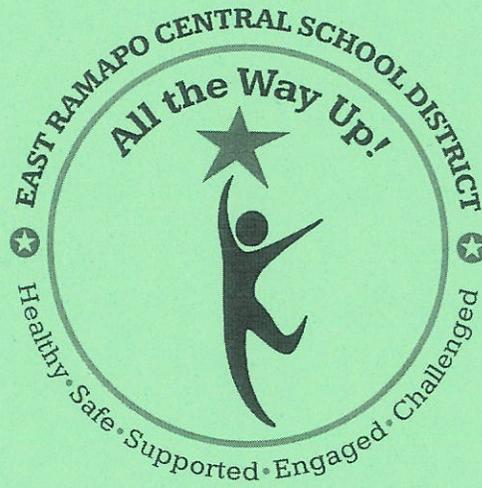


# **EAST RAMAPO CENTRAL SCHOOL DISTRICT**

Central Registration

105 South Madison Ave.

Spring Valley, NY 10977



## **Registration Packet**

Please read and complete the entire packet and bring it in person to the office of Central Registration. Fill out one packet per student.

**PLEASE FILL THE PACKET IN BLACK OR BLUE PEN.**

Thank you,

Central Registration Staff

**\*Updated 05/2025**



# East Ramapo Central School District

105 S. Madison Ave, Spring Valley, NY 10977 T: (845)577-6000

Dear Parents and Guardians:

Welcome to East Ramapo!

Enclosed you will find forms and documentation to facilitate student registration. To complete your registration, the district requires the following documentation along with this completed packet (in blue or black ink). This packet includes step-by-step instructions and further details to complete registration for your child/children.

Please provide the documents listed below:

1. **Student identification**- this can be passport, birth certificate or consular ID (a detailed list is on the following pages)
2. **Parent/Guardian identification**- this can be a passport, birth certificate or license. (a detailed list is on the following page). **\*NOTE\*** Guardians **MUST** provide legal proof of guardianship of the child.
3. **Proof/s of address**- You will need to provide two legal proofs of address- A detailed list of accepted proofs is listed in the following pages. **NOTE\*** If you rent/sublease please have the person that oversees the home fill out a notarized residency affidavit (included in this packet).
4. **ALL THESE DOCUMENTS SHOULD BE AVAILABLE AT THE TIME OF REGISTRATION.** (please notify the registration staff prior to your appointment if you cannot provide any of the required documentation so that they can assist with an alternate solution).
5. **If the student went to another school within the United States**- please be ready to provide the schools information including school, name, phone number and address. Also notify the registrar if your child has an IEP. (individualized education program).
6. **PLEASE NOTIFY THE REGISTRATION STAFF IF YOUR CHILD HAS EVER ATTENDED SCHOOL IN EAST RAMAPO.**

**Please note:** East Ramapo CSD reserves the right to deny any of the documentation provided for reasons such as expiration dates, not readable, wet/torn, or incomplete.

We look forward to working with you,

Sincerely,

Registration team.

## Introduction

All children who meet the age and residency requirements established by state law have the right to attend school whether they are U.S citizens, documented alien, or undocumented immigrant children and youth.

### Registration Requirements checklist

The child's initial enrollment will occur on the next school day after the request for enrollment is made, or as soon thereafter as practicable. However, if the district can determine non-residency from the documentation provided on the day of the initial request, the child will not be enrolled. Following the request for enrollment, you will have 3 business days to present proof of custody, residency, and age of the students using the kinds of documentation listed below. If you do not present the required proof, your child will not be granted final registration in the district.

#### **Proof of age- MUST** be a certified copy

- Certified transcript of birth, including foreign birth certificate (with seal; or religious certificate (Baptism or Bris Certificate).

If neither of the above are available:

- Passport (including foreign passport) showing the date of birth of the minor.

If none of the above-mentioned documentation is available, the following will be considered:

- Permanent resident/ green card.
- Official driver's license.
- State or other government issued ID.
- School photo ID with date of birth.
- Consulate identification card.
- Hospital or health records (in New York City, Hospital birth records).
- Military dependent ID card.
- Court orders issued by federal state or local agencies.
- Court orders or court issues documents.
- Native American tribal document.
- Record(s) from nonprofit international aid agencies and voluntary agencies (VOLAGS)

Other than birth certificates, religious certificates and passports, documentation of age must have been in existence for two years or more.

**Proof of immunization-** you have (30) days to submit to the school nurse the; month, date and year of New York State immunization signed by the doctor or clinic. If documentation of immunization is not obtained after this period, the

student may be excluded from school until documentation/immunization is obtained.

**Proof of parental identification-** the parent/guardian/person in parental relation **MUST** be present at the time of registration and provide valid identification such as:

- Driver's License.
- A government issued photo ID.
- DSS-299.

**Proof of residency-** you must provide at least one form of proof of residency from list **A** or **B**. In addition, please provide at least one other document from list **C**, below.

**A. Homeowner/Condominium owner**

- Mortgage statement
- Deed
- Closing papers

**B. Renter/Tenant**

- Lease
- Affidavit or unsworn statement by landlord
- Affidavit or unsworn statement by owner or tenant from whom parent/person in parental relation leases or shares property
- Statement by any other party establishing parent(s)/person in parental relations' physical presence in the district.

**C. Other documentation of residency**

In addition to providing at least one Item from list **A** or **B** above, please provide at least one additional document demonstrating residency if available. Below is a list of examples of documentation that may be used. Please note that this list is intended only to provide examples of documentation that may be relevant to residency determination. The district will consider other kinds of documentation. The list below is not intended to be exhaustive, nor is it a list of required documentation.

- Pay stub
- Income tax form
- Utility (such as gas/electric/oil bill, e.g. Orange and Rockland)
- Other bills (such as water bill e.g. united water), home telephone bill (eg Verizon, optimum, etc.) cable tv/digital tv bill (e.g. cablevision, direct TV, etc.) or broadband/ internet service provider bill (e.g. Verizon, AOL, etc.)
- Membership documents
- Official driver's license, learners permit or non-driver identification
- State or other government issued identification

- Documents issued by the federal, state or local agencies (e.g. local service agency, federal office of refugee resettlement or
- Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers.

**Please note:** *the district will be flexible in considering different kinds of documentation of residency. Any documentation you present will be considered. However, the district has found the following kinds of documents to be less reliable proof of residency: checkbooks' bank statements; credit card statements; car insurance statements/cards; cellular telephone bills; car notes or loan statements (other than mortgage loans).*

**Proof of parental relationship/custody-**

- An affidavit of the parents or persons in parental relation including either:
  - 1) That they are the parents with whom the child lawfully resides; or
  - 2) That they are the person/s in parental relation to the child, over whom they have total and permanent custody and control, and describing how they obtained total and permanent custody and control, whether through guardianship or otherwise
- documentation indicating that the child resides with a sponsor with whom the child has been placed by a federal agency.
- Guardianship documents or custody order signed by the judge or court officer (this specific documentation is not required; but is one form of proof of the parental relationship that may be used).

**Additional documents**

Please submit any previous school records, transcripts, or any other relevant documents regarding your child's education as these will assist us in placing your child in the proper grade and class.

**PLEASE COMPLETE THIS PACKET IN BLUE OR BLACK INK ONLY, THIS PACKET AND ALL PROVIDED DOCUMENTATION WILL BE COPIED AND SAVED INTO YOUR CHILD'S FILE.**

**East Ramapo Central School District  
New Registrant Form**

**STUDENT HOUSEHOLD INFORMATION**

**Surname** \_\_\_\_\_ **Date** \_\_\_\_\_

**Address** \_\_\_\_\_ **Apartment** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip-Code** \_\_\_\_\_

\*Mailing address, if different \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Proof of residency:**

Lease  Mortgage statement  Sworn/unsworn residency  Other documentation

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**STUDENT REGISTRATION INFORMATION**

**Name** \_\_\_\_\_  
(Last name) (First name) (Middle name)

**Date of Birth** \_\_\_\_\_ **Gender:**  Female  Male  
(Month/Day/Year)

**Race:**  American Indian/ Alaskan Native  Asian  Black  Pacific Islander  White  Other \_\_\_\_\_

**Proof of Age:**  Birth Certificate  Baptismal Certificate or other religious certificate (Bris Certificate), including a certified transcript of a foreign birth certificate or record of baptism  Passport, including a foreign passport  Other documentation

**Pre-K experience:**  Universal Pre-K  Private Provider  None

**Has the student attended school in this district?**  Yes  No

If yes, which school: \_\_\_\_\_

**Does your child have a current I.E.P?**  Yes  No

**Previous School Information:**

**School name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Grade:** \_\_\_\_\_

**Report card/ School Transcript attached?**  Yes  No

## MOTHER/GUARDIAN INFORMATION

Name \_\_\_\_\_ Gender:  Female  Male  
(Last name) (First name)

Relationship \_\_\_\_\_

1. Phone number \_\_\_\_\_ Phone Type:  Cell  Work

2. Phone number \_\_\_\_\_ Phone Type:  Cell  Work

Email \_\_\_\_\_

Do you live in the household?  Yes  No

If you live out of the household, please provide your address.

Address \_\_\_\_\_ Apartment \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip-Code \_\_\_\_\_

## FATHER/GUARDIAN INFORMATION

Name \_\_\_\_\_ Gender:  Female  Male  
(Last name) (First name)

Relationship \_\_\_\_\_

1. Phone number \_\_\_\_\_ Phone Type:  Cell  Work

2. Phone number \_\_\_\_\_ Phone Type:  Cell  Work

Email \_\_\_\_\_

Do you live in the household?  Yes  No

If you live out of the household, please provide your address.

Address \_\_\_\_\_ Apartment \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip-Code \_\_\_\_\_

---

## EMERGENCY CONTACT INFORMATION

1. Name \_\_\_\_\_ Gender:  Female  Male

Relationship \_\_\_\_\_

Phone number \_\_\_\_\_ Phone Type:  Cell  Home  Work

2. Name \_\_\_\_\_ Gender:  Female  Male

Relationship \_\_\_\_\_

Phone number \_\_\_\_\_ Phone Type:  Cell  Home  Work



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

Elisa Alvarez, Associate 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 Person in Parental Relation:*  
*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.*

<b>STUDENT NAME:</b>		
First	Middle	Last
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
Month	Day	Year
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
Last Name	First Name	Relation to

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	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	_____	<input type="checkbox"/> Parent 2 _____
	<input type="checkbox"/> Guardian(s)	_____	_____
			<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not write
			<i>specify</i>

### 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? \_\_\_\_\_

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

Month:    Day:    Year:  
 \_\_\_\_\_  
 Date

Relationship to student:     Parent     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>	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>	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: _____	

If applicable

East Ramapo Central School District  
Office of Central Registration  
105 S. Madison Ave. Spring Valley, NY 10977  
Phone: (845) 577-6065

**DECLARATION OF RESIDENCE / AFFIDAVIT**

Note: The landlord/owner and tenant/resident may, but are not required to, have this document notarized.

NEW YORK STATE  
ROCKLAND COUNTY  
CITY OF RAMAPO

I \_\_\_\_\_ declare that \_\_\_\_\_  
(Name of owner/landlord) (Name of Parent/Guardian)

And the student(s), \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Have established their residency with me at:

Address: \_\_\_\_\_ Apartment: \_\_\_\_\_

City: \_\_\_\_\_ State: New York Zip Code: \_\_\_\_\_

I declare that my house is the real, sole and legal residence of the mentioned family.

\_\_\_\_\_  
Signature of the Owner/Proprietor/Lessor

\_\_\_\_\_  
Tenant's signature (Parent or guardian)

Sworn before me today  
Day \_\_\_\_\_ of \_\_\_\_\_, 20\_\_\_\_

Sworn before me today  
Day \_\_\_\_\_ of \_\_\_\_\_, 20\_\_\_\_

(NOTARY)

(NOTARY)

\* If notarized, the undersigned understands that making a false statement regarding the actual, current, and legal residence of the family living arrangements, as described in the declaration above, is a violation of Section 210.35 of the New York State Penal Law, which is a class misdemeanor, and may be punished by a fine of one thousand dollars and/or one year in prison. The district is permitted to evaluate the credibility of a sworn statement as opposed to an unsworn statement.

If applicable

East Ramapo Central School District  
Office of Central Registration  
105 S. Madison Ave. Spring Valley, NY 10977  
Phone: (845) 577-6065

Landlord/Owner: Attach a copy of one of the following documents with this form.

The name must match the landlord/owner or resident on one of the documents listed below:

- House or apartment lease/contract
- Mortgage papers/house deed
- Current phone bill
- Current Orange and Rockland bill
- Current water bill
- Current cable/digital cable bill
- Current internet service provider bill

East Ramapo Central School District  
Office of Central Registration  
105 S. Madison Ave. Spring Valley, NY 10977  
Phone: (845) 577-6065

If applicable

**THIRD PARTY RESIDENCY STATEMENT**

I, \_\_\_\_\_, residing at \_\_\_\_\_,  
(Name) (Address)

Submit this residency statement to the East Ramapo Central School District to personally verify that,

\_\_\_\_\_  
(Name(s) of Parent(s)/Guardian(s))

And their child(ren) \_\_\_\_\_  
(Name(s) of child(ren))

\_\_\_\_\_  
reside at \_\_\_\_\_  
(Address)

They have resided at this address since \_\_\_\_\_. I am personally  
(Date)

familiar with their current residence because (Explain how you know the family and are aware of where they live): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I understand that this document will be submitted to the East Ramapo Central School District and that it will be used to help determine whether the above-named child(ren) is/are legally entitled to attend school as (a) resident student(s).**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# EAST RAMAPO CENTRAL SCHOOL DISTRICT

105 S. Madison Avenue  
Spring Valley, NY 10977

## HOUSING QUESTIONNAIRE

Name of School: \_\_\_\_\_

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

Last

First

Middle

Gender:  Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade: \_\_\_\_\_ ID: \_\_\_\_\_

Month Day Year (Preschool-12)

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

\_\_\_\_\_  
Name of Parent/Guardian or Student  
(For unaccompanied homeless youth)

\_\_\_\_\_  
Signature of Parent/Guardian or Student  
(For unaccompanied homeless youth)

\_\_\_\_\_  
Date



## Immunization Verification

SCHOOL: \_\_\_\_\_ DATE \_\_\_\_\_

STUDENT NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

The staff of central registration has reviewed the proof of immunization records for your child. The school nurse will complete the final review to confirm the information is valid and complete. The school principal will be notified regarding the status of the proof of immunization record.

Your child is admitted into the East Ramapo Central School District under a **30 DAY TEMPORARY ADMIT**. THIS WILL ALLOW SUFFICIENT TIME TO COMPLETE THE FINAL REVIEW AND VERIFY THAT THE IMMUNIZATION INFORMATION IS CORRECT.

The school nurse will contact you regarding the need for further documentation. **If further documentation is requested, it must be submitted by \_\_\_\_\_.**  
**Failure to provide such information will force the Building Principal to exclude your child from school.**

I have read and understand the above statement and have received a copy.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian (Print)

\_\_\_\_\_  
Date Signed and Received

\_\_\_\_\_  
Central Registration Staff

PROOF OF IMMUNIZATIONS: \_\_\_\_\_ ATTACHED \_\_\_\_\_ NOT ATTACHED

Dear Parent(s) and Guardian(s):

We want to take this opportunity to remind you of important health requirements for the upcoming school year. Please review the information below and reach out if you have any questions.

**Health Examinations (physicals):**

- New York State law requires a health examination\* for all new entrants and students in grades Pre-K or K, 1, 3, 5, 7, 9 & 11;
- Every year for students participating in athletics (sports);
- For working papers as needed; or
- When required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

*\*A dental exam form is also requested at the same time a grade-level health examination is required.*

**Immunizations (shots/vaccines):**

- New York State law requires all students entering or attending (including remotely) any New York State school (public, nonpublic, and charter schools) must receive all doses of immunizations required for their grade level in order to attend school. The immunization requirements for each grade level are outlined on [NYSDOH Immunization Requirements for School Entrance/Attendance Chart](#).
- A request for a medical exemption to an immunization must be completed annually on this form: [Medical Exemption Statement for Children 0-18 Years of Age \(ny.gov\)](#).

**Prescribed & Over-The-Counter Medications**

If your student requires medications during the school day, the school must have the following:

- A written healthcare provider order ( written attestation is also required for independent students)
- Written parent/guardian consent, and
- The medication must be brought to the school by an adult. The medications must be in their original labeled prescription or over-the-counter bottles/packaging. Any special supplies or equipment for the nurse to administer the medication must also be provided to the school.

**Attached is the [New York State Required Health Examination Form](#) to be used by the healthcare provider doing the health examination. An Electronic Equivalent Form is also accepted. A copy of the [NYSDOH Immunization Requirements for School Entrance/Attendance Chart](#) is also included.**

***EAST RAMAPO CENTRAL SCHOOL DISTRICT***

OFFICE OF SPECIAL STUDENT SERVICES

105 South Madison Avenue, Spring Valley, NY 10977

Dear Parent/Guardian:

The New York State Department of Education requires that **all new** students and students in grades **K, 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup>, 7<sup>th</sup>, 9<sup>th</sup>, and 11<sup>th</sup>** have a physical examination completed by a health care provider. A physical examination form is enclosed with this letter. If you prefer to have your child examined by a private physician it is imperative that the completed physical examination form be returned to the school nurse on the first day of school.

If the school nurse does not receive the completed physical examination form, an appointment will be scheduled for your child with a school district physician. The school health physical includes an assessment of the ears, mouth, heart, lungs, spine, and genitalia. Students will also be assessed according to the Tanner stages of puberty.

Enclosed please find a dental certificate. This form should be completed by a dentist for your child and returned to the school nurse as soon as possible.

**All forms should be Faxed or emailed directly to the Nurse**

Please call the school nurse indicated below with any questions or concerns.  
Thank you for your attention to this matter.

Sincerely,  
School Nurse

**Please make sure all forms submitted have the Student's Name,  
Date of birth AND Date of exam**

Note: For the school year 2025-2026 Physicals dated after  
September 1<sup>st</sup> 2024 are valid!

# 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: _____ Date of last seizure: _____ <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 $\geq 5$ $\mu\text{g}/\text{dL}$
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) <span style="float: right;">ICD-10 Code*</span>
<input type="checkbox"/> 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 <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

<b>Hearing Screening:</b> 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 <input type="checkbox"/>	Positive <input type="checkbox"/>	Referral <input type="checkbox"/> Yes	Not Done <input type="checkbox"/>
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**FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS\*/PLAYGROUND/WORK**

**\*Family cardiac history reviewed** – required for Dominic 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
<input type="checkbox"/> Confirmed free of communicable disease during exam	<input type="checkbox"/> Record Attached <input type="checkbox"/> 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.**

# Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

## Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Sex:  Male  Female Will this be your child's first oral health assessment?  Yes  No  
Month Day Year

School: Name Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities?  Yes  No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature Date

## Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of \_\_\_\_\_ on \_\_\_\_\_ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

- Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.
- No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means, that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address  
(please print or stamp)

Dentist's/Dental Hygienist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here.

### II. Oral Health Status (check all that apply).

- Yes  No Caries Experience/Restoration History – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
- Yes  No Untreated Caries – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].
- Yes  No Dental Sealants Present

Other problems (Specify): \_\_\_\_\_

### 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.

# 2025-2026 School Year

## New York State Immunization Requirements for School Entrance/Attendance<sup>1</sup>

**NOTES:**

All children must be age-appropriately immunized to attend school in NYS. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the "ACIP-Recommended Child and Adolescent Immunization Schedule." Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes must meet the immunization requirements of the grades for which they are age equivalent.

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

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) <sup>2</sup>	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older or 3 doses if 7 years or older and the series was started at 1 year or older		3 doses
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap) <sup>3</sup>		Not applicable		1 dose
Polio vaccine (IPV/OPV) <sup>4</sup>	3 doses		4 doses or 3 doses if the 3rd dose was received at 4 years or older	
Measles, Mumps and Rubella vaccine (MMR) <sup>5</sup>	1 dose		2 doses	
Hepatitis B vaccine <sup>6</sup>	3 doses		3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years	
Varicella (Chickenpox) vaccine <sup>7</sup>	1 dose		2 doses	
Meningococcal conjugate vaccine (MenACWY) <sup>8</sup>		Not applicable	Grades 7, 8, 9, 10 and 11: 1 dose	2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) <sup>9</sup>	1 to 4 doses			Not applicable
Pneumococcal Conjugate vaccine (PCV) <sup>10</sup>	1 to 4 doses			Not applicable



# **Free Immunization Clinics**

Free for children  
and teenagers  
(ages 5-18)

Free for uninsured/  
underinsured  
adults  
(age 19 and older)

**By Appointment Only. Call (845) 364-2520 or (845) 364-2524.**

## **Rockland County Department of Health**

50 Sanatorium Rd, Building A  
Pomona, NY 10970

14 S. Main Street  
Spring Valley, NY 10977

Mondays, Tuesdays (every other),  
Wednesdays  
8:30am-11:00am

Thursdays  
8:30am-11:00am

**Call to find out more about the shots you may need.**  
*You will not be asked about your immigration status.*



# **Gratis Klinik Vaksinasyon**

Gratis pou timoun  
ak adolèsan  
(laj 5-18)

Gratis pou granmoun  
ki pa gen asirans  
(laj 19 ak pi gran)

**Avek randevou sèlman. Rele (845) 364-2520 oswa (845) 364-2524.**

## **Rockland County Department of Health**

50 Sanatorium Rd, Building A  
Pomona, NY 10970

14 S. Main Street  
Spring Valley, NY 10977

Lendi, Madi (chak lòt), Mèkredi  
8:30am-11:00am

Jedi  
8:30am-11:00am

**Rele pou jwenn plis enfòmasyon sou vaksen yo ou ka bezwen.**  
*Yo pa pral mande ou kesyon sou sityasyon imigrasyon ou.*

