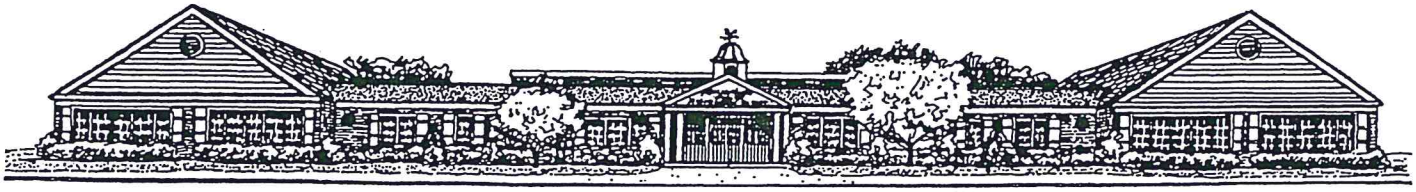


Remsenburg - Speonk U.F.S.D.

11 Mill Road • P.O. Box 900 • Remsenburg, New York 11960 • (631) 325-0203
Fax (631) 325-8439 • www.rsufsd.org

PARENT CONSENT FOR RELEASE OF SCHOOL RECORDS

Date Mailed/Faxed: _____

To: _____
(Name and Address of Child's Previous School)

_____

_____

I request that copies of all information concerning my child be released to the Remsenburg-Speonk Union Free School District.

Child's Name: _____

Date of Birth: _____

1. All Grades
2. Results of Standardized Tests
3. Health Records
4. Psychological Evaluation
5. Social History
6. Committee on Special Education Determinations
7. IEPs
8. Psychiatric/Neurological
9. Speech/Language Evaluation
10. Any other pertinent information

This information will be kept confidential and will be used to assist the district in meeting my child's educational needs.

Signed: _____
Parent's/Guardian's Signature

Address: _____ Telephone: _____

_____

_____ Date: _____

PLEASE FORWARD RECORDS TO:

REMSENBURG-SPEONK UFSD, P.O. BOX 900, MILL ROAD, REMSENBURG, NY 11960

REMSENBURG-SPEONK UNION FREE SCHOOL DISTRICT
Student Admission Form

Today's Date: _____ Admission Date: _____ Grade Entering: _____

Campus: ☐ Remsenburg-Speonk Elementary ☐ ESM 7-12 ☐ WHB 7-12

Student Information

First Name | Last Name | Date of Birth

M F

Place of Birth (If outside US, complete part B) | Gender

Parent/Guardian Name (*Father*)	Parent/Guardian Name (*Mother*)
( ) ( ) Home Phone Cell	( ) ( ) Home Phone Cell
Home Address	Home Address
City, State, Zip	City, State Zip
Mailing Address (PO if applicable)	Mailing Address (PO if applicable)
E-Mail Address	E-Mail Address
( ) Employer Work Phone	( ) Employer Work Phone
Custodial Parent? ☐ Yes ☐ No Correspondence? ☐ Yes ☐ No	Custodial Parent? ☐ Yes ☐ No Correspondence? ☐ Yes ☐ No

Ethnicity ☐ White ☐ Hispanic ☐ Black ☐ Asian ☐ Alaskan/Indian ☐ Other

Part B:

Birth country: _____ US Entry Date ____/____/____ Language spoken at home: _____

Transfer student? YES NO

If yes, what district did you formerly attend?

Address: _____

Phone: _____

Parent – Please Complete Side Two

Is child receiving special education services: ☐ Yes ☐ No

If yes, in district: Out of district:

Remedial Reading/Math? ☐ Yes ☐ No Speech Services? ☐ Yes ☐ No

ESL Program? ☐ Yes ☐ No Other _____

Indicate any health condition which the school should be aware of: _____

Is child on medication at home? ☐ Yes ☐ No

If yes, will child need medication during school hours? ☐ Yes ☐ No

Is child a Foster Child: ☐ Yes ☐ No

Foster Agency: _____ Telephone #: _____

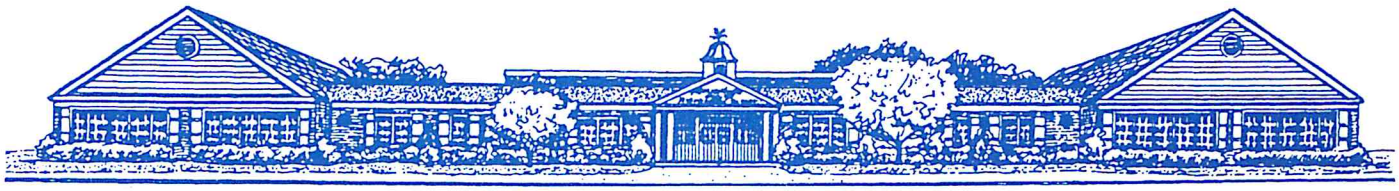
Address: _____

Household Information

Siblings			Adults
Name:	Sex:	D.O.B:	
Name:	Sex:	D.O.B:	
Name:	Sex:	D.O.B:	
Name:	Sex:	D.O.B:	

Parent/Guardian's Signature: **Date:**

Revised 3/2015



Remsenburg - Speonk U.F.S.D.

11 Mill Road • P.O. Box 900 • Remsenburg, New York 11960 • (631) 325-0203
Fax (631) 325-8439 • www.rsufsd.org

April, 2015

Dear Parents,

New York State law requires that all new entrants (whether Pre-K or K), 2nd , 4th, 7th, & 10th graders and all students entering a school district for the first time have a physical examination and a dental examination during the 2015-2016 school year.

For your convenience, we are enclosing a dental examination form and a physical form which includes immunization information for your health care provider to complete. Parental permission for authorization for use or disclosure of protected health information (HIPPA) is also included with the physical form. Please return these forms to the health office. If the forms are left at the doctor's office, please have a stamped envelope with the school's address so the physical may be sent to the school nurse.

We are requesting that your child's healthcare provider complete Body Mass Index information on the Health Appraisal Form. Please request that the provider complete that needed information in order to have a completed Health Appraisal on file at the school.

If your child has a physical scheduled during the school year, please notify the Health Office with the date of the scheduled physical exam. If you have any questions, please call the Health Office at (631) 325-0203 Ext. 112. Your physician may also fax the physical to (631)-325-8439.

Have a happy and healthy summer! See you in September.

Yours truly,

Jean Kuroski

Jean Kuroski, RN NCSN
School Nurse

Remsenburg-Speonk Elementary School

STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)

Note: NYSED requires an annual physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers

Name:	DOB:		Gender: ☐ M ☐ F
School:	Grade: ☐NA	Exam Date:	

HEALTH HISTORY

Specify Current Diseases

☐Asthma (☐Intermittent or ☐Persistent)
Quick relief inhaler: ☐Yes ☐No
Asthma Action Plan: ☐Yes ☐No
☐Type 1 Diabetes ☐Type 2 Diabetes
☐Hyperlipidemia ☐Hypertension
☐Other:

Sickle Cell Screen:	☐Positive	☐Negative	☐Not Done	Date:
PPD:	☐Positive	☐Negative	☐Not Done	Date:
Elevated Lead:	☐Yes	☐No	☐Not Done	Date:
Dental Referral:	☐Yes	☐No	☐Not Done	Date:

☐ Allergies - See page 2 for details.

Significant Medical/Surgical Information:

PHYSICAL EXAMINATION

Height: Weight: BP: Pulse: Respirations:

Scoliosis: ☐Negative ☐Positive
Degree of deviation: _____
Angle of trunk rotation via scoliometer: _____

Body Mass Index:
Weight Status Category (BMI Percentile):
☐ <5th ☐ 85th- 94th
☐ 5th- 49th ☐ 95th- 98th
☐ 50th-84th ☐ 99th & higher

Vision	Right	Left	*Referral*
Distance acuity			☐Yes ☐No
Distance acuity with lenses			
Vision - near vision			
Vision - color perception	☐ Pass	☐ Fail	

Hearing	Right	Left	*Referral*
☐ 20 db sweep screen both ears or			☐Yes ☐No

Circle developmental stage (ONLY for selection classification for 7th & 8th graders): Tanner: ☐I ☐ II ☐III ☐IV ☐ V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ See attached
Specify any abnormalities:

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

☐ Free from contagions and physically qualified for all activities (phys ed, athletics, playground, work, school)
☐ Expected Body Contact (full or limited): football, wrestling, basketball, ice/field/floor hockey, baseball, softball,
☐ Strenuous: cross-country, gymnastics, track & field, swim, diving, crew, ski, cheering, tennis, badminton, fencing,
☐ Non-contact/Non-strenuous: bowling, golfing, table tennis, archery, riflery, shuffleboard, walking
☐ Protective Equipment: ☐Athletic Cup ☐Sport/safety goggles ☐Other:
☐ Medical/prosthetic device:
☐ Recommendations/restrictions:

Name: DOB:

MEDICATIONS

To be completed by Health Care Provider

Diagnosis	ICD Code	Medication Name	Dose	Route	Time	Self Directed*	Self Admin/ Self Carry**
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

***Self Directed**: I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately, and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently

****Self Admin/Self-Carry**: I have determined this student is consistent and responsible in taking their own medication (self-directed), and in addition, give them permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

To be completed by Parent/Guardian if medication is prescribed

☐ I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/package with my child's name on it.

Parent/Guardian Signature: Date: Phone: ( )

☐ Parent permission & provider consent is required for students to self-administer & self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below.

Parent/Guardian Signature: Date: Phone: ( )

ALLERGIES

☐ **None** ☐ **Non Life-Threatening** ☐ **Life-Threatening**

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Specify allergen(s):

Specify previous symptoms: ☐History of anaphylaxis; last occurrence:

Emergency Care Plan for anaphylaxis: ☐ Yes ☐ No

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

IMMUNIZATIONS

☐ Immunization record attached ☐ Immunizations reported on NYSIIS	☐ Immunizations received today:
☐ No immunizations received today	☐ Will return on: to receive:

Provider / Parental Authorization

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: Date:

Provider Name: (please print) Phone #:

Provider Address: Fax #:

Parent/Guardian Signature: _____ Date:

Return to:

School Nurse: Mrs. Jean Kuroski School: Remsenburg-Speonk Elem.

Phone #: (631) 325-0203 Fax: (631) 325-8439 Date:

2014-15 School Year

New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES: Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee for Immunization Practices (ACIP).
This schedule reflects the minimum doses that are required for grades kindergarten through 12. Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. See footnotes for specific information for **each** vaccine.

Dose requirements MUST be read with the footnotes of this schedule.

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten	Grades 1 through 5	Grade 6	Grades 7 through 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap)[2]	**4 doses**	**4 to 5 doses** (See footnote 2b)	**4 to 5 doses** (See footnote 2b-e)	**3 doses** (See footnote 2c-e)	**3 doses** (See footnote 2d-e)
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)[3] (Required only for students enrolling in grades 6-12 who have not previously received a Tdap at 7 years of age or older)	Not applicable	Not applicable	Not applicable	**1 dose** (See footnote 3b)	**1 dose** (See footnote 3b)
Polio vaccine (IPV/OPV)[4]	**3 doses**	**3 to 5 doses** (See footnote 4b-d)	**3 doses**	**3 to 5 doses** (See footnote 4b-d)	**3 doses**
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**1 dose**	**2 doses** 2 doses required by age 7	**2 doses**	**2 doses**
Hepatitis B vaccine[6]	**3 doses**	**3 doses**	**3 doses**	**3 doses**	**3 doses**
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**	**1 dose**	**2 doses**	**1 dose**
Haemophilus influenzae type b conjugate vaccine (Hib)[8]	**1 to 4 doses** (See footnote 8a-g)	Not applicable	Not applicable	Not applicable	Not applicable
Pneumococcal Conjugate vaccine (PCV)[9]	**1 to 4 doses** (See footnote 9a-f)	Not applicable	Not applicable	Not applicable	Not applicable

Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15 through18 months, and 4 through 6 years. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose.
   b. If the fourth dose of DTaP was administered at age 4 years or older, the fifth (booster) dose of DTaP vaccine is not necessary.
   c. For children born prior to 1/1/2005, doses of DT and Td meet the immunization requirement for diphtheria toxoid-containing vaccine.
   d. Children ages 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. For these children, the required 6th grade adolescent Tdap vaccine should not also be given.
   e. For previously unvaccinated children 7 years of age and older, the immunization requirement is 3 doses. Tdap should be given for the first dose, followed by 2 doses of Td in accordance with the ACIP-recommended immunization schedule for persons 0-18 years of age.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
   a. Tdap can be received regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
   b. For children enrolling in grades 6 through 12 who received a dose of Tdap at 7 years of age or older, the booster dose of Tdap is not required.

4. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at ages 2, 4, 6 through 18 months, with a booster at age 4 through 6 years. The final dose in the series should be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If 4 or more doses were administered before age 4 years, an additional dose should be received on or after age 4 years.
   c. If both OPV and IPV were administered as part of a series, a total of 4 doses should be received, regardless of the child's current age.
   d. For children 4 years of age or older who have previously received less than 3 doses, a total of 3 doses are required if the third dose is administered at age 4 years or older and at least 6 months after the previous dose.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)
   a. The first dose of MMR vaccine should be received at age 12 through 15 months, and the second dose at age 4 through 6 years. The second dose may be received before age 4 years, provided at least 4 weeks have elapsed since the first dose.
   b. Students 7 years of age and older must have 2 doses of measles-containing vaccine, 2 doses of mumps-containing vaccine and at least 1 dose of rubella-containing vaccine.

6. Hepatitis B vaccine
   a. For children in grades 7 through 12, either 3 doses of pediatric hepatitis B vaccine or 2 doses of adult hepatitis B vaccine (Recombivax), administered at least 4 months apart are required (applies only to children 11 through 15 years old).
   b. Administration of a total of 4 doses of hepatitis B vaccine may be necessary when a combination vaccine containing hepatitis B is administered after the birth dose resulting in an inadequate interval between doses.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The ACIP routinely recommends that the first dose of varicella vaccine should be received at age 12 through 15 months and the second dose at age 4 through 6 years. The second dose may be received before age 4 years, provided at least 3 months have elapsed since the first dose. **NYS requires 2 doses of varicella vaccine for kindergarten entry.**
   b. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

8. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children who start the series on time should receive a Hib vaccine primary series and a booster dose to all infants. The primary series doses should be received at 2, 4, and 6 months of age. One booster dose should be received at age 12 through 15 months.
   b. If the first dose was administered at ages 7 through 11 months, a second dose should be received at least 4 weeks later and a final dose at 12 through 15 months of age.
   c. If 2 doses of vaccine were administered at 11 months of age or younger, a third and final dose should be received at 12 through 15 months of age and at least 8 weeks after the second dose.
   d. If dose 1 was administered at ages 12 through 14 months, a final dose should be received at least 8 weeks after dose 1.
   e. For children who received 1 dose of vaccine at 15 months of age or older, no further doses are necessary.
   f. For unvaccinated children 15 months of age or older, 1 dose of vaccine is required.
   g. Hib vaccine is not routinely required for children 5 years of age or older.

9. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of PCV13 vaccine at ages 2, 4, 6 months with a booster at age 12 through 15 months.
   b. Unvaccinated children 7 through 11 months of age should receive 2 doses, at least 4 weeks apart, followed by a 3rd dose at age 12 through 15 months.
   c. Unvaccinated children 12 through 23 months of age should receive 2 doses of vaccine at least 8 weeks apart.
   d. Previously unvaccinated children 24 through 59 months of age should receive only 1 dose.
   e. PCV13 is the preferred vaccine for use in healthy unvaccinated/partially vaccinated children 2 through 59 months of age. A single supplemental dose of PCV13 is recommended for children 14 through 59 months who have already completed the age appropriate series of PCV7. (Note: PCV13 has been licensed and recommended for children in the U.S. since 2/2010. PCV13 replaced the previous version of Prevnar, known as PCV7, which included 7 pneumococcal serotypes.)
   f. For further information, refer to the PCV chart available at http://www.health.ny.gov/prevention/immunization/schools/.

For further information contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433.

REMSENBURG-SPEONK ELEMENTARY SCHOOL

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. 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.

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district. Please sign and give the form to your healthcare provider and/or to your school nurse to avoid delays.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____authorize my child's healthcare provider(s) listed below to release my child's_____ medical records to the district's medical officer, physical (PT), occupational (OT), speech therapists (ST) and/or school nurse:

Name_____Phone_____FAX_____
Name_____Phone_____FAX_____
Name_____Phone_____FAX_____
Name_____Phone_____FAX_____

The healthcare provider may disclose the following protected health information: (check all that apply)

☐ Immunizations
☐ Health Appraisals
☐ Past/Current Medical Condition and Its Impact on Attendance, School Programming, and/or PT, OT, ST needs
☐ Other_____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (check all that apply)

☐ To develop care or therapy plans for routine and emergent school management
☐ To design appropriate educational programs
☐ To assess the impact of the medical condition(s) on school programming and/or attendance
☐ To share school observations/concerns surrounding behavior
☐ To assess a medical basis for modification of transportation and/or home tutoring
☐ Medication delivery and/or therapy prescriptions for PT, OT, ST
☐ At patient's request with no specified purpose
☐ Other_____

Please select one:

☐ This authorization is valid for the entire academic school year 20___ - 20_____
☐ This authorization shall expire on ____/_____/_____(MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building.

I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice.

I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that my child's treatment is not dependent on my agreement to release or withhold information.

Date Signature of Patient (Over 18), Parent, or Guardian Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A signed copy of this authorization must be given to the adult patient or parent of the minor child

Remsenburg-Speonk Union Free School District

STUDENT HEALTH HISTORY (completed by parent)

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
Been hospitalization	☐	☐	
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	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections
☐ GI Conditions (ulcer, reflux, IBS)
☐ 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:_____

REMSENBURG-SPEONK UNION FREE SCHOOL DISTRICT
REMSENBURG, NEW YORK

ENROLLMENT FORM – RESIDENCY QUESTIONNAIRE

Name of LEA: Remsenburg-Speonk Union Free School District

Name of School: Remsenburg-Speonk Elementary School

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ___/___/___ Grade: _____ ID#: _____
Month Day Year *(preschool – 12)* *(optional)*

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? *(Please check one box.)*

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe):
  _____
- ☐ In permanent housing

_____	_____	_____
Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)	**Signature** of Parent, Guardian, or Student (for unaccompanied homeless youth)	**Date**

The University of the State of New York • The State Education Department • Office of Bilingual Education
Albany, New York 12234

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 English. Your assistance in answering these questions is greatly appreciated.

Thank You

TO BE COMPLETED BY SCHOOL PERSONNEL

Please print or type clearly

DISTRICT

SCHOOL GRADE

STUDENT NAME

DATE OF BIRTH
Month: Day: Year:

STUDENT IDENTIFICATION NUMBER

COUNTRY OF BIRTH / ANCESTRY

NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.

NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION

DETERMINATION:
❑ Possible LEP
❑ English Proficient

(✔ boxes that apply)

1. What language(s) is spoken in the student's home or residence? ❑ **English** ❑ **Other** _____ *specify*

2. What language(s) are spoken most of the time to the student, in the home or residence? ❑ **English** ❑ **Other** _____ *specify*

3. What language(s) does the student understand? ❑ **English** ❑ **Other** _____ *specify*

4. What language(s) does the student speak? ❑ **English** ❑ **Other** _____ *specify*

5. What language(s) does the student read? ❑ **English** ❑ **Other** _____ *specify* ❑ **Does Not Read**

6. What language(s) does the student write? ❑ **English** ❑ **Other** _____ *specify* ❑ **Does Not Write**

7. In your opinion, how well does the student understand, speak, read and write English?

	Very well	*Only a little*	*Not at all*
Understands English	❑	❑	❑
Speaks English	❑	❑	❑
Reads English	❑	❑	❑
Writes English	❑	❑	❑

_____ Month: Day: Year: _____

Signature of Parent/Guardian/Other *Date*

SREI

REMSENBURG-SPEONK SCHOOL DISTRICT
STUDENT RACIAL AND ETHNIC IDENTIFICATION

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.

English Only

Name of School:

School District Student Identification Number:

Date of Birth (Month/Day/Year):
/ /

Student Name: Last, First, Middle:

Grade Level:

DIRECTIONS TO PARENT/GUARDIAN

PLEASE ANSWER QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) Check (√) the box that best describes your child.] Check (√) only ONE box.

☐ **YES, Hispanic**

☐ **NO, not Hispanic**

1. 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.

2. Select one or more races from the following five racial groups [For question (2) Check (√) all groups that apply to your child; check (√) **at least** ONE box.]:

☐ **AMERICAN INDIAN OR ALASKA NATIVE**: A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition. e.g. Cherokee, Mohawk, Inuit.

☐ **ASIAN**: 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.

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **BLACK, NOT OF HISPANIC ORIGIN**: A person having origins in any of the black racial groups of Africa

☐ **WHITE, NOT OF HISPANIC ORIGIN**: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East

Signature of Parent/Guardian/Other

Date

Relationship to Student (please check one box below):

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify): _____

See reverse for important message to Parents/Guardians and Confidentiality Procedures and Regulations.

FORM
SREI

REMSENBURG-SPEONK SCHOOL DISTRICT
STUDENT RACIAL AND ETHNIC IDENTIFICATION

To the Parent/Guardian: The *SAMPLE SCHOOL DISTRICT* has adopted a policy which requires the collection and recording of the ethnic identity of students in the *SAMPLE SCHOOL DISTRICT* 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.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the back of this page. Put a check (√) in the box for the category or categories which best describe your child. The *SAMPLE 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. 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.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

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

To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

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

Please complete the form on the reverse side of this page