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

- Original Birth Certificate

- 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 914-478-6281
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)**

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<thead>
<tr>
<th>Names</th>
<th>Date of Birth</th>
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**Student resides with (check all that apply):**

- [ ] Father
- [ ] Mother
- [ ] Stepmother
- [ ] Stepmother
- [ ] 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:**

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<th>Last Name</th>
<th>First Name</th>
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**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:**


**STUDENT NAME:** ____________________________________________
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: ___________________________________________

Name: ___________________________________________  Phone: (____) ___________  □ Home  □ Cell  □ Work

Address: ___________________________________________

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  
Parragut 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 and 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 and 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: ____________________________________________
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: Mateotoi@hohschools.org

HLQ Form Link in 41 languages:
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.

Home Language Questionnaire (HLQ)

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<tr>
<th>STUDENT NAME:</th>
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<td>First</td>
<td>Middle</td>
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<tr>
<th>DATE OF BIRTH:</th>
<th>GENDER:</th>
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<tr>
<td>Month Day Year</td>
<td>Male</td>
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<td></td>
<td>Female</td>
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</table>

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<tr>
<th>PARENT/PARENT IN PARENTAL RELATION INFO:</th>
<th></th>
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<tbody>
<tr>
<td>Last Name</td>
<td>First Name</td>
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</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>SCHOOL DISTRICT INFORMATION:</th>
<th>STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:</th>
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</table>
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:          Date

Signature of Parent or of Person in Parental Relation

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:

_________________________________________

OFFICIAL ENTRY ONLY: 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 NYSETTLE    ☐ ENGLISH PROFICIENT
   ☐ REFER TO LANGUAGE PROFICIENCY TEAM

_________________________________________

OFFICIAL ENTRY ONLY: NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSETTLE

NAME: ___________________________     POSITION: ___________________________

DATE OF NYSETTLE ADMINISTRATION: ___________________________

   MO    DAY    YR

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

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

<table>
<thead>
<tr>
<th>DISTRITO</th>
<th>IMPRIMA O ESCRIBE CLARAMENTE</th>
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<tbody>
<tr>
<td>(District)</td>
<td>(Print or type clearly)</td>
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<tr>
<td>ESCUELA</td>
<td>GRADE</td>
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<tr>
<td>(School)</td>
<td>(Grade)</td>
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<tr>
<td>NOMBRE DEL ESTUDIANTE</td>
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<tr>
<td>(Student Name)</td>
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<tr>
<td>FECHA DE NACIMIENTO</td>
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<tr>
<td>(Date Of Birth)</td>
<td>Month</td>
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<td>Day</td>
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<td></td>
<td>Year</td>
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<tr>
<td>NUMERO DE IDENTIFICACION DEL ESTUDIANTE</td>
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<tr>
<td>(Student Identification Number)</td>
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<td>PAIS NATAL O ASCENDENCIA</td>
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<tr>
<td>(Country of Birth/Ancestry)</td>
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<tr>
<td>NUMERO DE AÑOS MATRICULADO EN ESCUELA(S) FUERA DE LOS E.U.</td>
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<tr>
<td>(Number of years enrolled in school outside the U.S.)</td>
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<tr>
<td>NOMBRE/POSICION DEL PERSONAL ESCOLAR LLENANDO ESTA SECCION</td>
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<tr>
<td>(Name/Position School Personnel Completing This Section)</td>
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<tr>
<td>DETERMINACION</td>
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<td>(Determination)</td>
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<td></td>
<td>□ Posiblemente LEP (Possibly LEP)</td>
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<td></td>
<td>□ Dominante en Ingles (English Proficient)</td>
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(✓) 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  □ No lee
   (Qué idioma(s))

6. ¿En qué idioma(s) escribe el estudiante?
   □ Inglés  □ Español  □ Otro  □ No escribe
   (Qué idioma(s))

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  □  □  □

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

Fecha
(Date)

Mes:
(Month)

Año:
(Year)
Cuestionario de idioma del Hogar (HLQ) — Página Dos

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) puede tener dificultades, interferencias o problemas educacionales que le afectan su capacidad para entender, hablar, leer o escribir en inglés o en cualquier otro idioma? En caso afirmativo, por favor describalos.

☐ No ☐ Sí

* En caso afirmativo, por favor explique: ____________________________________________________________

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

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

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

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

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

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

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

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

_________________________________________________________________________________________

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

Firma del padre/madre o de la persona en relación paterna: ____________________________

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

Mes: __________ Dia: ________ Año: ________

-----------------------------------------------------------------------------------------------

** Date of Individual Interview: ______/______/______

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

-----------------------------------------------------------------------------------------------
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 _______________________

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

What school? _______________________________ Address _______________________

Please list all brothers and sisters

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<th>Name</th>
<th>Age</th>
<th>School</th>
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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

Nombre del Niño_________________________________________ Fecha de Nacimiento__________________________________

Nombre de los padre(s)_____________________________________ ________________________________________________

Número de teléfono de casa____________________ de Celular____________________ ______________________________________

¿Su niño ha asistido a cualquier escuela antes?  Si ______ No ______ ¿Por cuánto tiempo? ______

¿Cuál escuela? __________________________ Dirección ______________________________________________________________________

Enumere por favor a todos los hermanos y hermanas

<table>
<thead>
<tr>
<th>Nombre</th>
<th>Edad</th>
<th>Escuela</th>
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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 comentario:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
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                                  John DeKams
Principal                                  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
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: 

Types of Information needed:

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

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: ____________________________________________
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 ENTIREITY 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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Sex: □ M □ F</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Exam Date:</td>
</tr>
</tbody>
</table>

### HEALTH HISTORY

<table>
<thead>
<tr>
<th>Allergies □ No</th>
<th>□ Medication/Treatment Order Attached</th>
<th>□ Anaphylaxis Care Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes, indicate type</td>
<td>□ Food □ Insects □ Latex □ Medication □ Environmental</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Asthma □ No</th>
<th>□ Medication/Treatment Order Attached</th>
<th>□ Asthma Care Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes, indicate type</td>
<td>□ Intermittent □ Persistent □ Other:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Seizures □ No</th>
<th>□ Medication/Treatment Order Attached</th>
<th>□ Seizure Care Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes, indicate type</td>
<td>□ Type: Date of last seizure:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diabetes □ No</th>
<th>□ Medication/Treatment Order Attached</th>
<th>□ Diabetes Medical Mgmt. Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes, indicate type</td>
<td>□ Type 1 □ Type 2 □ HbA1c results: Date Drawn:</td>
<td></td>
</tr>
</tbody>
</table>

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.*

<table>
<thead>
<tr>
<th>BMIKg/m2</th>
<th>Percentile (Weight Status Category): □ &lt;5th □ 5th-49th □ 50th-84th □ 85th-94th □ 95th-98th □ 99th and+</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hyperlipidemia: □ No □ Yes</th>
<th>Hypertension: □ No □ Yes</th>
</tr>
</thead>
</table>

### PHYSICAL EXAMINATION/ASSESSMENT

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
<th>BP:</th>
<th>Pulse:</th>
<th>Respiration:</th>
<th>Other Pertinent Medical Concerns</th>
</tr>
</thead>
</table>

- **TESTS**
  - PPD/PRN
  - Sickle Cell Screen/PRN
  - Lead Level Required Grades Pré-K & K

- **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**

- **Diagnoses/Problems (list):**
  - □ Extremities □ Speech
  - □ Skin □ Social Emotional
  - □ Neurological □ Musculoskeletal

- **ICD-10 Code**

- **Additional Information Attached**

Rev. 5/4/2018 Page 1 of 2
Name:  

<table>
<thead>
<tr>
<th>Vision</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/20</td>
<td>20/20</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Distance Acuity With Lenses</td>
<td>20/20</td>
<td>20/20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision—Near Vision</td>
<td>20/20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision—Color</td>
<td>☐ Pass ☐ Fail</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hearing</th>
<th>Right dB</th>
<th>Left dB</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pure Tone Screening</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scoliosis: Required for boys grade 9</th>
<th>Negative</th>
<th>☐ Positive</th>
<th>☐ Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>And girls grades 5 &amp; 7</td>
<td>☐</td>
<td>☐</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

Deviations Degree: Trunk Rotation Angle:

Recommendations:

☐ Full Activity without restrictions including Physical Education and Athletics.

☐ Restrictions/Adaptations

☐ No Contact Sports

☐ No Non-Contact Sports

☐ 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 NYSII ☐ Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:  

Date:  

Provider Name: (please print)  

Provider Address:

Phone:

Fax:

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

Rev. 5/4/2018 Page 2 of 2
# STUDENT HEALTH HISTORY

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>Grade:</th>
<th>Age:</th>
<th>Gender: ☐ M ☐ F</th>
<th>Parent/Guardian: (person completing this form)</th>
<th>Home Phone:</th>
<th>Cell Phone:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Has your child ever:</th>
<th>YES</th>
<th>NO</th>
<th>If Yes, please explain and include date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had an ongoing medical condition</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Seen a medical specialist</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Had allergies:</td>
<td>☐</td>
<td>☐</td>
<td>☐ food ☐ environmental ☐ insect ☐ medication ☐ other ☐ epi-pen</td>
</tr>
<tr>
<td>Had a hospitalization</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Had an operation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Had an injury requiring an Emergency Room visit</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Missed 5 days of school in a row due to illness/injury</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Had a bone/muscle injury</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Passed out, had a concussion or serious head injury</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Had a convulsion/seizure</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Had a vision problem or condition</td>
<td>☐</td>
<td>☐</td>
<td>☐ glasses ☐ contacts</td>
</tr>
<tr>
<td>Had a hearing problem or condition</td>
<td>☐</td>
<td>☐</td>
<td>☐ hearing aid ☐ cochlear implant</td>
</tr>
<tr>
<td>Worn dental bridge, braces or mouthpiece</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have any family members under the age of 50 ever:</th>
<th>YES</th>
<th>NO</th>
<th>If Yes, please specify:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had a heart attack</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Had other serious health problems</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**CHECK ALL THAT APPLY TO YOUR CHILD:**
- ADHD
- Asthma/touble 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:

<table>
<thead>
<tr>
<th>✅</th>
<th>YES</th>
<th>NO</th>
<th>Please list name, dose, time(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>Given at school</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>☐</td>
<td>Taken at home</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### ASSISTIVE EQUIPMENT:

<table>
<thead>
<tr>
<th>✅</th>
<th>YES</th>
<th>NO</th>
<th>Please check all that apply</th>
</tr>
</thead>
</table>
| ☐ | 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: ___________________________
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**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<tr>
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<td></td>
</tr>
</tbody>
</table>

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
☐ ____________________________ which requires rapid administration of ____________________________

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: ___________________________