

## HUNTINGTON UNION FREE SCHOOL DISTRICT

**Registration Hours:** 9:00AM - 1:00PM (Monday-Friday)  
For appointments outside of these hours call  
(631) 673-2974

**Location:** 50 Tower Street, Huntington Station, 11746 (Rm. 109)

*Welcome to the Huntington Union Free School District!* When a child's parent(s), the person(s) in parental relation to the child, or the child, as appropriate, requests enrollment in the District, such child shall be enrolled and shall begin attendance in school on the next school day, or as soon as practicable.

Determinations as to whether a child is entitled to attend District schools shall be made by the District on the basis of the documentation and statements provided to the District, in accordance with applicable law and District policy. A meeting with the child's parent(s), person(s) in parental relation the child, or the child, as appropriate, may be held to determine whether the child is entitled to attend the schools of the District.

The District reserves its right to question whether any child is entitled to attend school in the District at any time.

If the District makes a determination that a child is not entitled to attend its schools, the parent(s), person(s) in parental relation, or child, as appropriate, will be so notified, and the child will be excluded from attendance in District schools, unless such exclusion is prohibited.

Below please find a list of all forms and supporting documents to be submitted to the District to demonstrate your child's eligibility to attend District schools. If you are unable to produce the documents listed below, please make an appointment with our registrar (call 631-673-2974).

### **You Should Bring the Following Documents to Registration:**

#### **I. Proof of District Residency**

##### **Homeowner:**

☐ Tax Bill, Mortgage Statement, House Deed or Closing Statement; and

Any three of the following:

- ☐ Current Utility Bill (water, electric, gas or cable)
- ☐ Social Service Statements
- ☐ Medical Bills,
- ☐ Pay Stubs
- ☐ Credit Card Statements

##### **Renter/Lease Holder:**

☐ Lease Agreement signed by the property owner (Notarized) OR Property Owner Affidavit – Notarized (enclosed); and

Any three of the following:

- ☐ Current Utility Bill (water, electric, gas or cable)
- ☐ Social Service Statements
- ☐ Medical Bills,
- ☐ Pay Stubs
- ☐ Credit Card Statements

If the above-listed documents are not available, the following documents may be considered by the District:

- A statement by a third-party landlord, owner or tenant from whom the parent(s) or person(s) in parental relation leases or with whom they share property within the district;
- Such other statement by a third party establishing the parent(s)' or person(s) in parental relation's physical presence in the district;
- Income Tax Form;
- Other Bills;

- Membership documents (e.g., library cards) based upon residency;
- Voter Registration Documents;
- Official driver's license, learner's permit, or non-driver identification;
- State or other government issued identification;
- Documents issued by federal, state, or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement); or
- Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers.

(If the documents in this section are not available, the District may accept other proofs of eligibility.)

## II. Student Information

- ☐ Original birth certificate or record of baptism (including a certified transcript of a foreign birth certificate or record of baptism) giving the date of birth
  - If a birth certificate or record of baptism is not available, a passport (including a foreign passport) may be submitted to the District.
  - If a birth certificate or record of baptism and a passport (including a foreign passport) are not available, other evidence of a child's age may be submitted including, but not limited to the following documents: official driver's license; state or other government issued identification; school photo identification with date of birth; consulate identification card; hospital or other health records; military dependent identification card; documents issued by federal, state, or local agencies (e.g. local social service agency, federal Office of Refugee Resettlement); court orders or other court-issued documents; Native American tribal document; or records from non-profit international aid agencies and voluntary agencies.
- ☐ Proof of Immunization (Enclosed form or other)
- ☐ Physical Exam Record within the last 12 months (Enclosed form or other)
- ☐ Academic Records – Transcript/Report Card, Transfer Form from Sending School, IEP. (Not for Kindergarten Registration)

## III. Parent/Guardian Information

- ☐ Photo ID; and

If not natural parent, one of the following:

- ☐ Court Ordered Guardianship or Custody Document
- ☐ Adoption Papers
- ☐ Foster Children: Form DS 2999 from Agency
- ☐ Documentation indicating that the child resides with a sponsor with whom the child has been placed by a federal agency.

If the above-listed documents are not available, the District may require the parent(s) or person(s) in parental relation to provide an affidavit either: (1) indicating that they are the parent(s) with whom the child lawfully resides; or (2) indicating that they are the person(s) in parental relation to the child, over whom they have total and permanent custody and control, and describing how they obtained permanent custody and control, whether through guardianship or otherwise.

### The following forms should be completed:

- ☐ Enrollment Application (One per Family)
- ☐ Ethnicity/Race Form (One per Family)
- ☐ Registration Affidavit (One per Family)
- ☐ Chapter 53 Screening Notice
- ☐ Home Language Questionnaire
- ☐ Release of Information Form
- ☐ School History Form
- ☐ Adult at Bus Stop Form (Kindergarten Only)
- ☐ Physical Exam Form with Immunization Record
- ☐ Health History Form and Health Emergency Card

Family Name \_\_\_\_\_  
New Entry \_\_\_\_\_  
Re-Entry \_\_\_\_\_

**HUNTINGTON UNION FREE SCHOOL DISTRICT**  
PO Box 1500, Huntington, NY 11743

Current Enrollment \_\_\_\_\_  
September Enrollment \_\_\_\_\_

**ENROLLMENT APPLICATION**

LAST NAME	FIRST NAME	MI	SEX	DOB	ETHNICITY	HOME LANGUAGE	SCHOOL	GRADE

\*AI=American Indian/Alaskan Native; A=Asian; B=Black; H=Hispanic; M=Multiracial; P=Pacific Islander; W=White

Please indicate if there are other siblings who are already enrolled in our district:

LAST NAME	FIRST NAME	SCHOOL	GRADE	DOB

HOUSEHOLD ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

DID STUDENT PREVIOUSLY ATTEND OUR SCHOOLS? \_\_\_\_\_ IF YES, WHEN AND WHERE? \_\_\_\_\_

FORMER ADDRESS, IF RECENTLY MOVED \_\_\_\_\_ LAST DISTRICT/SCHOOL ATTENDED \_\_\_\_\_

PARENTS' NAMES	MARITAL STATUS	RELATIONSHIP TO CHILD	HOME ADDRESS	CUSTODIAL PARENT?	REC MAIL?	HOME PHONE	CELL PHONE	WORK PHONE

Homeowner or Renter \_\_\_\_\_ Is current address temporary? \_\_\_\_\_ If temporary, is it due to economic hardship? \_\_\_\_\_

Where is student presently living? Motel \_\_\_\_\_ Shelter \_\_\_\_\_ House/Apt. \_\_\_\_\_ Moving from place to place \_\_\_\_\_ Other \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

For Office Use:

Proof of Birth \_\_\_\_\_ Proof of Guardianship \_\_\_\_\_ Is Student Receiving Services? \_\_\_\_\_

4 Proofs of Residency \_\_\_\_\_

Registrar Signature \_\_\_\_\_ Date Entered District \_\_\_\_\_ Enrollment Date \_\_\_\_\_

**HUNTINGTON UNION FREE SCHOOL DISTRICT**  
**P.O. Box 1500**  
**Huntington, New York 11743**  
**(631) 673-4299 Fax (631) 673-9174**

**REGISTRATION AFFIDAVIT**

The following persons (list all residents of the address below):

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Reside at \_\_\_\_\_

\_\_\_\_ Huntington      \_\_\_\_ Huntington Station      \_\_\_\_ Cold Spring Harbor

which is within the boundaries of the Huntington Union Free School District.

I understand that in the event that I move from or do not reside at the above address and if the children listed above continue to attend the Huntington Union Free School District schools, I will be liable for tuition for each student. At such time that the Huntington Union Free School District determines that those listed above no longer reside in the school district, those students will be dropped from the attendance register and will no longer be allowed to attend school within this district.

I hereby attest that my child is not currently suspended from any prior school district, nor has any Superintendent Hearing been or is about to be convened.

I understand that this affidavit is a true representation of the above statements that the Huntington Board of Education will rely upon and any misstatements made could result in criminal (perjury) charges being brought against the person whose signature appears hereon.

\_\_\_\_\_  
Parent/Guardian Signature

County of Suffolk )  
                                  )  
State of New York )

Sworn to before me this \_\_\_\_\_ day

of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Notary Public

**\*\*\*USE THIS FORM ONLY IF YOU RENT AND DO NOT HAVE A LEASE\*\*\***

**HUNTINGTON UNION FREE SCHOOL DISTRICT  
P.O. Box 1500, Huntington, New York 11743  
Phone (631) 673-2974 Fax (631) 673-9174**

**PROPERTY OWNER AFFIDAVIT**

*Please Print*

***Property Owner Information***

\_\_\_\_\_  
Name of Property Owner

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Telephone Number

***Lease Holder Information***

\_\_\_\_\_  
Name of Family

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Telephone Number

**BUILDING INFORMATION**

Please specify the type of building in which the apartment is located.

\_\_\_\_ Single Family House \_\_\_\_ Two Family House \_\_\_\_ Three Family House \_\_\_\_ Condominium  
\_\_\_\_ Multi-Dwelling \_\_\_\_ Number of Apartments \_\_\_\_ Other \_\_\_\_\_

**LEASING INFORMATION**

Please specify the terms of the lease.

Starting Lease Date \_\_\_\_ End of Lease Date \_\_\_\_ Relation to Renter: No Relation \_\_\_\_ Family Member(s) \_\_\_\_

**LIST THE NAMES OF ALL PERSONS LIVING IN THE APARTMENT/HOUSE**

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

I attest that to the best of my knowledge the aforementioned information is true, and I am aware that fraudulent statements or claims may be prosecuted to the fullest extent of the law.

\_\_\_\_\_  
Property Owner's Signature

State of New York }

County of Suffolk } \_\_\_\_\_

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
Notary Public

**NOTE: If you are unable to provide the above information please contact Noreen Hernandez, Attendance Teacher, at (631) 673-2974 to discuss alternative district residency verifications.**

# HUNTINGTON UNION FREE SCHOOL DISTRICT ETHNICITY/RACE FORM

Date: \_\_\_\_\_

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status. **PLEASE ANSWER QUESTION 1 AND 2.**

1.		2. Choose one or more racial groups:	
Student Name:	Grade: School:	Is the student Hispanic, Latino, or of Spanish origin?  Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.	<p><b>BLACK:</b> A person having origins in any of the black racial groups of Africa.</p> <p><b>WHITE:</b> A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.</p> <p><b>NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:</b> A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</p> <p><b>ASIAN:</b> A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.</p> <p><b>AMERICAN INDIAN OR ALASKA NATIVE:</b> A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.</p>
		YES or NO	<input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native

Signature of Parent or Guardian: \_\_\_\_\_ Relationship to Student (s): \_\_\_\_\_

## STUDENT RACIAL AND ETHNIC IDENTIFICATION:

To the Parent/Guardian: The *Huntington Union Free School District* has adopted a policy which requires the collection and recording of the ethnic identity of students in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Study the movement of students in different ethnic groups as they move from school to school.
- Analyze differences in academic performance, attendance and completion of school.

The *Huntington School District* understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and federal student privacy laws and regulations. It is protected by the Confidentiality Regulations cited below.\* If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

To School Staff: This form will be filed in the student's permanent record as confidential information

\*The Family Educational Rights and Privacy Act (1974) prohibits unauthorized release of any student record information identifiable by either student name or student identification number

# HUNTINGTON UNION FREE SCHOOL DISTRICT

"A Tradition of Excellence Since 1657"

Registration Office

50 Tower Street

Huntington Station, NY 11746

Noreen Hernandez  
Attendance Teacher

(631) 673-4299  
Fax: (631) 673-9174

\_\_\_\_\_  
Date

Dear Parent/Guardian:

The Huntington School District, like all districts in New York State, must conduct a screening of all new entrants who have not been previously screened.

Chapter 53 of the Laws of 1980 requires that this screening include physical development, cognitive development, receptive and expressive language development, articulation skills and motor development. Persons conducting this screening include the school nurse, a speech/language therapist, a school psychologist, and an ESL teacher.

If, as a result of the screening, it is determined that there is a need for further evaluation, you will be contacted in order to discuss our concerns about your youngster and to ask your permission for a further and more extensive evaluation.

If you have any questions regarding this form, please feel free to call me at the above number.

Sincerely,

Noreen Hernandez

I have read and I understand this notice \_\_\_\_\_

*Signature of Parent*

School \_\_\_\_\_ Grade \_\_\_\_\_

Student Name \_\_\_\_\_

*Please Print*



**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

☐ Male  
☐ Female

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

Last Name

First Name

Relation to  
Student

HOME LANGUAGE CODE

### Language Background

(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?

☐ English ☐ Other

specify

2. What was the first language your child learned?

☐ English ☐ Other

specify

3. What is the Home Language of each parent/guardian?

☐ Mother ☐ 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.

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT  
INFORMATION SYSTEM:

District Name (Number) & School

Address

## Home Language Questionnaire (HLQ)—Page Two

### Educational History

8. Indicate the total number of years that your child has been enrolled in school \_\_\_\_\_

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes\*    No    Not sure

☐    ☐    ☐    \*If yes, please explain: \_\_\_\_\_

How severe do you think these difficulties are?    ☐ Minor    ☐ Somewhat severe    ☐ Very severe

10a. Has your child ever been referred for a special education evaluation in the past?    ☐ No    ☐ Yes\* \*Please complete 10b below

10b. \*If referred for an evaluation, has your child ever received any special education services in the past?

☐ No    ☐ Yes – Type of services received: \_\_\_\_\_

Age at which services received (Please check all that apply):

☐ Birth to 3 years (Early Intervention)    ☐ 3 to 5 years (Special Education)    ☐ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)?    ☐ No    ☐ Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

12. In what language(s) would you like to receive information from the school? \_\_\_\_\_

Month:    Day:    Year:  
\_\_\_\_\_  
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:    ☐ No    ☐ Yes

\*\*DATE OF INDIVIDUAL  
INTERVIEW:

MO.    DAY    YR.

OUTCOME OF  
INDIVIDUAL  
INTERVIEW:

☐ ADMINISTER NYSITELL  
☐ ENGLISH PROFICIENT  
☐ REFER TO LANGUAGE PROFICIENCY TEAM

### NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

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

DATE OF NYSITELL  
ADMINISTRATION:

MO.    DAY    YR.

PROFICIENCY LEVEL  
ACHIEVED ON  
NYSITELL:

☐ ENTERING    ☐ EMERGING    ☐ TRANSITIONING    ☐ EXPANDING    ☐ COMMANDING

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

# HUNTINGTON UNION FREE SCHOOL DISTRICT

P.O. BOX 1500, Huntington, NY 11743

Registration Office 631-673-2974

## RECORDS REQUEST

The student named below has registered in our school district. Kindly fax academic and health reports (including immunizations), to the school as indicated. A prompt response is greatly appreciated.

SCHOOL

FAX NUMBER

___ Flower Hill Primary	631-425-6255	___ Jack Abrams STEM School	631-421-7178
___ Washington Primary	631-425-6259	___ Woodhull Intermediate	631-425-4718
___ Southdown Primary	631-425-6258	___ Finley Middle School	631-425-4746
___ Jefferson Primary	631-425-6257	___ Huntington HS	631-425-4730

STUDENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

Last Grade Attended \_\_\_\_\_

Former School Name \_\_\_\_\_

School Address \_\_\_\_\_

Town/State/Zip \_\_\_\_\_

Fax Number \_\_\_\_\_

### PARENTAL PERMISSION:

I give my permission to release this information to the Huntington School District.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## HUNTINGTON UNION FREE SCHOOL DISTRICT

### SCHOOL HISTORY

Please provide a list of the schools, districts, and states that your child has attended.

STUDENT NAME \_\_\_\_\_

GRADE	SCHOOL	DISTRICT	STATE	DATE STARTED	DATE ENDED	COMPLETED GRADE?
K						
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

School Health Service  
Huntington Public Schools  
Huntington, New York 11743

## HEALTH HISTORY FORM

Student's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Physician's Name \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Native language spoken in the home \_\_\_\_\_

**Adults in Household (Name)**

**Health Problems**

Mother \_\_\_\_\_

Father \_\_\_\_\_

Other \_\_\_\_\_

**Children in Household (Name)**

**Age**

**School**

**Health Problems**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**Please indicate if your child has any of the following:**

	<u>Year</u>	<u>Please Explain</u>
Anemia	_____	Asthma/Allergies _____
Chickenpox	_____	Diabetes _____
Ear Conditions	_____	Frequent Nose Bleeds _____
Nephritis	_____	Heart Disease/Cardiac Problems _____
Urinary Problems	_____	Orthopedic Problems _____
Rheumatic Fever	_____	Neurological Problems _____
Tuberculosis	_____	Seizure Disorder/Epilepsy _____
Contact with TB	_____	Skin Disorder _____
Fifth Disease	_____	Frequent Colds/Sore Throat _____

**Is your child presently taking any medications?** \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**

Is yes, please list the medical problem and medication: \_\_\_\_\_

To the best of your knowledge, please answer the following questions:

Does your child have visual problems? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No** Explain \_\_\_\_\_

Does your child wear corrective lenses? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**

Is anyone in your family colorblind? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No** Who? \_\_\_\_\_

Is your child under treatment for a hearing loss? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No** If there are any special considerations, please explain \_\_\_\_\_

Are there any apparent speech problems? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No** Is child receiving speech therapy? \_\_\_\_\_

Does your child have any known allergies? \_\_\_\_\_  
(a) Food allergies? \_\_\_\_\_  
(b) Lactose intolerance? \_\_\_\_\_  
(c) Latex allergies? \_\_\_\_\_

If there are any special considerations with the above, please explain:

Was your child hospitalized at all since birth? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, state reason and date: \_\_\_\_\_  
(a) Any operations? \_\_\_\_\_ Reason and Date \_\_\_\_\_  
(b) Any serious illness or injuries? \_\_\_\_\_

Did the mother have any difficulties during her pregnancy, labor or delivery? \_\_\_\_\_ Yes \_\_\_\_\_ No. If yes, please explain \_\_\_\_\_

Did your child have difficulties at birth? \_\_\_\_\_ Yes \_\_\_\_\_ No  
(a) Jaundice? \_\_\_\_\_  
(b) Difficulty in breathing? \_\_\_\_\_ Explain \_\_\_\_\_  
(c) Infections? \_\_\_\_\_ Yes \_\_\_\_\_ No. What type? \_\_\_\_\_  
(d) Feeding problems? \_\_\_\_\_ Yes \_\_\_\_\_ No. Explain \_\_\_\_\_

Was your child born with a Congenital Defect? \_\_\_\_\_ Yes \_\_\_\_\_ No. If yes, please describe: \_\_\_\_\_

Was your child placed in a neonatal intensive care nursery or a high-risk nursery? \_\_\_\_\_ Yes \_\_\_\_\_ No  
How long? \_\_\_\_\_

Was your child born prematurely? \_\_\_\_\_ Yes \_\_\_\_\_ No. How many weeks? \_\_\_\_\_  
Was your child born post-maturely? \_\_\_\_\_ Yes \_\_\_\_\_ No. How many weeks? \_\_\_\_\_

Please list any restrictions/limitations of physical activities: \_\_\_\_\_

Is there anything concerning the health of this child that school personnel should be aware of? \_\_\_\_\_

Additional comments? \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**  
**TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**  
**IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

**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**

<b>Allergies</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<b>Asthma</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<b>Seizures</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type:      Date of last seizure: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<b>Diabetes</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

**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    ☐ Not Done

**Hypertension:** ☐ No    ☐ Yes    ☐ Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>List Other Pertinent Medical Concerns</b> (e.g. concussion, mental health, one functioning organ)
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Lead Level Required Grades Pre- K &amp; K</b>		<b>Date</b>		
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g}/\text{dL}$				
<input type="checkbox"/> <b>System Review and Abnormal Findings Listed Below</b>				
<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*	
<input type="checkbox"/> Additional Information Attached			*Required only for students with an IEP receiving Medicaid	

Name:				DOB:	
<b>SCREENINGS</b>					
<b>Vision</b> (w/correction if prescribed)	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>	
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Near Vision Acuity	20/	20/		<input type="checkbox"/>	
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>	
Notes					
<b>Hearing</b> Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				<b>Not Done</b>	
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Notes					
<b>Scoliosis Screen</b> Boys in grade 9, and Girls in grades 5 & 7	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b> <input type="checkbox"/> <b>Student is restricted from participation in:</b> <div style="margin-left: 20px;"> <input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.  <input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.  <input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track &amp; Field.  <input type="checkbox"/> <b>Other Restrictions:</b> </div>					
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level. <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V      Age of First Menses (if applicable) : _____					
<input type="checkbox"/> <b>Other Accommodations*:</b> (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain.    *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.					
<b>MEDICATIONS</b>					
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School Attached</b>					
<b>IMMUNIZATIONS</b>					
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS					
<b>HEALTH CARE PROVIDER</b>					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form To Your Child's School When Completed.</b>					

## HEALTH EMERGENCY CARD

STUDENT'S FIRST AND LAST NAME \_\_\_\_\_ PARENT'S E-MAIL \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

Children's Names

Grade / Teacher

FATHER'S NAME \_\_\_\_\_

1.

**Where father can be reached 8 A.M. - 3 P.M.** CELL # \_\_\_\_\_

2.

Address \_\_\_\_\_

3.

MOTHER'S NAME \_\_\_\_\_

4.

**Where mother can be reached 8 A.M. - 3 P.M.** CELL # \_\_\_\_\_

5.

Address \_\_\_\_\_

AUTHORIZED ALTERNATES ( Relative, Friend, Neighbor )

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

FAMILY DOCTOR IN EMERGENCY \_\_\_\_\_ Phone \_\_\_\_\_

FAMILY DENTIST IN EMERGENCY \_\_\_\_\_ Phone \_\_\_\_\_

MEDICAL CONCERNS \_\_\_\_\_

( Please fill in above information completely and return to school )