



Central School District  
230 June Road • North Salem, NY 10560  
(914) 669-5414 Fax (914) 669-8753  
<http://www.northsalemschools.org>

Adam VanDerStuyf, Ed.D.  
Superintendent of Schools

Dear Registrant,

Welcome to the North Salem Central School District. We are confident that your child(ren) will have a wonderful educational experience at North Salem.

This packet contains all the necessary forms that you need to complete in order to register your child(ren) in school. A person in parental relation must complete a registration form for each of their students and return the complete packet along with all necessary information/documentation to the district registrar.

The following information/documentation must be provided along with the completed packet:

- Proof of Age - Birth certificate or baptismal certificate
- Proof of Residency (deed, mortgage document)
- If renting, acceptable proof of residency would be a rental agreement with landlord's residency information.
- Health History Form — (All new students require a physical exam within 12 months prior to the date of enrollment) (enclosed)
- Immunization Record — (there is a 14-day grace period during which the student can obtain the necessary immunizations documentation) (enclosed)
- Proof of Guardianship (if applicable)
- Records Release Form (enclosed)

Once the registration paperwork is complete and reviewed with the District Registrar, an appointment can be made with the appropriate school personnel.

- If the student is enrolled in grades K-5, the appointment should be made with Ms. Mary Johnson, Principal of Pequenakonck Elementary School.
- If the student is enrolled in grades 6-12 the appointment should be made with a MS/HS guidance counselor.
- If the student is a pre-schooler, the appointment should be made with the CPSE Chairperson

The District Registrar, Ms. Sharon Verdejo, is available Monday-Friday, 8 a.m. — 4 p.m. Should you have any questions, please feel free to contact Ms. Verdejo by calling 669-5414, ext. 1061. If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Adam VanDerStuyf, Ed.D.  
Superintendent of Schools



# NORTH SALEM

Central School District

230 June Road · North Salem, New York 10560  
(914) 669-5414 · Fax: (914) 669-8753  
<http://www.northsalemsschools.org>

**Adam VanDerStuyf, Ed.D.**  
Superintendent of Schools

**Kelly Rudyk**  
Director of Pupil Personnel Services

Dear Parents/Guardians:

Welcome to the North Salem Central School District. In accordance with the Individuals with Disabilities Education Act and New York State Education Law, I am writing to make you aware that the parent or person in parental relation of any student may refer such student to the District's Committee on Special Education for an evaluation to determine the student's eligibility for special education programs and services. Please know that the Pupil Personnel Services Department is here to support you and your child if he or she has, or is suspected of having, an educational disability.

Below is a link to the New York State Education Department's "*A Parent's Guide to Special Education*" in both English and Spanish. The parent guide provides an overview of a parent's rights regarding referral and evaluation of their child for the purposes of special education programs or services upon a student's enrollment in public school.

<http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm>.

<http://www.p12.nysed.gov/specialed/publications/policy/spanishparentguide.htm>

In addition, you may contact the office of the Director for Pupil Personnel Services, Kelly Rudyk, at (914) 669-5414 ext. 1016 to make a referral to the Committee on Special Education, to obtain a copy of the Parent's Guide or to obtain further information concerning the referral process.

Sincerely,

*Adam VanDerStuyf*

Adam VanDerStuyf  
Superintendent

# NORTH SALEM CENTRAL SCHOOL DISTRICT STUDENT INFORMATION AND REGISTRATION FORM

Today's Date \_\_\_\_\_

<b>Student's Last Name:</b>		<b>First Name:</b>		<b>Middle:</b>
<b>Date of Birth:</b>		<b>Place of Birth:</b>		<b>Gender:</b>
<b>Present Grade Level:</b>		<b>Currently attending (please indicate name of school):</b>		
<b>If student will be starting school in September, which grade did student just complete?</b>				
<b>If student is transferring from another school, has the "Release of Records" been completed and signed by the parent/guardian?</b> <input type="checkbox"/> yes <input type="checkbox"/> no		<b>Street Address:</b>		
		<b>City:</b>		<b>State/Zip</b>
		<b>Telephone #</b>		<b>Fax #</b>
<b>Has the student received any additional education services? If yes, please indicate:</b>				
<input type="checkbox"/> reading room		<input type="checkbox"/> speech therapy		<input type="checkbox"/> physical therapy
<input type="checkbox"/> math remediation		<input type="checkbox"/> occupational therapy		<input type="checkbox"/> language support
<input type="checkbox"/> special education program				
<input type="checkbox"/> social service agencies who support family or child:				
<input type="checkbox"/> other:				
<b>Sibling Information – please include first and last names</b>				
<b>Name:</b>		<b>M/F</b>	<b>Date of Birth</b>	<b>Current School and Grade:</b>
<b>Has this family been previously registered in the North Salem Central School District? <input type="checkbox"/> yes <input type="checkbox"/> no</b>				

<b>Student's Last Name:</b>			<b>First Name:</b>		<b>Middle:</b>
<b>Student's Residence Address:</b> Street:			<b>Student's mailing address, if different:</b>		
City	State	Zip	City	State	Zip
Student's home telephone number: (please include area code)					
With whom is the student living? (check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian <input type="checkbox"/> Other			If the parents are divorced, who has custody?		
			In addition to student's residence, to whom should mail be sent?		
<b>Mother's Name:</b>			US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Mother's Residence Address</b> Street:			<b>Mother's Mailing Address, if different</b>		
City	State	Zip	City	State	Zip
Home Telephone	Cellular		E-mail address		
Highest Level of Education:			Occupation:		
Employer Name/Address			Employer Telephone		
<b>Father's Name:</b>			US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Father's Residence Address</b> Street:			<b>Father's Mailing Address, if different</b>		
City	State	Zip	City	State	Zip
Home Telephone	Cellular		E-mail address		
Highest Level of Education:			Occupation:		
Employer Name/Address			Employer Telephone:		
<b>Stepparent/Guardian Information</b> Name Address City Telephone			<b>Stepparent/Guardian Information</b> Name Address City Telephone		

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

<b>For Office Use Only:</b>		
Intake by: _____	Proof of Birth: _____	Proof of Residency _____
Health registration complete? _____	Immunization record: _____	Request for Release of Records: _____
Medical Alert? _____	Legal Alert? _____	Student Residency Questionnaire _____



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
		<input type="checkbox"/> Male
		<input type="checkbox"/> 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?	<input type="checkbox"/> English <input type="checkbox"/> Other <small>specify</small>
2. What was the first language your child learned?	<input type="checkbox"/> English <input type="checkbox"/> Other <small>specify</small>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother <small>specify</small> <input type="checkbox"/> Father <small>specify</small> <input type="checkbox"/> Guardian(s) <small>specify</small>
4. What language(s) does your child understand?	<input type="checkbox"/> English <input type="checkbox"/> Other <small>specify</small>
5. What language(s) does your child speak?	<input type="checkbox"/> English <input type="checkbox"/> Other <small>specify</small> <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English <input type="checkbox"/> Other <small>specify</small> <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English <input type="checkbox"/> Other <small>specify</small> <input type="checkbox"/> 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:
<small>District Name (Number) &amp; School</small>	
<small>Address</small>	

## Home Language Questionnaire (HLQ)—Page Two

<i>Educational History</i>	
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* <input type="checkbox"/>	No <input type="checkbox"/> Not sure <input type="checkbox"/>
*If yes, please explain: _____	
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe	
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below	
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past?	
<input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____	
Age at which services received (Please check all that apply):	
<input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)	
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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: \_\_\_\_\_

Date

Signature of Parent or of Person in Parental Relation \_\_\_\_\_

Relationship to student:  Mother  Father  Other: \_\_\_\_\_

<b>OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ</b>							
NAME: _____	POSITION: _____						
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:							
<b>NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW</b>							
NAME: _____	POSITION: _____						
ORAL INTERVIEW NECESSARY: <input type="checkbox"/> No <input type="checkbox"/> Yes							
*DATE OF INDIVIDUAL INTERVIEW: _____ <small>MO DAY YR</small>	<table style="width: 100%; border: none;"> <tr> <td style="border: none;">OUTCOME OF INDIVIDUAL INTERVIEW:</td> <td style="border: none;"><input type="checkbox"/> ADMINISTER NYSITELL</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> ENGLISH PROFICIENT</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM</td> </tr> </table>	OUTCOME OF INDIVIDUAL INTERVIEW:	<input type="checkbox"/> ADMINISTER NYSITELL		<input type="checkbox"/> ENGLISH PROFICIENT		<input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
OUTCOME OF INDIVIDUAL INTERVIEW:	<input type="checkbox"/> ADMINISTER NYSITELL						
	<input type="checkbox"/> ENGLISH PROFICIENT						
	<input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM						
<b>NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL</b>							
NAME: _____	POSITION: _____						
DATE OF NYSITELL ADMINISTRATION: _____ <small>MO DAY YR</small>	<table style="width: 100%; border: none;"> <tr> <td style="border: none;">PROFICIENCY LEVEL ACHIEVED ON NYSITELL:</td> <td style="border: none;"><input type="checkbox"/> ENTERING</td> <td style="border: none;"><input type="checkbox"/> EMERGING</td> <td style="border: none;"><input type="checkbox"/> TRANSITIONING</td> <td style="border: none;"><input type="checkbox"/> EXPANDING</td> <td style="border: none;"><input type="checkbox"/> COMMANDING</td> </tr> </table>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL:	<input type="checkbox"/> ENTERING	<input type="checkbox"/> EMERGING	<input type="checkbox"/> TRANSITIONING	<input type="checkbox"/> EXPANDING	<input type="checkbox"/> COMMANDING
PROFICIENCY LEVEL ACHIEVED ON NYSITELL:	<input type="checkbox"/> ENTERING	<input type="checkbox"/> EMERGING	<input type="checkbox"/> TRANSITIONING	<input type="checkbox"/> EXPANDING	<input type="checkbox"/> COMMANDING		
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:							
_____							

**NOTE TO SCHOOLS/LEAS:** Please assist students and families filling out this form. The form should be included at the top page of registration materials that the district shares with families. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the student is not required to submit proof of residency and other required documents that may be part of the registration packet.

### HOUSING 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

If **ANY** box other than **"In Permanent Housing"** is checked, then the student/family should be immediately referred to the MV Liaison. In such cases, **proof of residency** and other documents normally needed for enrollment are **not required** and the student is to be **immediately enrolled**. **After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

Dear Parent/Guardian:

Beginning with the 2010-2011 school year, school districts and states are required to follow new standards in collecting and recording individual-level race and ethnicity data 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
- Do statistical analysis

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the Student Racial and Ethnic Identification on the reverse side of this page and complete the form for each of your children who will be enrolled in the North Salem Central School.

There are TWO areas that are needed to be checked off on the form.

- ✓ First, check YES or NO regarding whether or not the child is of Hispanic, Latino or Spanish origin.
- ✓ Second, check ONE OR MORE of the following choices that are true about the child's ethnicity/race. For example, you would check Asian *and* White for a child that was Asian and White.

North Salem Central 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 we are unable to get this information from you then, according to State and Federal regulations, we are required to use our own judgment to identify the race and ethnicity of the child. The form may not be blank.

Thank you for your cooperation. If you have any questions, please call your school's principal.

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### **CONFIDENTIALITY PROCEDURES AND REGULATIONS**

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) and Regulations of the Chancellor A-820 prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number



**NORTH SALEM CENTRAL 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 to a public school because of race, color, creed, national origin, gender, gender identity, pregnancy, immigration/citizenship status, disability, sexual orientation, religion, or ethnicity.

<b>Name of School:</b>	
<b>Student Identification Number:</b>	<b>Date of Birth (Month/Day/Year):</b>
<b>Student Name: Last, First, Middle:</b>	<b>Grade Level:</b>

**DIRECTIONS TO PARENT/GUARDIAN**

PLEASE ANSWER BOTH QUESTIONS (1) AND (2). PLEASE READ THEM CAREFULLY BEFORE YOU RESPOND.

<p><b>1. Is the student Hispanic, Latino, or of Spanish origin?</b> 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 [Check (✓) <u>one</u> that best describes your child].</p> <p style="text-align: center;"> <input type="checkbox"/> YES, Hispanic      <input type="checkbox"/> NO, not Hispanic         </p>
<p><b>2. Check (✓) one or more races from the following five racial groups</b> [Check (✓) all groups that apply to your child; check (✓) <u>at least ONE</u> box.]:</p> <p><input type="checkbox"/> <b>AMERICAN INDIAN OR ALASKAN NATIVE:</b> A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. E.g. Cherokee, Mohawk, Inuit.</p> <p><input type="checkbox"/> <b>ASIAN:</b> 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.</p> <p><input type="checkbox"/> <b>NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:</b> A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or Other Pacific Islands.</p> <p><input type="checkbox"/> <b>BLACK:</b> A person having origins in any of the Black racial groups of Africa.</p> <p><input type="checkbox"/> <b>WHITE:</b> A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.</p>

\_\_\_\_\_  
Signature of Parent/Guardian/Other

\_\_\_\_\_  
Date

Relationship to Student:

- Mother     
  Father     
  Guardian     
  Other (Specify) \_\_\_\_\_

**NORTH SALEM CENTRAL SCHOOL DISTRICT  
STUDENT HEALTH HISTORY AND REGISTRATION FORM**  
*(To be completed by parent of a student who did not attend North Salem Central School District last year)*

Student's Last Name:	First Name:	Middle:
Date of Birth:	Gender:	Grade:

Please record approximate year child had any of the following:

Chicken Pox _____	Ulcers _____	Rheumatic Fever _____
Measles _____	Contact with Tuberculosis _____	Epilepsy _____
Mumps _____	Diabetes _____	Poliomyelitis _____
Whooping Cough _____	Major Fractures _____	High Blood Pressure _____
Heart Disease _____	Extended Illness _____	Ear Problems (tubes?) _____
Lyme Disease _____	Other: _____	

Please provide information about the entries selected above:

Has the child had any surgery, injuries or illnesses requiring hospitalization?  No  
 Yes: please explain \_\_\_\_\_

Is there any allergy to drugs, foods or stinging insects?  No  
 Yes: please explain \_\_\_\_\_

Does this child have asthma or hay fever?  No  
 Yes: please explain and include medication information \_\_\_\_\_

Does this child experience convulsive episodes or fainting spells?  No  
 Yes: please explain \_\_\_\_\_

Does this child wear glasses?  No  Yes  
If yes, are glasses to be worn at all times?  No  Yes For reading only?  No  Yes For distance?  No  Yes

Is this student under treatment or taking medication for any condition at the present time?  No  
 Yes: (please indicate the diagnosis and the name of the medication/dosage/frequency)

Is this student on medication that should be taken during school hours?  No  
 Yes: please explain \_\_\_\_\_

Is there any other condition for which the Health Office should be made aware?  No  
 Yes: please explain \_\_\_\_\_

Name of physician: \_\_\_\_\_ Telephone \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Please use reverse for additional notes, and check here

## 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: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

### HEALTH HISTORY

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

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: <span style="float: right;">Date of last seizure:</span> <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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/m<sup>2</sup>

Percentile (Weight Status Category):  < 5<sup>th</sup>  5<sup>th</sup>- 49<sup>th</sup>  50<sup>th</sup>- 84<sup>th</sup>  85<sup>th</sup>- 94<sup>th</sup>  95<sup>th</sup>- 98<sup>th</sup>  99<sup>th</sup> 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
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

System Review Within Normal Limits

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid	

Name:	Affirmed Name (if applicable):	DOB:
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**SCREENINGS**

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

Vision Screening	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>

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.	<b>Not Done</b>
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Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes	<input type="checkbox"/>
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Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	Negative	Positive	Referral	Not Done
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>

**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, Rifle, 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**

Confirmed free of communicable disease during exam

**IMMUNIZATIONS**

Record Attached  Reported in NYSIS

**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.

**PQ ELEMENTARY**

Danielle Zaetz, R.N.

Phone # 914-669-5317 Ext. 3043

Fax #-914-669-5442

5/2023

**MIDDLE/HIGH SCHOOL**

Rita Driscoll, R.N.

Phone #-914-669-5414 Ext. 2017

Fax #-914-276-3240

  
**NORTH SALEM**

Central School District  
**230 June Road \* North Salem \* NY \* 10560**

**PERMISSION TO RECEIVE/RELEASE RECORDS**

I give permission for the North Salem Central School District to receive all educational, psychological and medical records pertaining to my child. This includes Transcripts, Report Cards, Attendance Records, Disciplinary Records and, if applicable, IEP or Section 504 Plan, (including past placement, medical, psychological and physical histories).

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Current Grade

\_\_\_\_\_  
Date of Birth

**Please send a copy of any applicable records (including but not limited to):**

Transcript  
Report Card  
Current Schedule  
IEP  
Section 504 Plan  
Psychoeducational Testing  
ELL NYSSLAT or NYSITELL Testing  
Attendance Records  
Disciplinary Records

**Please send a copy of the above student's records to the school indicated below:**

North Salem Middle/High School  
230 June Road  
North Salem, NY 10560  
914-669 5414  
914-669 8554 (fax)

Pequenakonck Elementary School  
173 June Road  
North Salem, NY 10560  
914-669 5317  
914-669 4326 (fax)

I, \_\_\_\_\_, request my child's records to be released to the above school.  
Parent/Guardian SIGNATURE