Welcome to the Dobbs Ferry School District!

Registration for the Dobbs Ferry School District is now an online process.

Please read the following carefully before beginning the registration process.

If you have any questions, or want to schedule an appointment, please contact our Registrar:

Mercedez Dominguez at 914-693-1500 ext. 3034 or email dominguezm@dfsd.org

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In Order to Register Your Child:

Go to the **eSchoolData Online Registration** link at https://parentportal-lhric.eschooldata.com/DobbsFerryUFSD/register/0/en. This will bring you to the Dobbs Ferry Online Registration screen. This starts the registration process for your child.

- Once you have submitted the form, you will receive an email confirmation.
- Once this email is received, please contact the Registrar to schedule an appointment to submit the registration documentation required (see below).
- Your registration is not complete, and students cannot be scheduled, until this documentation has been received by the District.

Required Registration Documents & Forms

To register a student, the following documents must be presented to the Registrar.
All required documents that need to be submitted are included in this packet.

Proof of Residency

You are asked to provide the following proofs of residency:

- **ONE** of the following pertaining to a home in the District:
  - A Mortgage or Closing Statement
  - Deed
  - A Notarized (by both landlord and lessee) Signed Lease
  - A Notarized Rent Receipt
- In addition, required in conjunction with the lease when the name on the lease is different from parent name and utilities are included in the rent, or in the absence of a lease:
  - Affidavit of Property Owner/Landlord
- In addition, copies of any **TWO** of the following documents must be submitted:
  - Property Tax Bill
  - Telephone Bill
  - Gas & Electric Utility Bill
  - Water Bill
  - Driver's License/Picture ID
  - Oil Company Bill
  - Insurance Bill
  - Bank Statement
  - Voter Registration Card

Proof of Birth

To determine the student's age, you are asked to provide **ONE** of the following:

- Birth Certificate
- Passport

Proof of Custody

If you, as a parent or guardian, are separated, divorced, or have custody as the result of a court order agreement, a fully-executed copy of the court order or agreement must be submitted. Please provide **ONE** of the following;

- Court-issued Legal Guardianship Papers
- Court Order granting custody
- Court Appointment as Foster Parent
- Affidavits from parent surrendering control and person assuming responsibility for student

Parent's Statement

- PARENT'S STATEMENT - Please complete, sign, and notarize.

Academic Transcript/Record of Grades Release Form

Complete the applicable Records Release Authorization Form for each previous school your child attended:

- SPRINGHURST ELEMENTARY RECORDS RELEASE AUTHORIZATION FORM
- MIDDLE/HIGH SCHOOL RECORDS RELEASE AUTHORIZATION FORM
- **OTHER RECORDS**
  CURRENT REPORT CARD
  OFFICIAL HIGH SCHOOL TRANSCRIPT

Consent for Release of Preschool Information

For students entering Kindergarten complete the applicable Records Release Authorization Form for each previous school your child attended:

- CONSENT FOR RELEASE OF PRESCHOOL INFORMATION - We would like your permission to obtain information about your child's learning style, and basic academic and social skills from his or her preschool or daycare teacher. We find that communication with preschool personnel helps to facilitate the student's transition from preschool to elementary school. The preschool teacher is familiar with your child and many facets of his or her development and school life. Sharing this information with us assists in making class placement decisions, and can help the kindergarten teacher work effectively with your child during his/her first year in elementary school.

Acceptable Use Policy for Internet Access

- ACCEPTABLE USE POLICY - Please review the policy with your child, and return the last page signed by both the parent/guardian and student.

HEALTH FORMS & REQUIREMENTS

- WELCOME TO THE HEALTH OFFICE
- HEALTH & DENTAL REQUIREMENTS
- NYS IMMUNIZATION REQUIREMENTS FOR SCHOOL - **(All students entering Kindergarten & all students transferring into the District must present a verified copy of all immunizations.)**
- PHYSICAL HEALTH EXAM FORM (performed within the past 12 months)
- DENTAL CERTIFICATE
- AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION (if applicable)
- ALLERGY/MEDICATION ADMINISTRATION FORM (if applicable)
- ASTHMA MEDICATION ADMINISTRATION FORM (if applicable)

Home Language Questionaire (HLQ)

- HOME LANGUAGE QUESTIONAIRE (HLQ) - Please complete this form in order for us to determine how well your child understands, speaks, reads and writes English. This will help us provide the best possible education for your child.

Other Forms - if applicable

- STUDENT RESIDENCY QUESTIONAIRE - This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. If your current living arrangements are temporary due to loss of housing or economic hardship, please complete the Student Residency Questionnaire and bring to registration.
- COMMITTEE ON SPECIAL EDUCATION AUTHORIZATION TO RELEASE INFORMATION - Please complete this form only if applicable. Students who are classified for Special Education must forward all IEP documentation prior to meeting with Pupil Personnel Services.

Dobbs Ferry School District
Independent Thinkers Change Worlds

505 Broadway
Dobbs Ferry, NY 10522
t 914. 693-1500
f 914. 693-5952
www.dfsd.org

State of New York
County of Westchester

Parent's Statement

TO THE BOARD OF EDUCATION OF THE DOBBS FERRY UNION FREE SCHOOL DISTRICT

This is to certify that I, _____, being duly sworn, depose and say

1. I understand that this statement is being made **Under the Penalties of Perjury**, so that _____ *(Name(s) of Child(ren))* may be admitted to the schools of the Dobbs Ferry Public Schools.

2. I reside at _____, *(Address)* my legal residence. I further certify that I do not maintain another residence outside the boundaries of the Dobbs Ferry School District. (Attach a copy of one of the following proofs pertaining to a home (1) a mortgage or closing statement, (2) a deed, (3) a notarized signed lease or (4) a notarized rent receipt.

In addition, copies of any two of the following proofs of residency containing your name at the above address (1) Westchester County tax bill, (2) telephone bill, (3) gas & electric bill, (4) water bill (5) driver's license/picture ID, (6) insurance bill, (7) bank statement, (8) voter registration card or (9) oil company bill.

3. My former address was _____

_____

I understand that if the above mentioned child(ren) is (are) found not to be a legal resident(s) of the Dobbs Ferry Union Free School District, **I will be legally responsible for and will pay the school district's annual tuition rate retroactive on the first day of admission as follows**

2024-2025 Estimated State Education Department Non-Resident Tuition Rate

K-6	**$17,869**
7-12	**$18,662**

I also realize that theft of governmental services is a crime punishable under the State Penal Law, and that a false statement made in connection with this application will make me liable to criminal prosecution. I have been informed that the school district will make unannounced home visits for purposes of residency verification.

I further understand that if I move out of the home listed above, I will immediately notify the school district.

Sworn to and before me

this _____ day of _____, 20_____

_____ _____

Signature of Parent *Notary Public*

Springhurst Elementary School
Independent Thinkers Change Worlds

175 Walgrove Avenue
Dobbs Ferry, NY 10522
t 914. 693-1503
f 914. 693-3188
http://dfsd.org/sh

SPRINGHURST RECORDS RELEASE AUTHORIZATION FORM

I hereby authorize you to forward the following applicable records pertaining to my son/daughter

_____ _____

Student Name Date of Birth

Name of former school: _____

Address of former school: _____

Fax No. _____ Email Address: _____

___ Permanent Record

___ Health Records

___ Report Cards

___ Disciplinary Records

___Attendance

___ Standardized Test Scores

___ Psychological Reports

___ ELL Service Record

(Include ESLAT Scores)

Please indicate whether or not this child has been designated as a CSE student by the committee of Special Education. ___Yes ___ No

Please forward records to: Springhurst Elementary School

175 Walgrove Avenue

Dobbs Ferry, NY 10522

FAX: 914-693-3188

Email: panl@dfsd.org

Parent/Guardian Signature: _____

Relationship to Student: _____ Date:_____

Dobbs Ferry School District
Independent Thinkers Change Worlds

505 Broadway
Dobbs Ferry, NY 10522
t 914.693-1500
f 914.693-5962
http://www.dfsd.org

MIDDLE/HIGH SCHOOL RECORDS RELEASE AUTHORIZATION

Re _____ _____ **Date:** _____

(Student Name)

The above named student was a former pupil in your school and has registered in the Dobbs Ferry School District. Please send a copy of his/her academic records (transcript), standardized test scores, disciplinary records, and health records in order to facilitate the registration process and to determine the proper placement for this student. Also, please indicate whether this child has been designated a CSE student by the Committee on Special Education.

Below is a signed authorization from the parent/guardian to release this information to the Dobbs Ferry School District. Thank you.

MS/HS RELEASE AUTHORIZATION

As Parent/Guardian of _____ , I hereby authorize:

_____
(Name of Former School)

_____ _____
(Address)

_____
(Tel No.) / (Fax No.)

To release all records to: **Dobbs Ferry School District**
Guidance Department
505 Broadway
Dobbs Ferry, NY 10522
FAX: 914 693-1536

Student's Name: _____ **Current Grade:** _____

CSE Student: ___Yes ___No **If Yes:** ___IEP ___504

Parent Signature: _____

Dobbs Ferry School District
Independent Thinkers Change Worlds

505 Broadway
Dobbs Ferry, NY 10522
t 914. 693-1500
f 914. 693-5952
http://www.dfsd.org

Dear Parent/Guardian,

We would like your permission to obtain information about your child's learning style, and basic academic and social skills from his or her preschool or day care teacher. We find that communication with preschool personnel helps to facilitate the student's transition from preschool to elementary school. The preschool teacher is familiar with your child and many facets of his or her development and school life.

Sharing this information with us assists in making class placement decisions, and can help the kindergarten teacher work effectively with your child during his/her first year in elementary school.

If you would like to give us permission to obtain information, please sign the consent form below and bring it with you at registration time.

Thank you for helping to make the transition from preschool to elementary school a smooth one for your child.

Sincerely,

Tashia Brown
Principal

CONSENT FOR RELEASE OF PRESCHOOL INFORMATION

I give permission for Springhurst Elementary School to obtain information from the following preschool or day care center concerning my child:

Child's Name: _____

Preschool/Day Care: _____

Address: _____

Phone: _____

Email of Preschool Contact: _____

Parent/Guardian Signature: _____ Date: _____

Dobbs Ferry Schools

Student Network/Internet Agreement and Permission Form

Introduction

Dobbs Ferry is pleased to offer our students access to the District's computer technology resources. To use these resources, students and their parents/guardians must sign and return the attached form. Please read this document carefully, review its contents with your son or daughter, sign where appropriate and return to your child's school. Any questions or concerns about this permission form may be referred to the building principal.

General Network Use

The network is provided for students to conduct research, complete assignments, publish their work, and communicate with others. Access to network services is given to students who agree to act in a considerate and responsible manner. Students are responsible for good behavior on school computer networks just as they are in a classroom or a school hallway. As such, general school rules for behavior and communications apply, and users must comply with district standards and honor the agreements they have signed. Beyond the clarification of such standards, the district is not responsible for restricting, monitoring or controlling the communications of individuals utilizing the network.

Network storage areas are similar to school lockers. Network administrators may review files and communications to maintain system integrity and ensure that the system is used responsibly. Users should not expect that files stored on district servers will be private.

In general, when using school technology, students are **not** permitted to:

- Use others' passwords or share their passwords with others
- Damage or modify computers, operating systems or computer networks
- Send or display offensive messages or pictures
- Use obscene language
- Give personal information, such as complete name, phone number, address or photo
- Harass, insult or attack others
- Violate copyright laws
- Access others' folders or files without express permission
- Intentionally waste limited resources, such as paper or bandwidth
- Employ the network for commercial purposes, financial gain or fraud

Internet / World Wide Web / Social Networking / E-mail Access

Within reason, freedom of speech and access to information will be honored. Families should be warned that some material accessible via the Internet might contain items that are illegal, defamatory, inaccurate or potentially offensive to some people. While our intent is to make Internet access available to further educational goals and objectives, students may find ways to access other materials as well. Filtering software is in use to block content as specified in the Children's Internet Protection Act, but no filtering system is capable of blocking 100% of the inappropriate material available on the Internet. Dobbs Ferry believes that the benefits to students accessing the Internet and using social networking resources outweigh the disadvantages. By using these resources responsibly, opportunities for collaboration enable each student to become self-directed lifetime learners. Ultimately, parents and guardians of minors are responsible for setting and conveying the standards that their children should follow when using media and information sources.

Dobbs Ferry Schools

Student Network/Internet Agreement and Permission Form

Publishing to the World Wide Web

Although most of students' work at Dobbs Ferry will be done within a secure, password-protected portal, students will from time to time publish work to the web. This provides students with an opportunity to share their work with a wider audience, receive feedback from external professionals and share with the public what is going on at school. Students agree to only use their first names, not their last names or any other personal identifying information such as age, address, phone number, photos, etc. Students should also not publish work that contains copyrighted materials without proper permission and/or citation when appropriate.

Violations to this Policy

Violations may result in a loss of access as well as other disciplinary or legal action.

Student User Agreement:

As a user of the Dobbs Ferry computer network, I hereby agree to comply with the statements and expectations outlined in this document and to honor all relevant laws and restrictions.

Student Printed Name _____

Student Signature _____ Date _____

Parent/Guardian Permission for the Publication of Student Work to the World Wide Web:

I have spoken with my son or daughter about the responsibilities outlined above when using school technology resources.

Parent Printed Name _____

Parent Signature _____ Date _____

These permissions are granted for an indefinite period of time, unless otherwise requested.

Revised 7/12/2012

Dobbs Ferry School District
Independent Thinkers Change Worlds

Bill of Rights for Data Security and Privacy Parent's Bill of Rights

Dobbs Ferry School District

EDUCATION LAW § 2-D BILL OF RIGHTS FOR DATA PRIVACY AND SECURITY

Parents (includes legal guardians or persons in parental relationships) and Eligible Students (students 18 years and older) can expect the following:

1. A student's personally identifiable information (PII) cannot be sold or released for any commercial purpose. PII, as defined by Education Law § 2-d and FERPA, includes direct identifiers such as a student's name or identification number, parent's name, or address; and indirect identifiers such as a student's date of birth, which when linked to or combined with other information can be used to distinguish or trace a student's identity. Please see FERPA's regulations at 34 CFR 99.3 for a more complete definition.

2. The right to inspect and review the complete contents of the student's education record stored or maintained by an educational agency. This right may not apply to parents of an Eligible Student.

3. State and federal laws such as Education Law § 2-d; the Commissioner of Education's Regulations at 8 NYCRR Part 121, the Family Educational Rights and Privacy Act ("FERPA") at 12 U.S.C. 1232g (34 CFR Part 99); Children's Online Privacy Protection Act ("COPPA") at 15 U.S.C. 6501-6502 (16 CFR Part 312); Protection of Pupil Rights Amendment ("PPRA") at 20 U.S.C. 1232h (34 CFR Part 98); the Individuals with Disabilities Education Act ("IDEA") at 20 U.S.C. 1400 et seq. (34 CFR Part 300); protect the confidentiality of a student's identifiable information

4. Safeguards associated with industry standards and best practices including but not limited to encryption, firewalls and password protection must be in place when student PII is stored or transferred.

5. A complete list of all student data elements collected by NYSED is available at www.nysed.gov/data-privacy-security, and by writing to: Amber Klebanoff, 9146931500 ext 3066, DPO@dfsd.org, 505 Broadway, Dobbs Ferry, NY 10522.

6. The right to have complaints about possible breaches and unauthorized disclosures of PII addressed. Complaints may be submitted mail to: Amber Klebanoff, Data Privacy

Officer, Dobbs Ferry School District, 505 Broadway, Dobbs Ferry, NY 10522; by email to dpo@dfsd.org; or by telephone at 914-693-1500 ext 3066.

7. To be notified in accordance with applicable laws and regulations if a breach or unauthorized release of PII occurs.

8. Educational agency workers that handle PII will receive training on applicable state and federal laws, policies, and safeguards associated with industry standards and best practices that protect PII.

9. Educational agency contracts with vendors that receive PII will address statutory and regulatory data privacy and security requirements.

Dobbs Ferry School District
Independent Thinkers Change Worlds

505 Broadway
Dobbs Ferry,NY 10522
t 914. 693-1500
http://www.dfsd.org

Dear Parents/Guardians,

Welcome to the Dobbs Ferry School District!

New York State law (law effective July 1, 2018) requires a physical examination for all students entering Kindergarten, Grades 1, 3, 5,7,9 and 11 and all students transferring into the Dobbs Ferry School District.

The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner and on the approved NYS Student Health Examination Form for School.

All students entering Kindergarten and all students transferring into the district must present a verified copy of all immunizations. Students whose immunization records are already on file only need to present proof of additional immunizations that they receive.

A dental certificate which states your child has been seen by a dentist or dental hygienist is requested for students entering Kindergarten, Grades 1, 3, 5, 7, 9 and 11, and students transferring into the school district.

- A copy of the physical examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts K, 1, 3, 5, 7, 9, & 11 grades. If a copy is not given to the school within 30 days, the school will contact you.
- For your convenience, a physical exam form and dental certificate for your health care providers is available on the Health Services page of the school's website.
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the time of your child's appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office. We appreciate your time in collaborating with us to maintain a healthy community and to provide your child and our student with the necessary documentation as required by law.

School Nurses:

Cara de Leon, RN
Middle School & High School
deleonc@dfsd.org
Phone: 914-693-1500, ext. 3046 / Fax: 914-693-1536

Gina DiMaria, RN
Springhurst Elementary School
dimariag@dfsd.org
Phone: 914-693-1503, ext. 1467 / Fax: 914-693-3188

Kelli Cronin, RN
Dobbs Ferry School District
cronink@dfsd.org

School Physician:

Pediatrics on Hudson
615 Broadway
Hastings-on-Hudson, NY 10706
914-963-1663
www.pediatricsonhudson.com

School Health Requirements for the 2023-2024 School Year
For New and Current Students

1. **Physicals:**
   Physical Exam Forms are required for students entering Kindergarten, Grades 1, 3, 5, 7, 9, and 11.

   Forms:
   In accordance with new NYS regulations, **only the Required NYS School Health Examination Form or an electronic health record equivalent can be accepted by the school for student physical exam forms**.

   Date of Physical Exams:
   Physical exams conducted by a NYS licensed medical provider within twelve months prior to the start of the 2023-2024 school year are acceptable. **This means any physical exam that was done before September 5, 2022 will not be accepted.**

   Physical Exam Forms must be submitted to the school health office by Tuesday, October 5, 2023.

   Link: Required NYS School Health Examination Form

2. **Immunizations:**
   Students must meet New York State Immunization Requirements for School Entrance/Attendance for the grade level they are entering. Requirements include correct intervals between vaccines, correct ages at which vaccines were received, as well as the correct number of doses.

   Generally, students entering Grade 6 need a Tdap vaccine; students entering Grade 7 need dose 1 of Menactra vaccine; students entering Grade 12 need dose 2 of Menactra vaccine. Check with your School Nurse to see if your child is up to date for the 2021-2022 School Year.

   Proof of up-to-date immunizations is due by Thursday, September 19, 2023.

   Any student who does not meet immunization requirements by September 19, 2023, may be referred to building administrators for exclusion from school.

   Links:
   2023-2024 School Year New York State Immunization Requirements for School Entrance/Attendance
   NYS DOH School Vaccinations Website

3. **Medications:**
   ALL medication, including over-the-counter medication, prescription medication, medication that a student "self-carries," requires a medication order from a medical provider by way of a Medication Administration form.
   - Medication that can be given at home before or after school hours should be scheduled in this manner.
   - Please be sure each form is completed in its entirety before leaving the doctor's office and before submitting it to the Nurse's office.
   - Medication must be supplied by the parent/guardian in original over-the-counter or prescription packaging.

   Links:
   Medication Administration Form
   Allergy Medication Administration Form
   Asthma Medication Administration Form

2023-24 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

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)[2]	**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)[3]	**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses** **or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**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[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]	**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)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019, and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
   c. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 9: 10 years; minimum age for grades 10, 11, and 12: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2023-2024, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 9; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 10, 11, and 12.
   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 10: 10 years; minimum age for grades 11 and 12: 6 weeks).
   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.
   f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
    a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
    b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
    c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
    d. If one dose of vaccine was received at 24 months or older, no further doses are required.
    e. PCV is not required for children 5 years or older.
    f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

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

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

STUDENT INFORMATION

Name	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	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: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL				

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ 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:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.			**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No ☐
Notes			

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

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

☐ **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 <u>ONLY</u> 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 Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School 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: / / Month Day Year

Sex: Male Female

Will this be your child's first oral health assessment? Yes No

School: Name

Grade

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

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

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

Parent's Signature_____ Date

Section 2. To be completed by the Dentist/ 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):_____

II. 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.

MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS

Provider Medication Order Form | Office of School Health | School Year 2023-2024

Student Last Name	First Name	Middle	**Date of birth** __/__/____ MM DD YYYY	☐ Male ☐ Female
School			**Grade**	

HEALTH CARE PRACTITIONERS COMPLETE BELOW

1. Diagnosis: _____ ICD-10 Code: ☐ ___.___

Medication: _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

Student Skill Level *(Select the most appropriate option):*

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision

In School Instructions

☐ Standing daily dose: at __:__ AM / PM and __:__ AM / PM

AND/OR

☐ PRN

_____
specify signs, symptoms, or situations

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in __ minutes or __hours for a maximum of __ times.

Conditions under which medication should not be given:

---

2. Diagnosis: _____ ICD-10 Code: ☐ ___.___

Medication: _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

Student Skill Level *(Select the most appropriate option):*

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision

In School Instructions

☐ Standing daily dose: at __:__ AM / PM and __:__ AM / PM

AND/OR

☐ PRN

_____
specify signs, symptoms, or situations

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in __ minutes or __hours for a maximum of __ times.

Conditions under which medication should not be given:

---

3. Diagnosis: _____ ICD-10 Code: ☐ ___.___

Medication: _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

Student Skill Level *(Select the most appropriate option):*

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision

In School Instructions

☐ Standing daily dose: at __:__ am / pm and __:__ AM / PM

AND/OR

☐ PRN

_____
specify signs, symptoms, or situations

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in __ minutes or __hours for a maximum of __ times.

Conditions under which medication should not be given:

Health Care Practitioner (Please Print) LAST NAME	FIRST NAME	Signature
Address	Tel. No. (___)___-____	Fax. No (___)___-____
E-mail address	Cell phone (___)___-____	
NYS License No **(Required)** __-____	NPI No. ____ ____ ____	Date __/__/____

PARENTS MUST SIGN PAGE 2 ➔

MEDICATION ADMINISTRATION FORM page 2

THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2023-2024

PARENTS/GUARDIANS FILL BELOW

By signing below, I agree to the following:

- I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner.
- I understand that:
    - I must give the school nurse my child's medicine.
    - All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will get another medicine for my child to use when he or she is not in school or is on a school trip.
        - Prescription medicine must have the original pharmacy label on the box or bottle.
    - No student is allowed to carry or give him or herself controlled substances.
    - I must immediately tell the school nurse about any change in my child's medicine or the doctor's instructions. I will give my child's school nurse a new medication administration form written by my child's health care practitioner.
    - The medication order in this medication administration form expires at the end of my child's school year. I will give my child's school nurse a new medication administration form at the beginning of every school year.

Student Last Name First	Date of Birth ___ / ___ / _____
Parent/Guardian Print Name:	Signature:
Date Signed ___ / ___ / _____	Cell Phone:
Other Phone:	Email:

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2023-2024

Student Last Name	First Name	Middle	**Date of birth** __/__/____ MM DD YYYY	☐ Male ☐ Female
	Weight _____			
School			**Grade**	

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergy	**Specify Allergy**	**Specify Allergy**
☐ Allergy to	☐ Allergy to	☐ Allergy to

History of asthma?	☐ Yes (*If yes, student has an increased risk for a severe reaction*)	☐ No	**Does this student have the ability to:**		
History of anaphylaxis?	☐ Yes Date __/__/____	☐ No	Self-Manage *(See 'Student Skill Level' below)*	☐ Yes	☐ No
If yes, system affected	☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic		Recognize signs of allergic reactions	☐ Yes	☐ No
Treatment	Date __/__/____		Recognize/avoid allergens independently	☐ Yes	☐ No
History of allergy testing?	☐ Yes *(attach copy of results)* Date __/__/____	☐ No	Comments:		

Select In School Medications

1. SEVERE REACTION

- **CALL 911**, Immediately administer:

☐ **Epinephrine** Auto-Injector 0.15 mg

☐ **Epinephrine** Auto-Injector 0.3 mg (retractable devices preferred) intramuscularly into the anterolateral of thigh for the following symptoms:

- Shortness of breath, wheezing, or coughing
- Pale or bluish skin color
- Weak pulse
- Many hives or redness over body
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Lip or tongue swelling that bothers breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Feeling of doom, confusion, altered consciousness or agitation

☐ Other:_____

☐ If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____
Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine.**

- If no improvement, or if symptoms recur, repeat in _____ minutes for maximum of _____ times (not to exceed a total of 3 doses)

Student Skill Level *(select the most appropriate option)*
☐ Dependent Student: nurse/nurse-trained staff must administer
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer

Practitioner's Initials _____

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

2. MILD REACTION:

- Give antihistamine: Name:_____ Preparation/Concentration:_____ Dose:_____ Route: _____
  Frequency: ☐ **Q4** hours **or** ☐ **Q6** hours as needed for the following symptoms:
  - Itchy nose, sneezing, itchy mouth
  - A few hives
  - Mild stomach nausea or discomfort
  - Other: _____
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine.

Student Skill Level *(select the most appropriate option)*
☐ Dependent Student: nurse must administer
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer

Practitioner's Initials _____

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

3. OTHER MEDICATION (e.g., inhaler/bronchodilator if child has asthma):

- Give Name:_____ Preparation/Concentration:_____ Dose: _____
  Route:_____ Frequency: Q_____ ☐ minutes ☐ hours as needed

Specify signs, symptoms, or situations:_____
If no improvement, indicate instructions:_____
Conditions under which medication should not be given: _____

Student Skill Level *(select the most appropriate option)*
☐ Nurse-Dependent Student: nurse must administer
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer

Practitioner's Initials _____

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Home Medications *(include over-the counter)*

_____

_____

Health Care Practitioner Name LAST FIRST (Please Print)		Signature	Date __/__/____
Address		Tel. (___)___-____	Fax. (___)___-____
NYS License # **(Required)**	NPI # _____		

PARENTS MUST SIGN PAGE 2 →

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM page 2
PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2023-2024

PARENTS/GUARDIANS FILL BELOW

By signing below, I agree to the following:

- I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner.
- I understand that:
    - I must give the school nurse my child's medicine.
    - All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will get another medicine for my child to use when he or she is not in school or is on a school trip.
        - Prescription medicine must have the original pharmacy label on the box or bottle.
    - I must immediately tell the school nurse about any change in my child's medicine or the doctor's instructions. I will give my child's school nurse a new medication administration form written by my child's health care practitioner.
    - The medication order in this medication administration form expires at the end of my child's school year. I will give my child's school nurse a new medication administration form at the beginning of every school year.

Student Last Name First	Date of Birth ___ / ___ / _____
Parent/Guardian Print Name:	Signature:
Date Signed ___ / ___ / _____	Cell Phone:
Other Phone:	Email:

FOR SELF ADMINISTRATION OF MEDICINE:

- I confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing, and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school.
- I consent to the school nurse or trained school staff giving my child medicine if my child is temporarily unable to carry and give him or herself medicine.

Parent/Guardian Print Name:	Signature:
	Date Signed ___ / ___ / _____

PARENTS/GUARDIANS FILL BELOW

By signing below, I agree to the following:

I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner.

I understand that:

- I must give the school nurse my child's medicine.
- All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will get another medicine for my child to use when he or she is not in school or is on a school trip.
  - Prescription medicine must have the original pharmacy label on the box or bottle.
- I must immediately tell the school nurse about any change in my child's medicine or the doctor's instructions. I will give my child's school nurse a new medication administration form written by my child's health care practitioner.
- The medication order in this medication administration form expires at the end of my child's school year. I will give my child's school nurse a new medication administration form at the beginning of every school year.

Student Last Name First	Date of Birth / /
Parent/Guardian Print Name:	Signature:
Date Signed / /	Cell Phone:
Other Phone:	Email:

FOR SELF ADMINISTRATION OF MEDICINE:

I confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing, and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school.

I consent to the school nurse or trained school staff giving my child medicine if my child is temporarily unable to carry and give him or herself medicine.

Parent/Guardian Print Name:	Signature:
	Date Signed / /

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2023-2024

Student Last Name First Name Middle Initial | Date of Birth __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y) | ☐ Male ☐ Female

Grade/Class _____

School Name

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis
☐ Asthma

Control *(see NAEPP Guidelines)*
☐ Well Controlled
☐ Not Controlled / Poorly Controlled
☐ Unknown

Severity *(see NAEPP Guidelines)*
☐ Intermittent
☐ Mild Persistent
☐ Moderate Persistent
☐ Severe Persistent

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

History of near-death asthma requiring mechanical ventilation	☐Y	☐N	☐U	
History of life-threatening asthma (loss of consciousness or hypoxic seizure)	☐Y	☐N	☐U	
History of asthma-related PICU admissions (ever)	☐Y	☐N	☐U	
Received oral steroids within past 12 months	☐Y	☐N	☐U	____ times last : __ __ / __ __ / __ __
History of asthma-related ER visits within past 12 months	☐Y	☐N	☐U	____ times
History of asthma-related hospitalizations within past 12 months	☐Y	☐N	☐U	____ times
History of food allergy or eczema, specify: _____	☐Y	☐N	☐U	

Student Skill Level *(Select the most appropriate option)*
☐ Nurse-Dependent Student: nurse must administer medication
☐ Supervised Student: student self-administers under adult supervision
☐ Independent Student: student is self-carry / self-administer

_____ Practitioner Initials

I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.

Home Medications *(Include over the counter)*
☐ Reliever _____
☐ Controller _____
☐ Other _____

Quick Relief In-School Medication (Select ONE)

☐ **Albuterol MDI**
[*Ventolin® MDI can be provided by school for shared usage (plus individual spacer)*]:
☐ MDI w/ spacer
☐ DPI

☐ **Other**: Name: _____ Strength: _____
Dose: _____ Route: _____ Time Interval: ☐ ___ hrs

In-School Instructions *(Check all that apply)*

☐ **Standard Order:** Give 2 puffs/1 AMP q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath ("asthma flare symptoms"). Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE.**
If in Respiratory Distress*: Call 911 and give 6 puffs/1 AMP; may repeat q 20 minutes until EMS arrives.
☐ **Pre-exercise:** 2 puffs/1 AMP 15-20 mins before exercise.
☐ **URI Symptoms or Recent Asthma Flare** *(Within 5 days)*: 2 puffs/1 AMP @ noon for 5 days.
Special Instructions:

Controller Medications for In-School Administration
(Recommended for Persistent Asthma, per NAEPP Guidelines)

☐ **Fluticasone MDI**
[*Flovent® 110 mcg MDI can be provided by school for shared usage*]:
☐ MDI w/ spacer
☐ DPI

☐ **Other:** Name: _____ Strength: _____
Dose: _____ Route: _____ Time Interval: ☐ ___ hrs

☐ **Standing Daily Dose:**
___ puffs/1AMP ONCE a day at ___ AM
Special Instructions:

Health Care Practitioner (Please Print Name) Last First		Signature	Date __ __ / __ __ / __ __ __ __
Address	Tel. (_ _ _) _ _ _ - _ _ _ _	Fax (_ _ _) _ _ _ - _ _ _ _	NPI # _ _ _ _ _ _ _ _ _ _
Email Address	NYS License # **(Required)**	CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.	

PARENTS MUST SIGN PAGE 2 ➔

ASTHMA MEDICATION ADMINISTRATION FORM page 2

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2023-2024

PARENTS/GUARDIANS FILL BELOW

By signing below, I agree to the following:

- I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner.
- I understand that:
  - I must give the school nurse my child's medicine.
  - All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will get another medicine for my child to use when he or she is not in school or is on a school trip.
    - Prescription medicine must have the original pharmacy label on the box or bottle.
  - I must immediately tell the school nurse about any change in my child's medicine or the doctor's instructions. I will give my child's school nurse a new medication administration form written by my child's health care practitioner.
  - The medication order in this medication administration form expires at the end of my child's school year. I will give my child's school nurse a new medication administration form at the beginning of every school year.

Student Last Name First	Date of Birth ___ / ___ / _____
Parent/Guardian Print Name:	Signature:
Date Signed ___ / ___ / _____	Cell Phone:
Other Phone:	Email:

FOR SELF ADMINISTRATION OF MEDICINE:

- I confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing, and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school.
- I consent to the school nurse or trained school staff giving my child medicine if my child is temporarily unable to carry and give him or herself medicine.

Parent/Guardian Print Name:	Signature:
	Date Signed ___ / ___ / _____

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

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

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

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

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:

❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

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

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

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

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

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

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

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

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

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

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

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

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

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

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

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: **POSITION:** _____

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

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

NAME: **POSITION:** _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

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

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

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:**

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

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

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

Dobbs Ferry School District

505 Broadway
Dobbs Ferry, NY 10598
t 914.693.1500
f 914.693.5952
http://www.dfsd.org

Student Residency Questionnaire

Name of School: _____

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

Birth Date_____/_____/_____ Age:_____ Sex:____Male ____Female
Month *Day* *Year*

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive. The District's homeless liaisons are:

Springhurst Elementary – Patricia Clifford – 914-693-1503 ext. 1451
Middle/High School – Danielle Pecora – 914-693-1500 ext. 3320
Middle School – Sheila Kusi-Asare – 914-693-1500 ext. 3026

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

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

Where is the student presently living? *(Check one box.)*

☐ 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

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

Address _____

Phone Number _____

Signature of Parent(s)/Legal Guardian(s)_____Date_____

I certify the above named student qualifies as a student in transition under the provisions of the McKinney-Vento Act.

_____ _____
Date *McKinney-Vento Liaison Signature*

Dobbs Ferry School District
Independent Thinkers Change Worlds

505 Broadway
Dobbs Ferry, NY 10522
t 914. 693-1500
f 914. 693-5952
http://www.dfsd.org

COMMITTEE ON SPECIAL EDUCATION
PERMISSION TO RELEASE/OBTAIN INFORMATION

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

I hereby authorize the Dobbs Ferry Union Free School District:

Release the following information to:

Name: _____

Agency: _____

Street: _____

City: _____ State: _____ Zip: _____

Obtain the following information from:

Name: _____

Agency: _____

Street: _____

City: _____ State: _____ Zip: _____

Communicate over the telephone with and/or to arrange a classroom observation by:

Name: _____

Agency: _____

Phone: _____

Most Recent	All	Specific Information or Dates	
☐	☐	_____	cumulative file records (report cards, general ed. Records)
☐	☐	_____	standardized test scores (DRP, CMT, SAT, CMAT)
☐	☐	_____	educational evaluations
☐	☐	_____	psychological evaluations
☐	☐	_____	social work evaluations
☐	☐	_____	minutes of CSE/IEP Team meetings
☐	☐	_____	IEP
☐	☐	_____	Other, Specify _____
☐	☐	_____	Other, Specify _____

Parent/Guardian		Administrator Authorizing Release
_____	Name	_____
_____	Relationship/Position	_____
_____	Signature	_____
_____	Date	_____

Date Withdrew_____ F _____ R _____ D_____

2023-2024 Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and **return it to the address listed below.** Call Mia Alfano at 914-693-1500 x3045**,** if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to:

Dobbs Ferry School District
505 Broadway
Dobbs Ferry, NY 10522

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	Homeless Migrant, Runaway
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:

If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. **Skip to Part 4 and sign the application.**

Name: _____ CASE #: _____

3. Report all income for ALL Household Members (Skip this step if you completed step 2)

All Household Members (including yourself and all children that have income).

List all Household members not listed in Step 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any other source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of household member	Earnings from work before deductions ***Amount / How Often***	Child Support, Alimony ***Amount / How Often***	Pensions, Retirement Payments ***Amount / How Often***	Other Income, Social Security ***Amount / How Often***	No Income
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐

Total Household Members (Children and Adults) ☐☐

*__Last Four Digits of Social Security Number:__ XXX-XX- __ __ __ __ I do not have a SS# ☐

*When completing section 3, an adult household member must provide the last four digits of their Social Security Number (SS#) or mark the "I do not have a SS# box" before the application can be approved.

4. Signature: An adult household member must sign this application before it can be approved. I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school will get federal funds; the school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Signature: _____ **Date:** _____

Email Address: _____ Home Phone: _____ Work Phone: _____

Home Address: _____

5. Ethnicity and Race are optional; responding to this section does not affect your children's eligibility for free or reduced price meals.

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino Race (Check one or more): ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Island ☐White

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application) Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

☐ SNAP/TANF/Foster

☐ Income Household: Total Household Income/How Often: _____/_____ Household Size: _____

☐ ☐ Free Meals ☐ Reduced Price Meals ☐ Denied/Paid

Signature of Reviewing Official_____ **Date Notice Sent:** _____

Dear Parent/Guardian:

Children need healthy meals to learn, **Dobbs Ferry School District** offers healthy meals every school day. Breakfast costs **$1.25,** lunch costs **$2.75**. Your children may qualify for free meals or for reduced price meals. **Students in New York State that are approved for reduced price meals will receive breakfast and lunch meals and snacks served through the Afterschool Snack Program at no charge. Below are common questions and answers to help you with the application process.**

1. **DO I NEED TO FILL OUT AN APPLICATION FOR EACH CHILD?** No. Complete one Application for Free and Reduced Price School Meals/Milk to apply for free or reduced price meals for all students in your household attending this School Food Authority. We cannot approve an application that is not complete, so be sure to fill out all required information as indicated on the application and application instructions. **Return the completed application to Mia Alfano, 505 Broadway, Dobbs Ferry, NY, 10522, 914-693-1500x 3045.**

2. **WHO CAN GET FREE MEALS?**

- All children in households receiving benefits from the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) or Temporary Assistance to Needy Families (TANF), are eligible for free meals. Categorical eligibility for free meal benefits is extended to all children in a household when the application lists an Assistance Program's case number for any household member.
- Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals.
- Children participating in their school's Head Start Program are eligible for free meals.
- Children who meet the definition of homeless, runaway, or migrant are eligible for free meals. Households with children who meet the definition of homeless, runaway or migrant should contact the SFA for assistance in receiving benefits.
- Children may receive free meals if your household's gross income is within the free or reduced price limits on the Federal Income Eligibility Guidelines. Students in New York State that are approved for reduced price meals will receive breakfast and lunch meals and snacks served through the Afterschool Snack Program at no charge.
- Your children may qualify for free or reduced price meals if your household income falls at or below the limits on this chart:

2023-2024 REDUCED PRICE INCOME ELIGIBILITY GUIDELINES

Total Household Size	Annual	Monthly	Twice per Month	Every Two Weeks	Weekly
1	$ 26,973	$ 2,248	$ 1,124	$ 1,038	$ 519
2	$ 36,482	$ 3,041	$ 1,521	$ 1,404	$ 702
3	$ 45,991	$ 3,833	$ 1,917	$ 1,769	$ 885
4	$ 55,500	$ 4,625	$ 2,313	$ 2,135	$ 1,068
5	$ 65,009	$ 5,418	$ 2,709	$ 2,501	$ 1,251
6	$ 74,518	$ 6,210	$ 3,105	$ 2,867	$ 1,434
7	$ 84,027	$ 7,003	$ 3,502	$ 3,232	$ 1,616
8	$ 93,536	$ 7,795	$ 3,898	$ 3,598	$ 1,799
*Each add'l person, add	$ 9,509	$ 793	$ 397	$ 366	$ 183

3. **CAN FOSTER CHILDREN GET FREE MEALS?** Yes, foster children that are under the legal responsibility of a foster care agency or court, are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Foster children may also be included as a member of the foster family if the foster family chooses to also apply for benefits for other children. Including children in foster care as household members may help other children in the household qualify for benefits. If non-foster children in a foster family are not eligible for free or reduced price meal benefits, an eligible foster child will still receive free benefits.

4. **CAN HOMELESS, RUNAWAY, AND MIGRANT CHILDREN GET FREE MEALS?** Yes, children who meet the definition of homeless, runaway, or migrant qualify for free meals. If you haven't been told your children will get free meals, please call or e-mail **HS Michelle Ciccone at 914-693-1500 x3037, MS Shelia Kusi-Assare 914-693-1500 x3026, Springhurst, Patricia Clifford information]** to see if they qualify.

5. **SHOULD I FILL OUT AN APPLICATION IF I RECEIVED A LETTER THIS SCHOOL YEAR SAYING MY CHILDREN ARE APPROVED FOR FREE MEALS?** Please read the letter you got carefully and follow the instructions. Call the school at **914-693-1500 x3045** if you have questions.

6. **MY CHILD'S APPLICATION WAS APPROVED LAST YEAR. DO I NEED TO FILL OUT ANOTHER ONE?** Yes. Your child's application is only good for that school year and carried over for the first 30 operating days of this school year (or until a new eligibility determination is made, whichever comes first). You must send in a new application unless the school told you that your child is eligible for the new school year. If you do not send in a new application that is approved by the school or you have not been notified that your child is eligible for free meals, your child will be charged the full price for meals.

7. **I GET WOMEN, INFANTS AND CHILDREN (WIC) BENEFITS. CAN MY CHILD(REN) GET FREE MEALS?** Children in households participating in WIC may be eligible for free or reduced price meals. Please fill out an Application for Free and Reduced Price School Meals/Milk.

8. **WILL THE INFORMATION I GIVE BE CHECKED?** Yes. We may also ask you to send written proof of the household income you report.

9. **IF I DON'T QUALIFY NOW, MAY I APPLY LATER?** Yes, you may apply at any time during the school year. For example, children with a parent or guardian who becomes unemployed or who experiences financial hardship mid-year may become eligible for free and reduced price meals if the household income drops below the income limit.

10. **WHAT IF I DISAGREE WITH THE SCHOOL'S DECISION ABOUT MY APPLICATION?** You should talk to school officials. **You also may ask for a hearing by calling or writing to: Ron Clamser Jr., 505 Broadway, Dobbs Ferry, NY, 10522, clamserr@dfsd.org**

11. **MAY I APPLY IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN?** Yes. You, your child(ren), or other household members do not have to be U.S. citizens to qualify for free or reduced price meals.

12. **WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD?** You must include all people living in your household, related or not (such as grandparents, other relatives, or friends) who share income and expenses. You must include yourself and all children living with you. If you live with other people who are economically independent (for example, people who you do not support, who do not share income with you or your children, and who pay a pro-rated share of expenses), do not include them.

13. **WHAT IF MY INCOME IS NOT ALWAYS THE SAME?** List the amount that you normally receive. For example, if you normally make $1000 each month, but you missed some work last month and only made $900, put down that you made $1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.

14. **WE ARE IN THE MILITARY. DO WE REPORT OUR INCOME DIFFERENTLY?** Your basic pay and cash bonuses must be reported as income. If you get any cash value allowances for off-base housing, food, clothing, it must also be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income. Any additional combat pay resulting from deployment is also excluded from income.

15. **MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR?** To find out how to apply for **SNAP** or other assistance benefits, contact your local assistance office or call **1-800-342-3009**.

How to Apply: To get free or reduced price meals for your children, carefully complete one Application for Free and Reduced Price School Meals/Milk, following the instructions on the form, for your household and **return it to the designated office listed on the application**. All household members and children should be listed on one application.

- If you receive SNAP or TANF benefits or participate in the FDPIR, the application must include the children's names, the household SNAP, TANF or FDPIR case number and the signature of an adult household member.
  - Contact your local Department of Social Services for your SNAP or TANF case number, if necessary.
  - No application is necessary if the household was notified by the School Food Authority that their children have been directly certified based on Assistance Program participation. If the household is not sure if their children have been directly certified, the household should contact the school.
- If you do not list a SNAP, TANF or FDPIR case number for any household member, the application must include the names of everyone in the household, the amount of income for each household member, how often it is received and where it comes from. It must include the signature of an adult household member and the last four digits of that adult's social security number or check the box if the adult does not have a social security number.
- **An application for free and reduced price benefits cannot be approved unless complete eligibility information is submitted, as indicated on the application and in the instructions.** We will let you know when your application is approved or denied.

Reporting Changes: The benefits that you are approved for at the time of application are effective for the entire school year and up to 30 operating days into the new school year (or until a new eligibility determination is made, whichever comes first). You no longer need to report changes for an increase in income or decrease in household size, or if you no longer receive SNAP.

Meal Service to Children with Disabilities: Federal regulations require schools and institutions to serve meals at no extra charge to children with a disability which may restrict their diet. A student with a disability is defined in 7CFR Part 15b.3 of Federal regulations, as one who has a physical or mental impairment which substantially limits one or more major life activities of such individual, a record of such an impairment or being regarded as having such an impairment. Major life activities include but are not limited to: functions such as caring for one's self, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. You must request meal modifications from the school and provide the school with medical statement from a State licensed healthcare professional. **If you believe your child needs substitutions because of a disability, please get in touch with us for further information, as there is specific information that the medical statement must contain.**

Confidentiality: The United States Department of Agriculture has approved the release of students names and eligibility status, without parent/guardian consent, to persons directly connected with the administration or enforcement of federal education programs such as Title I and the National Assessment of Educational Progress (NAEP), which are United States Department of Education programs used to determine areas such as the allocation of funds to schools, to evaluate socioeconomic status of the school's attendance area, and to assess educational progress. Information may also be released to State health or State education programs administered by the State agency or local education agency, provided the State or local education agency administers the program, and federal State or local nutrition programs similar to the National School Lunch Program. Additionally, all information contained in the free and reduced price application may be released to persons directly connected with the administration or enforcement of programs authorized under the National School Lunch Act (NSLA) or Child Nutrition Act (CNA); including the National School Lunch and School Breakfast Programs, the Special Milk Program, the Child and Adult Care Food Program, Summer Food Service Program and the Special Supplemental Nutrition Program for Women Infants and Children (WIC); the Comptroller General of the United States for audit purposes, and federal, State or local law enforcement officials investigating alleged violation of the programs under the NSLA or CNA. **The disclosure of eligibility information not specifically authorized by the NSLA requires a written consent statement from the parent/guardian.**

In the operation of child feeding programs, no child will be discriminated against because of race, sex, color, national origin, age, disability or limited English proficiency.

If you have other questions or need help, call Mia Alfano, 914-693-1500x3045.

Thank you,

Nondiscrimination Statement: This explains what to do if you believe you have been treated unfairly.
In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
2. **fax:**
(833) 256-1665 or (202) 690-7442; or
3. **email:**
program.intake@usda.gov

This institution is an equal opportunity provider.

FAXED BY _____ **DISTRICT** _____

PROGRAMA DE EDUCACIÓN PARA MIGRANTES DEL ESTADO DE NEW YORK

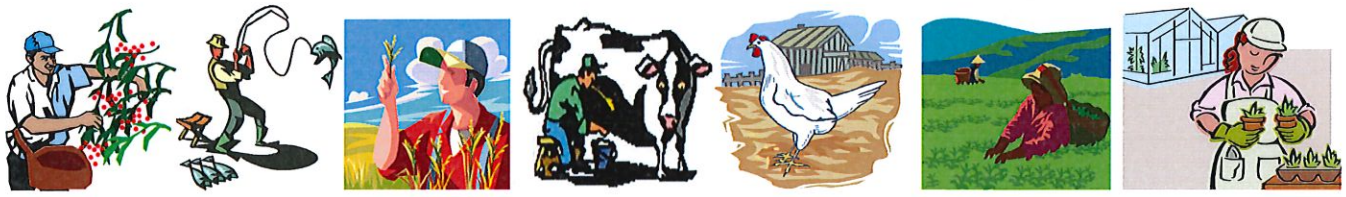
OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Ley Cada Estudiante Triunfa (ESSA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, **sin importar su nacionalidad o estado legal**. Este programa **es gratuito** para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito, excursiones, programa de verano, actividades de envolvimiento para padres, programa de emergencias y referidos a otras organizaciones o agencias.

Por favor tome unos minutos para completar este cuestionario.

¿Usted o alguien en su familia ha trabajado en la agricultura?
¿Se han mudado durante los últimos 3 años?

- ☐ Cualquier trabajo agrícola (como plantando, seleccionando, o cosechando frutas o vegetales, cultivando o cortando flores o árboles, trabajo en lechería u otro rancho de animales, pescando, etc.)
- ☐ Trabajando en la cultivación o procesamiento de los árboles.
- ☐ Trabajando en una planta de procesamiento, empacando, lavando o cortando vegetales, frutas o carnes.



Si usted contestó que sí, por favor complete la siguiente información:

Nombre del Padre/Encargado: _____

Dirección Física: _____ Ciudad_____

Teléfono: (_____)-_____-_____ Mejor tiempo para ser contactado _____ AM/PM

Dirección anterior: _____

Nombre del estudiante: _____ Edad_____ Grado_____

Nombre del estudiante: _____ Edad_____ Grado_____

Para someter este referido, por favor envíelo por fax a 845-257-2953, o por correo a Mid-Hudson Migrant Education Program- 353 VH Annex – 1 Hawk Drive New Paltz, NY 12561

FAXED BY _____ DISTRICT_____

NEW YORK STATE MIGRANT EDUCATION PROGRAM

IDENTIFICATION & RECRUITMENT OFFICE

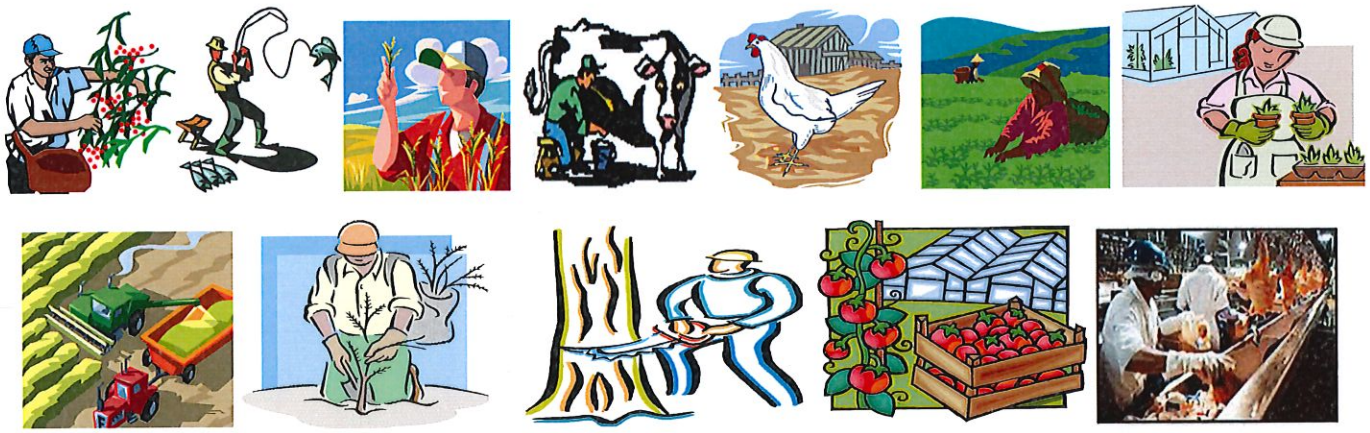
PARENT SURVEY

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

Please take few minutes to complete this questionnaire.

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

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



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

Parent/Guardian Name: _____

Home address: _____City/Town_____

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

Previous Address: _____

Student name: _____ Age _____Grade_____

Student name: _____ Age _____Grade_____

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