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 _____

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 all that apply)

☐ 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: _____

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: _____

Name of Student's Physician:

_____

Address: _____

Phone: _____

Information Updated Annually

Guardian 1: _____ _____
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: _____

Guardian 2: _____ _____
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: _____

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:* _____

STUDENT NAME: _____

Hillside Elementary School

120 Lefurgy Avenue, Hastings-on-Hudson, NY 10706 (914) 478-6270 ~ Fax (914) 478-6279

Amy Cazes, Principal cazesa@hohschools.org

John DeKams, Assistant Principal dekamsj@hohschools.org

Must Be Completed For All Grades K-12
Home Language Questionnaire (HLQ)

Welcome to our school! We have a few questions about languages spoken in your home. We are required by the US Department of Education to ask for this information because it will help us know how we can best support your child, and how we can best communicate with you.

Attached is a Home Language Questionnaire. The purpose of this questionnaire is to inform the district of what language(s) is/are used in your home. This is important because your child may be eligible for academic language support in their classroom. If needed, an English language specialist may meet with you and your child to describe the next steps in the process, which can include an interview and an assessment of your child's English proficiency. It's important to be as thorough as possible when completing this form because after the screening identification process is complete, we cannot reverse the decision or offer language services that may help your child succeed academically.

All of the information gathered in the screening process will help us determine whether or not your child qualifies for language support that will enhance their learning.

If you still have questions after completing the form, please contact:

Hillside Elementary School - Kristen Aimi: AimiK@hohschools.org

Farragut Middle School - Chadia Madera: MaderaC@hohschools.org

Farragut Middle School - Dr. June Wai: Waij@hohschools.org

Hastings High School- Jenice Mateo-Toledo: Mateotoj@hohschools.org

HLQ Form Link in 41 languages:

http://www.nysed.gov/bilingual-ed/ell-identification-placementhome-language-questionnaire

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: *Month* *Day* *Year*

GENDER: ❑ Male ❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

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

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:

The University of the State of New York • The State Education Department • Office of Bilingual Education
Albany, New York 12234

CUESTIONARIO SOBRE EL IDIOMA QUE SE HABLA EN EL HOGAR
("Home Language Questionnaire, HLQ") – Spanish

Estimado Padre/Madre o Guardián:

Para poder ofrecer a su hijo(a) la mejor educación posible, necesitamos determinar cuán efectivamente él o ella entiende, habla, lee y escribe el idioma inglés. Su ayuda será apreciada si contesta estas preguntas.

Gracias.

PARA SER COMPLETADO POR EL PERSONAL ESCOLAR
(TO BE COMPLETED BY SCHOOL PERSONNEL)

DISTRITO (District) — *IMPRIMA O ESCRIBA CLARAMENTE (Please print or type Clearly)*

ESCUELA (School) — GRADO (Grade)

NOMBRE DEL ESTUDIANTE (Student Name)

FECHA DE NACIMIENTO (Date Of Birth) Mes: (Month) Día: (Day) Año: (Year)

NUMERO DE IDENTIFICACION DEL ESTUDIANTE (Student Identification Number)

PAIS NATAL O ASCENDENCIA (Country of Birth/Ancestry)

NUMERO DE AÑOS MATRICULADO EN ESCUELA(S) FUERA DE LOS E.U. (Number of years enrolled in school outside the U.S.)

NOMBRE/POSICIÓN DEL PERSONAL ESCOLAR LLENANDO ESTA SECCION (Name/Position School Personnel Completing This Section)

DETERMINACIÓN: (Determination)
- ❑ Posiblemente LEP (Possibly LEP)
- ❑ Dominante en Inglés (English Proficient)

(✔ Marque las casillas que aplican)

1. ¿Qué idioma(s) se habla en el hogar o residencia del estudiante? ❑ Inglés ❑ Español ❑ Otro _____ *(Especifique cuál)*
2. ¿En qué idioma(s) se le habla al estudiante la mayor parte del tiempo en el hogar o residencia? ❑ Inglés ❑ Español ❑ Otro _____ *(Especifique cuál)*
3. ¿Qué idioma(s) entiende el estudiante? ❑ Inglés ❑ Español ❑ Otro _____ *(Especifique cuál)*
4. ¿Qué idioma(s) habla el estudiante? ❑ Inglés ❑ Español ❑ Otro _____ *(Especifique cuál)*
5. ¿En qué idioma(s) lee el estudiante? ❑ Inglés ❑ Español ❑ Otro _____ *(Qué idioma)* ❑ No lee
6. ¿En qué idioma(s) escribe el estudiante? ❑ Inglés ❑ Español ❑ Otro _____ *(Qué idioma)* ❑ No escribe
7. ¿En su opinión, qué tan bien el estudiante entiende, habla, lee y escribe inglés?

	Muy bien	Un poco	Nada
Entiende Inglés	❑	❑	❑
Habla Inglés	❑	❑	❑
Lee Inglés	❑	❑	❑
Escribe Inglés	❑	❑	❑

Mes: (Month) Día: (Day) Año: (Year)

Firma del Padre/Madre/Guardián/Otro (Signature of Parent/Guardian/Other)

Fecha (Date)

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

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

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

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

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

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

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

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

_____

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

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

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

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

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

_____ Mes: Día: Año:
Firma del padre/madre o de la persona en relación paternal *Date*

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

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

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

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

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ NO ☐ YES

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

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

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

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

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

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

HILLSIDE ELEMENTARY SCHOOL

PARENT QUESTIONNAIRE

To be filled out for grades K-4 only

Child's Name _____ Birth Date _____

Parent(s) _____ Parent(s) _____

Home Phone _____ Parent Cell _____ Parent Cell _____

Has your child attended any schools before? Yes _____ No _____ How long? _____

What school? _____ Address _____

Please list all brothers and sisters

Name	Age	School

Please describe the siblings' feeling about school _____

Does your child have playmates of his/her own age? Yes/No

Does your child enjoy playing with other children? Yes/No

Does your child enjoy having time to spend alone? Yes/No

Does your child prefer to play with others or alone? Others/Alone

Is there any other child your child should not be placed with? _____

What are your child's special interests? _____

Please list some experiences that have enriched your child's knowledge.

What does your child most enjoy doing? _____

What kinds of things have you tried to teach your child at home? _____

How does your child respond to efforts to teach? _____

What responsibilities does your child have at home? _____

What kinds of things does your child find difficult to do? _____

How does your child react when he/she fails at something? _____

Does your child respond to encouragement and / or help? _____

When your child misbehaves, what methods do you find work best to correct the behavior? _____

Do you expect any difficulty for your child adjusting to kindergarten? _____

Has your child had any frightening or upsetting experiences? _____

Is your child able to sit and listen to a story? _____

Is your child able to separate from you when he/she goes to a birthday? _____

Other comments: _____

HILLSIDE ELEMENTARY SCHOOL

Cuestionario para los padres

Completar solamente para los grados K-4

Nombre del Niño_____Fecha de Nacimiento_____

Nombre de los padre(s)_____ _____

Numero de telèfono de casa_____ de Celular_____ _____

¿Su niño ha atendido cualquier escuela antes? Si _____ No _____ ¿Por cuanto tiempo? _____

¿Cual escuela? _____ Dirección_____

Enumere por favor a todos los hermanos y hermanas

Nombre	**Edad**	**Escuela**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Por favor describe los sentimientos de escuela para los hermanos_____

_____

¿Su niño tiene amigos de su propia edad? Si___ No___

¿A su niño le gusta jugar con otros niños? Si___ No___

¿A su niño le gusta tener tiempo para pasar solo? Si___ No___

¿Su niño prefiere jugar con otros o solamente? Con Otros___ Solamente___

¿Hay cualquier otro niño que su niño no debe ser colocado juntos? _____

_____

¿Cuáles son intereses especiales de su niño?_____

_____

Enumere por favor algunas experiencias que han enriquecido el conocimiento de su niño_____

_____

¿Qué le gusta hacer la mayoría del tiempo?_____

_____

¿Qué tipos de cosas ha intentado enseñar a su niño en su casa?_____

_____

¿Cómo su niño responde a los esfuerzos de enseñar?_____

_____

¿Qué responsabilidades tiene su niño en su casa?_____

_____

¿Qué tipos de cosas su niño encuentra difíciles de hacer?_____

_____

¿Cómo su niño reacciona cuando falla en algo?_____

_____

¿Su niño responde positivamente al estímulo y/o a la ayuda?_____

_____

¿Cuándo su niño se comporta mal, qué métodos usa que trabajan lo más mejor posible para corregir el comportamiento?_____

_____

¿Usted piensa será difícil para su niño ajustar al kindegarten?_____

_____

¿Su niño ha tenido experiencias asustadas o tristes?_____

_____

¿Puede su niño sentarse y escuchar una historia entera?_____

_____

¿Puede su niño separarse de usted cuando el/ella va a un cumpleaños?_____

_____

Otro commentario:_____

_____

_____

_____

_____

Kindergarten only

HILLSIDE ELEMENTARY SCHOOL

120 Lefurgy Avenue, Hastings-on-Hudson, NY 10706 (914) 478-6270 ~ Fax (914) 478-6279

Amy Cazes, Principal cazesa@hohschools.org
John DeKams, Assistant Principal dekamsj@hohschools.org

Dear Parent/Guardian:

We find that communication with a child's preschool helps to facilitate the child's transition from preschool to kindergarten. The preschool teacher is familiar with your child and many aspects of your child's development and school functioning.

Information from preschool assists us in making class placement decisions that will benefit your child. The kindergarten teacher can also work more effectively with your child when he/she knows what to expect and how your child is likely to react in certain situations.

We would like your permission to obtain information about your child's learning style, basic skills, and social skills from your child's preschool. Please indicate your consent for obtaining this information by completing the form below.

Thank you for being partners in learning with us.

Sincerely,

Amy Cazes
Principal

John DeKams
Assistant Principal

---------- CONSENT FOR RELEASE OF PRESCHOOL INFORMATION ----------

Child _____

Preschool Name, Address, Phone #

_____

_____

Parent/Guardian Signature:_____

Please return form to Hillside School – Attention Mrs. Day

8/10/2018

Grades 1 - 12

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

Hillside Nurse: 478.6280 Middle/High School Nurse: 478.6225

Dear Parents/Guardians:

Welcome to the Hastings on Hudson School District. As school nurses we understand how important good health is to academic performance. We look forward to partnering with you to keep your child as healthy as possible. With that common goal in mind, the requirements for school outlined below are in place to support your child's health and well-being.

New York State Education Law requires a health certificate (physical examination) to be on file for all students **new** to the Hastings on Hudson School District. All physical exams **must** be performed **within 12 months prior to the date of entry.** The physical exam and documentation of required immunizations must be completed, signed and stamped by your **physician, physician assistant or nurse practitioner authorized to practice in New York State.** A dental certificate is requested for students new to the district.

The physical examination form must be handed in within 30 days of the date of entry into school. Please note that a student **cannot** participate in physical education or a sport until there is a current copy of their New York State physical exam on file.

New York Public Health Law 2164 requires **all** students to be **fully immunized** against **Polio, Diphtheria, Tetanus, Pertussis, Measles, Mumps, Rubella (MMR), Hepatitis B, Meningococcal and Varicella (Chicken Pox).** Acceptable proof of immunity may include a physician's documented record of disease or a positive titer (blood test). These immunizations are required for school entrance and attendance. **Exclusion from school will result if immunization requirements are not met.**

We appreciate your compliance with these regulations. If you have any concerns or questions regarding your child's health, please contact the health office.

Sincerely,

Hastings on Hudson School Nurses

PARENT/GUARDIAN HEALTH OFFICE FORM CHECKLIST

Health Certificate (Physical exam) form – signed by healthcare provider
Health History – completed and signed by parent/guardian
Current Immunization Record – signed by healthcare provider
Dental Certificate – signed by dentist (optional)
Medication Authorization (if applicable) – signed by healthcare provider and parent/guardian
Emergency Information form – signed by parent/guardian

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

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

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre-K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

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

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

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

Recommendations:

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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

STUDENT HEALTH HISTORY

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other ☐epi-pen
Had a hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Dental Injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
- ☐ Scoliosis
- ☐ Single Organ (☐kidney, ☐testicle)
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Urinary Condition

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

Is there any condition that would prevent your child from participating in physical education or sports?
☐ No ☐ Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

_____

Parent/Guardian Signature: _____ Date: _____

Hastings-On-Hudson Public Schools
Health Offices

Hillside Elementary School
120 Lefurgy Avenue
Hastings-On-Hudson, NY 10706
(Tel) 914 478-6280
(Fax) 914 478-3795

High School-Middle School
27 Farragut Avenue
Hastings-On-Hudson, NY 10706
(Tel) 914 478-6224
(Fax) 914 478-6340

Parent and Prescriber's Authorization for Administration of Medication in School

A. To be completed by parent/guardian:

I request that my child_____ grade____ receive the medication(s) 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. (*In the event of an emergency the district's stock Albuterol may be used when the student's prescription is empty)*

Parent/Guardian Signature:_____ (Tel #)_____

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

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

Student Name:_____ **DOB:**_____

Diagnosis:_____

****MEDICATIONS MUST BE ORDERED IN PROPER DOSAGE NOTATION (i.e. mg, concentration) TO BE ACCEPTED****

Medication:_____ **Dosage:**_____ **Frequency:**_____ **Route:** _____
Medication:_____ **Dosage:**_____ **Frequency:** _____ **Route:**_____
Medication:_____ **Dosage:**_____ **Frequency:** _____ **Route:**_____
Medication:_____ **Dosage:**_____ **Frequency:**_____ **Route:**_____
Medication:_____ **Dosage:**_____ **Frequency:**_____ **Route:**_____
Possible Side Effects:_____

Health Care Provider Permission for Independent Use and Carry (not applicable for grades K-4)

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications checked below:

This student is diagnosed with:

- ☐ Allergy and requires Epinephrine Auto-injector
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ☐ _____ (State Diagnosis) which requires rapid administration of _____ (Medication Name)

Signature: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: _____ Date: _____

Licensed Prescriber:_____ **Date**_____ **Stamp:**
Name and Title (print):_____
Signature: _____
Address:_____

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: _____

Utility Bill 3: Name of Utility: _____ Date: _____

Proof of Age: Birth Certificate (original) _____ Passport _____ Other: _____

Home Language Survey: _____ Additional HLS: _____

Health Records:

Physical form completed: _____ Date of physical: _____

Date Immunization records received: _____

Date Health History form received: _____ Verified by: _____

Request for Previous Records _____

Requested from: _____ Date: _____

Address: _____ Phone # _____

_____ Fax # _____

Received: _____ Special Education Files: _____

Standardized Test Scores: _____ Section 504 Files: _____

Medical Records: _____ Other: _____

Parent Questionnaire _____

E-Blast Registration _____

STUDENT NAME: _____