

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

- o 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.
- o 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
- o Original Birth Certificate
- o School Physical form. Physical must be completed and the form must be signed and stamped by physician.
- o Immunization Records, form must be signed and stamped by physician.
- o 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.
- o 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*



**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: \_\_\_\_\_

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: \_\_\_\_\_ 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](mailto:cazesa@hohschools.org)

John DeKams, Assistant Principal

[dekamsj@hohschools.org](mailto: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](mailto:AimiK@hohschools.org)

Farragut Middle School - Chadia Madera: [MaderaC@hohschools.org](mailto:MaderaC@hohschools.org)

Farragut Middle School - Dr. June Wai: [Waij@hohschools.org](mailto:Waij@hohschools.org)

Hastings High School- Jenice Mateo-Toledo: [Mateotoj@hohschools.org](mailto: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)

Grade Entering: \_\_\_\_\_

*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
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**DATE OF BIRTH:** \_\_\_\_\_ **GENDER:** \_\_\_\_\_

Month	Day	Year	<input type="checkbox"/> Male
			<input type="checkbox"/> Female

**PARENT/PERSON IN PARENTAL RELATION INFO:**

Last Name	First Name	Relation to Student
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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 \_\_\_\_\_  Father \_\_\_\_\_  
*specify* *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 \_\_\_\_\_  Does not speak  
*specify*

6. What language(s) does your child read?  English  Other \_\_\_\_\_  Does not read  
*specify*

7. What language(s) does your child write?  English  Other \_\_\_\_\_  Does not write  
*specify*

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

<b>SCHOOL DISTRICT INFORMATION:</b>	<b>STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:</b>
_____	_____
<i>District Name (Number) &amp; School</i>	<i>Address</i>

## 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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *If yes, please explain: _____
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* <i>*Please complete 10b below</i>
10b. <i>*If referred for an evaluation</i> , has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____
Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> Yes
11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.) _____ _____
12. In what language(s) would you like to receive information from the school? _____

\_\_\_\_\_  
 Signature of Parent or of Person in Parental Relation
 
 Month:    Day:    Year:  
 \_\_\_\_\_  
 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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ MO.    DAY    YR.	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> 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: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: _____ _____	





**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 \_\_\_\_\_  No lee  
(Qué idioma)

---

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

---

  7. ¿En su opinión, qué tan bien el estudiante entiende, habla, lee y escribe inglés?
- |                 | Muy bien                 | Un poco                  | Nada                     |
|-----------------|--------------------------|--------------------------|--------------------------|
| Entiende Inglés | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Habla Inglés    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lee Inglés      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Escribe Inglés  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## 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* <input type="checkbox"/> No <input type="checkbox"/> No se sabe <input type="checkbox"/> * En caso afirmativo, por favor explique: _____
¿Qué gravedad considera usted que tienen estas dificultades educacionales? <input type="checkbox"/> Poca gravedad <input type="checkbox"/> Algo grave <input type="checkbox"/> Muy grave
10a. ¿Alguna vez se ha recomendado a su hijo(a) a tener una evaluación de educación especial? <input type="checkbox"/> No <input type="checkbox"/> Sí* * Por favor, llene 10b.
10b. <u>*Si se le ha recomendado alguna vez una evaluación, ¿ha recibido su hijo(a) alguna vez alguna forma de educación especial?</u> <input type="checkbox"/> No <input type="checkbox"/> 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): <input type="checkbox"/> De nacimiento a 3 años (Intervención Temprana) <input type="checkbox"/> 3 a 5 años (Educación Especial) <input type="checkbox"/> 5 años o mayor (Educación Especial)
10c. ¿Tiene su hijo(a) un Programa de Educación Individualizada ("IEP" por sus siglas en Inglés)? <input type="checkbox"/> No <input type="checkbox"/> 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 paterna \_\_\_\_\_ 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: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
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**NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL**

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_

DATE OF NYSITELL ADMINISTRATION: _____ Mo. DAY YR.	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
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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

<u>Name</u>	<u>Age</u>	<u>School</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 teléfono 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

<u>Nombre</u>	<u>Edad</u>	<u>Escuela</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# HILLSIDE ELEMENTARY SCHOOL

120 Lefurgy Avenue, Hastings-on-Hudson, NY 10706

(914) 478-6270 ~ Fax (914) 478-6279

Amy Cazes, Principal  
John DeKams, Assistant Principal

[cazesa@hohschools.org](mailto:cazesa@hohschools.org)  
[dekamsj@hohschools.org](mailto: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

**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:

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: \_\_\_\_\_



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

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**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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

**HEALTH HISTORY**

Allergies <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Environmental

Asthma <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	

Seizures <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____	Date Drawn: _____

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

BMI \_\_\_\_\_ kg/m2 Percentile (Weight Status Category):  <5<sup>th</sup>  5<sup>th</sup>-49<sup>th</sup>  50<sup>th</sup>-84<sup>th</sup>  85<sup>th</sup>-94<sup>th</sup>  95<sup>th</sup>-98<sup>th</sup>  99<sup>th</sup> and >

Hyperlipidemia:  No  Yes      Hypertension:  No  Yes

**PHYSICAL EXAMINATION/ASSESSMENT**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respirations: \_\_\_\_\_

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

System Review and Exam Entirely Normal

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

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

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:  	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:70%;">Diagnoses/Problems (list)</th> <th style="width:30%;">ICD-10 Code</th> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	Diagnoses/Problems (list)	ICD-10 Code	_____	_____	_____	_____	_____	_____
Diagnoses/Problems (list)	ICD-10 Code								
_____	_____								
_____	_____								
_____	_____								

Additional Information Attached

Name:			DOB:	
<b>SCREENINGS</b>				
<b>Vision</b>	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Notes</b>
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
<b>Hearing</b>	<b>Right dB</b>	<b>Left dB</b>	<b>Referral</b>	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Scoliosis</b> Required for boys grade 9: And girls grades 5 & 7	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
<b>Recommendations:</b>				
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>				
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics. <input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications <input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling <input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field <input type="checkbox"/> Other Restrictions:				
<input type="checkbox"/> Developmental Stage for Athletic Placement Process ONLY Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports Student is at Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> Accommodations: Use additional space below to explain <input type="checkbox"/> Brace*/Orthotic <input type="checkbox"/> Colostomy Appliance* <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Insulin Pump/Insulin Sensor* <input type="checkbox"/> Medical/Prosthetic Device* <input type="checkbox"/> Pacemaker/Defibrillator* <input type="checkbox"/> Protective Equipment <input type="checkbox"/> Sport Safety Goggles <input type="checkbox"/> Other:				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
<b>MEDICATIONS</b>				
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached				
List medications taken at home:				
<b>IMMUNIZATIONS</b>				
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIS Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>HEALTH CARE PROVIDER</b>				
Medical Provider Signature:			Date:	
Provider Name: (please print)			Stamp:	
Provider Address:				
Phone:				
Fax:				
<b>Please Return This Form To Your Child's School When Entirely Completed.</b>				

## STUDENT HEALTH HISTORY

Name:	DOB:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)	Grade:	Home Phone:	Date:
		Cell Phone:	

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

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

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

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

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

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

Please list any additional concerns: (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
- \_\_\_\_\_ which requires rapid administration of \_\_\_\_\_

(State Diagnosis)

(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: \_\_\_\_\_