



HILLSIDE ELEMENTARY SCHOOL

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

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

Amy Cazes, Principal
Farid Johnson, Assistant Principal

cazesa@hohschools.org
johnsonf@hohschools.org

January 2017

Dear Hastings-on-Hudson Community Members:

We are excited to welcome your child to the September 2017 Hillside Kindergarten class. All children who will turn five on or before December 1, 2017 are eligible for registration. Attached is the registration packet which needs to be filled out completely prior to registration. If you would prefer to complete the packet electronically, you can access it at the Hastings-on-Hudson school website – (www.hohschools.org). Please remember to print out a copy to bring with you. The following must be completed and brought with you when you come to registration:

- Registration Form
- Parent Questionnaire
- Home Language Survey
- Health History Form
- Immunization Record

Parents/Guardians must provide evidence of a child's vaccination history before he/she can be admitted to school. This must be presented at the time of registration. Education Law requires that every child attending school submit proof of the immunizations required by Public Health Law. The immunization certificate presented at the time of registration **must be signed by a licensed physician.** Your doctor's immunization document will be accepted, or enclosed in the packet is a blank immunization form for your convenience.

- Health Certificate/Physical Form
- Consent Form for Preschool Information

In addition to the above listed forms, you **must** bring the following documents with you:

- **3** Proofs of Residency (see registration packet and Board of Ed policy)
- Proof of child's age
- Proof of Guardianship (if applicable)

****PLEASE BRING THE ORIGINAL AND ONE COPY OF EACH DOCUMENT.**

Our Kindergarten registration will take place at Hillside School during the week of February 13th from 9:00-11:00 am. This registration is organized to simply facilitate the process of handing in the necessary paperwork required above. Your incoming kindergarten student **does not** need to accompany you on this day. The schedule is as follows. Last names beginning with:

A-L – Monday, 2/13 and Tuesday, 2/14

M-Z – Wednesday, 2/15 and Thursday, 2/16

If, on any of these days, school is closed due to snow, make-up registration will continue on Friday.

Once all documents have been submitted, we will schedule opportunities for your child to visit Hillside with you:

- **Kindergarten Screening**
 - o May 16th-19th and May 22nd – 24th
 - o Your child will meet with various staff members to assess their stage of learning.
- **Kindergarten Visitation/Parent Orientation**
 - o May 31st, June 1st or June 2nd
 - o Together, parents and incoming students will enjoy a read aloud with the building administration. Incoming students will then visit kindergarten classes while parents are provided with an informational session.

Other Important Events:


Kindergarten Bus Run – September 2017 (exact date TBD)

If you know of a neighbor or friend that has an incoming kindergartner and has not received a packet, please encourage them to contact the Registrar at the Central Office located at the high school, or e-mail Susan Day (days@hohschools.org).

We look forward to meeting you and welcoming you into our Hillside family!

Warmest regards,


Amy Cazes
Principal


Farid Johnson
Assistant Principal

**HASTINGS-ON-HUDSON
UNION FREE SCHOOL DISTRICT**

27 Farragut Avenue
Hastings-on-Hudson, NY 10706

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

REGISTRATION CHECK LIST

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

○ **Student Registration Form**

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

○ **Proof of Residency** (Needed per family entering Hastings-on-Hudson UFSD)

▪ **Utility Bills (3 needed)**

- Telephone (NOT cell phone)
- Cable Bill
- Utility Bill (Con Ed, Gas/Electric)
- Water Bill
- Homeowners or Renters Insurance

▪ **And (At least 1 needed)**

- Deed to House
- Tax Bill
- Lease
- Notarized letter from owner of house and copy of tax bill or deed

○ **Proof of Age**

○ **School Physical form.** Physical must be completed and the form must be signed and stamped by physician.

○ **Immunization Records,** form must be signed and stamped by physician.

○ **School Records/Release of Records Form**

- Report Cards (Final report card from past 2 grades.)
- Transcript (If available)
- Standardized Test Scores
- Medical Records
- I.E.P.

○ **Proof of Guardianship**

This applies to parents who are separated or divorced and for those children not living with biological/adoptive parents.

- Court Order Agreement re: Guardianship/Custody
- Other document(s) establishing Guardianship/Custody

ALL ITEMS MUST BE SUBMITTED PRIOR TO ADMITTANCE INTO SCHOOL.

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

STUDENT NAME: _____

Registration Information
Kindergarten through Grade 12

Student's First Name _____

Student's Middle Name _____

Student's Last Name _____

Student Gender: Male Female

Student's Nickname _____

Student's Code _____

Students Date of Birth: _____ Grade Level _____ School Year _____

Place of Birth _____

Date child entered the U.S. _____

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

What Language did your child first learn? _____

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

Hispanic, Latino or of Spanish origin: Yes No

Ethnicity/Race: (Please check one)

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

Student's Address:

Street # _____

Street Name _____

P.O. Box _____

Apt. _____

City _____

State _____

Zip Code _____

Home Telephone: _____ Unlisted? Yes No

Parent Email address: _____

Previous Address

Street # _____

Street Name _____

Apt. # _____

City _____

State _____

Zip Code _____

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

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

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

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

STUDENT NAME: _____

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

Names

Date of Birth

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

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

Marital Status: Married Divorced Separated Widow/Widower Single

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

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

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

Name: _____
Last Name First Name

Relationship to student: _____

Address (if known): _____

Employer: _____

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

Cell Phone: () _____ Beeper: () _____

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

Name: _____

Address: _____

STUDENT NAME: _____

Information Updated Annually

Mother/Guardian: _____
First Name Last Name

Relationship to Student: _____ Same address as Student: Yes No

If no, please specify: _____

Employer: _____

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

Cell Phone: () Beeper: ()

Home Email: _____ Work Email: _____

Father/Guardian: _____
First Name Last Name

Relationship to Student: _____ Same address as Student: Yes No

If no, please specify: _____

Employer: _____

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

Cell Phone: () Beeper: ()

Home Email: _____ Work Email: _____

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

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

Name: _____ Phone: () Home Cell Work

Address: _____ Relationship to Student: _____

Name: _____ Phone: () Home Cell Work

Address: _____ Relationship to Student: _____

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

If yes, please explain: _____

Daycare Arrangements (if applicable):

Name of person or facility: _____ Phone #: _____

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

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

Signatures of:

Mother/Father/Guardian (circle one)

Date

STUDENT NAME: _____



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cazesa@hohschools.org

johnsonf@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

Farid Johnson
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: _____



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

Lisette 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 _____ <i>specify</i>	<input type="checkbox"/> Father _____ <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 _____ <i>specify</i>
		<input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not write

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

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

District Name (Number) & School

Address

Home Language Questionnaire (HLQ)—Page Two

Educational History
8. Indicate the total number of years that your child has been enrolled in school _____
9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them. Yes* <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. <u>If referred for an evaluation</u> , 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: _____
 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:	
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:	



Lisette Colon-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

Cuestionario de Idioma del Hogar ("HLQ" por sus siglas en inglés)

Estimados padres o tutores:
Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura, escritura y comprensión en el inglés, así como conocer su educación previa e historial personal. Por favor, llene con su información las secciones "Conocimientos de idiomas" e "Historial educativo". Apreciamos mucho su colaboración respondiendo a estas preguntas. Gracias.

Por favor escriba con claridad al completar esta sección.		
NOMBRE DEL ESTUDIANTE:		
Nombre	Segundo nombre	Apellido
FECHA DE NACIMIENTO:		GÉNERO:
_____	_____	<input type="checkbox"/> Masculino
Mes	Día	Año
_____	_____	_____
INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL		
Apellido	Primer Nombre	Relación con el estudiante
_____	_____	_____
CÓDIGO DEL IDIOMA DEL HOGAR _____		

Conocimientos de Idiomas (Por favor, marque todas las opciones que sean aplicables)		
1. ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro _____ <i>especifique</i>
2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro _____ <i>especifique</i>
3. ¿Cuál es el idioma primario de cada padre / tutor?	<input type="checkbox"/> Madre _____ <i>especifique</i>	<input type="checkbox"/> Padre _____ <i>especifique</i>
	<input type="checkbox"/> Tutor(es) _____ <i>especifique</i>	
4. ¿Qué idioma o idiomas entiende su hijo(a)?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro _____ <i>especifique</i>
5. ¿Qué idioma o idiomas habla su hijo(a)?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro _____ <i>especifique</i>
		<input type="checkbox"/> No sabe hablar
6. ¿Qué idioma o idiomas lee su hijo(a)?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro _____ <i>especifique</i>
		<input type="checkbox"/> No sabe leer
7. ¿Qué idioma o idiomas escribe su hijo(a)?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro _____ <i>especifique</i>
		<input type="checkbox"/> No sabe escribir

TO BE COMPLETED BY THE DISTRICT IN WHICH THE STUDENT IS REGISTERED	
SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School _____	_____
Address _____	
PARA LLENAR POR EL DISTRITO EN EL QUE EL ESTUDIANTE SE HA INSCRITO	

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. <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="margin-right: 20px;"> <p>Si* <input type="checkbox"/> No <input type="checkbox"/> No se sabe <input type="checkbox"/></p> </div> <div> <p>* En caso afirmativo, por favor explique: _____</p> </div> </div> <p>¿Qué gravedad considera usted que tienen estas dificultades educacionales? <input type="checkbox"/> Poca gravedad <input type="checkbox"/> Algo grave <input type="checkbox"/> Muy grave</p>
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.	*Si se le ha recomendado alguna vez una evaluación, ¿ha recibido su hijo(a) alguna vez alguna forma de educación especial? <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"/> 6 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 paternal _____
 Relación con el estudiante: Madre Padre Otra: _____ Date

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 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: _____

Newsletter/E-Blast Registration

E-blast & E-newsletter Registration

If you would like to receive e-blasts and e-newsletters from the Hastings-on-Hudson UFSD, please fill out the information below. If you are already receiving information, PLEASE DO NOT REGISTER AGAIN.

1. Please enter your first name:

2. Please enter your last name:

3. If you would like to receive our e-blasts and e-newsletters, please enter your email address.

Your email address will not be distributed to any outside sources and will be used solely to receive information you request from the Hastings-on-Hudson School District.

4. Please choose which newsletters you would like to subscribe to from the Hastings-on-Hudson UFSD.

- Hastings-on-Hudson District News and E-blasts
- Hastings High School News and E-blasts
- Farragut Middle School News and E-blasts
- Hillside Elementary School News and E-blasts

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

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

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

Dear Parent/Guardian:

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

Immunizations:

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

Health Appraisal/Physical:

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

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

Sincerely,

Health Office Staff

STUDENT NAME: _____

**STUDENT HEALTH HISTORY FORM
EMERGENCY INFORMATION**

HEALTH PROVIDER INFORMATION

Physician Name: _____ Telephone #: () _____

Address: _____
Street Address City State Zip Code

Dentist Name: _____ Telephone #: () _____

Address: _____

STUDENT HEALTH INFORMATION

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

1. Do you have any concerns about your child's general health? No Yes _____

2. Does your child have any specific illness or problem? No Yes _____

3. Does your child have any allergies (food, medication, insects, etc.)? No Yes _____

4. Does your child have asthma? No Yes _____

5. Does your child take any medication (daily or occasionally)? No Yes _____

6. Does your child have any problems with vision, hearing or speech (glasses, ear tubes, hearing aids, contacts)?
 No Yes _____

7. Has your child had any hospitalization, operation, or major illness (specify)? No Yes _____

8. Has your child had any significant injury or illness (specify)? No Yes _____

9. Has your child ever had Chicken Pox, Scarlet Fever or Fifth Disease? No Yes _____

10. Would you like to discuss anything about your child's health and/or family medical history with the school nurse?
 No Yes _____

STUDENT NAME: _____

SIGNIFICANT MEDICAL HISTORY

Please include any allergies, medical conditions and medications: _____

HEALTH/EMERGENCY DECLARATION

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

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

Printed Name of Parent or Guardian: _____

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

Date: _____

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

Signature: _____

Date: _____

STAFF USE ONLY

Printed Name of Staff Processing Health Packet: _____

STUDENT NAME: _____

EMERGENCY INFORMATION SHEET
HASTINGS ON HUDSON UFSD

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

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

Child's Name: _____

Grade: _____

Home Address: _____

Home Telephone #: _____

PARENT/GUARDIAN INFORMATION:

Mother/Guardian Name: _____

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

Mother/Guardian cell #: _____ *Pager #:* _____

Mother/Guardian Work #: _____

Father/Guardian Name: _____

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

Father/Guardian cell #: _____ *Pager #:* _____

Father/Guardian Work #: _____

EMERGENCY CONTACT:

#1 Name: _____ *Relationship:* _____

Phone: _____ *Cell:* _____ *Work:* _____

#2 Name: _____ *Relationship:* _____

Phone: _____ *Cell:* _____ *Work:* _____

#3 Name: _____ *Relationship:* _____

Phone: _____ *Cell:* _____ *Work:* _____

STUDENT NAME: _____

Hastings-on-Hudson Union Free School District

New York State requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and Annual & Program Reviews and Reevaluations for the Committee on Special Education (CSE).

PARENTS: BOTH you and your child's healthcare provider must sign and date

Name: _____
School: _____

Date of Birth: ___/___/___ Gender: M F
Grade: _____

IMMUNIZATIONS/HEALTH HISTORY

Immunization record attached
 No immunizations given today
 Immunizations given since last Health Appraisal: (include dates) _____

Sickle Cell Screen: Positive Negative Not done Date: _____
 PPD: _____ Please complete screening on reverse side of form
 Elevated Lead: Yes No Not done Date: _____
 Dental Referral Yes No Not done Date: _____

Significant Medical/Surgical History: See attached _____

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

Allergies: LIFE THREATENING Food: _____ Insect: _____
 None Seasonal Medication: _____ Other: _____

PHYSICAL EXAM

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

Body Mass Index: _____ (required by NYS)				<i>Referral</i>
Weight Status Category (BMI Percentile): (required by NYS)	Vision - without glasses/contact lenses	R	L	
<input type="checkbox"/> Less than 5 th	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> 5 th through 49 th	Vision - Near Point	R	L	
<input type="checkbox"/> 50 th through 94 th	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	
<input type="checkbox"/> 95 th through 98 th				
<input type="checkbox"/> 99 th and higher				

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____

For Girls: Date/Age of onset of menses: _____ LMP: _____

Specify any abnormality (use separate paper if needed): _____

PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK QUALIFICATION/CSE and 504 CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
 ___ Limited contact: cheerleading, gymnastics, skiing, volleyball, cross-country, handball, fencing, baseball, softball, floor hockey.
 ___ Non-contact: badminton, bowling, golf, swimming, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jumping.

Specify medical accommodations needed for school: _____ None
 Known or suspected disability: _____ Please monitor
 Restrictions: _____ Please monitor

Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other: _____

SPORTS CLEARANCE: By signing and submitting this form, the parent and physician attest that they have fully disclosed all of the student's health history, conditions, medications and relevant family history (e.g. early cardiac death). Parent and physician assume liability for non-disclosures of such information. The School District Physician has final authority to medically clear students for interscholastic sports participation.

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

I consent to the above child being examined by the School Physician to fulfill the requirements of Education Law, Section 904

(signature) _____ (relationship) _____ (date) _____

For Office Use Only

Proof of Residency:

Lease: _____ Expiration Date: _____ Notarized letter from Landlord _____ End Date: _____

Or

Deed to house: _____ or tax bill _____

Utility Bill 1: _____ Name of Utility: _____ Date: _____

Utility Bill 2: _____ Name of Utility: _____ Date: _____

Original Birth Certificate: _____

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

Health Records:

Physical form completed: _____ Date of physical: _____

Date Immunization records received: _____

Date Health History Form Received: _____ Verified by: _____

Previous Records:

Requested from: _____ Date: _____

Address: _____ Phone # _____

Fax # _____

Received:

Report Cards: _____

Standardized Test Scores: _____

Medical Records: _____

Parent Questionnaire _____

Special Education files: _____

E-Blast Registration _____

Section 504 files: _____

Other: _____

STUDENT NAME: _____