Spackenkill Registration Form/Student Information

Child's First and Last Name_____ Grade____ Date

1. Has your child ever attended school at Spackenkill? Yes ◯ No ◯

If Yes, please list with dates:

2. Has your child ever attended school in other districts Yes ◯ No ◯

If Yes, please provide each school district name, school name and grade, school address, and school phone number.

3. Is your child currently under suspension from another school district?

   Yes ◯ No ◯

   If Yes, please explain:

4. Has your child repeated a grade? Yes ◯ No ◯

   If Yes, please explain and list grade(s) repeated:

5. Is your child receiving special education services? Yes ◯ No ◯

   If Yes, please explain:

6. Does your child have a 504 Plan? Yes ◯ No ◯

   If Yes, please explain:

7. Has your child ever received remedial math? Yes ◯ No ◯

   If Yes, please explain and list in which grades received:

8. Has your child ever received remedial reading and/or writing services? Yes ◯ No ◯

   If Yes, please explain and list in which grades received:

9. Has your child ever received speech or language services? Yes ◯ No ◯

If Yes, please explain and list in which grades received:

10. What is your child's first language? _____

11. Which language is spoken in the home? _____

12. Does your child need help learning English as a second language?

Yes ◯ No ◯

13. Has your child ever received English as a Second Language (ESL) services?

Yes ◯ No ◯

If Yes, please explain with dates/grades:

14. Has your child participated in a Gifted and Talented Program? Yes ◯ No ◯

If Yes, please list school district and name of the program:

_____

15. Has your child ever had difficulties in school (attendance, behavior, academic, etc.)?

Yes ◯ No ◯

If Yes, please explain:

16. Is your child covered under any health insurance? Yes ◯ No ◯

If Yes, please indicate the name of the individual(s) that the student is insured under.

Name:_____ Relationship: _____

Address: _____

Phone: _____

Name of Insurance Company: _____

Policy Number_____

17. Are there circumstances or experiences in your child's life that may impact your child's performance in school?

Yes ◯ No ◯

If Yes, please explain:

18. Is your child homeless? Yes ◯ No ◯

If Yes, please list the last school your child attended and former district of residence:

19. Is child a foster child? Yes ◯ No ◯

If Yes, please provide name, phone number, and email address of case worker:

20. Are parents separated/ divorced? Yes ◯ No ◯

If Yes, who has custody?

21. In an effort to better know your child, please use the area below to offer additional information that you wish to share with us.

Spackenkill Union Free School District Student Registration

Dear Parents/Guardians:

New York State Education Law requires new entrants to a school to have a physical examination by a provider licensed in New York State. **A copy of the completed physical along with up-to-date immunizations must be provided to the school health office within 14 days of entrance to school. Dental certificates, if available, may also be provided. The required immunizations for school attendance are:**

- **DTaP/DTP**: for Gr. K-3, 5 doses unless 4th dose was given at 4 yrs or older / for Gr. 4 & 5, 5 doses unless 4th dose was received at 4 yrs or older / Gr 6-9, 3 doses / and Gr 10-12, 3 doses.
- **Tdap**: Gr 6-12, 1 dose
- **Polio**: for Gr K-3 and 6-8 / 4 doses (3 if 3rd does was given at age 4 or older)/ for Gr 4-5 and 10-12, 3 doses
- **MMR**: 2 doses for all students
- **Hepatitis B**: 3 doses for all students (or 2 doses of adult hepatitis B vaccine (Recombivax for Gr. 6-12))
- **Meningococcal:** by Grade 6, 1 dose / 12th Grade , 1 dose

Please make arrangements for your child to have a physical examination as soon as possible. A copy of a physical exam completed no more than twelve months prior to the commencement of the school year is acceptable. If documentation is not received, the school physician will examine your child.

Please contact the school nurse with any questions:

To Be Named, RN	Hagan 463-8398
Nora Bergstraser, RN	Nassau 463-6390
Elizabeth Giancaspro, RN	Todd 463-6527
Joan Dwyer, RN	High School 463-2043

Very truly yours,
Spackenkill School Nurses

****

Student Name_____ Grade_____

_____ My child has been examined by his/her personal physician. Certificate to be provided within 30 days of registration.

_____ My child may be examined by the school physician.

Medications_____□ None

Health conditions_____□ None

Allergies_____□ None

Parent signature_____ Date_____

Printed name_____

HEALTH INFORMATION – NEW REGISTRANTS

Student's legal name (print)_____ ___M ___F

Date of birth_____ Place of birth:_____

Legal residence_____

Parent/Guardian name_____ Employer_____

Phone (w)_____ (c)_____ (h)_____ Custodial parent? ___Yes ___ No

Parent/Guardian name_____ Employer_____

Phone (w)_____ (c)_____ (h)_____ Custodial parent? ___Yes ___ No

Physician's name_____ Phone_____

Dentist's name_____ Phone_____

Allergies_____

Current medications_____

Any medications in school?_____

Medical conditions_____

Significant medical history:_____

_____

Does your child wear glasses or contacts? ___Yes ___No If yes, are they needed for near work? ___Yes ___No Distance? ___Yes ___No

Does your child receive any of the following special services? Please circle any that apply.

Resource Room Special Class Counseling Speech OT PT

Academic Intervention for _____

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: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ 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): ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

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

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL				

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing 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.			**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.

☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.

☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.

☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, 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.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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

Spackenkill Union Free School District Student Registration

RELEASE OF STUDENT INFORMATION

for Spackenkill Union Free School District

I hereby authorize (Name and address of former school) ____

____

____

Phone: Fax:

to release any and all school (including attendance and discipline records) and health records including: psychiatric evaluations, psychology evaluations, neurological evaluations and any other pertinent information concerning my child ____ .

(please print student name above)

Please send to:

__ **Hagan Elementary School**
42 Hagan Drive
Poughkeepsie, NY 12603
Phone: (845) 463-7840
Fax: (845) 463-7881

__ **Nassau Elementary School**
7 Nassau Road
Poughkeepsie, NY 12601
Phone: (845) 463-7843
Fax: (845) 463-7842

__ **O.A. Todd Middle School**
11 Croft Road
Poughkeepsie, NY 12603
Phone: (845) 463-7825
Fax: (845) 463-7832

__ **Spackenkill High School**
112 Spackenkill Road
Poughkeepsie, NY 12603
Phone: (845) 463-7822
Fax: (845) 463-7877

__ **Spackenkill District Office**
15 Croft Road
Poughkeepsie, NY 12603
Phone: (845) 463-7800
Fax: (845) 463-7804

It is understood that the privileged and confidential nature of such records will be preserved.

________________________________ __________
Parent/Guardian Signature Date

- -

Release Mail Date __________ Release Fax ___________

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*	❑ 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 _____ *specify*	❑ Father _____ *specify*	❑ Guardian(s) _____ *specify*
4. What language(s) does your child understand?	❑ English	❑ Other _____ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other _____ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other _____ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other _____ *specify*	❑ Does not write

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

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:
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: ❑ 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:

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
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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:
Mes / *Día* / *Año*		❑ Masculino ❑ Femenino
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?	❑ Inglés	❑ Otro	*especifique*	
2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?	❑ Inglés	❑ Otro	*especifique*	
3. ¿Cuál es el idioma primario de cada padre / tutor?	❑ Madre *especifique*	❑ Padre *especifique*	❑ Tutor(es) *especifique*	
4. ¿Qué idioma o idiomas entiende su hijo(a)?	❑ Inglés	❑ Otro	*especifique*	
5. ¿Qué idioma o idiomas habla su hijo(a)?	❑ Inglés	❑ Otro	*especifique*	❑ No sabe hablar
6. ¿Qué idioma o idiomas lee su hijo(a)?	❑ Inglés	❑ Otro	*especifique*	❑ No sabe leer
7. ¿Qué idioma o idiomas escribe su hijo(a)?	❑ Inglés	❑ Otro	*especifique*	❑ 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.

*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:
❑ 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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: