Student Name ____________, ____________ School / Grade ____________________
Last First

KINGSTON CITY SCHOOL DISTRICT

Meagher Administration Building
21 Wynkoop Place
Kingston, NY 12401-3879

Dr. Paul J. Padalino
Superintendent of Schools

CHECKLIST FOR Pre-KINDERGARTEN REGISTRATION

The following documents are required for enrolling into the Kingston City School District.

☐ **Birth Certificate, Passport, or Baptismal Certificate**

☐ **Immunization Record**
Prepared by a physician or authorized person who administers the immunizing agent and shall specify the vaccines given and the dates of administration, proof of past immunizations or proof of pending appointment with physician/medical practice.

☐ **Custody/Guardian papers**: Necessary if the child does not live with both biological parents

☐ **Parent or Guardian photo identification**: Driver's License, passport, state id.

☐ **Physical Exam dated within one year:** Must be completed by a NYS licensed physician, physician assistant or nurse practitioner on the **NYSED Student Health Examination Form** (included in this packet).

☐ **District Residency**
One of the following residency proofs must be provided:

A. Owns home
1. Most recent utility bill/tax or mortgage statement – must have name and property/residence address

B. Rents home
1. Lease agreement, must have name property/residence address
2. Parent's name must appear on lease
3. Most recent utility bill – one only (electric, phone, water bill) must have name and property/residence address

C. Affidavit of Property Owner/Landlord Form – Must be Notarized
1. To be completed by the landlord/property owner, in instances where there is no lease
2. If you are living with a relative, that person must complete the form and also provide you with a bill (electric, phone, water) showing their name and property/residence address

** The following will not be accepted as proof of residency: Driver's License, Checkbook, Rent Receipt, Car Insurance Cards, and Bank Statements.

****CLASSIFIED – YES or NO**

We Inspire. We Educate. We Graduate.
All Students, All of the Time

Completed Application ________________
(for office use only)

DATE: ____________________

CHILD'S NAME: ____ DOB: ______________ Sex: ☐M ☐F

PARENTS/GUARDIANS NAME: ____

ADDRESS: ____ CITY: ____________________ ZIP: ___________

MAILING ADDRESS (IF DIFFERENT): __________________________ E-MAIL: ___________________________

PHONE: (h) ______________________ (w) ______________________ (mobile) _______________________

Have you had a child previously attend Pre-K ☐ YES ☐ NO If yes, name of Agency _______________________

Do you feel your child has any special needs? If so, please explain: ___________

____

PLEASE CHECK PREFERRED 3-YEAR-OLD UPK SITE: PLEASE PICK A 1ST, 2ND, AND 3RD CHOICE

FULL DAY 3-YEAR-OLD UPK (5 HOURS)

☐ **GEORGE WASHINGTON MONTESSORI SCHOOL- 67 WALL STREET, KINGSTON (845) 943-3513** ***HOURS 9-2 NO WRAPAROUND CARE***

☐ **LIL' LEARNERS PRESCHOOL (CENTER FOR CREATIVE EDUCATION) – 16 CEDAR STREET, KINGSTON – 845-338-7664** ***HOURS 9-2 WRAPAROUND CARE AVAILABLE***

☐ **KINGSTON CATHOLIC – 159 BROADWAY, KINGSTON – 845-331-9318** ***HOURS 7:45-12:45 WRAPAROUND CARE AVAILABLE***

Universal Pre-Kindergarten program is a program which provides curriculum and activities, 5 days/week, Full-day (5 hrs), which are appropriate to the age-level and individual needs of eligible children, and which promote cognitive, linguistic, physical, cultural, emotional, and social development. Activities shall be learner-centered and shall be designed and provided in a way that promotes the child's total growth and development in all areas including emergent English literacy. Children are encouraged to be self-assured and independent.

Eligible children are those who reside within the school district and are THREE years of age on or before December 1st of the year in which he or she is enrolled. Selection is based on a lottery system.

Transportation is NOT provided and is the responsibility of the parent/caregiver.

***After you have completed the entire application and compiled all supporting documents, email all documents to jbarber@kingstoncityschools.org or call the Registration Office to schedule an appointment. ***

Kingston City School District

ATTN: Jill Barber, Registration Office, 21 Wynkoop Place, Kingston, NY 12401

P: 845-943-3011 E: jbarber@kingstoncityschools.org

We Inspire. We Educate. We Graduate.

All Students, All of the Time

Welcome to the Kingston City School District!

This packet will need to be completed in full to be registered with the Kingston City School District.

Please check a box below to let us know what this application is for:

- ☐ Universal Preschool Application
- ☐ Preschool Special Education Evaluation Referral
- ☐ Both- UPK Application and Preschool Age Special Education Evaluation Referral

Thank you.

Registration will contact you once the application is received.

KINGSTON CITY SCHOOL DISTRICT   PUPIL REGISTRATION FORM

DATE ______________________________ GRADE ___________

Student Name ____ Gender ______ Hispanic? ☐ Yes ☐ No
(Last) (First) (Middle)

Race (choose all that apply): ☐ Asian ☐ Black ☐ Native American/Native Alaskan ☐ Pacific Islander ☐ White

Date of Birth______________ Place of Birth (city, state)___________________________ Country (if not US) _______________

Custody Papers or Guardian Warnings? ☐ No ☐ Yes
Explain ____

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 ____

Phone/Fax (circle one) (if known) _______________________________ If high school: date entered 9th grade ________

For Immigrant Students and ESL (English as a second language) students ONLY **ESL?** ☐ Yes ☐ No

Date of US Entry: ____________________________ Date First Entered School in US _________________________________

These questions address the McKinney-Vento Act 42 U.S.C. 11435. This information helps determine eligibility for services:

1. Is your current address a temporary living arrangement? ☐ Yes ☐ No If "No" stop here. If "Yes" please continue:
2. Is your temporary living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No

Where is the student presently living?

☐ In a motel ☐ In a shelter ☐ With more than one family in a house or apartment ☐ Moving from place to place

☐ In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite.

PARENTS/GUARDIANS WITH WHOM CHILD(REN) RESIDE(S)

Home Phone # ______________________________ Unlisted? ☐ Yes ☐ No Contact Priority____

Address_____________________________________ City________________ State________ Zip________

Mailing Address, if different____

Dominant Home Language_________________________ ESL ☐ YES ☐ NO

Resident Type: ☐ Lease ☐ Own ☐ Rent ☐ Trailer Park/Condo Unit ☐ Unknown

Proof of Residency: ☐ Mortgage Statement ☐ Property Tax Bill ☐ Real Estate Statement ☐ Utility Bill

☐ Lease ☐ Landlord Verification Form ☐ Other ____

INFORMATION TO BE COMPLETED FOR PARENTS/GUARDIANS *WHO LIVE IN THE SAME HOUSEHOLD* AS THE CHILD(REN):

Parent/Guardian Name ____

(Last) (First) (Middle)

Relationship______________________ Legal custody? ☐YES ☐ NO

Phone1__________________________Phone Type ☐Cell ☐Home☐ Office; Contact Priority__

Phone2__________________________Phone Type ☐Cell ☐Home☐ Office; Contact Priority__

Email address___________________________

Employer's Name ________________________ Employer's Phone # _____________Priority___

Employer's Address __________________________________

(City) (State/Zip)

Currently Serving Active Military Duty ☐YES ☐ NO If yes, date enlisted:_________Date Exited:__________

Parent/Guardian Name ____

(Last) (First) (Middle)

Relationship______________________ Legal custody? ☐YES ☐ NO

Phone1__________________________Phone Type ☐Cell ☐Home☐ Office; Contact Priority__

Phone2__________________________Phone Type ☐Cell ☐Home☐ Office; Contact Priority__

Email address___________________________

Employer's Name ________________________ Employer's Phone # _____________Priority___

Employer's Address __________________________________

(City) (State/Zip)

Currently Serving Active Military Duty ☐YES ☐ NO If yes, date enlisted:_________Date Exited:__________

INFORMATION TO BE COMPLETED FOR A PARENT/GUARDIAN *WHO DOES NOT LIVE IN THE SAME HOUSEHOLD* AS *THE CHILD(REN):*

Name ____

(Last) (First) (Middle)

Relationship____

Address ____

Address____Correspondence☐ Yes ☐ No

(City) (State/Zip)

Phone1__________________________Phone Type ☐Cell ☐Home☐ Office; Contact Priority__

Phone2__________________________Phone Type ☐Cell ☐Home☐ Office; Contact Priority__

Currently Serving Active Military Duty ☐YES ☐ NO If yes, date enlisted:_________Date Exited:__________

EMERGENCY CONTACT INFORMATION—OTHER THAN PARENT/GUARDIAN:

Name____ Gender ______
(Last) (First) (Middle)

Resides in Same Household ☐ Yes ☐ No

If different household:

Address__________________________ City____________ State______ Zip_______

Phone 1 ____________________________ Phone Type ☐ Cell ☐ Home ☐ Office

Phone 2____________________________ Phone Type ☐ Cell ☐ Home ☐ Office

Relationship to the Student____________________

Name____ Gender ______
(Last) (First) (Middle)

Resides in Same Household ☐ Yes ☐ No

If different household:

Address__________________________ City____________ State______ Zip_______

Phone 1 ____________________________ Phone Type ☐ Cell ☐ Home ☐ Office

Phone 2____________________________ Phone Type ☐ Cell ☐ Home ☐ Office

Relationship to the Student____________________

OTHER CHILDREN WHO RESIDE IN HOUSEHOLD

Children not yet enrolled in school

Name ____ DOB________

Name ____ DOB________

Name ____ DOB________

Children enrolled in school

Name ______________________________ DOB_______ SCHOOL ________________

Name ______________________________ DOB_______ SCHOOL ________________

Name ______________________________ DOB_______ SCHOOL ________________

Guardian Warnings? ☐ No ☐ Yes Explain ________________________________

Custody Papers? ☐ No ☐ Yes Explain ________________________________

Information collected by (name of registrar): ________________________________

October 2017

NEW YORK STATE EDUCATION DEPARTMENT
Emergent Multilingual Learners Language Profile for Prekindergarten Students[i]

Dear Parent or Guardian,
Thank you for completing the Emergent Multilingual Learners Language Profile. This survey will assist your new school with valuable information about your child's experience with languages. Information gathered will assist Prekindergarten educators in delivering academically and linguistically relevant instruction that strengthens the language and literacy of all students.

THIS SECTION TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY AND MAINTAINED ON FILE
Date Profile Completed:
Student Name:
Gender:
Date of Birth:
District or Community Based Organization Name:
Student ID (if applicable):
Name of Person Administering Profile:
Title:

Parent or Person in Parental Relation Information

Name of parent or person in parental relation:

Relationship (to student) of person providing information for this profile: ☐ mother ☐ father ☐ other ______________

In what language(s) would you like to receive information from the school? ☐ English ☐ other home language:

Language in the Home

1. In what language(s) do you (parents or guardians) speak to your child at home?

2. What is/are the primary language(s) of each parent/guardian in your home? (List all that apply.)

3. Is there a caretaker in the home? ☐ yes ☐ no

If yes, what language(s) does the caretaker speak most frequently?

4. What language(s) does your child understand?

5. In what language(s) does your child speak with other people?

6. Does your child have siblings? ☐ yes ☐ no

If yes, in what language(s) do the children speak with each other most of the time?

7a. At what age did your child begin to speak in short sentences?

In what language?

7b. At what age did your child begin to speak in full sentences?

In what language?

8. In what language does your child pretend play?

9. How has your child learned English so far (television shows, siblings, childcare, etc.)?

Language Outside the Home/Family

10. Has your child attended any nursery, Head Start or childcare program? ☐ yes ☐ no

If yes, in what language was the program conducted?

In what language does your child interact with other people in the nursery or childcare setting?

11. How would you describe your child's language use with friends?

Language Goals

12. What are your language goals for your child? For example, do you want child to become proficient in more than one language?

13. Have you exposed your child to more than one language to ensure that he or she is bilingual or multilingual? ☐ yes ☐ no

14. Does your child need to speak a language other than English in order to communicate with your relatives or extended family?
☐ yes ☐ no

If yes, in what language(s)?

Emergent Literacy

15. Does your child have books at home or does he or she read books from the library?

In what language(s) are these books read to him or her?

16a. Can your child name any letters or sounds in English? ☐ yes ☐ no

16b. Can your child recognize letters or symbols in another language? ☐ yes ☐ no

If yes, in what language(s)?
17a. Does your child pretend to read? ☐ yes ☐ no ☐ unsure If yes, in what language(s)? 17b. Does your child pretend to write? ☐ yes ☐ no ☐ unsure If yes, in what language(s)?
18. Does your child tell the stories from his/her favorite books or videos? ☐ yes ☐ no If yes, in what language(s)?
19. Does your child's childcare or nursery program describe goals for his or her learning? ☐ yes ☐ no If so, what goals do they describe?
20. Please describe anything special you did to prepare your child to begin Prekindergarten.

[1] For more information contact: the New York State Education Department Office of Early Learning at (518) 474-5807 or email OEL@nysed.gov or the New York State Education Department Office of Bilingual Education and World Languages at (518) 474-8775 or (718) 722-2445 or email OBEWL@nysed.gov.

36 Month Questionnaire

33 months 0 days through 41 months 30 days

ASQ:SE-2
Ages & Stages Questionnaires®
Social-Emotional
SECOND EDITION

Date ASQ:SE-2 completed: ______________________

Child's information

Child's first name: ______ Child's middle initial: ______ Child's last name: ______

Child's date of birth: ______

Child's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name: ______ Middle initial: ______ Last name: ______

Street address: ______

City: ______ State/ province: ______ ZIP/postal code: ______

Country: ______ Home telephone number: ______ Other telephone number: ______

E-mail address: ______

Relationship to child: ◯ Parent ◯ Guardian ◯ Teacher ◯ Other: ______
◯ Grandparent/ other relative ◯ Foster parent ◯ Child care provider

People assisting in questionnaire completion: ______

Program information

(For program use only.)

Child's ID #: ______ Age at administration in months and days: ______

Program ID #: ______

Program name: ______

P201360000

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36 Month Questionnaire *33 months 0 days through 41 months 30 days*

Questions about behaviors children may have are listed on the following pages. Please read each question carefully and check the box ☑ that best describes your child's behavior. Also, check the circle ✓ if the behavior is a concern.

Important Points to Remember:

- ☐ Answer questions based on what you know about your child's behavior.
- ☐ Answer questions based on your child's *usual* behavior, not behavior when your child is sick, very tired, or hungry.
- ☐ Caregivers who know the child well and spend more than 15–20 hours per week with the child should complete ASQ:SE-2.
- ☐ Please return this questionnaire by: ______________
- ☐ If you have any questions or concerns about your child or about this questionnaire, contact: ______________
- ☐ Thank you and please look forward to filling out another ASQ:SE-2 in ________ months.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
1. Does your child look at you when you talk to her?	☐ z	☐ v	☐ x	○ v	____
2. Does your child like to be hugged or cuddled?	☐ z	☐ v	☐ x	○ v	____
3. Does your child talk or play with adults he knows well?	☐ z	☐ v	☐ x	○ v	____
4. Does your child cling to you more than you expect?	☐ x	☐ v	☐ z	○ v	____
5. When upset, can your child calm down within 15 minutes?	☐ z	☐ v	☐ x	○ v	____
6. Does your child seem too friendly with strangers?	☐ x	☐ v	☐ z	○ v	____
7. Does your child settle herself down after exciting activities?	☐ z	☐ v	☐ x	○ v	____

TOTAL POINTS ON PAGE ____

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Check the box ☑ that best describes your child's behavior.
Also, check the circle ✓ if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
8. Does your child move from one activity to the next with little difficulty (for example, from playtime to mealtime)?	☐ z	☐ v	☐ x	○ v	____
9. Does your child seem happy?	☐ z	☐ v	☐ x	○ v	____
10. Is your child interested in things around him, such as people, toys, and foods?	☐ z	☐ v	☐ x	○ v	____
11. Does your child do what you ask her to do?	☐ z	☐ v	☐ x	○ v	____
12. Does your child seem more active than other children his age?	☐ x	☐ v	☐ z	○ v	____
13. Does your child stay with activities she enjoys for at least 5 minutes (other than watching shows or videos, or playing with electronics)?	☐ z	☐ v	☐ x	○ v	____
14. Do you and your child enjoy mealtimes together?	☐ z	☐ v	☐ x	○ v	____
15. Does your child have eating problems? For example, does he stuff food, vomit, eat things that are not food, or ________? (Please describe.) ______________________ ______________________	☐ x	☐ v	☐ z	○ v	____
16. Does your child sleep at least 8 hours in a 24-hour period?	☐ z	☐ v	☐ x	○ v	____
17. Does your child use words to tell you what she wants or needs?	☐ z	☐ v	☐ x	○ v	____

TOTAL POINTS ON PAGE ____

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Check the box ☑ that best describes your child's behavior.
Also, check the circle ◯✓ if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
18. Does your child follow routine directions? For example, does he come to the table or help clean up his toys when asked?	☐ z	☐ v	☐ x	◯ v	____
19. Does your child cry, scream, or have tantrums for long periods of time?	☐ x	☐ v	☐ z	◯ v	____
20. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	☐ z	☐ v	☐ x	◯ v	____
21. Does your child do things over and over and get upset when you try to stop her? For example, does she rock, flap her hands, spin, or ________? (Please describe.) ________________________ ________________________	☐ x	☐ v	☐ z	◯ v	____
22. Does your child hurt himself on purpose?	☐ x	☐ v	☐ z	◯ v	____
23. Does your child stay away from dangerous things, such as fire and moving cars?	☐ z	☐ v	☐ x	◯ v	____
24. Does your child destroy or damage things on purpose?	☐ x	☐ v	☐ z	◯ v	____
25. Does your child use words to describe her feelings and the feelings of others? For example, does she say, "I'm happy," "I don't like that," or "She's sad"?	☐ z	☐ v	☐ x	◯ v	____
26. Can your child name a friend?	☐ z	☐ v	☐ x	◯ v	____

TOTAL POINTS ON PAGE ____

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Check the box ☑ that best describes your child's behavior.
Also, check the circle ✓ if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
27. Do *other* children like to play with your child?	☐ z	☐ v	☐ x	◯ v	____
28. Does *your child* like to play with other children?	☐ z	☐ v	☐ x	◯ v	____
29. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	☐ x	☐ v	☐ z	◯ v	____
30. Does your child show an unusual interest in or knowledge of sexual language and activity?	☐ x	☐ v	☐ z	◯ v	____
31. Does your child try to show you things by pointing at them and looking back at you?	☐ z	☐ v	☐ x	◯ v	____
32. Does your child pretend objects are something else? For example, does he pretend a banana is a phone?	☐ z	☐ v	☐ x	◯ v	____
33. Does your child wake three or more times during the night?	☐ x	☐ v	☐ z	◯ v	____
34. Is your child too worried or fearful? If "sometimes" or "often or always," please describe: ______ ______ ______	☐ x	☐ v	☐ z	◯ v	____
35. Has anyone shared concerns about your child's behaviors? If "sometimes" or "often or always," please explain: ______ ______ ______	☐ x	☐ v	☐ z	◯ v	____

TOTAL POINTS ON PAGE ____

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OVERALL Use the space below for additional comments.

36. Do you have concerns about your child's eating, sleeping, or toileting habits? If yes, please explain: ◯ YES ◯ NO

___

___

___

37. Does anything about your child worry you? If yes, please explain: ◯ YES ◯ NO

___

___

___

38. What do you enjoy about your child?

___

___

___

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Kingston City School District

HEALTH HISTORY for REGISTRATION & ATHLETES

Please complete in blue or black ink.

Name: School:	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/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	☐	☐	
Cardiac History:	**YES**	**NO**	**If Yes, please specify:**
Has anyone in your immediate family had any serious cardiac history such as: heart attack or sudden cardiac death under the age of 50, irregular heart beat, pacemaker, cardiomyopathy, structural defects, genetic heart defects	☐	☐	
Has your student had any irregular heartbeats, symptoms during or after exercise, fainting	☐	☐	

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: ______________

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All Students, All of the Time

Dr. Paul J. Padalino
Superintendent of Schools

AFFIDAVIT OF PROPERTY OWNER/LANDLORD
IN SUPPORT OF RESIDENCY IN THE KINGSTON CITY SCHOOL DISTRICT

I, ______________________________ a property owner or manager/agent of the dwelling located at
(Name of Property Owner/Landlord or Property Manager)

______________________________ ______________________________
(Street Address/Apt #) (City, State, Zip)

Hereby certify that I am renting space in this dwelling on a ____________ basis beginning on ____________
(Weekly/monthly/yearly) (Date)

The following persons are identified as tenants having the right to be occupants in the dwelling:

- Parent/Guardian: ______________________________
- Parent/Guardian: ______________________________

Student Name: ______________________________ Grade: __________

Student Name: ______________________________ Grade: __________

Student Name: ______________________________ Grade: __________

Student Name: ______________________________ Grade: __________

Student Name: ______________________________ Grade: __________

The payment of Electric Utility Bill is included in rent: Yes: ☐ No: ☐

I certify that the information provided on this form is true and correct and that the statements made herein are being made under the penalties of perjury, knowing that the Kingston City School District will rely upon them in determining whether the above-named child(ren) reside in the school district.

____
(Signature of Property Owner/Landlord or Property Manager)

____
(Print Name)

Sworn to before me on this
__________ Day of ______________, 20_____

____
(Notary Public)
State of:
County of:

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	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 Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: 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*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

*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.