Rye Neck Schools

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www.ryeneck.org

APPLICATION *for* REGISTRATION

TO BE FILLED OUT BY PARENT / GUARDIAN

The following papers must be presented when registering your child:

1. Child's Birth Certificate or Baptismal Certificate (giving date of birth) or a certified transcription of the Birth Certificate or Baptismal Certificate (including a foreign certified transcription of either certificate); a Passport (including a foreign passport); or other proof of the child's age acceptable to the District. ***The district must make a copy of the original document.***

2. **Three (3)** Other forms of documentation, including, but not limited to:
    - Copy of a residential lease or proof of ownership of a house or condominium (i.e., deed, mortgage statement, tax bill, etc.)
    - Other statements from a third party establishing the parent/guardian's physical presence in the District;
    - Affidavits of guardianship if applicable;

You may also submit other documents in support of the child's enrollment in the District such as:

- Pay Stub;
- Income tax form;
- Utility or other bills;
- Membership documents based upon residency;
- Voter Registration documents;
- Official Driver's license, learner's permit, or non-driver identification;
- State or government issued identification;
- Documents issued by federal, state or local agencies (such as the local social service agency or the Office of Refugee Resettlement).

3. **Renters:** Complete Landlord's Affidavit (obtain from registration clerk or download from district website)

4. Current Health Appraisal, TB Screening Forms and immunization record completed and signed by a NYS physician (must be within 1 year from the start of school). Each certificate or appraisal must be signed by a licensed physician, physician assistant or nurse practitioner, authorized to practice in NYS. The physician's office should be located within approximately 50 miles of the state border.

If you would like information regarding the referral and evaluation process, please reference "A Parents Guide to Special Education" on the NYSED website: http://www.p12.nysed.gov/specialed/parentpubs.htm You may also contact Mr. H. Wil Siegel, Director of Pupil Personnel Services, for the Rye Neck School District at 914-777-4864

You may also download registration documents from our web site: www.ryeneck.org

Students will not be placed in a class until medical documentation is complete.

Thank you,
Dolores Ayaso
Registration Clerk
(914) 777-4882

Rye Neck Union Free School District
300 Hornidge Road
Mamaroneck, NY 10543
(914) 777-5200

Evidence of Custody of the Child, including but not limited to an affidavit indicating:

- That they are the parent with whom the child lawfully resides

  OR

- That they are the person in parental relation to the child and they have total and permanent custody and control

  OR

- If applicable, judicial custody order or an order of guardianship papers (this is not a requirement).

Eric Lutinski Ed. D.
Superintendent of Schools

RYE NECK UNION FREE SCHOOL DISTRICT

Daniel Warren Elementary School
1310 Harrison Avenue
Mamaroneck, NY 10543
Grades K- 2
Contact: Debbie Hutchinson-914-777-4202
dhutchinson@ryeneck.org

F. E. Bellows
200 Carroll Avenue
Mamaroneck, NY 10543
Grades 3- 5
Contact: April Laychak-914-777-4602
alaychak@ryeneck.org

Rye Neck Middle School
300 Hornidge Road
Mamaroneck, NY 10543
Grades 6- 8
Contact: 914-777-4732
Meegan Lawlor mlawlor@ryeneck.org
Coleen Sullivan csullivan@ryeneck.org

Rye Neck High School
300 Hornidge Road
Mamaroneck, NY 10543
Grades 9- 12
Contact: Guidance Office -914-777-4872
Maureen Williams mwilliams@ryeneck.org
Corinne Ryan cryan@ryeneck.org

Request for Information
Release for Records

TO:_____

Name of Current School

_____

School Address

_____

Town/City State Zip Code

RE:_____ _____

Child's Name Grade Entering

The above named student has enrolled in the Rye Neck Union Free School District. Please forward the following records at your earliest convenience to the appropriate school listed above:

- Transcript
- Current Report Card
- Health Records
- New York State Competency Test Record
- Test Scores
- Disciplinary Records
- Any other information that would assist us in the placement of this student

Name of Parent/ Guardian_____

Please Print

Date_____ _____

Signature of Parent / Guardian

RYE NECK SCHOOL DISTRICT STUDENT REGISTRATION FORM

For Office Use Only:

Proof of: Legal Residence ☐ Student Number_____

Birth Certificate ☐ Family Number_____

Medical Records ☐ Gender M ☐ F ☐ ☐

Academic Records ☐ Entering Grade_____

Custody Papers (If applicable) ☐ Date Entering _____

Today's Date_____

TO BE FILLED OUT BY PARENT / GUARDIAN

STUDENT INFORMATION

Child's Last Name_____First Name_____

Date of Birth___/___/___

Siblings_____Grade_____Gender_____

_____Grade_____Gender_____

Student Lives with: ☐ Both Parents ☐ Mother ☐ Father
☐ Legal Guardian(s) ☐ Parent/ Step-parent
☐ Other _____

PARENT/GUARDIAN INFORMATION

Mother
Last Name_____First Name_____Title_____

Address_____

City_____Zip Code_____

Telephone:_____Cell Phone:_____

E-Mail Address(es)_____

Employer_____Occupation_____

Work Address_____City_____State_____Zip Code_____

Work Telephone_____
Previous Home Address_____

RYE NECK SCHOOL DISTRICT STUDENT REGISTRATION FORM

Father
Last Name_____**First Name**_____**Title**____

Address_____

City_____Zip Code_____

Telephone:_____Cell Phone:_____

E-Mail Address(es)_____

Employer_____Occupation_____

Work Address_____City_____State_____Zip Code_____

Work Telephone_____
Previous Home Address_____

School Child Last Attended_____

Address_____City_____State____Zip Code_____

Total Years in U. S. Schools _____ Telephone_____

Special Programs / Needs_____

CHILD'S HEALTH HISTORY

Was your child a premature baby? Yes ☐ No ☐ Birth Weight___lbs. _____oz.
Were there any notable complications during pregnancy or birth? Yes ☐ No ☐
Does your child suffer from any of the following: (please check)
☐ Asthma ☐ Allergies ☐ Chronic Diseases such as diabetes, heart disease, muscular dystrophy, etc.
Please Specify_____

Has your child ever had any serious illness, injuries or operations? Yes ☐ No ☐

Please Specify_____
Has your child ever worn glasses or had visual problems? Yes ☐ No ☐
Has your child ever had a hearing problem or hearing evaluation? Yes ☐ No ☐
Is your child presently required to take any form of medication? Yes ☐ No ☐
Has your child received any special services as a pre-schooler? Yes ☐ No ☐

Parent/ Guardian signature_____

Student Name:_____
Last Name **First Name**

EMERGENCY CONTACT INFORMATION

Physician_____Telephone_____

Additional Contacts

1. Name_____Telephone_____Relationship_____

Address_____City_____State____Zip Code_____

2. Name_____Telephone_____Relationship_____

Address_____City_____State____Zip Code_____

3. Name_____Telephone_____Relationship_____

Address_____City_____State_____Zip Code_____

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:		
First	*Middle*	*Last*

DATE OF BIRTH:			GENDER:
Month	*Day*	*Year*	❑ Male ❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to Student*

HOME LANGUAGE CODE _____

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other _____ *specify*	
2. What was the first language your child learned?	❑ English	❑ Other _____ *specify*	
3. What is the Home Language of each parent/guardian?	❑ Mother _____ *specify*	❑ Father _____ *specify*	❑ Guardian(s) _____ *specify*
4. What language(s) does your child understand?	❑ English	❑ Other _____ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other _____ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other _____ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other _____ *specify*	❑ Does not write

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

SCHOOL DISTRICT INFORMATION:		STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School	*Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

Yes* ***No*** ***Not sure***
❑ ❑ ❑ ***If yes,** please explain:_____

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

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

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
❑ No ❑ Yes – Type of services received:_____

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

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

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

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

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ Mother ❑ Father ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ **POSITION:** _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

****DATE OF INDIVIDUAL INTERVIEW:** _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:** _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

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

RyeNeck Schools
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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 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.

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.

- ☐ Yes, Hispanic
- ☐ No, not Hispanic

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 American 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**: A person having origins in any of the black racial groups of Africa
- ☐ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East

_____ _____

Signature of Parent/Guardian/Other Date

STUDENT RESIDENCY QUESTIONNAIRE

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C.11435. The answers to this residency form will assist in determining if the student meets the definition of homelessness and may be eligible to receive services.

Name of Student: _____ Sex ☐ Male ☐ Female
Last First Middle

1. Is your current address a temporary living arrangement? ☐ Yes ☐ No
2. Is this temporary living arrangement due to loss of housing or economic hardship ☐ Yes ☐ No

If you answered YES to the above questions, please complete the remainder of this form.
If you answered NO, you may stop here.

Where is the student presently living (Check one box)
( ) Temporarily with relatives or in another family's house or apartment **due to loss of housing**
( ) Temporarily with an adult that is not the parent/guardian **due to loss of housing**
( ) In a motel or hotel
( ) In a shelter
( ) In a place not designed for ordinary sleeping accommodations such as a car, trailer park or campsite
( ) In a rented trailer/motor home on private property
( ) In a rented garage
( ) Awaiting foster placement

Name of Parent(s)/Legal Guardian(s)_____

Address_____Zip_____Phone_____

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs TEC Sec. 25.002(3)(d)

Signature of Parent/Legal Guardian_____Date_____

Please send a copy to Ana Luisa Crivorot (K-12 Social Worker and McKinney-Vento Liaison)

I certify the above named student qualifies for the Child Nutrition Program (free school meals) under the provisions of the

McKinney-Vento Act.

_____ _____
Date McKinney-Vento Liaison Signature

FAXED BY _____ DISTRICT_____

NEW YORK STATE MIGRANT EDUCATION PROGRAM

IDENTIFICATION & RECRUITMENT OFFICE

PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Every Student Succeeds Act (ESSA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take few minutes to complete this questionnaire.

Have you or has someone in your family worked on a farm?
Have you moved during the past three years?

- ☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- ☐ Work related to logging, harvesting, or initial processing of trees.
- ☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)

If you answer YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____City/Town_____

Telephone number: (____)-_____-_____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____Grade_____

Student name: _____ Age _____Grade_____

To submit this referral please fax to 845-257-2953 or mail to Mid-Hudson Migrant Education Program-353 VH Annex 1 Hawk Drive New Paltz, NY 12561

If you need further clarification, please do not hesitate to call the school nurse in your building.

Daniel Warren	Wendy Abbatantono, RN	Grades K, 1, 2	777-4210
F.E. Bellows	Samantha Krench, RN	Grades 3, 4, 5	777-4610
MS/ HS	Ardijane Mahmud , RN	Grades 6-8, 9-12	777-4810

Medical Exemption- A certificate from a physician licensed to practice medicine in the State of New York that one or more of the required immunizations may be detrimental to the child's health. This certificate must specify which immunizations may be detrimental and the specific contraindications.

The Rye Neck UFSD will accept an immunization transfer card or a transcript of your child's cumulative health record, demonstrating New York State requirements have been met, from the school previously attended.

We trust that you will understand our need to make certain that all of our students are properly immunized, and that you will cooperate with us in our efforts to protect all of our students.

If you have any questions or would like to speak with the school nurse regarding any medical conditions or medical history your child may have, please do not hesitate to call the school nurse in your child's building.

With best wishes,

Samantha Krench, RN Ardijane Mahmud , RN Wendy Abbatantono, RN

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

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

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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

BMI_____kg/m2

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

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

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

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

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision	**With Correction** ☐ Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/		☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

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

If Restrictions Apply – Complete the information below

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

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

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

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

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

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

Name: DOB:

TUBERCULOSIS TESTING / SCREENING – EITHER A OR B MUST BE COMPLETED BY THE PHYSICIAN

A. PPD (Mantoux):

1. Date Placed:_____ Date Read:_____ Result in mm:_____
2. If PPD is Positive: CXR: Date of Exam:___/___/___ Result:_____

Treatment: _____

_____

B. Tuberculin screening not indicated _____ (MD must initial)

Date:_____

Provider's Signature:_____ Phone: _____

Provider's Name/Address:_____ Fax: _____

NEW STUDENT HISTORY

Student Name: Grade:	Parents' Name: Phone Number:
Counselor: Date:	Previous School Contact: Phone Number:

EARLY CHILDHOOD/OVERALL HEALTH

- Any developmental delays (walking, talking, riding a bike)?
- Any serious or chronic health conditions?
- Any behavioral or emotional problems (tantrums, anxiety, school attendance)?

ACHIEVEMENTS AND ACCOMPLISHMENTS

- Extracurricular activities?
- Makes friends easily?
- Other (clubs, interests)?

ACADEMIC STRENGTHS

- Standardized Tests
- Report Cards
- Awards
- Parent Comments

ACADEMIC AREAS FOR DEVELOPMENT

- What type of school setting is your child coming from (urban, suburban, ex-elementary school w/one teacher or departmentalized middle school)?
- Did your child ever receive any type of additional help (special education, AIS, private tutoring, remedial support)?
- Most difficult subject?

HOME

- If student does not live with both parents, is there a custody agreement?
- Any orders of protection or PINS petitions?
- Outside agencies involved with the family?

PARENT/STUDENT COMMENTS

-
-
-

Check off as completed:

☐ **MEETING WITH PRINCIPAL** ☐ TUTORIALS YES/NO WHY? ☐ TOUR

☐ RECORD REVIEW ☐ PARENT/STUDENT INTERVIEW ☐ CONTACT PREVIOUS SCHOOL

☐ ID ☐ COMPUTER PERMISSION FORM ☐ CREATE SCHEDULE

☐ LOCKER/HANDBOOK/MAP/BELL SCHEDULE ☐ EMAIL TEACHERS

SCREENING, IF NECESSARY: ☐ MATH ☐ READING ☐ SCHOOL CALENDAR