

HASTINGS-ON-HUDSON
UNION FREE SCHOOL DISTRICT

27 Farragut Avenue
Hastings-on-Hudson, NY 10706

phone: 914-478-6207
fax: 914-478-6259

REGISTRATION CHECK LIST

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

- Student Registration Form
Proper documentation must be provided for each child entering the school district. (This includes an original Birth Certificate, Health Forms, and all other necessary documents) Please make sure that the Registration Form is filled out completely.
- Proof of Residency (Needed per family entering Hastings-on-Hudson UFSD)
 - Utility Bills (**3 needed**)
 - Telephone (NOT cell phone)
 - Cable Bill
 - Utility Bill (Con Ed, Gas/Electric)
 - Water Bill
 - Homeowners or Renters Insurance
 - And (**At least 1 needed**)
 - Deed to House
 - Tax Bill
 - Lease
 - Notarized letter from owner of house and copy of tax bill or deed
- 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, Deborah Augarten, at 914-478-6261

STUDENT NAME: _____

Registration Information
Kindergarten through Grade 12

Student's First Name	Student's Middle Name	Student's Last Name
_____	_____	_____
Student Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		_____
Student's Nickname	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? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Parent Email address: _____

Previous Address

Street #	Street Name	Apt. #	
_____	_____	_____	_____
City		State	Zip Code

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

1) Is your current address a temporary living arrangement? Yes No

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

In a motel In a shelter With more than one family in a house or apartment

Moving from place to place In a place not designed for ordinary sleeping accommodations such as a car, park or campsite

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

STUDENT NAME: _____

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

Names	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

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

Parent/Guardian Salutation: _____

Marital Status: Married Divorced Separated Widow/Widower Single

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

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

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

Name: _____
Last Name First Name

Relationship to student: _____

Address (*if known*): _____

Employer: _____

Home Phone: () _____ Work Phone: () _____ ext: _____

Cell Phone: () _____ Beeper: () _____

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

Name: _____

Address: _____

Name of Student's Physician:

Address: _____

Phone: _____

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: _____



STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

*Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.*

Please write clearly when completing this section.		
STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
Month	Day	Year
<input type="checkbox"/> Male <input type="checkbox"/> Female		
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to Student

HOME LANGUAGE CODE

Language Background (Please check all that apply.)	
1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English <input type="checkbox"/> Other _____ <i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English <input type="checkbox"/> Other _____ <i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <i>specify</i> <i>specify</i> <input type="checkbox"/> Guardian(s) _____ <i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English <input type="checkbox"/> Other _____ <i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English <input type="checkbox"/> Other _____ <input type="checkbox"/> Does not speak <i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English <input type="checkbox"/> Other _____ <input type="checkbox"/> Does not read <i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English <input type="checkbox"/> Other _____ <input type="checkbox"/> Does not write <i>specify</i>

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:	
SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School _____ Address _____	

Home Language Questionnaire (HLQ)—Page Two

Educational History	
8. Indicate the total number of years that your child has been enrolled in school _____	
9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them. Yes* <input type="checkbox"/> No <input type="checkbox"/> Not sure <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* *Please complete 10b below	
10b. *If referred for an evaluation, 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? _____	

Month: _____ Day: _____ Year: _____

Signature of Parent or of Person in Parental Relation

Date

Relationship to student: Mother Father Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ	
NAME: _____	POSITION: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:	
NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW	
NAME: _____	POSITION: _____
ORAL INTERVIEW NECESSARY: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <small>Mo. DAY YR.</small>	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: _____ <small>Mo. DAY YR.</small>	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)		<input type="checkbox"/> Posiblemente LEP (Possibly LEP) <input type="checkbox"/> Dominante en Inglés (English Proficient)	

(✓ Marque las casillas que aplican)

- ¿Qué idioma(s) se habla en el hogar o residencia del estudiante? Inglés Español Otro _____
(Especifique cuál)
- ¿En qué idioma(s) se le habla al estudiante la mayor parte del tiempo en el hogar o residencia? Inglés Español Otro _____
(Especifique cuál)
- ¿Qué idioma(s) entiende el estudiante? Inglés Español Otro _____
(Especifique cuál)
- ¿Qué idioma(s) habla el estudiante? Inglés Español Otro _____
(Especifique cuál)
- ¿En qué idioma(s) lee el estudiante? Inglés Español Otro _____ No lee
(Qué idioma)
- ¿En qué idioma(s) escribe el estudiante? Inglés Español Otro _____ No escribe
(Qué idioma)
- ¿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"/>

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

Mes:
(Month)
Fecha
(Date)

Día:
(Day)

Año:
(Year)

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

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

9. ¿Cree usted que su hijo(a) pueda tener dificultades, interferencias o problemas educacionales que le afecten su capacidad para entender, hablar, leer o escribir en inglés o en cualquier otro idioma? En caso afirmativo, por favor descríbalos.
 Sí* No No se sabe * En caso afirmativo, por favor explique: _____

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

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

10b. *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? _____

Mes: _____ Día: _____ Año: _____

Firma del padre/madre o de la persona en relación paternal _____ Date _____

Relación con el estudiante: Madre Padre Otra: _____

OFFICIAL ENTRY ONLY: NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

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

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

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: No Yes

**DATE OF INDIVIDUAL INTERVIEW: _____ Mo. DAY YR.	OUTCOME OF INDIVIDUAL INTERVIEW: <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:

If you answered Yes to Question 1 on the previous home language survey, please complete the following:

Hastings-on-Hudson UFSD – Extended Home Language Survey

Child's Name: _____

Date of Screening: _____

Grade Entering: _____

Date of Birth: _____ Place of Birth: _____

Date Student Entered the US (if not US born) _____

Languages spoken at home _____

1. I have _____ children. This child is number _____ in the family.
2. My child first started to speak at age _____. The first language spoken by my child was _____.
3. Now my child speaks _____ the most at home.
4. My child understands _____ best.
5. The mother speaks _____ to the child.
6. The father speaks _____ to the child.
7. Mother and father speak _____ to each other.
8. Other adults in the family speak _____ to each other.
9. Brothers and sisters speak _____ to the child.
10. The children speak _____ to adults at home.
11. The child thinks in _____
12. With friends, my child speaks _____
13. My child's caretaker speaks _____
14. My child plays with children from other families:
____ every day
____ a few times a week
____ sometimes
____ never
____ only at school

15. My child watches TV in _____ language each day for:
____ 4-6 hours
____ 2-4 hours
____ less than 2 hours
____ rarely
16. My child was in a special class for learning English for _____ years.
17. Other family members live in my home (grandparents, aunts, uncles...)
____ always
____ some visits
____ summers/vacations
18. My child spends time in _____ (country)
____ once a year for _____ weeks
____ sometimes
____ never
19. (older students only): My child's English language learning was interrupted for

20. My child has been absent from school
____ a lot
____ sometimes
____ almost never
21. Do you have any concerns about your child's language development in English and/or in your other language?

Understanding directions:

English _____
Other Language _____

Communicating clearly with others:

English _____
Other Language _____

Pronouncing words:

English _____
Other Language _____

Knowing what words mean:

English _____
Other Language _____

MOTHER'S LANGUAGE HISTORY

The child's mother:

Was born in _____ (country)

Came to the United States _____ years ago

Can understand _____ (languages)

Can speak _____ (languages)

Can read and write _____ (languages)

Began learning English _____ years ago

FATHER'S LANGUAGE HISTORY

The child's father:

Was born in _____ (country)

Came to the United States _____ years ago

Can understand _____ (languages)

Can speak _____ (languages)

Can read and write _____ (languages)

Began learning English _____ years ago.

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
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

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"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Anaphylaxis Care Plan Attached <input type="checkbox"/> Environmental
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Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	<input type="checkbox"/> Asthma Care Plan Attached
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Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type: _____	<input type="checkbox"/> Seizure Care Plan Attached Date of last seizure: _____
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Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____ Date Drawn: _____	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
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Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

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

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

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	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 $\mu\text{g}/\text{dL}$				<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:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name:	DOB:
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SCREENINGS

Vision	Right	Left	Referral	Notes
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				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis <small>Required for boys grade 9 And girls grades 5 & 7</small>	Negative	Positive	Referral	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

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

Full Activity without restrictions including Physical Education and Athletics.

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

No Contact Sports **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

No Non-Contact Sports **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

Other Restrictions:

Developmental Stage for Athletic Placement Process ONLY
 Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports
 Student is at **Tanner Stage:** I II III IV V

Accommodations: Use additional space below to explain

<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: _____

MEDICATIONS

Order Form for Medication(s) Needed at School attached

List medications taken at home:		

IMMUNIZATIONS

Record Attached Reported in NYSIS Received Today: Yes No

HEALTH CARE PROVIDER

Medical Provider Signature:	Date:
Provider Name: <i>(please print)</i>	Stamp:
Provider Address:	
Phone:	
Fax:	

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

STUDENT HEALTH HISTORY

Name:	DOB:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)	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
<input type="checkbox"/> Asthma/trouble breathing
<input type="checkbox"/> Autism/Asperger
<input type="checkbox"/> Dental Injuries
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Ear Infections | <input type="checkbox"/> GI Conditions (ulcer, reflux, IBS)
<input type="checkbox"/> Headaches/migraines
<input type="checkbox"/> Heart Conditions
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Mental Health Condition
(depression, eating disorder, anxiety,
OCD, ODD, etc.) | <input type="checkbox"/> Scoliosis
<input type="checkbox"/> Single Organ (<input type="checkbox"/> kidney, <input type="checkbox"/> testicle)
<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Speech Condition
<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 _____

Name and Title (print): _____

Signature: _____

Address: _____

Stamp:

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: _____