TROY
CITY SCHOOL DISTRICT

Central Registration

475 First Street
Troy, New York 12180
(518) 328-5007

Registration Checklist for K - 12

Welcome to Troy Schools!

In order to register your child, a parent or guardian must be present with photo identification at Central Registration Office located at School 12, 475 First Street. Office hours 7:30 am to 3:00 pm/Summer hours 7:00 am to 2:00 pm. Summer Hours are in effect during school breaks.

All attached forms must be completed.

The following documents are also required for registration:

Required documents checklist ☑

(1) Health Certificate signed by a doctor
(2) Up-to-date Immunization Record
(3) Birth Certificate
(4) Proof of Residency (mortgage statement, lease, electric bill within 30 days or district residency form with the name of parent/guardian – all must include name of parent/guardian)
(5) Photo Identification of Parent/Guardian
(6) Dental Health Certificate (optional)

Questions? Contact Central Registration at 518-328-5007
Fax# 518-271-5445 email: reg@troycsd.org

Se habla español: 518-629-5757 Arabic Interpreter: 518-431-9281

TROY SCHOOLS

Elementary Schools
School 2 – 470 Tenth Street
School 14 – 1700 Tibbits Avenue
School 16 – 40 Collins Avenue
School 18 -412 Hoosick Street
Carroll Hill School – 112 Delaware Avenue

Troy Middle School
1976 Burdett Avenue

Troy High School
1950 Burdett Avenue

TROY
CITY SCHOOL DISTRICT

Central Registration
(518) 328-5007
475 First Street
Troy, New York 12180

TROY CSD LEARNING AND TRANSPORTATION CHOICE FORM

Name of Student: _____ Date of Birth: ____/____/_____

Learning Choice

Please choose one of the following:

☐ **In-Person Instruction Grades Pre-K – 5**

Daily in-person instruction.

(PLEASE NOTE: We do not provide transportation for Pre-K students.)

☐ **In-Person Instruction Grades 6 – 12**

This is a hybrid version of both in-person and at-home instruction. The student's schedule will alternate two consecutive days in-person followed by two consecutive days of virtual instruction.

☐ **Remote ONLY Learning Grades K – 12**

Parents who opt for the Remote ONLY learning option **must commit to this option from September through December.**

Transportation Choice for In-Person Instruction

Please choose one of the following:

☐ **Student will require bus transportation**

Select this option if you require transportation to and from school or if you only require AM or PM transportation.

☐ **Student does not require bus transportation**

Student is walking or is transported via parent drop off/pickup, CDTA, or other means.

Parents who opt for No Bus Transportation **must commit to this option from September through December.**

_____ _____
Print name of Parent/Guardian Signature of Parent/Guardian

_____
Date

For more details go to www.troycsd.org/reopening

TROY CITY SCHOOL DISTRICT

Central Registration
475 First Street
Troy, New York 12180
(518) 328-5007

Housing Questionnaire

Name of School: _____ Grade: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____
Month Day Year

Address: _____ Zip: _____ 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 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 permanent housing
☐ In a shelter
☐ In a motel/hotel
☐ With another family or person because of loss of housing or economic hardship
☐ In a car, park, bus, train, or campsite
☐ Other temporary living situation _____

_____ X _____
Print name of Parent, Guardian or Student Signature of Parent/Guardian or Student

_____
Date

TROY CITY SCHOOL DISTRICT

STUDENT REGISTRATION FORM

STUDENT NAME: _____ / _____ / _____
First Middle Last

Last Name of Parent/Guardian with whom student is living: _____

Address: _____ / _____ / _____ NY _____
Street Apt/Flr City State Zip

Household Phone Number: _____ Is this a cell phone: ☐ Yes ☐ No

What language is spoken in the student's home: _____ Are translation services needed: ☐ Yes ☐ No

Ethnicity: Is the student Hispanic, Latino, or of Spanish origin? ☐ Yes, Hispanic ☐ No, not Hispanic

Race: Select one or more races from the following five racial groups
☐ Black ☐ White ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

Gender: ☐Male ☐Female What language does the student speak and understand the most: _____

Date of Birth: ____/____/_____ Place of Birth: _____ _____ _____
City State Country

Has the student previously attended a school in Troy ☐ Yes ☐ No If yes, what school _____

Registering for Grade: _____

Has the student attended school in the USA: ☐ Yes ☐ No If yes, number of years enrolled in US schools: _____

Does the student have a parent/guardian on active duty in the Armed Forces? ☐ Yes ☐ No
Did the student take any final High School level exam(s) out of state while his/her guardian was in the military?____

Office Use Only

☐NCLB ☐SP ☐Summer Serv **Date:** ____/____/_____

ID: _____ Home School: _____ School Enrolled: _____

Documents provided to the district:
☐ Photo ID
☐Proof of Residency
- ☐National Grid Bill
- ☐Lease
- ☐Notarized Landlord Letter
- ☐Mortgage Statement
- ☐Other _____
- ☐MCKINNEY-VENTO

☐Birth Certificate ☐Passport
☐Court Papers
- ☐DSS 299-District _____
- ☐Custody
- ☐Parent/Custodial Affidavits
- ☐Adoption

Enrollment Exceptions:
☐School Choice ☐Opt In
☐Wynantskill student ☐Permission Rcvd
☐N. Greenbush student ☐Permission Rcvd
☐Employee's child – District _____ ☐Emp ID
☐Foreign Exchange
☐ Tuition Paying – District _____

☐ Lunch Form Completed
☐ Network Form

☐Immunization ☐14 Day Letter
☐Religious Exemption
☐Physical
☐Dental certificate

Parent/Guardian Information

Mother/ Guardian: _____ / _____ / _____
First Middle Initial Last

Relationship to child: ☐ Mother ☐ Step-parent ☐ Legal Guardian ☐ Foster Parent ☐ Other _____

Resides in Home ☐ Yes ☐ No Custodial Parent ☐ Yes ☐ No Is to receive Correspondence ☐ Yes ☐ No

Mailing Address if different from above: _____ / _____ / _____ _____ _____
Street Apt/Flr City State Zip

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Email Address: _____ Phone call priority (1-3): Home____ Work____ Cell ____

Father/ Guardian: _____ / _____ / _____
First Middle Initial Last

Relationship to child: ☐ Father ☐ Step-parent ☐ Legal Guardian ☐ Foster Parent ☐ Other _____

Resides in Home ☐ Yes ☐ No Custodial Parent ☐ Yes ☐ No Is to receive Correspondence ☐ Yes ☐ No

Mailing Address if different from above: _____ / _____ / _____ _____ _____
Street Apt/Flr City State Zip

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Email Address: _____ Phone call priority (1-3): Home____ Work____ Cell ____

Other Children Living in the Household –Please include children not of school age

Name: _____ Date of Birth: ____/____/____
Gender: ☐Male ☐Female Past Registrant ☐ Yes ☐ No

Name: _____ Date of Birth: ____/____/____
Gender: ☐Male ☐Female Past Registrant ☐ Yes ☐ No

Please list the names of ANY and ALL persons Troy City School District is allowed to contact or release your child to in case of an emergency, including illness, serious injury, early dismissal of school or an evacuation emergency.

Emergency Contact 1: Name: _____ Relationship to Student: _____
Other than parent/guardian

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Address: _____

Emergency Contact 2: Name: _____ Relationship to Student: _____
Other than parent/guardian

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Address: _____

Emergency Contact 3: Name: _____ Relationship to Student: _____
Other than parent/guardian

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Address: _____

Additional Emergency Contacts: _____

Legal Information (If Applicable)

If parents are divorced or separated, is there a court approved custody document? ☐ Yes ☐ No
Who retains legal custody? _____ Relationship to child _____
If joint, who has residential (primary physical) custody? _____
☐ Legal guardianship document provided
Is the student in the care of a guardian(s) other than his/her mother or father? ☐ Yes ☐ No
If yes, name of legal guardian(s) _____ Relationship to child _____

Is the student in foster care? ☐ Yes ☐ No If yes, please provide copy of placement order (DSS-2999)

Additional Services (If Applicable)

Special Education Services
Does the student currently have an IEP (Individualized Education Plan) ☐ Yes ☐ No
Does your child receive any of the following type of services?
☐ Consultant Teacher ☐ Self-Contained Classroom ☐ Resource Room
☐Out of District Class (BOCES or QUESTAR) ☐ Yes ☐ No

Related Services
☐ Speech and Language Therapy ☐ Occupational Therapy ☐Physical Therapy
☐ Counseling ☐ Other, please describe _____

Academic Intervention Services (AIS/Remedial)
☐ Math ☐ English Language Arts ☐ Science ☐ Social Studies

Other Services
☐ 504 Plan
☐ English as a New Language (ENL) If yes how many years of service? _____
☐ Other _____

If your child requires special education or English as a new language services, he or she may not be attending their home school. If it is feasible, do you wish for siblings to attend the same school? ☐ YES ☐ NO

IF REGISTERING FOR PREK –Is or will your child be receiving Summer Service this year ☐ Yes ☐ No

Parent Statement:
I certify that the above information is true and correct. Any misinformation regarding residency may result in being billed to cover the cost of instruction and/or exclusion from attending the Troy City School District.

Parent or Guardian Signature X _____ **Date** _____

All documents are to be returned to:
Troy City School District Central Registration Office
School 12, First Floor 475 First St., Troy, NY 12180
Phone: (518) 328-5007 Fax: (518) 271-5445

TROY
CITY SCHOOL DISTRICT

475 First Street
Troy, New York 12180

REQUEST FOR RECORDS

I give permission for the release of information concerning my child:

Student: _____ Grade: _____ Date of Birth: _____

Name of Former District: _____ City: _____ State: _____

Name of Former School: _____ Phone: _____

Address: _____ Fax: _____

Signature of Parent/Guardian X _____ ***Date:*** _____

Office Use Only

REQUEST FOR RECORDS

Please send records to: **Date sent: ___/___/_____**

√	SCHOOL	ADDRESS	PHONE/FAX	CONTACT
	Troy High School	1950 Burdett Avenue Troy, NY 12180	P: (518) 328-5472 F: (518) 271-5164	Guidance Office
	Troy Middle School	1976 Burdett Avenue Troy, NY 12180	P: (518) 328-5365 F: (518) 271-5492	Guidance Office
	Carroll Hill School	112 Delaware Avenue Troy, NY 12180	P: (518) 328-5701 F: (518) 274-4587	Kate Talham
	School 2	470 Tenth Street Troy, NY 12180	P: (518) 328-5601 F: (518) 271-5205	Nickole Farnan
	School 14	1700 Tibbits Avenue Troy, NY 12180	P: (518) 328-5801 F: (518) 274-0371	Secretary
	School 16	40 Collins Avenue Troy, NY 12180	P: (518) 328-5101 F: (518) 274-4585	Latonia Berkley
	School 18	412 Hoosick Street Troy, NY 12180	P: (518) 328-5501 F: (518) 274-4374	Emily Ruffinen
	Central Registration	School 12 475 First St. Troy, NY 12180	P: (518) 328-5007 F: (518) 271-5445	Central Registration Office
	Special Education Department	School 12 475 First St. Troy, NY 12180	P: (518) 328-5075 F: (518) 279-7600	Pupil Services Office

Items Requested:

- o Transcripts
- o Current Report Cards
- o Standardized Test Scores
- o Regents Competency Test (RCT) Results
- o NYS Regents Scores
- o NYS Regents Science Labs
- o Birth Certificate
- o NYS Proficiency Scores
- o Cumulative Health Records/Immunizations
- o Attendance Records
- o Psychological Evaluations
- o Disciplinary Records
- o NYS _____ Grade Test Results
- o Special Education Records, including most recent IEP

Thank you for your prompt attention to this matter.

Parent Consent to Release Information
Medical Authorization Form

To Whom It May Concern:

In regard to my (Son/Daughter):_____

I, _____, hereby authorize any physician or nurse who has attended, examined, or treated my child to furnish his/her teachers or pertinent staff with whom (he/she) comes in daily contact, with any and all information which may be necessary regarding (his/her) past or present physical condition and treatment rendered therefore, to ensure that said school personnel are fully cognizant of his/her condition and to safeguard their health and safety.

_____ X _____

Date Signature of Parent/Guardian

_____

Please Print Name

TROY CITY SCHOOL DISTRICT

SCHOOL HEALTH SERVICES Entering Date _____ Grade _____ School _____ Sex _____

Student Name _____ Address _____ DOB _____ Place of Birth _____
Last First MI

Mother's Name _____ Address (if different) _____ Home Phone: _____ Cell Phone: _____
Place of Employment _____ Phone _____

Father's Name _____ Address (if different) _____ Home Phone: _____ Cell Phone: _____
Place of Employment _____ Phone _____

Guardian/Step Parent Name _____ Address (if different) _____ Home Phone: _____ Cell Phone: _____
Place of Employment _____ Phone _____

The answers to the questions on this form will be held in the School Health Office and will be kept confidential.
Has your child ever had the following? Please explain with date of onset, any "yes" answers.

Has Your Child Ever Had the Following?	N	Y	Explain with Date/Medication	Has Your Child Ever Had the Following?	N	Y	Explain with Date/Medication
ALLERGIES				Anemia/Bleeding Disorder			
Food				Sickle Cell			
Bees				Chronic Ear Infections			
Environmental				Hearing Loss			
Medication				Hearing Aid			
Eczema				Speech Concerns			
Asthma				Vision Problems (Glasses, Contacts)			
ADHD/ADD				Loss of Vision			
Behavior Concerns				Bladder/Kidney Condition			
Diabetes				Absence Kidney			
Seizure Disorder (Epilepsy)				Absence of Testicle			
Heart Murmur				Arthritis			
Cardiac Condition/Surgery				Fractures			
High/Low Blood Pressure				Scoliosis			
Fainting During Exercise				Chicken Pox/Date			
Head Injury				Surgery (Tonsils, Hernia)			
Migraine Headaches				Under Current Medical Care			

List any special medical problems or serious injuries or gym restrictions _____
Parent/Guardian Signature _____ Date _____

TROY CITY SCHOOL DISTRICT

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.

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*

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:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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:

TROY
CITY SCHOOL DISTRICT

475 First Street
Troy, New York 12180

NETWORK COMPUTING AND INTERNET SAFETY POLICY 4526

USER ACKNOWLEGEMENT

After reading the Networking Computing and Internet Safety Policy, please print and sign your name below acknowledging that you accept Policy 4526 and its terms. A copy with your User ID and Password will be issued to you when signed.

STUDENTS NAME: _____

BUILDING/SCHOOL: _____

USER'S ID NUMBER: _____

USER'S SIGNATURE: _____

PARENT'S SIGNATURE: X _____

DATE: _____

PRINCIPAL/SUPERVISOR (please print): _____

PHONE NUMBER: _____

PRINCIPAL/SUPERVISOR SIGNATURE: _____

DATE: _____

PLEASE REMOVE ACKNOWLEDGEMENT PAGE AND KEEP POLICY PORTION FOR YOUR RECORDS.

STUDENTS: **RETURN TO PRINCIPAL**
BOE Approved 2-1-12

TROY CITY SCHOOL DISTRICT

475 First Street
Troy, New York 12180

PHYSICAL EXAMINATION REQUIREMENT

Dear Parent /Guardian:

New York State Education Law requires that all children attending school in New York State have a physical examination and dental screening at the following grade levels: **Pre K, Kindergarten, 1st grade, 3rd grade, 5th grade, 7th grade, 9th grade and 11th grade, and all new students entering into the Troy City School District.**

As part of your child's education and in recognition of a desirable health practice, the annual health examinations by your health care providers continue to be encouraged. The examiner that is familiar with your child's health history is able to give a more thorough physical. They can immediately advise you regarding any condition that might be found.

If your child has had a physical in the past year or you plan to have your child examined by his/her own doctor, please have the Health Certificate filled out by the doctor and returned to school.

When we require that your child have a physical examination, we will be requesting a dental certificate as well. There is a sample certificate available for you to take to your child's dentist. Once it is completed, it should be returned to the School Nurse as it will be filed in your child's Cumulative Health Record.

Please call the school's health office if you have any questions or concerns.

Thank you for your cooperation in this health endeavor.

Please return the completed form to the Health Office of your child's school.

Carroll Hill
Phone 328-5720
Fax 274-4587

Pre-K
Phone 328-5436
Fax 271-7692

School 2
Phone 328-5620
Fax 271-5205

School 14
Phone 328-5825
Fax 274-0371

School 16
Phone 328-5120
Fax 274-4585

School 18
Phone 328-5520
Fax 274-4374

Troy Middle School
Phone 328-5323
Fax 271-5175

Troy High School
Phone 328-5425
Fax 271-5174

School 12
Home 328-5025
Fax 203-6874

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. 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.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE 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:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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 **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

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

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

TROY
CITY SCHOOL DISTRICT

Paul Reinisch, Coordinator
Health, Physical Education
Recreation, Athletics & Safety
(518) 328-5417
I.G. Racela, MD, Medical Officer
(518) 328-5425

CONSENT TO ADMINISTER MEDICATION

Dear Parent/Guardian:

A list of medications, which will be available in your school's Health Office, are listed below. Due to New York State Education Department regulations, the following medications will only be administered with your health care provider's written order and your written permission.

Please have your health care provider check the medications appropriate for your child.
Only one student per form is allowed. Each student must have this individual medication order on file.
Please return the signed completed form to the Health Office of your school.

	Comments
_____ **Acetaminophen – 325 mg – pain relief**	_____
_____ **Acetaminophen – 80 mg – liquid/chewable-pain**	_____
_____ **Antacid – liquid - relief of upset stomach**	_____
_____ **Hydrocortisone topical cream 1%**	_____
_____ **Benadryl Cream**	_____
_____ **Benzolkonium-antiseptic solution**	_____
_____ **Calamine – relieves itching**	_____
_____ **Orajel – oral pain relief**	_____
_____ **Vaseline Lotion and Ointment**	_____

Student Name_____ Date of Birth_____

School_____ Grade_____

PHYSICIAN SIGNS HERE

Health Care Provider's Signature_____ Phone#_____ Date_____

PARENT SIGNS HERE

Parent/Guardian's Signature_____ Phone#_____ Date_____

TROY
CITY SCHOOL DISTRICT

Pupil Personnel Services
Donna Fitzgerald, Director
Pupil Personnel Services

475 First Street
Troy, New York 12180

(518) 328-5006 Director's Office
(518) 328-5075 Main Office
(518) 279-7600 Fax

April 23, 2015

Dear Parents/Guardians:

The Enlarged City School District of Troy provides special education services and programs to students with disabilities pursuant to applicable federal and state laws. Any parent or person in parental relation who suspects that his/her child has a disability may refer the child for an evaluation by the District's Committee on Special Education (CSE) for eligibility for special education services and programs. More detailed information on this process is available in *A Parent's Guide to Special Education*, which is published on the New York State Education Department's website in English and Spanish.

English - http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm.

Spanish-http://www.p12.nysed.gov/specialed/publications/policy/spanishparentguide.htm

Parents or persons in parental relation should contact the District's Director of Pupil Personnel Services, Donna Fitzgerald, at School 12 475- First Street Troy, N.Y. 12180 or by calling 328-5075.

2020-2021 Community Eligibility Provision (CEP)/Provision 2 Non-base Year
Household Income Eligibility Form

The Enlarged City School District of Troy is participating in the Community Eligibility Provision (CEP) or Provision 2 in a non-base year. All children in the school will receive meals/milk at no charge regardless of household income or completion of this form. ***This form is to determine eligibility for additional State and Federal program benefits that your child(ren) may qualify for. Read the instructions on the back, complete only one form for your household, sign your name and return it to the school named above. Call 518-328-5005 if you need help.***

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

Student Name	School	Grade/Teacher	Foster Child	No Income
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

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 5, and sign the application.

Name: ______________________ CASE # ______________________

3. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box. If you have listed a foster child above, you must report their personal income.

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
	$______ /______	$______ /______	$______ /______	$______ /______	☐
	$______ /______	$______ /______	$______ /______	$______ /______	☐
	$______ /______	$______ /______	$______ /______	$______ /______	☐
	$______ /______	$______ /______	$______ /______	$______ /______	☐
	$______ /______	$______ /______	$______ /______	$______ /______	☐
	$______ /______	$______ /______	$______ /______	$______ /______	☐
	$______ /______	$______ /______	$______ /______	$______ /______	☐
	$______ /______	$______ /______	$______ /______	$______ /______	☐

4. Household Size: __________ (Include in this number: yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living in your household.)

5. Signature: An adult household member must sign this application.

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 may receive 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 Address: ______________________

Home Phone: ______________________ Work Phone: ______________________

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 Eligibility ___ Reduced Eligibility ___ Denied Eligibility

___ **Signature of Reviewing Official** ______________________

CEP/Provision 2 Non-Base Year Household Income Form INSTRUCTIONS

PART 1 — **ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE FORM FOR YOUR HOUSEHOLD.**

(1) Print the names of the children, including foster children, for whom you are applying on one form.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, and check the box for each child with no income.

PART 2 — **HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 5.**

(1) List a current SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families) or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. Do not use the 16-digit number on your benefit card. The case number is provided on your benefit letter.
(2) An adult household member must sign the form in PART 5. **SKIP PART 3 and 4** - Do not list names of household members or income if you list a SNAP, TANF or FDPIR number.

PARTS 3, 4 & 5 — **ALL OTHER HOUSEHOLDS MUST COMPLETE ALL OF PARTS 3, 4 AND 5.**

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box.** The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). In order to determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

PRIVACY ACT STATEMENT

The Enlarged City School District of Troy is committed to maintaining the privacy of our students and families and the confidentiality of sensitive personal information. The information you have provided on this form will be used only for the purpose(s) stated above and will otherwise be maintained by the District in confidence in accordance with the applicable provisions of the Federal Educational Rights and Privacy Act (FERPA) and the privacy protections of Public Officers Law section 89.