Name of School: ___________________________________
Grade: ____________________

Name of Student: _______________________________________________________________

First name __________________________ Middle name __________________________
Last name __________________________

Gender: [ ] Male [ ] Female

Date of Birth: ______/____/____
Month Day Year

Address: __________________________________________ Zip: _______

Phone: ____________________

This questionnaire is intended to help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? – Please check one box.

[ ] In 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 ____________________________________

Signature of Parent/Guardian or Student

_____________________________________

Date

[ ] 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

Name of Parent/Guardian or Student, please print

_____________________________________

Signature of Parent/Guardian or Student

_____________________________________

Date

[ ] 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

Name of Parent/Guardian or Student, please print

_____________________________________

Signature of Parent/Guardian or Student

_____________________________________

Date
I AGREE TO FOLLOW THE ATTENDANCE EXPECTATIONS OF THE TROY CITY SCHOOL DISTRICT UNIVERSAL PREKINDERGARTEN PROGRAM.

- My child will be in school each day Universal Prekindergarten is in session unless he or she is sick.
- If my child is not in attendance and is not sick, I understand that my child can be dropped from the program.
- I will send a written excuse each day my child is absent.
- If I can, I will call the Prekindergarten school/center to notify the school that my child will be absent.
- My child will be picked up at the end of the program. I will sign my child in and out each day of the program. I understand that my child may be dropped from the program by not complying.
- I understand that if I move outside the Troy City School District area, my child will no longer be able to attend the Universal Prekindergarten program. I will also notify the district that my child has moved.

X

Signature of Parent/Guardian

Date
Prekindergarten Student Registration Form

The following sites hold a Prekindergarten program in conjunction with the Troy City School District:

<table>
<thead>
<tr>
<th>School Number</th>
<th>School Name</th>
<th>Program Hours</th>
<th>Head Start Collaboration</th>
<th>Additional Paperwork Required</th>
<th>Parents Transport</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>School #2</td>
<td>7:45 – 2:00</td>
<td>Head Start collaboration</td>
<td>Additional Paperwork Required</td>
<td>Parents transport</td>
<td></td>
</tr>
<tr>
<td>470 Tenth Street</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>School #12</td>
<td>7:40 – 1:00</td>
<td>Parents transport</td>
<td>Head Start Collaboration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>475 First Street</td>
<td></td>
<td>7:45 – 2:00</td>
<td></td>
<td>Additional Paperwork Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>School #14</td>
<td>7:45 – 1:00</td>
<td>Parents transport</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1700 Tibbits Avenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEO</td>
<td>8:00 – 2:00</td>
<td>Parents Transport</td>
<td>Head Start Collaboration</td>
<td>Additional Paperwork Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fifth Avenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sacred Heart</td>
<td>1:00 – 8:00</td>
<td>Parents transport</td>
<td>Wrap-around &amp; After School Care option</td>
<td>School Uniform required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>308 Spring Avenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Wrap-around & After School Care option

School Uniform required

Parents transport

Head Start Collaboration

Additional Paperwork Required
Prekindergarten Student Registration Form

استمارة تسجيل طالب الحضانة

TROY CITY SCHOOL DISTRICT

المنطقة التعليمية لمدينة تروي

SITE REQUEST FORM

نموذج طلب الموقع

Child’s Name: __________________________________________________________

Criteria for Acceptance:

- Child must reside within the Troy City School District.
- The child must be 4 years of age on or before December 1st of the school year they are enrolling for.

Preceding this page is a list of names and addresses of the Pre K providers within the Troy City School District. The hours of operation and what options the program has is listed.

Please rank order your top 5 choices below.

1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________
4. __________________________________________________________
5. __________________________________________________________

Random Selection

New York State requires random selection of all Universal Prekindergarten programs. Applications will be accepted beginning February 22nd. Applications will be selected at random to fill the available Pre K classrooms. You will be notified by mail of your child’s placement. Every effort will be made on our part to grant you your Prekindergarten preference.

Random Selection

اختيار عشوائي

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Prekindergarten Student Registration Form

CHILD PROFILE

Child’s name ________________________________

Language(s) spoken in the home ________________________________

Is your child currently attending:

daycare _____ nursery school _____ or Head Start _____

Does your child have any special health challenges we should know about?

______________________________________________________________

Does your child have any religious dietary needs?

______________________________________________________________

Mother’s name ____________________ Age ______ education ______

Phone: Home: __________________ Cell: __________________ Work: ______________

Father’s name ____________________ Age ______ Education ______

Phone: Home: __________________ Cell: __________________ Work: ______________

Sitter’s/Day Care Name ________________________________

Address ________________________________

Phone ________________________________
Prekindergarten Student Registration Form

Please indicate the names of the people who can pick up your child at dismissal time if you are unable to do so yourself. We will not release your child to any unauthorized person. Persons who pick up your child may be asked to show identification.

I hereby give the staff at ____________________________ Pre K الروضة (name of school) permission to release my child ____________________________ to the ____________________________ (name of child)

following person(s). إلى الأشخاص المذكورين أدناه.

X

__________________________                 __________________________

Parent Signature           Date

Please Print Names of Authorized People: الرجاء كتابة أسماء المفوضين:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Relationship to Child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Parent</td>
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<td></td>
<td></td>
<td>Parent</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Prekindergarten Student Registration Form

I desire to have my child _________________________________ go with the Prekindergarten on _________________________________ go with the Prekindergarten on _________________________________ go with the Prekindergarten on (name of child) (name of child) (name of child) go with the Prekindergarten on go with the Prekindergarten on go with the Prekindergarten on

I shall be responsible for his/her actions while the class is taking the trip.

X ________________________________

Parent Signature

__________________________

Date
Prekindergarten Student Registration Form

TROY CITY SCHOOL DISTRICT

Parent Consent to Release Information

Medical Authorization Form

To Whom It May Concern:

In regard to my (Son/Daughter): ________________, 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.

______________________________
Signature of Parent/Guardian

Date

Please Print Name

امضاء الاهل/والي الأمر

يرجى كتابة الاسم

X

Printer
Home Language Questionnaire (HLQ)

<table>
<thead>
<tr>
<th>STUDENT NAME</th>
<th>الكنية الاسم الأول</th>
<th>Middle</th>
<th>الكنية الاسم الأول</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>First</td>
<td>Last</td>
<td>Middle</td>
</tr>
</tbody>
</table>

Date of Birth: تاريخت الولادة

GENDER: الجنس

- Male
- Female

Parent /Person in Parental Relation info: الوالد / الشخص في معلومات العلاقة الأبوية

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.

Language Background

(Please check all that apply)

1. What language(s) is(are) spoken in the student’s home or residence?
   - English
   - Other

2. What was the first language your child learned?
   - English
   - Other

3. What is the Home Language of each parent/guardian?
   - Mother
   - Father
   - Guardian(s)

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

5. What language(s) does your child speak?
   - English
   - Other
   - Does not speak
6. What language(s) does your child read?  
- English  
- Other (specify)  
- Does not read (specify)  

7. What language(s) does your child write?  
- English  
- Other (specify)  
- Does not write (specify)
### 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

*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?

   - [ ] special talents
   - [ ] health concerns
   - [ ] Other

---

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

---

**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:**

**NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL**

**NAME:** ____________________

**POSITION:** ____________________

**PROFICIENCY LEVEL TO CSE RECOMMENDATION:** ____________________

**DATE OF NYSITELL ADMINISTRATION:**

---

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT...
ENTERING  EMERGING
TRANSITIONING
EXPANDING  COMMANDING
Prekindergarten Student Registration Form

Number of people living in the household _____________________

Single Parent Household _______ yes _______ no

Foster Child _______ yes _______ no

Non-English Speaking Household _______ yes _______ no

Temporary Housing _______ yes _______ no

Parent/Guardian Working _______ yes _______ no

If yes, location and hours of work: 

Parent/Guardian #1 والي الأمر / الوصي رقم 1 _____________________________

Parent/Guardian #2 والي الأمر / الوصي رقم 2 _____________________________

Parent/Guardian attending school _______ yes _______ no

Parent/Guardian on Unemployment _______ yes _______ no

Is your child covered by Medicaid _______ yes _______ no
An outside approved agency may help assist with the Developmental Screenings for Troy City School District Pre K rooms. The screening is an informal assessment to identify possible developmental delays (speech, motor, educational and behavioral). Each child is seen individually by a teacher, speech therapist, or motor therapist. If any concerns do exist, a formal evaluation may be recommended. Please sign and date below for an outside approved agency to assist with your child’s screening.

Child’s Name: ________________________________

Child’s date of birth: ________________________________

Child’s Gender: Male or Female (please circle)

Parent(s) Name: ________________________________

Telephone Number: ________________________________

I give permission for my child, ________________________________, to receive a developmental screening from an out of district provider.

X

Parent or Guardian Signature: ________________________________

Date: ________________________________

التاريخ
Prekindergarten Student Registration Form

Information Sheet

What do you want your child to be called at school? ________________________

Child’s birthday (M/D/Y) ____________________________________________

Parent/Guardian Name(s) ___________________________________________

Child’s Siblings (this will help us spell their names on their artwork):

________________________________________

Family Pets: __________________________________________

Email Address: ____________________________________________

Child’s Allergies (please include food, animal or other allergies):

_________________________________________________________________

_________________________________________________________________

What are you child’s favorite snack foods? ________________________

_________________________________________________________________

_________________________________________________________________

What are your child’s interests? ________________________

_________________________________________________________________

_________________________________________________________________

What activities does your child like to do? ________________________

_________________________________________________________________

_________________________________________________________________

What are you child’s dislikes (food, activities, other)? ________________________

_________________________________________________________________

What else you would like to tell us about your child? ________________________

_________________________________________________________________

_________________________________________________________________
Please complete this form only if you OBJECT to the use of your child’s photograph or video.

Photographs and videos of our students may be used to promote programs and activities in print and online materials.

**School** ___________________ **Grade**: ____________

**Child’s Name**: __________________________________________

**Address**: ________________________________________________

**Parent/Guardian Signature**: __________________________________

**DO NOT RELEASE**: 

☐ I do NOT wish my child’s photograph to appear online on District sites or in the District print newsletter.

☐ I do NOT wish my child to be photographed or videotaped by an outside agency (such as newspaper or television media).

**NOTICE**: 

Only if you object to the release of your child’s photograph.

Note: If you do not sign below, your child’s photograph will be released as per your child’s participation in school activities.
Dear Parent/Guardian:

New York State Education Law requires that all children attending school in New York State have a physical examination 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 who are entering the Troy City School District.

As part of your child’s education and in recognition of a desirable health practice, the annual health examination by your health care providers continues 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 School
Kindergarten
Phone 328-5720
Fax 274-4587

Pre-K
Phone 328-5012
Fax 271-7692

School 16
Middle School
Phone 328-5120
Fax 274-4585

School 18
Middle School
Phone 328-5520
Fax 274-4374

School 2
Middle School
Phone 328-5620
Fax 271-5205

Troy Middle School
Phone 328-5323
Fax 271-5175

Troy High School
Secondary School
Phone 328-5425
Fax 271-5174

17
### DENTAL HEALTH CERTIFICATE - OPTIONAL

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

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Will this be your child's first visit to a dentist?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes  No</td>
</tr>
</tbody>
</table>

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

I. The Dental Health condition of _______________________________ on _________________ (date of exam) The date of the exam 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 name and address (please print or stamp) Dentist’s Signature

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

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

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

Other problems (Specify):

### III. Treatment Needs (check all that apply)

- No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
- May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
- Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.
INSERT UPDATED HEALTH FORM PAGE 1

أدخل صفحة نموذج صحي محدث 1
INSERT UPDATED HEALTH FORM PAGE 2

ادخل صفحة نموذج صحي محدث 2
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.

<table>
<thead>
<tr>
<th>Comments</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>______ Acetaminophen – 325 mg – pain relief</td>
<td>مسكن للالألم</td>
</tr>
<tr>
<td>______ Acetaminophen – 80 mg – liquid/chewable-pain</td>
<td>سائل / ألم قابل للمضغ</td>
</tr>
<tr>
<td>______ Antacid – liquid - relief of upset stomach</td>
<td>مضاد للحموضة - سائل - يزيل اضطراب المعدة</td>
</tr>
<tr>
<td>______ Hydrocortisone topical cream 1%</td>
<td>كريم موضعي هيدروكورتيزون 1%</td>
</tr>
<tr>
<td>______ Benadryl Cream</td>
<td>كريم بينادريل</td>
</tr>
<tr>
<td>______ Benzalkonium-antiseptic solution</td>
<td>محلول بنزالكونيوم المطهر</td>
</tr>
<tr>
<td>______ Calamine – relieves itching</td>
<td>كالمين - يخفف الحكة</td>
</tr>
<tr>
<td>______ Orajel – oral pain relief</td>
<td>أوراجل - لتخفيض الألم عن طريق الفم</td>
</tr>
<tr>
<td>______ Vaseline Lotion and Ointment</td>
<td>مرهم وغسول فازلين</td>
</tr>
</tbody>
</table>

Student Name ____________________________ Date of Birth ________________

Comments: ________________________________

Student Name: ____________________________ Date of Birth: __________________________

22
PHYSICIAN SIGNS HERE

Health Care Providers Signature

Phone #_________ Date ________

PARENT SIGNS HERE

Parent/Guardian Signature

Phone #_________ Date ________
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.

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.

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.

