HASTINGS-ON-HUDSON
UNION FREE SCHOOL DISTRICT
27 Farragut Avenue
Hastings-on-Hudson, NY 10706
phone: 914-478-6207
fax: 914-478-6259

REGISTRATION CHECK LIST

Items needed to complete the Registration Process
for Each Student Entering Hastings-on-Hudson UFSD

- **Student Registration Form**

  Proper documentation must be provided for each child entering the school district. (This includes an original Birth Certificate, Health Forms, and all other necessary documents) Please make sure that the Registration Form is filled out completely.

- **Proof of Residency** (Needed per family entering Hastings-on-Hudson UFSD)
  - Utility Bills **(3 needed)**
    - Telephone (NOT cell phone)
    - Cable Bill
    - Utility Bill (Con Ed, Gas/Electric)
    - Water Bill
    - Homeowners or Renters Insurance
  - And **(At least 1 needed)**
    - Deed to House
    - Tax Bill
    - Lease
    - Notarized letter from owner of house and copy of tax bill or deed
- **Proof of Age**
- **School Physical form**. Physical must be completed and the form must be signed and stamped by physician.
- **Immunization Records**, form must be signed and stamped by physician.
- **School Records/Release of Records Form**
  - Report Cards (Final report card from past 2 grades.)
  - Transcript (If available)
  - Standardized Test Scores
  - Medical Records
  - I.E.P.
- **Proof of Guardianship**
  This applies to parents who are separated or divorced and for those children not living with biological/adoptive parents.
  - Court Order Agreement re: Guardianship/Custody
  - Other document(s) establishing Guardianship/Custody

ALL ITEMS MUST BE SUBMITTED PRIOR TO ADMITTANCE INTO SCHOOL.

If your child has previously received Special Education Services or has a Section 504 Accommodation Plan, please call our Director of Special Education, Laura Sullivan, at 914-478-6261

STUDENT NAME: ______________________________

Registration Information

Kindergarten through Grade 12

Student's First Name ____________ **Student's Middle Name** ____________ **Student's Last Name** ____________

Student's Nickname ____________ **Student Gender:** ☐ **Male** ☐ **Female** **Student's Code** ____________

Students Date of Birth: ____________ **Grade Level** ________ **School Year** ____________

Place of Birth ____________

Date child entered the U.S. ____________

How many years has the child been enrolled in U.S. schools? __________ **Pre-school?** _______

What Language did your child first learn? ____________

What language does your child respond to in the home? ____________

Hispanic, Latino or of Spanish origin: ☐ **Yes** ☐ **No**

Ethnicity/Race: (Please check one)

☐ **White** ☐ **Black** ☐ **Asian** ☐ **Native Hawaiian/Pacific Islander** ☐ **American Indian/ Native Alaskan**

Student's Address:

Street # ________ Street Name ____________ P.O. Box ________ Apt. ________

City ____________ State ________ Zip Code ________

Home Telephone: ____________ **Unlisted?** ☐ **Yes** ☐ **No**

Parent Email address: ____________

Previous Address

Street # ________ Street Name ____________ Apt. # ________

City ____________ State ________ Zip Code ________

This question is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1) Is your current address a temporary living arrangement? ☐ Yes ☐ No
2) Is this temporary living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No If yes, please answer:
   Where is the student currently living:)*check one box)*

☐ In a motel ☐ In a shelter ☐ With more than one family in a house or apartment
☐ Moving from place to place ☐ In a place not designed for ordinary sleeping accommodations such as a car, park or campsite

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition and other costs TEC Sec. 25.002(3)(d).

STUDENT NAME: ____________

Names and Dates of Birth of brothers and Sisters *(living in household)*

Names	**Date of Birth**
____________________	____________
____________________	____________
____________________	____________
____________________	____________

Student resides with *(check all that apply):* ☐ Father ☐ Mother ☐ Stepmother ☐ Stepfather ☐ Other
If other, specify relationship:

____

Parent/Guardian Salutation: ☐ Mr. & Mrs. ☐ Mr. & Ms. ☐ Mrs. ☐ Mr. ☐ Ms. ☐ Miss ☐ Dr.
If parents prefer not to be addressed as Mr. & Mrs., please write out both names:

____

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower ☐ Single

Is there anything about your family arrangement that we should be aware of: *(split/joint custody, guardianship, live-in au pair, grandparent, etc.)?* Please explain:

____

If parents are not living together, indicate name and address of non-custodial parent:

We must have copies of legal papers or other acceptable documents to confirm any custody or guardianship arrangements. Copies received? ☐ Yes ☐ No

Name: ________________________ ________________________
Last Name First Name

Relationship to student: ________________________

Address *(if known)*: ____

Employer: ____

Home Phone: ( ) ________________ Work Phone: ( ) ________________ ext: ________

Cell Phone: ( ) ________________ Beeper: ( ) ________________

Please list the names and addresses of any Step-parents:

Name: ________________________

Address: ____

STUDENT NAME: ____

Information Updated Annually

Mother/Guardian: ______________________ ______________________
First Name Last Name
Relationship to Student: ______________________ Same address as Student: ☐ Yes ☐ No

If no, please specify: ______________________

Employer: ______________________

Home Phone: ( ) ______________ Work Phone: ( ) ______________ ext: ________

Cell Phone: ( ) ______________ Beeper: ( ) ______________

Home Email: ______________________ Work Email: ______________________

Father/Guardian: ______________________ ______________________
First Name Last Name
Relationship to Student: ______________________ Same address as Student: ☐ Yes ☐ No

If no, please specify: ______________________

Employer: ______________________

Home Phone: ( ) ______________ Work Phone: ( ) ______________ ext: ________

Cell Phone: ( ) ______________ Beeper: ( ) ______________

Home Email: ______________________ Work Email: ______________________

Do the people listed above have the authority in all school and medical matters? ☐ Yes ☐ No
If no, a copy of the court order or other acceptable documentation must be provided.

In the case of an emergency, when the parent/guardian is unavailable, please list two people who would be available to come for your child:

Name: ______________________ **Phone:** ( ) ______________ ☐ Home ☐ Cell ☐ Work

Address: ______________________ **Relationship to Student:** ______________________

Name: ______________________ **Phone:** ( ) ______________ ☐ Home ☐ Cell ☐ Work

Address: ______________________ **Relationship to Student:** ______________________

Are there any medical issues that the school should be made aware of? ☐ Yes ☐ No

If yes, please explain: ______________________

____

Daycare Arrangements (if applicable):

Name of person or facility: ______________________ Phone #: ______________________

Days applicable, check all that apply: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

By signing here, you are attesting to the information you have provided is accurate. If it is determined that the information is false, the Hastings-on-Hudson UFSD may seek legal recourse, including, but not limited to, seeking judgment for non-resident tuition.

Signatures of:

______________________ ______________________
Mother/Father/Guardian (circle one) Date

STUDENT NAME: ______________________

HASTINGS PUBLIC SCHOOLS

HASTINGS-ON-HUDSON, N.Y. 10706

RELEASE FORM FOR STUDENT INFORMATION

(In compliance with Federal General Education Provision Act, Part C, the Protection of the Rights and Privacy of Parents and Students, Public Law 93-380.)

To: ___________________________________ (School, Organization, Agency)

Address: ______________________________________

____

____

We are in need of information for _________________________________(birthdate) ________________ who is enrolled in our school/program. We have received student/parent signature as indicated below for you to release or impart this information to us. All information will be treated as confidential.

Please provide information to:

Registrar's Office
27 Farragut Avenue
Hastings-on-Hudson, N.Y. 10706

Types of Information needed:

______ Transcript/Grade Reports
______ Health/Medical Records/Information
______ Test Scores/Appraisal Reports
______ Withdrawal Grades
______ Other _____________________

Thank you for your prompt consideration of this request.

_________________________________ (Signature)   ____________________ (Title)   _____________ (Date)

===

I understand the need for information being transferred and hereby grant my permission for you to release or impart any information you may have concerning the above named student to the person or organization requesting as above.

_______________________________ (Student signature - if 18 or older)   ____________________________________ (Parent Signature)

______________ (date)

STUDENT NAME: ____

Hastings-on-Hudson UFSD
Parent/Guardian Home Language Survey

New York State requires that parents fill out a Home Language Questionnaire for each child they register in a public school. Please take a few moments to answer the following questions. Thank you.

NAME OF CHILD: ____________________________ GRADE: _______________

NAME OF PERSON COMPLETING THIS SURVEY: ___________________________

1. Is any other language besides English spoken in your home?

If the answer to question #1 is NO, stop here. If the answer is YES, please answer the remaining questions.

2. What other language is spoken in your home?
3. Who speaks the other language?
4. What language did your child learn when he/she first began to talk?
5. At what age did your child begin to speak? _______________
6. At what age did your child begin to speak English? ____________
7. What language does your family speak at home most of the time?
8. What language does the mother speak to her child most of the time?
9. What language does the father speak to his child most of the time?
10. What language does the child speak to his/her mother most of the time?
11. What language does the child speak to his/her father most of the time?
12. What language does the child speak to other adults at home most of the time?
13. What language does your child speak to his/her brothers and sisters most of the time?
14. What language does your child speak to his/her friends most of the time?
15. How well does your child communicate in the other language?

Thank you. Please sign below.

____ ___________________

STUDENT NAME: ____

Hastings-on-Hudson UFSD
Student
Network Access Form

Please read the included policy packet with your parents. Your network and eChalk access will be activated once this form has been returned.

Name: ____

Grade Level: ________________

ACCEPTABLE USE POLICY

I have read and understood the district Technology Acceptable User Policy for students. By signing this form I agree to abide by the rules, policies, and regulations set forth in this agreement.

Student Signature: ____

Date: ____

Parent Signature:_______________________________________

Date:____

FOR OFFICE USE ONLY

Create the appropriate information in the following locations for:

______ Network; ______E Chalk

STUDENT NAME: ____

HASTINGS-ON-HUDSON
UNION FREE SCHOOL DISTRICT
27 Farragut Avenue
Hastings-on-Hudson, New York 10706
Tel: (914) 478-2900
www.hohschools.org

Farragut Health Complex-914-478-6224
Fax 914-478-6340

Hillside Health Complex-914-478-6280
Fax 914-478-3795

Dear Parent/Guardian:

The last few pages of this packet includes an Emergency Contact form, a Health History a Health Appraisal/Physical, Medication Authorization, Tuberculin Screening and Dental form. Please note that the Appraisal/Physical must be accompanied with the students Immunization history. These forms should be returned directly to the Health Office.

Immunizations:
New York State Law Section 2164 requires certain immunizations (shots) to enter kindergarten and certain immunizations to enter grades 1-5, and to enter grade 6. Please check with your health care provider as soon as possible to make sure your child has all the needed immunizations.

Health Appraisal/Physical:

You may use the form in the packet, or one that your health care provider uses. Please note, the state mandated years for submitting a Health Appraisal/ Physical are as follows: all new entrances, and grades K, 2, 4, 7, and 10. In addition, if your child (children) is playing a sport an Annual Health Appraisal/Physical is required. It is a good habit to send in a copy of the Health Appraisal/physical whenever your child receives it.

Please feel free to discuss anything about your child's health history with the school nurse.

Sincerely,

Health Office Staff

STUDENT NAME: ______________________________

STUDENT HEALTH HISTORY FORM
EMERGENCY INFORMATION

HEALTH PROVIDER INFORMATION

Physician Name: ______________________________ **Telephone #:** ( ) ____________

Address: ____
Street Address *City* *State* *Zip Code*

Dentist Name: ______________________________ **Telephone #:** ( ) ____________

Address: ____

STUDENT HEALTH INFORMATION

Please check "Yes" or "No" for each question. Explain all "Yes" answers in space provided and include age and/or year where appropriate.

1. Do you have any concerns about your child's general health? ☐No ☐Yes ____________
2. Does your child have any specific illness or problem? ☐No ☐Yes ____________
3. Does your child have any allergies (food, medication, insects, etc.)? ☐No ☐Yes ____________
4. Does your child have asthma? ☐No ☐Yes ____________
5. Does your child take any medication (daily or occasionally)? ☐No ☐Yes ____________
6. Does your child have any problems with vision, hearing or speech (glasses, ear tubes, hearing aids, contacts)?
☐No ☐Yes ____________
7. Has your child had any hospitalization, operation, or major illness (specify)? ☐No ☐Yes ____________
8. Has your child had any significant injury or illness (specify)? ☐No ☐Yes ____________
9. Has your child ever had Chicken Pox, Scarlet Fever or Fifth Disease? ☐No ☐Yes ____________
10. Would you liked to discuss anything about your child's health and/or family medical history with the school nurse?
☐No ☐Yes ____________

STUDENT NAME: ______________________________

SIGNIFICANT MEDICAL HISTORY

Please include any allergies, medical conditions and medications: ______________________________

____

____

____

____

HEALTH/EMERGENCY DECLARATION

IN CASE OF AN ACCIDENT OR SERIOUS ILLNESS, I REQUEST THAT THE SCHOOL NURSE, ADMINISTRATOR (OR HIS/HER DESIGNEE) SEEK MEDICAL CARE FOR MY CHILD AND MAKE ANY NECESSARY MEDICAL DECISIONS UNTIL I CAN BE REACHED.

I UNDERSTAND AND ACCEPT THAT THE INFORMATION PROVIDED TO THE HEALTH OFFICE REGARDIN MY CHILD MAY BE PROVIDED TO OTHER HASTINGS-ON-HUDSON SCHOOL PERSONNEL ON AN "AS NEEDED" BASIS IN ORDER TO ENSURE THE SAFETY AND WELL BEING OF MY CHILD.

Printed Name of Parent or Guardian: ______________________________

Signature (Applies to this Health/Emergency Declaration): ______________________________

Date: ______________________

Printed Name of Parent or Guardian Filling Out Registration Form: ______________________________

Signature: ______________________________ Date: ______________________

STAFF USE ONLY

Printed Name of Staff Processing Health Packet: ______________________________

STUDENT NAME: ______________________________

EMERGENCY INFORMATION SHEET
HASTINGS ON HUDSON UFSD

Hillside Main Office: 478.6270 - Nurse's Office: 478.6280
Farragut Middle School Main Office: 478.6230 - Nurse's Office: 478.6226
High School Main Office: 478.6250 - Nurse's Office: 478.6226

Please fill in the following information regarding emergency contacts. If this information should change at any time, please notify the office as soon as possible.

Child's Name: ____

*Grade:*________________

Home Address: ____

Home Telephone #: ____________________________

PARENT/GUARDIAN INFORMATION:

Mother/Guardian Name: ______________________________________

Does mother/guardian live with child? Yes ____ *No* ________ **If no, supply address& telephone on back.*

Mother/Guardian cell #: ________________________ *Pager #:* ____________________

Mother/Guardian Work #: ____________________________

Father/Guardian Name: ______________________________________

Does father/guardian live with child? Yes _____ *No* ________ **If no, supply address& telephone on back.*

Father/Guardian cell #: ________________________ *Pager #:* ____________________

Father/Guardian Work #: ____________________________

EMERGENCY CONTACT:

*#1 Name:*________________________________ *Relationship:* ____________________

Phone: ________________ *Cell:* ________________ *Work:* ____________________

*#2 Name:*________________________________ *Relationship:* ____________________

Phone: ________________ *Cell:* ________________ *Work:* ____________________

*#3 Name:*________________________________ *Relationship:* ____________________

Phone: ________________ *Cell:* ________________ *Work:* ____________________

STUDENT NAME: ____

HEALTH CERTIFICATE / APPRAISAL FORM

Name: ____________________ **Date of Birth:** ____________________

School: ____________________ **Gender:** ❑ **M** ❑ **F** **Grade:** ____________________

IMMUNIZATIONS / HEALTH HISTORY

❒ Immunization record attached
❒ No immunizations given today
❒ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ❒ Positive ❒Negative ❒ Not done Date: __________
PPD: ❒ Positive ❒Negative ❒ Not done Date: __________
Elevated Lead: ❒ Yes ❒ No ❒ Not done Date: __________
Dental Referral ❒ Yes ❒ No ❒ Not done Date: __________

____

Significant Medical/Surgical History: ❒ See attached ____________________

____

Allergies: ❒ **LIFE THREATENING** ❒ Food: __________ ❒ Insect: __________ ❒ Other: __________

❒ Seasonal ❒ Medication: ____________________ __________

PHYSICAL EXAM

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

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

❒ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❒ Negative ❒ Positive: __________

Specify any abnormality (use reverse of form if needed): ____________________

____

____

MEDICATIONS

Medications (list all): ❒ None ❒ Additional medications listed on reverse of form

Name: ____________________ Dosage/Time: ____________________

Name: ____________________ 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. 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.

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 resistant eyewear ❒ Other: __________

OPTIONAL INFORMATION, if known

Specify current diseases: ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2 ❒ Hyperlipidemia ❒ Hypertension
❒ Other: ____________________

Provider's Signature: ____________________ Phone: __________ (Stamp below)

Provider's Name/Address: ____________________ Fax: __________

Parent Signature: ____________________ Date: __________

STUDENT NAME: ____________________

Hastings Public Schools

Health Offices

High School-Middle School
(914) 478-6340
Fax (914) 478-6340
27 Farragut Avenue

Hillside School
(914) 478-6280
Fax (914) 478-6279
120 Lefurgy Avenue

Hastings on Hudson, New York 10706

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATIONS IN SCHOOL

A. To be completed by parent/guardian:

I request that my child ______________________________grade_____ receive the medication as prescribed below by our licensed health care prescriber.

The medication is to be furnished by me in a properly labeled original container from the pharmacy.

Signature: (Parent/Guardian) ___________________________________

Address: ____

Telephone: Home ____________________ **Work**___________________

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Student Name: ________________________**DOB:**________________________

Diagnosis: ____

Medication: _____________**Dosage:** ____________ **Frequency/Route**___

Medication: _____________ **Dosage:** ____________ **Frequency/Route**___

Medication: _____________ **Dosage:** ____________ **Frequency/Route**___

Possible side effects/adverse reaction: ___________________________________

PLEASE CHECK ONE:

C. ____ **I deem this child to be self directed. He/she has been instructed in the proper use of the above medication. He/she understands the purpose, appropriate method of its administration and frequency of use.**

____ **I do not deem this child to be self directed in the above medication**

Licensed Prescriber: Name and Title (print please) _______________________

Signature: _____________________________________

Address: ______________________________________

Phone: ____

STUDENT NAME: ____

For Office Use Only

Proof of Residency:

Lease: ______ **Expiration Date:** __________________ **Notarized letter from Landlord** _____ **End Date:** __________

Or

Deed to house: _____________ **or tax bill** __________

Utility Bill 1: _________ **Name of Utility:** ________________________________ **Date:** ____________________

Utility Bill 2: _________ **Name of Utility:** ________________________________ **Date:** ____________________

Original Proof of Age: ____________________

Does a home language survey need to be completed? ☐ **Yes** ☐ **No**

Health Records:

Physical form completed: ________________________ **Date of physical:** _______________________________

Date Immunization records received: ____________________________

Date Health History Form Received: _______________________ **Verified by:** ______________________

Previous Records:

Requested from: ____ **Date:** _____________________

Address: ____ **Phone #** ___________________

____ **Fax #** ___________________

Received:

Report Cards: ____________________

Standardized Test Scores: ________________

Medical Records: ________________________

Special Education files: ___________________

Section 504 files: ________________________

Other: __________________________________

STUDENT NAME: ____