

## Central Registration

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

## Checklist for School 12 Prekindergarten (3-year-olds) Registration Applicants

### Welcome to the Troy City School District!

Your child must be age 3 by December 1, 2022 for the 2022-2023 school year to register your child for the four-year-old Pre-Kindergarten program.

To register your child, a parent or guardian must be present with photo identification at the Central Registration Office located at School 12, 475 First Street.

Office hours are 7:30 am – 3:00 pm. During school breaks and summer, hours are 7:00 am – 2:00 pm.

All attached forms must be completed.

The following documents are also required for registration:

### Required documents checklist:

- ☐ Health Certificate signed by a doctor
- ☐ Up-to-date immunization record
- ☐ Birth Certificate
- ☐ Proof of Residency (one of the following must be provided):
  - Utility bill or deposit (dated 30 days prior to registration)
  - Lease or rental agreement
  - Mortgage statement
  - Affidavit of Residence (only applies if parent lives in a dwelling that they do not lease or own in their name. The affidavit can be found at <https://www.troycsd.org/district-services/registration>)
- ☐ Photo identification of parent/guardian
- ☐ Dental Health Certificate (optional)

**Arabic Interpreter: Nicole (518) 431-9281**

**Spanish Interpreter: Loreley (518) 416-6343**

## 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

**Your child's registration will not be complete unless you have received verification from the Central Registration Department.**

### **NYS Prekindergarten Regulations**

According to the revisited New York State Prekindergarten Regulations 151-2.6 Admission Requirements for Children:

No child may participate in the Prekindergarten program unless:

1. A report of a medical examination of the child signed by a physician is submitted with 30 days of admission which states that the child is free from contagious or communicable disease.
2. The child has been immunized to the extent appropriate to his/her age in accordance with Section 2164 of the Public Health Law; or has been granted an exemption from such immunization.

**Note:** *Pre-K for three year olds is dependent upon funding under the grant from the New York State Education Department for the 2022-2023 school year. The amount of funding received determines the number of Pre-K slots.*

**Questions?** Contact Juli Currey at (518) 328-5436 or Registration at (518) 328-5007

Fax: (518) 271-5445 Email: [reg@troycsd.org](mailto:reg@troycsd.org)

**Arabic Interpreter: Nicole (518) 431-9281**

**Spanish Interpreter Loreley (518) 416-6343**

### **PreK Locations:**

School 2 - 470 Tenth Street

School 12 - 475 First Street

Sacred Heart School - 308 Spring Avenue

**PLEASE NOTE: IF STUDENTS WANT TO CONTINUE ON TO THE 4 YEAR OLD PRE-K PROGRAM THE NEXT YEAR, IT WILL BE NECESSARY TO RE-REGISTER. STUDENTS WILL NOT AUTOMATICALLY ROLL OVER TO THE 4 YEAR OLD PROGRAM.**

Date \_\_\_\_\_

☐ Dental certificate

## Parent/Guardian Information

**Mother/Guardian:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*First Middle Initial Last*

Relationship to child: ☐ Mother ☐ Stepmother ☐ 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 ☐ Stepfather ☐ 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

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 2:** 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 (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 Second Language (ESL) 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

**Other Information:**

Has the family moved within the past three (3) years to obtain migratory employment? ☐ Yes ☐ No

\*If yes, complete Migrant Education Form located at the end of the packet.

**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, 475 First St., Troy, NY 12180

Phone: (518) 328-5007 Fax: (518) 271-5445

## Attendance Expectations

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

- My child will be in school each day 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 at school and picked up on time daily and will stay for the full Pre K 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.
- My child will be dropped off at the start of the program and picked up at the end of the program. I understand that it is important for my child to be present for the entire day and by not complying my child may be dropped from the program.
- I understand it is my responsibility to be sure to give the Pre K teacher and staff updated phone numbers.
- I understand that if I move outside the Troy City School District area, my child will no longer be able to attend the Prekindergarten program. I will also notify the district that my child has moved.

X

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

\_\_\_\_\_  
Date



## Selection Criteria

Acceptance into the Troy City School District's Prekindergarten for 3 year old program is based on need.  
Please put a check by each item that relates to your child.

Selection Criteria Troy CSD 3-year-old Pre-K		
✓	Criteria	Points
	3 years old by Dec 1, 2022	10
	Both parents employed full time	20
	Domestic Violence	25
	Drug or Alcohol Abuse	10
	Foster Child	50
	Homeless	100
	Medical Issue	15
	Receives Special Ed Services	20
	Parent Incarcerated	10
	Parent attending college	15
	Parent attending High School	20
	Parent is actively seeking employment	15
	Parent is employed full time	25
	Parent is employed part time	10
	Parent needs interpreter	10
	Parent receives disability payment	15
	SSI	100
	TANF	100
	Total Points	

## Site Request Form

Child's Name: \_\_\_\_\_

Criteria for Acceptance:

- Child must reside within the Troy City School District.
- The child must be 3 years of age on or before December 1st of the school year they are enrolling for.

**Below is a list of names and addresses of the Pre K providers for three-year olds within the Troy City School District. The hours of operation and what options the program has is listed.**

Please rank order your program site choices below.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### Prekindergarten Program Sites For Three Year Olds

1. School #2 470 Tenth Street	7:30-2:00	Head Start collaboration Additional Paperwork Required Parents transport
2. School #12 475 First Street	7:50-1:50	Head Start Collaboration Additional Paperwork Required Parents transport
3. CEO Fifth Avenue	8:00-2:00	Parents transport Head Start Collaboration Additional Paperwork Required
4. Sacred Heart School	8:00-1:00	Parent Transport Uniforms Required

### Random Selection

New York State requires random selection of all Universal Prekindergarten programs. 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.

### Additional Childcare

Wrap-around childcare is an option at some Pre K sites. This means that a parent can have the option of childcare before and/or after the Pre K day. However, the cost associated with the additional childcare is the responsibility of the parent or guardian.

## 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/Daycare

Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_

## Child Release Form

Please indicate the names of the people who can pick up your child at dismissal 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 permission to release my child  
(name of school)

\_\_\_\_\_ to the following person(s)  
(name of child)

X \_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**Please print names of authorized people:**

Name	Phone Number	Relationship to Child
		Parent
		Parent



## Walking Trip Permission Slip

I desire to have my child \_\_\_\_\_ go with the Pre-Kindergarten on all  
*(name of child)*  
walking trips the class may take from September 2022 to June 2023. I shall be responsible for his/her actions  
while the class is taking the trip.

X \_\_\_\_\_  
*Parent Signature*

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

**Parent Consent to Release Information  
Medical Authorization Form**

**To Whom It May Concern:**

In regard to my child: \_\_\_\_\_

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 my child 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 her/her condition and to safeguard their health and safety.

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Please Print Name

## School Health Services

Entering Date \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sex \_\_\_\_\_

Student Name \_\_\_\_\_ Address \_\_\_\_\_ DOB \_\_\_\_\_ Place of Birth \_\_\_\_\_

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 \_\_\_\_\_ 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.

	No	Yes	Explain with Date/Medication		No	Yes	Explain with Date/Medication
Allergies				Anemia/Bleeding Disorder			
Food				Sickle Cell			
Bees				Chronic Ear Infection			
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 of Kidney			
Seizure Disorder (Epilepsy)				Absence of Testicle			
Heart Murmur				Arthritis			
Cardiac Conditions/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: \_\_\_\_\_

## Home Language Questionnaire (HLQ)

Dear Parent or Person in Parental Relation:

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

Thank you.

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

HOME LANGUAGE CODE

--

Language Background (Please check all that apply.)			
1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	<input type="checkbox"/> Parent 2	_____ specify
	<input type="checkbox"/> Guardian(s)		_____ specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write

<b>SCHOOL DISTRICT INFORMATION:</b>	<b>STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:</b>
District Name (Number) & School: _____ Address: _____	



## Home Language Questionnaire (HLQ) Page 2

### 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: ☐ Parent ☐ 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:

## Household Survey

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 \_\_\_\_\_

Parent/Guardian #2 \_\_\_\_\_

Parent/Guardian Attending School: Yes \_\_\_\_\_ No \_\_\_\_\_

Parent/Guardian on Unemployment: Yes \_\_\_\_\_ No \_\_\_\_\_

Is your child covered by Medicaid: Yes \_\_\_\_\_ No \_\_\_\_\_

## 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 your child's favorite snack foods?

---

---

What are your child's interests?

---

---

What activities does your child like to do?

---

---

What are your child's dislikes (food, activities, other)?

---

---

Anything else you would like to tell us about your child?

---

---

## Developmental Screenings

An outside approved agency will help assist with Developmental Screenings for Troy City School District Pre-K rooms. This 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 Female Nonbinary (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

## Do Not Release Media Form

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.

DO NOT RELEASE:

☐

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

**ONLY IF YOU OBJECT** to the release of your child's photograph.

## Network Computing and Internet Safety Policy 4526

### USER ACKNOWLEDGEMENT

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.

**USER'S NAME (please print):** \_\_\_\_\_

**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.**

**Faculty/staff: return to human resources**

**Students: return to principal**

## Physical Examination Requirement

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-Kindergarten, Kindergarten, 1<sup>st</sup> grade, 3<sup>rd</sup> grade, 5<sup>th</sup> grade, 7<sup>th</sup> grade, 9<sup>th</sup> grade and 11<sup>th</sup> 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 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.**

**Pre-K**

Phone: 328-5436  
Fax: 271-7692

**School 2**

Phone: 328-5620  
Fax: 271-5205

**School 12**

Phone: 328-5025  
Fax: 203-6874

**School 14**

Phone: 328-5025  
Fax: 203-6874

**School 16**

Phone: 328-5120  
Fax: 274-4585

**School 18**

Phone: 328-5120  
Fax: 274-4585

**Carroll Hill**

Phone: 328-5720  
Fax: 274-4587

**Troy Middle School**

Phone: 328-5436  
Fax: 271-7692

**Troy High School**

Phone: 328-5425  
Fax: 271-5174

## 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first oral health assessment? <input type="checkbox"/> Yes <input type="checkbox"/> 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): \_\_\_\_\_

#### 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.



<b>REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM</b> <b>TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR</b> <b>IF AN AREA IS NOT ASSESSED INDICATE NOT DONE</b>					
<b>Note:</b> 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).					
<b>STUDENT INFORMATION</b>					
Name				Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
School:				DOB:	
				Grade:	
				Exam Date:	
<b>HEALTH HISTORY</b>					
<b>Allergies</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached			
<b>Asthma</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached			
<b>Seizures</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type:      Date of last seizure: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached			
<b>Diabetes</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached			
<b>Risk Factors for Diabetes or Pre-Diabetes:</b> <i>Consider screening for T2DM if BMI% &gt; 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.</i>					
<b>BMI</b> _____ kg/m2					
<b>Percentile (Weight Status Category):</b> <input type="checkbox"/> <5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> -49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> -84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> -94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> -98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and>					
<b>Hyperlipidemia:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Done <b>Hypertension:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Done					
<b>PHYSICAL EXAMINATION/ASSESSMENT</b>					
<b>Height:</b>		<b>Weight:</b>		<b>BP:</b>	
				<b>Pulse:</b>	
				<b>Respirations:</b>	
<b>Laboratory Testing</b>		<b>Positive</b> <b>Negative</b>		<b>Date</b>	
TB- PRN		<input type="checkbox"/>		<input type="checkbox"/>	
Sickle Cell Screen-PRN		<input type="checkbox"/>		<input type="checkbox"/>	
<b>Lead Level Required Grades Pre- K &amp; K</b>				<b>Date</b>	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ µg/dL					
<input type="checkbox"/> <b>System Review and Abnormal Findings Listed Below</b>					
<input type="checkbox"/> HEENT		<input type="checkbox"/> Lymph nodes		<input type="checkbox"/> Abdomen	
<input type="checkbox"/> Dental		<input type="checkbox"/> Cardiovascular		<input type="checkbox"/> Extremities	
<input type="checkbox"/> Neck		<input type="checkbox"/> Lungs		<input type="checkbox"/> Skin	
		<input type="checkbox"/> Genitourinary		<input type="checkbox"/> Neurological	
				<input type="checkbox"/> Speech	
				<input type="checkbox"/> Social Emotional	
				<input type="checkbox"/> Musculoskeletal	
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:				Diagnoses/Problems (list)      ICD-10 Code*	
<input type="checkbox"/> Additional Information Attached				*Required only for students with an IEP receiving Medicaid	

Name:				DOB:	
<b>SCREENINGS</b>					
<b>Vision</b> (w/correction if prescribed)	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>	
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Near Vision Acuity	20/	20/		<input type="checkbox"/>	
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>	
Notes					
<b>Hearing</b> Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				<b>Not Done</b>	
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Notes					
<b>Scoliosis</b> Screen Boys in grade 9, and Girls in grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b> <input type="checkbox"/> <b>Student is restricted from participation in:</b> <div style="margin-left: 20px;"> <input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.  <input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.  <input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track &amp; Field.  <input type="checkbox"/> <b>Other Restrictions:</b> </div>					
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level. <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V      Age of First Menses (if applicable) : _____					
<input type="checkbox"/> <b>Other Accommodations*:</b> (e.g. Brace, orthotics, insulin pump, prosthetic, 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.					
<b>MEDICATIONS</b>					
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School Attached</b>					
<b>IMMUNIZATIONS</b>					
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS					
<b>HEALTH CARE PROVIDER</b>					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form To Your Child's School When Completed.</b>					

**Pupil Personnel Services**

Donna Fitzgerald, Director  
(518) 328-5075

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 518-328-5075



## IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). 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 school 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.***

**Has anyone in your family worked or looked for work at the following occupations during the past 3 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 answered YES, please provide your contact information below:***

Parent/Guardian Name: \_\_\_\_\_

Home address: \_\_\_\_\_

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 607-436-3606, or by mail to NYS Migrant Education Program-  
Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.**