IRVINGTON
UNION FREE SCHOOL DISTRICT

2020-21 school year

NEW STUDENT KINDERGARTEN REGISTRATION

Welcome to the Irvington Union Free School District. The mission of the Irvington School District is to create a challenging and supportive learning environment in which each student attains his or her highest potential for academic achievement, critical thinking and lifelong learning. Our schools encourage the discovery and development of students' individual strengths, skills and talents, and foster social and civic responsibility.

To complete the enrollment process, safeguard the health of your child/children, to place your child/children in the most appropriate program, and to conform to New York State law and District Policy, we need certain information and records. Documentation of age, proof of residency and the District's registration packet must be completed and submitted in person by a guardian to the District Registrar.

The registration packet may be obtained in Registration Department tab at IrvingtonSchools.org or from the District Registrar, 6 Dows Lane, Irvington New York 10533. These documents must be submitted at the time of registration or within two days of enrollment in order for the District to make a timely determination as to the student's entitlement to attend District schools. (Except for Kindergarten Pre-Registration)

When printing the forms from our website, please print them SINGLE SIDED and not Doubled Sided. Documents need to be separated.

1. **New Student Registration Form -** All students between the age of 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. The Irvington U.F.S.D. collects information in line with New York State requirements. The collection and recording of the ethnic identity of students in the Irvington U.F.S.D. district is in accordance with the federal categories and definitions. The information will be used to :
    a. **Report** information to the State and Federal Education Departments.
    b. **Plan** educational programs and make sure that they are readily available to all students.
    c. **Study** the movement of students in different ethnic groups as they move from school to school.
    d. **Analyze** differences in academic performance, attendance and completion of school.

    The Irvington U.F.S.D. 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. If the information requested is not provided on the New Student Registration 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.

2. **Documentation of age -** In order to determine, for instance, the programming needs of your child/children, you will need to provide proof of age by providing one of the following:
    a. An original or certified transcript of a birth certificate or record of baptism (including an original or certified transcript of a foreign birth certificate or record of baptism) giving the date of birth; or
    b. passport (including foreign passport) giving the date of birth

Where the above are not available, the School District may consider certain other documents/records in existence two years or more to determine age. One or more of these documents may be necessary. The documents are the following:

- official driver's license
- state or other government issued identification
- school photo identification with date of birth
- consulate identification card
- hospital or health records
- military dependent identification card
- documents issued by federal, state or local agencies (for instance, local social services agency, federal Office of Refugee Resettlement)
- court orders or other court-issued documents
- Native American trial document
- records from non-profit international aid agencies and voluntary agencies
- Note: The School District may need to verify these documents/record

3. **Proof of Residency** is required. *According to NY State Law, In order to register your child/children in the School District, you must be physically domiciled (live) at your address within the School District's geographic boundaries*

Proof of Residency is required – You should provide at least one item from Section A and two items from Section B; if you cannot provide an item from Section A, you will need to provide four items from Section B.

Section A	Section B – Address must be clearly listed on form of proof.
1) *Copy of a residential lease or proof of ownership of a house or condominium, such as a deed or mortgage statement* *2)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* *3) such other statement by a third-party establishing parent(s) or person(s) in parental relation physical presence in the School District*	*1) pay stub* *2) income tax form(s)* *3) utility bill or other bills (e.g., power company, cable, National Grid, etc.).* *4) membership documents that are based upon residency that contain your address (e.g., library cards)* *5) voter registration document(s)* *6) official driver's license, learner's permit or non-driver identification* *7) documents issued by federal, state or local agencies (for instance, local social services agency, federal Office of Refugee Resettlement)* *8) evidence of custody of the child/children, including, but not limited to judicial custody orders or guardianship papers* *9) Other forms of documentation and/or information establishing parent(s) or person(s) in parental relation physical presence in the School District.*

If you have any questions regarding the fulfillment of the District's residency requirements or are homeless, please contact the District Registrar.

4. **Parent(s)/Guardian(s) shall provide proper proof of parental relationship -** The School District may require the parent(s) or person(s) in parental relation to provide the School District with an affidavit either: (1) indicating that they are the parent(s) with whom the child/children lawfully resides; or (2) indicating that they are the person(s) in parental relation to the child/children, over whom they have a total and permanent custody and control, and describing how they obtained total and permanent custody and control, whether through guardianship or otherwise. The School District may also accept other proof, such as documentation indicating that the child/children reside with a sponsor with whom the child/children have been placed by a federal agency. Please contact the District Registrar for additional information.

5. **Health Info Packet/Immunizations records and physical exams -** Details of all public health requirements are outlined in the registration packet. The school nurse will review and approve immunization records prior to the enrollment of new students.

6. **Release for Dows Lane Preschool Questionnaire -** from the preschool the student is currently enrolled.

7. **New Student Screening: Parent Interview** – information contained in this form will be given to your child's teacher to provide further insight about your child.

8. **Home Language Questionnaire -** this two-page form is required by New York State and used for reporting purposes. The district uses this form to assess if language support for your child is required.

9. Please call **(914) 269-5011** to set up an appointment with the ***District Registrar***, to enroll the student(s). The office of the District Registrar is located at 6 Dows Lane 2nd Floor, Irvington, New York. Follow up questions and documentation can be sent to Registration@irvingtonschools.org. Walk-ins are not encouraged as the District Registrar or Designee must review the registration packet with the family. (No appointment is needed during the February Pre-Registration dates.)

PLEASE BE ADVISED that in order for your child/children to attend the Irvington Union Free School District, you must be a resident of the School District boundaries.

Section 210.45 of the Penal Law of the State of New York prohibits the making of a false written statement. The statements contained in your registration application must be true and accurate.

If the School District determines at any time that you are not a resident of the School District, your child/children will be excluded from the School District. Further, you will be liable to the School District for payment of tuition from their date of enrollment through their date of exclusion, as well as the costs of collection.

Thank you for your cooperation.

NEW STUDENT REGISTRATION FORM

PLEASE COMPLETE ALL QUESTIONS *(Print Clearly) Please note: The student's legal name must be used*

STUDENT INFORMATION

Student Last Name:	Gender: M - F
First Name:	DOB:
Middle Name:	Grade Level:
Home Phone:	
Address:	

Ethnicity: Hispanic/Latino or of Spanish origin? ☐ Yes ☐ No

Race: (Choose all that apply)

☐ **(A) Asian** ☐ **(B) Black or African American** ☐ **(N) Native Hawaiian or Other Pacific Islander**

☐ **(I) American Indian or Alaskan Native** ☐ **(W) White**

Student resides with:

☐ **Both Parents** ☐ **Mother Only** ☐ **Father Only** ☐ **Mother/Stepfather*** ☐ **Father/Stepmother*** ☐ **Foster parents**

☐ **Other (Complete Special Home Circumstance Section on page 2)**

* Please indicate stepparent name:_____

PARENT/GUARDIAN INFORMATION:

ADDRESS MAILING AS

Please Circle One Ms.; Mrs.; Mr.; Mr./Mrs.; Dr./Mrs.; Dr./Dr.; Other

Guardian 1 Last Name:	DOB:	Relationship:
First Name:	E-mail:	
Address:		
Home Phone:	Cell Phone:	Work Phone:
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Active in the U.S. Armed Forces		

(Please complete only where information is different from above)

Please Circle One Ms.; Mrs.; Mr.; Mr./Mrs.; Dr./Mrs.; Dr./Dr.; Other

Guardian 2 Last Name:	DOB:	Relationship:
First Name:	E-mail:	
Address:		
Home Phone:	Cell Phone:	Work Phone:
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Active in the U.S. Armed Forces		

PLEASE LIST SIBLINGS NAME(S)/AGE(S):

NAME	AGE/SCHOOL

SPECIAL HOME CIRCUMSTANCES: (Complete if a Single Parent, Legal Guardian, Foster Parent or Agency)

If separated or divorced, other parent will have the right to visit student in school and have access to student's records unless we have a legal document indicating otherwise. Please indicate any restrictions in the area below and provide a copy of legal document, if applicable.

Legal Custody of child is with_____. Is there a joint custody agreement?_____

List any restrictions other parent has regarding child_____

List type and date of legal document provided_____

If you are a Guardian please complete the following:

Name of child's natural parent(s)_____

Address or whereabouts of natural parent(s)_____

Official document indicating custody and restrictions, etc., if any_____

If you are a Foster Parent or Foster Care Agency you must complete the following or registration will be held until all missing information is provided. Also, a DSS-2999 Form and a letter verifying information below are required or registration will be held.

Name of Foster Parent(a)_____

Name of Agency_____ Agency Code #_____

Agency Address_____ Type of Agency_____

Case Worker and/or Social Worker_____ Phone No._____

DSS Case #_____ CIN #_____ CB#_____

Date child was placed at current location_____Date at previous location_____

PREVIOUS ADDRESS INFORMATION

Dates To/From (most recent first)	Address	Location: Country/City/State/Zip Code

PREVIOUS SCHOOL INFORMATION

Schools Attended	Dates To/From (most recent first)	Location: City/State/Country	Special Programs (E.S.L., Special Education, etc)

EMERGENCY CONTACTS

Name:		Relationship:
Address:		
Home Phone:	Cell Phone:	Work Phone:
Name:		Relationship:
Address:		
Home Phone:	Cell Phone:	Work Phone:
Name:		Relationship:
Address:		
Home Phone:	Cell Phone:	Work Phone:

ADDENDUM TO REGISTRATION OF NEW STUDENT:

Does your child have a known or suspected disability that substantially impacts his/her learning? ___Yes ___No
If so, describe:_____
_____

Has your child been evaluated for a disability? ___Yes___No
If so, please describe:_____
_____

Has your child been classified by a Committee on Special Education as a student eligible for ___Yes___No
Special Education Services? If so, please describe:_____
_____

Has your child received any special services (i.e.) Speech, OT, PT, AIS, ESL, etc.) in a previous school? ___Yes___No
If so, Please describe:_____
_____

This questionnaire is intended to address the McKinney-Vento Homeless Assistance Improvement Act. Your responses to this questionnaire will help our district determine which services your child may be eligible to receive,

1. Is your current address a temporary living arrangement? _____Yes _____No

2. If so, is this temporary living arrangement due to loss of housing or economic hardship? ___Yes ___No

If you answered **YES** please complete the remainder of this form.
If you answered **NO**, please **STOP HERE**.

****

Please check what best describes where this student is <u>currently</u> living:

___ In a shelter

___ in a motel or hotel

___ in a transitional housing program

___ temporarily in another family's house or apartment due to loss of housing

___ awaiting foster placement

___ in a single room occupancy building

___ in a car, trailer or campsite

PARENT OR LEGAL GUARDIAN OATH:

I, _____, say that I am the parent/guardian of

_____, and that I have read the foregoing

application and know the contents thereof; that the same are true to my own knowledge and that I have given the answers set forth above knowing that the Irvington School District will rely upon them in determining whether the child is to be admitted to its school system.

_____
Signature of Parent/Guardian *Date*

IRVINGTON UNION FREE SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

Dows Lane Elementary	Main Street School	Middle School	High School
914-269-5150, fax 914-591-6863	914-269-5250, fax 914-591-3099	914-269-5350, fax 914-591-2643	914-269-5450, fax 914-591-1956

Dear Parents/Guardians: 2020-2021 School Year

Welcome to the Irvington School District. As school nurses we understand how important good health is to academic performance. We look forward to partnering with you to keep your child as healthy as possible. With that common goal in mind, the requirements for school outlined below are in place to support your child's health and well-being.

New York State Education Law requires a physical examination of all students **new** to the Irvington School District and **all** students in grades K, 1, 3, 5, 7, 9, and 11. All physical exams **must** be performed **within 12 months from the start of the school year** (i.e. Physicals dated on or after September 7, 2019 will be accepted.) The **NYS physical exam form** and documentation of required immunizations must be completed, signed and stamped by your **physician, physician assistant or nurse practitioner authorized to practice in New York State or within a state that has standards of licensure and practice comparable to those of New York State.** A dental certificate is *requested* for students new to the district and only in the following grades: Kindergarten, 1, 3, 5, 7, 9, and 11. **The physical examination form must be handed in within 30 days of entrance into school or required Grade.**

New York Public Health Law 2164 requires **all** students to be **fully immunized** against **Polio, Diphtheria, Tetanus, Pertussis, Measles, Mumps, Rubella (MMR), Hepatitis B and Varicella (Chicken Pox)** or a physician's documented record of disease or positive titer (blood test). Students **entering 6th-12th grade** and who are 11 years of age or older are **required to receive a Tdap** vaccine (Tetanus, Diphtheria and acellular Pertussis). **Meningococcal** (Meningitis) vaccine is **required for Grades 7, 8, 9, 10, 11 and 12 for the 2020-2021 school year.** These immunizations are required for school entrance and attendance. **The immunization record must be submitted within 14 days of attendance. Exclusion from school will result if the above requirements are not met.**

We appreciate your compliance with these regulations. If you have any concerns or questions regarding your child's health, please contact us during school hours.
Sincerely,
Irvington School Nurses

HEALTH FORMS CHECKLIST

- ❑ **Health History- completed and signed by parent/guardian**
- ❑ **Emergency Information form- signed by parent/guardian**
- ❑ **School Health Examination form- signed by healthcare provider**
- ❑ **Current Immunization Record-signed by healthcare provider**
- ❑ **Medication Authorization (if applicable)-signed by healthcare provider and parent/guardian**
- ❑ **Dental Certificate- signed by dentist/dental hygienist**

IRVINGTON UNION FREE SCHOOL DISTRICT

STUDENT HEALTH HISTORY

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

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

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Diabetes
☐ Ear Infections
☐ GI Conditions (ulcer, reflux, IBS, Crohn's, Celiac)
☐ Headaches/migraines
☐ Heart Conditions
☐ High Blood Pressure
☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
☐ Scoliosis
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition
☐ Speech Condition
☐ Urinary Condition

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

Is there any condition that would prevent your child from participating in physical education or sports?
☐No ☐Yes:_____

Please list any additional concerns: (use back of sheet if necessary)_____
_____

Parent/Guardian Signature:_____Date:_____

IRVINGTON UFSD

Health Office Emergency Form
(Please print and complete all sections)

Date of Birth___/___/___ **Home Room Teacher**_____
Mo Day Year

_____ _____ _____ _____
LAST NAME OF STUDENT FIRST NAME HOME phone GRADE

_____
ADDRESS

Parent/Guardian NAME (1) _____ **Parent/Guardian NAME (2)** _____

Reside with Student **(Yes)** ☐ (**No**) ☐
DAY OR WORK PHONE # (_____) _____-_____

CELL PHONE # (_____) _____-_____

Email_____

Reside with Student (**Yes**)☐ (**No**)☐
DAY OR WORK PHONE # (_____) _____-_____

CELL PHONE # (_____) _____-_____

Email_____

Doctor's Name_____**Phone**_____

MEDICAL INFORMATION :(Confidential)
Allergies to medication, food, insect_____epipen required yes___ no___

Health Condition (asthma, heart, seizures, diabetes, etc.)_____

Medications currently used (please update accordingly) _____

REQUIRED INFORMATION**

*In case of illness or injury, and your child **cannot** remain in school, a parent/guardian will be notified and your child **must** be picked up. We will **not** send your child home on the bus or if applicable to an after-school program. A child cannot leave school without an adult.*

In the event a parent/guardian cannot be reached, please list at **LEAST 2** adults who may pick up and assume temporary care of your child.

1) _____ _____
Name **Relationship** **Tel. #** **Cell#**

2) _____ _____
Name **Relationship** **Tel. #** **Cell#**

3) _____
Name **Relationship** **Tel #** **Cell#**

Information may be shared with appropriate staff members.

I, the undersigned, parent or guardian having legal custody of the above-named minor, hereby authorize officials of the Irvington Union Free School District to contact directly the persons named herein, and do authorize the named physician to render such treatment as may be deemed necessary in an emergency, for the health of said child. This form is to be used **only** in an **Emergency**, when I cannot be reached.

Parent/Guardian signature _____ **Date**_____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

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

HEALTH HISTORY

Allergies ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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

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

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

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code
_____	_____
_____	_____
_____	_____
_____	_____

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

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

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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

IRVINGTON UFSD
Irvington, NY 10533

Dows Lane Health Office: 914-269-5150 (fax. 914-591-6863)
Middle School Health Office: 914-269-5350 (fax. 914-591-2643)
Main Street School Health Office: 914-269-5250 (fax. 914-591-3099)
High School Health Office: 914-269-5450 (fax. 914-591-1956)

NYS Immunization Requirements for School Entrance/Attendance

New York State Required Physical Assessments: Grades K, 1, 3, 5, 7, 9, and 11
New York State Required Immunizations: **DTaP, Polio, MMR, Hepatitis B, Varicella (chicken pox), Tdap, Meningococcal**

Student's Name_____ Date of Birth_____

Immunization Report

	#1	#2	#3	#4	#5	#6	#7
*DPT/DTaP							
*Polio (IPV/OPV)							
*MMR							
*Hep B							
*Varivax							
*Meningococcal							
*Measles							
*Mumps							
*Rubella							
*Tdap							
Td (Tetanus/diphtheria)							
Hib (H influenza)							
Hep. A							
Human Papillomavirus (HPV)							
Pneumococcal							
PPD							
BCG							
Date of Chicken pox disease							
Titer report							

*Required by New York State Law

Physician's Signature **Date**

1/2018

Healthcare provider stamp

IRVINGTON UNION FREE SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

Dows Lane Elementary	Main Street School	Middle School	High School
914-269-5150; fax: 914-591-6863	914-269-5250; fax: 914-591-3099	914-269-5350; fax: 914-591-2643	914-269-5450; fax: 914-591-1956

MEDICATION AUTHORIZATION FORM

This form is valid for the current school year for both prescription and over the counter (OTC) medication.
Students may not carry any medication unless indicated on this form.

A. To be completed by parent/guardian:

I request that my child_____ grade ____ receive the medication(s) as prescribed below by our licensed health care prescriber. ALL medication, including OTC, is to be furnished by me in a **properly labeled original container from the pharmacy.**

Parent/Guardian Signature: _____ (Tel #) _____ Date: _____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication(s):

Student Name: _____ **DOB**: _____

Diagnosis: _____

Parameters for Medication to be administered: _____

****MEDICATIONS NOT ORDERED IN PROPER DOSAGE NOTATION (i.e. mg, concentration) WILL NOT BE ACCEPTED****

Medication: _____ Dosage:_____Time:_____ Frequency:_____ Route:_____
Medication: _____ Dosage:_____Time:_____ Frequency:_____ Route:_____
Medication: _____ Dosage:_____Time:_____ Frequency:_____ Route:_____
Medication: _____ Dosage:_____Time:_____ Frequency:_____ Route:_____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications checked below:

This student is diagnosed with:

❑ Allergy and requires Epinephrine Auto-injector
❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
❑ Other_____ which requires rapid administration of _____
(State Diagnosis) (Medication Name)

Signature of Prescriber: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: _____ Date: _____

Licensed Prescriber: _____ Date_____ Stamp:
Name and Title (print): _____
Signature: _____
Address: _____

Irvington Union Free School District
School Health Services

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: K, 1, 3,5,7,9 &11. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means, that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address (please print or stamp)	Dentist's/Dental Hygienist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

II. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

(5/2018)

IRVINGTON
UNION FREE SCHOOL DISTRICT

Dows Lane Elementary School
Andrea Kantor, Ph.D., Principal
Linda Langiulli, Interim Assistant Principal

2020-21 school year

Name of Child: _____

Name of Parent/Guardian: _____

We welcome you and your child to Dows Lane! This is where the journey begins! Please complete the portion below, along with the registration forms, and bring the entire packet with you to Kindergarten registration. Please be sure to fill out the entire preschool name and address. If your child did not attend preschool, designate at the top and sign the bottom. Thank you!

Circle one: My child ***did*** ***did not*** attend preschool.

Name of Preschool: _____

Preschool Address: _____

_____

Name of Teacher: _____

Name of Preschool Director: _____

Phone Number: _____

I give permission for the preschool named above to complete the Dows Lane Preschool Questionnaire and return it directly to the Dows Lane Elementary School.

_____ _____

Parent/Guardian Signature Date

Dows Lane Elementary School
6 Dows Lane, Irvington, NY 10533
(914) 591-6012
Andrea.Kantor@IrvingtonSchools.org Linda.Langiulli@IrvingtonSchools.org

IRVINGTON
UNION FREE SCHOOL DISTRICT

Dows Lane Elementary School
Andrea Kantor, Ph.D., Principal
Linda Langiulli, Interim Assistant Principal

2020-21 New Student Screening: Parent Interview

Date: _____

Student Name: _____ DOB: _____

BACKGROUND INFORMATION:

Name of Parent 1:_____ Occupation: _____

Phone: Home: _____ Work: _____ Cell: _____

Name of Parent 2: _____ Occupation: _____

Phone: Home: _____ Work: _____ Cell: _____

Name of Step-Parent or Guardian if living with child: _____

Phone: Home: _____ Work: _____ Cell: _____

In case of separation or divorce, who has legal custody of the child?

_____

Please specify any special provisions about visitation with the noncustodial parent which the school needs to know (i.e. child's visitation schedule, court orders, etc.):

_____

_____

_____

What is the primary language spoken at home? _____

Is it understood by the child? Yes____ No ____

Is the child fluent in it? Yes____ No ____

What other languages does the child hear at home? _____

Is it understood by the child? Yes____ No ____

Is the child fluent in it? Yes____ No ____

Person to contact in case of an emergency:

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____

Are there any special health-related issues for which your child might need special care that might affect him/her in school?

_____

_____

_____

Does your child have any specific needs that the teacher should be aware of?

_____

_____

_____

What behavioral aspects of your child's growth have you found most challenging?

_____

_____

_____

Does your child show signs of: (*please answer—frequently, infrequently, never*)

Anxiety_____ Hyperactivity _____ Disinterest _____ Fatigue _____

Negativity _____ Inappropriate Behavior _____ Poor Work Habits _____

Academic Difficulty _____ Difficulty w/Social Skills _____

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:
			❑ Male ❑ Female
Month	*Day*	*Year*	
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: