GREENWOOD LAKE UNION FREE SCHOOL DISTRICT
New Registrant Household Form

Student Name_____ **Surname of the Household**_____
(Last name of Primary Parent/Guardian)
Home Phone # _____ Contact Priority_____

Address_____ City_____ State_____ Zip_____

Mailing Address, if different_____

Dominant Home Language_____

Residence Type: ☐ Lease ☐ Own ☐ Rent ☐ Unknown

Proof of Residency (minimum of 2 required): ☐ Utility Bill ☐ Mortgage Statement ☐ Property Tax Bill ☐ Lease
☐ Income Tax Form ☐ Real Estate Statement ☐ Voter's Registration ☐ Official DMV ID ☐ State/Gov't ID ☐ Other

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PARENTS/GUARDIANS WITH WHOM CHILD RESIDES:

Name _____
(Last) (First) (Middle)
Relationship_____
Phone 1_____Phone Type ☐Cell ☐Home☐Office Contact Priority_____
Phone 2_____Phone Type ☐Cell ☐Home☐Office Contact Priority_____
Email address_____

Parent On Active Duty in the Armed Forces?: ☐ **Yes** ☐ **No** **If Yes, Branch of Service:** _____

Name _____
(Last) (First) (Middle)
Relationship_____
Phone 1_____Phone Type ☐Cell ☐Home☐ Office Contact Priority_____
Phone 2_____Phone Type ☐Cell ☐Home☐ Office Contact Priority_____
Email address_____

Parent On Active Duty in the Armed Forces?: ☐ **Yes** ☐ **No** **If Yes, Branch of Service:** _____

SIBLINGS WHO RESIDE IN HOUSEHOLD:

Name _____ DOB_____ Gender ☐ Male ☐Female

Name _____ DOB_____ Gender ☐ Male ☐Female

Name _____ DOB_____ Gender ☐ Male ☐Female

Name _____ DOB_____ Gender ☐ Male ☐Female

Only to be filled out if Parent/Guardian lives outside the household

Name _____
(Last) (First) (Middle)
Relationship_____

Address_____Correspondence☐ Yes ☐ No
(City) (State/Zip)
Phone1_____Phone Type ☐Cell ☐Home☐ Office Contact Priority_____

Phone2_____Phone Type ☐Cell ☐Home☐ Office Contact Priority_____

GREENWOOD LAKE UNION FREE SCHOOL DISTRICT
New Registrant Pupil Form

Student Name _____ Gender: ☐ Male ☐ Female ☐ Other
(Last) (First) (Middle) Pronoun: ☐ He/Him ☐ She/Her ☐ They/Them

Are you Hispanic: ☐ Yes ☐ No

Race (Choose all that apply):
It is required by law for us to report this data, if you do not indicate your choice it will be necessary for us to make the selection.
☐ Asian ☐ African American (Black) ☐ Native American/Native Alaskan ☐ Pacific Islander ☐ Caucasian (White)

Date of Birth _____

Place of Birth (City, State) _____ Country, if place of birth not in US_____

EMERGENCY CONTACT INFO: (OTHER THAN PARENT/GUARDIAN)

Name_____ Gender _____ Resides in Same Household: ☐Yes ☐ No
(Last) (First) (Middle)
If different household: Address_____ City_____ State_____ Zip_____

Phone_____Phone Type: ☐Cell ☐Home ☐Office

Relationship to the Student_____

Name_____ Gender _____ Resides in Same Household: ☐Yes ☐ No
(Last) (First) (Middle)
If different household: Address_____ City_____ State_____ Zip_____

Phone_____ Phone Type: ☐Cell ☐Home ☐Office

Relationship to the Student_____

Pre K Experience: ☐ Yes ☐ No

Has pupil ever attended school in this District? ☐ Yes ☐ No If yes, which school _____ Grade(s) _____
Name of last school attended_____ Grades attended in previous school_____
Address of school last attended _____

TO BE COMPLETED BY SCHOOL PERSONNEL:

School Assignment _____ Teacher _____ Grade _____ Homeroom # _____
Date of Enrollment _____ Bus # _____ Student ID # _____
Proof of Birth: ☐ Alien Card ☐ Baptismal Certificate ☐ Birth Certificate ☐ Passport

Greenwood Lake Union Free School District

STUDENT EMERGENCY INFORMATION SHEET

Building (Circle One): **Elementary** **Middle** **Date:** _____

Child's Full Name: _____ **DOB:** _____ **Teacher:** _____ **Grade:** _____

EMERGENCY MEDICAL INFORMATION

Please complete the information below to assist us in knowing current information about your child. (This confidential information will be shared with the school personnel deemed appropriate by the health professional in your child's building.)

Known Allergies

_____

Current Medications

_____

Other Medical Information

_____

PHYSICIAN INFORMATION

Family Physician: _____ Physician's Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

If the School District is unable to reach the aforementioned Emergency Contacts in the order listed, we do hereby authorize the School District to call the family physician listed. In the event the physician cannot be reached, we do hereby authorize the school district to transport the child to a hospital emergency room if in the judgment of the school district such emergency treatment seems warranted. This authorization also includes authority to release pertinent medical records needed.

Date: _____ **Parent's Signature:** _____

Greenwood Lake Union Free School District
P.O. Box 8 • Greenwood Lake, NY 10925
(845) 782-8678 • fax (845) 782-8582
www.gwlufsd.org

Sarah Hadden
Superintendent of Schools

January 2024

Dear Parent or Guardian:

The New York State Education Law requires that every child in grades **Pre-K, K, 1, 3, 5, 7, 10 and all new students** to the district have a health examination, which may be completed by your family physician or the school doctor. Your family physician, who has a more complete understanding of your child, can interpret their findings directly to you and assist you in carrying out any recommendations, which may be indicated.

Therefore, we respectfully ask that you take your child to your family physician and have the **Annual Health Examination Record** (included) **filled out and returned when your child enters school in the fall.**

We are asking that all statements from the private physician be returned to the Nurse's Office (**no later than October 1st**). If, by that time, we do not have the record of examination, it will be necessary to have the examination done by the school physician in order to have the record of the child's physical condition on hand for reference.

NY State Law, Section 2164, requires proof of immunization for school attendance. Effective July 1, 2014, the following doses of vaccine must be given at an age and interval that is in accordance with the ACIP (Advisory Committee for Immunization Practices) schedule:

Entering Pre-K (2014 or after)	Dose	Entering Kindergarten Thru Grade 5	Dose	Entering Grade 6 Thru Grade 12	Dose	Entering Grade 7	Dose
Diptheria/Tetanus/ Pertussis	4	Diphtheria/Tetanus/P etuses (must include 1 after age 4)	4-5	DTaP/DTP	3	DTaP/DTP	3
Polio	3	Polio (must include 1 after age 4)	3-4	Polio (must include 1 after age 4)	3-4	Polio (must include 1 after age 4)	3-4
MMR	1	MMR	2	MMR	2	MMR	2
Hepatitis B	3	Hepatitis B	3	Hepatitis B	3	Hepatitis B	3
Varicella (Chickenpox)	1	Varicella	2	Varicella	2	Varicella	2
HIB	1-4			Tdap	1	Tdap	1
Pneumococcal Conjugate Vaccine (PCV)	1-4					Meningococcal	1

Please check with your health care provider to make sure your child has all the required immunizations for school attendance. Proof of immunization must be any 1 of these 3 items:

- An immunization certificate signed by your health care provider
- Immunization Registry report (NYSIIS) from your health care provider or health dept.
- A blood test (titer) lab report that proves your child is immune to the diseases.
  (Varicella: note from health care provider that child had disease is acceptable.)

Please contact your child's building principal or me if you have questions or concerns about the information included in this letter.

Sincerely,

Sarah Hadden
Superintendent of Schools

GREENWOOD LAKE UNION FREE SCHOOL DISTRICT

Elementary *845-477-2411 FAX 845-477-3180* **Middle** *845-782-8678 Fax 845-782-2004*

NYSED requires an annual physical exam for new entrants, students in Grades K, 1, 3, 5, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** ❑ M ❑ F **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

❑ Immunization record attached
❑ No immunizations given today
❑ Immunizations given since last Health Appraisal:

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: _____

Significant Medical/Surgical History: ❑ See attached _____

Allergies: ❑ LIFE THREATENING ❑ Food: _____ ❑ Insect: _____ ❑ Other: _____
❑ Seasonal ❑ Medication: _____

PHYSICAL EXAM

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

Body Mass Index: _____ _____ . _____

Weight Status Category (BMI Percentile):
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ❑ Pass 20 db sc both ears or:	R	L	

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

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): ❑ None ❑ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ❑ Yes ❑ No Student may self carry and self administer medication ❑ Yes ❑ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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

❑ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

❑ **Specify medical accommodations needed for school:** _____ ❑ None

❑ **Known or suspected disability:** _____ ❑ Please monitor

❑ **Restrictions:** _____ ❑ Please monitor

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

OPTIONAL INFORMATION, if known

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

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

HEALTH HISTORY – To be completed by Parent

Has your child ever had (Please check)

	YES	NO
Medication Allergies	☐	☐
Environmental Allergies	☐	☐
Food Allergies	☐	☐
Bee sting Allergy	☐	☐
Asthma	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Bladder/Kidney Problems	☐	☐
Cancer	☐	☐
Convulsions/seizures	☐	☐
Chest Pain	☐	☐
Heart Disease/Murmur	☐	☐
Rheumatic Fever	☐	☐
Rapid Heart Beat	☐	☐
Elevated Blood Pressure	☐	☐
Diabetes	☐	☐
Ear Problems/Hearing Loss	☐	☐
Vision in only one eye	☐	☐
Contact Lenses	☐	☐
Emergency room visit	☐	☐
Fainting Spells	☐	☐
Fainting during exercise	☐	☐
Headaches/frequent or severe	☐	☐
Head injury/Concussion	☐	☐
Hospitalization	☐	☐
Tuberculosis	☐	☐
Chicken Pox	☐	☐
Measles/German Measles	☐	☐
Scarlet Fever	☐	☐
Pneumonia	☐	☐

	YES	NO
Injury to Spine	☐	☐
Infectious Mononucleosis	☐	☐
Fracture/of any bone	☐	☐
Joint Dislocation/Injury	☐	☐
Ligament Injury	☐	☐
Torn/Pulled Muscle	☐	☐
Back Pain/Injury	☐	☐
Neck Injury	☐	☐
Knee Pain/Injury	☐	☐
Ankle Pain/Injury	☐	☐
Prosthetic Appliances	☐	☐
Nose Bleeds/frequent or severe	☐	☐
Broken Nose	☐	☐
Operations	☐	☐
One Kidney	☐	☐
One Testicle	☐	☐
Orthopedic Appliance	☐	☐
Braces	☐	☐
Capped Teeth/Bonded	☐	☐
Stomach Ulcer	☐	☐
Sudden Weight Loss/Gain	☐	☐
Ill for five (5) consecutive days	☐	☐
Frequent Absences/lateness	☐	☐
Girls, Menstrual Period	☐	☐
If yes, age started? _____		
If yes, heavy bleeding? _____		
If yes, Cramps? _____		
Mumps	☐	☐
Poliomyelitis	☐	☐
Immunizations required	☐	☐

If yes to the above questions, please provide details: dates, physicians, treatment, current status of problems

_____

	YES	NO
Is your child under medical care now?	☐	☐
Is student on medication on a regular basis?	☐	☐
If yes, medication and reason _____		
_____		
Did anyone in your immediate family below age fifty (50) die of a heart attack suddenly?	☐	☐
Has your child been unconscious or lost memory from a blow on the head?	☐	☐
Has your child ever had an illness, condition, or injury that required him/her to go to the hospital? either as a patient overnight or in the emergency room or for x-rays or required an operation, or caused your child to miss school?	☐	☐

Is there any other information that the school should know in order to safeguard your child's health?

_____

I understand that this confidential information will be shared with the school personnel deemed appropriate by the health professional in my child's building.

Parent/Guardian Signature: _____ Date: _____

GREENWOOD LAKE UNION FREE SCHOOL DISTRICT

Dental Health Certificate - OPTIONAL

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination 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 dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist 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 visit to a dentist? ☐ 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

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam 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 name and address (please print or stamp) Dentist'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):_____

III. 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.

****IMPORTANT****
PLEASE ANSWER THE QUESTIONS BELOW

STUDENT NAME:_____

1. Is there a Court Order barring either parent from removing the student from school?

☐Yes ☐ No

(If yes, provide school with a copy of the applicable Court Order)

2. Do parents have shared (or joint) parental rights and responsibility?

☐Yes ☐ No

(If no, provide the school with a copy of the Court Order which limits either parent's parental rights or responsibilities regarding the student)

3. Does either parent have final decision making authority regarding educational decisions for the student?

☐Yes ☐ No

(If yes, provide the school with a copy of the Court Order stating that one parent has final parental decision making authority regarding education)

4. Is there a Temporary Restraining Order, Permanent Restraining Order, Order of No Contact, or other Court Order that restricts or impacts access to the student by anyone, including a parent?

☐Yes ☐ No

(If yes, provide school with a copy of the applicable Court Order)

5. Does this student have an IEP or a 504?

☐Yes ☐ No

6. Is there anything else you feel is important to share relating to your child's academic needs or personal welfare?

_____

_____

_____

_____

Greenwood Lake Union Free School District
P.O. Box 8 • Greenwood Lake, NY 10925
(845) 782-8678 • fax (845) 782-8582
www.gwlufsd.org

ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: _____

Name of 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

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: *Month* *Day* *Year*

GENDER: ❑ 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:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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: