience feeding difficulties during infancy?
If yes, please describe: ____

Did your child have any sleep problems during infancy?
If yes, please describe: ____

What was your child's temperament during infancy: ______________________________
____

What was your child's temperament as a toddler: ______________________________
____

Early Intervention Program
Did this child have EI services: ❐No ❐ Yes
If yes: Age at which services began: ________ months ________ years
Services: ❐Speech ❐ OT ❐PT ❐ SEIT ❐Other, specify: ____________________
Frequency of services: ____

Past Medical History:
Allergies to food or medicines? ❐Yes ❐ No Name of allergens: ________________

If yes, please describe: ____

____
(If yes, complete allergy history for registration)
Immunizations up to date? If not, please elaborate: ______________________

____

Medications (including name, dosage and frequency) taken:
1. ____
2. ____
3. ____

<u>Hospitalizations, accidents or broken bones (note any ICU admissions)</u>

Date	Child's Age	Name of hospital	Reason for hospitalization

<u>Major or serious illnesses</u>

Date	Child's Age	Illness	Physician	Treatment

<u>Surgical procedures (do not repeat information from neonatal history):</u>

Date	Child's Age	Physician	Procedure

Review of Systems:
Indicate which of the following conditions or problems the child has had. Give details and dates for the problems checked:

[ ]Skin trouble
[ ]Eye or vision problems]
[ ]Eyeglasses
[ ]Frequent ear infections
[ ]Difficulty hearing
[ ]Frequent nose bleeds
[ ]Nasal allergies]
[ ]Sinus problems
[ ]Frequent sore throats
[ ]Thyroid problems
[ ]Pneumonia
[ ]Asthma
[ ]Any other lung problems
[ ]Heart murmur
[ ]Any other heart problems
[ ]Jaundice
[ ]Frequent stomach aches
[ ]Frequent diarrhea
[ ]Frequent constipation
[ ]Black or tarry stools
[ ]Kidney or bladder infection
[ ]Frequent or painful urination
[ ]Bedwetting
[ ]Joint aches or pains
[ ]Orthopedic or bony problems
[ ]Seizures
[ ]Frequent headaches
[ ]Skin rashes
[ ]Insect bite reactions
[ ]Anemia
[ ]Speech problems
[ ]Increased lead levels
[ ]Current health concerns/issues

Girls: Menstrual History
Onset: ________________
Frequency: ____________
Cramps: ❐ Yes ❐ No
Irritability: ❐ Yes ❐ No
Other: ________________

[Note any important details in the space below.]

Current Practitioners:

Pediatrician/FP/NP: ____________________ Phone __________ Address ____________________

Specialist 1: ____________________ Phone __________ Address ____________________
[specify specialty]

Specialist 2: ____________________ Phone __________ Address ____________________
[specify specialty]

Specialist 3: ____________________ Phone __________ Address ____________________
[specify specialty]

Specialist 4: ____________________ Phone __________ Address ____________________
[specify specialty]

Behavioral History: Has your child ever been evaluated for, diagnosed with, or treated for:

1. ADHD	[ ]Yes	[ ]No	4. Depression	[ ]Yes	[ ]No
2. Anxiety Disorder	[ ]Yes	[ ]No	5. OCD	[ ]Yes	[ ]No
3. Tourette's Syndrome	[ ]Yes	[ ]No	6. Other ____________		

Details: (Including psychiatric hospitalizations) – If using separate sheet please check here [ ]

____
____
____
____

Name of Evaluating/Treating Physician\Psychiatrist\Psychologist

Physician Name ____________ Telephone ____________ FAX ____________

Street Address ____________ City ____________ ST ____ Zip ____

Pediatrician/FP/NP: ____________ Phone ____________ Address ____________

Specialist 1: ____________ Phone ____________ Address ____________
[specify specialty]

Specialist 2: ____________ Phone ____________ Address ____________
[specify specialty]

Family History:

Father's country of birth: ____________ Mother' country of birth: ____________

Father's occupation: ____________ Mother's occupation: ____________

Father's Education: ____________ Mother's Education: ____________

Does the child have any blood relatives (father, mother ,brother, sister, father's side or mother's side who have the following conditions? (mark with a check)

[ ]Birth deformity ____________
[ ]Mental retardation ____________
[ ]Convulsions, epilepsy ____________
[ ]Mental illness ____________
[ ]Family or inherited disease ____________
[ ]Death in childhood ____________
[ ]Eye problems ____________
[ ]Hearing Problems ____________
[ ]Asthma ____________
[ ]Hay fever ____________
[ ]Allergies ____________
[ ]Severe Anemia ____________
[ ]Sickle Cell disease ____________
[ ]Bleeding tendencies ____________
[ ]Tuberculosis ____________
[ ]Diabetes ____________
[ ]Heart Attack (under age 50) ____________
[ ]Cancer ____________
[ ]High blood pressure ____________
[ ]Kidney problems ____________
[ ]Obesity ____________
[ ]Thyroid Problems ____________
[ ]ADD/ADHD ____________
[ ]Speech issues ____________
[ ]Developmental delay ____________
[ ]Learning disability ____________
[ ]Autism ____________

For all conditions checked please describe: ____________

____

Educational History:

Previous School: ______________________ Location: ____________________Length of Attendance: _____

If not in New Rochelle: Has your child ever attended school in New Rochelle? [ ]Yes [ ]No
If yes, please list the schools and circle the name of the last school your child attended in New Rochelle.

____________________________________ ______________________________________

____________________________________ ______________________________________

Did your child have an? IEP [ ]Yes [ ]No 504 Plan [ ]Yes [ ]No
Did your child receive any services at previous school? [ ]Yes [ ]No If yes please describe: _________

____

Social History:

Living situation: ❐ Homeowner ❐ Home rental
❐ Apartment owner ❐ Apartment rental

Who lives in the home? ____

Does child have: Own room ❐ Yes ❐ No Own bed ❐ Yes ❐ No

Pets in the home? ❐ Yes ❐ No If yes, specify: ______________________________________

Does anyone smoke in the home? ❐ Yes ❐ No

First language of child: _________ Language spoken at home: ____________________

____
Signature of School Nurse Date