TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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

Checklist for Prekindergarten Registration Applicants

Welcome to the Troy City School District!

Your child must be age 4 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
  - Affadavit 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)

Questions? Contact Central Registration at (518) 328-5007
Fax: (518) 271-5445 Email: reg@troycsd.org

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: *Universal Pre K 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

Arabic Interpreter: Nicole (518) 431-9281
Spanish Interpreter Loreley (518) 416-6343

PreK Locations:

School 2 - 470 Tenth Street
School 12 - 475 First Street
School 14 – 1700 Tibbits Avenue
School 16 – 40 Collins Avenue
Sacred Heart School - 308 Spring Avenue
CEO – UTC – 2331 Fifth Avenue

TROY CITY SCHOOL DISTRICT

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Housing Questionnaire

Name of School:_____ Grade:_____

Name of Student:_____
Last *First* *Middle*

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

Address:_____ Zip Code:_____

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 <u>one</u> 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:_____

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

_____
Date

TROY CITY SCHOOL DISTRICT

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Student Registration Form

STUDENT NAME:_____
First *Middle* *Last*

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

Address:_____/_____/_____ NY _____
Street *Apartment/Floor* *City* *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 ☐ Nonbinary

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: _____ If applicable, what was the entry date into the USA? _____

Has the student attended school in the US ☐ 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

---

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
- ☐ Lunch Form Completed
- ☐ Birth Certificate ☐ Passport ☐ Network Form
- ☐ 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 _____

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

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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: _____

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

□ 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

TROY CITY SCHOOL DISTRICT

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Prekindergarten (4 year old) Program Sites

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

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	Parents transport Head Start Collaboration Additional Paperwork Required
3.	**School 14** 1700 Tibbits Avenue	7:45 – 1:00	Parents transport
4.	**CEO** Fifth Aveune	8:00 – 2:00	Parents transport Head Start Collaboration Additional paperwork required
5.	**Sacred Heart** 308 Spring Avenue	8:00 – 1:00	Parents transport Wrap around & after school care option School uniform required
6.	**School 16** 40 Collins Avenue	7:30 – 1:00	Parents transport

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

Site Request Form

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.

Preceeding 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.

Please rank in order your top five 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 28. 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 ot 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.

TROY CITY SCHOOL DISTRICT

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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:_____

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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

TROY CITY SCHOOL DISTRICT

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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

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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.

_____ X_____

Date Signature of Parent/Guardian

_____

Please Print Name

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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:_____

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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 writesin English, as well as prior school and personal history. Please complete thesections 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:		**GENDER:**
Month	*Day*	*Year*
		❑ 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?	❑ Parent 1 *specify*	❑ Parent 2 *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	

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

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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?

_____

_____

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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.

TROY CITY SCHOOL DISTRICT

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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.

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

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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, 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 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: ☐ 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 BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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

STUDENT INFORMATION

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

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

Percentile (Weight Status Category): ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

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

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

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

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

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

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

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

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

☐ **Student is restricted from participation in:**

☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.

☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.

☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.

☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

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

MEDICATIONS

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

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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

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

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

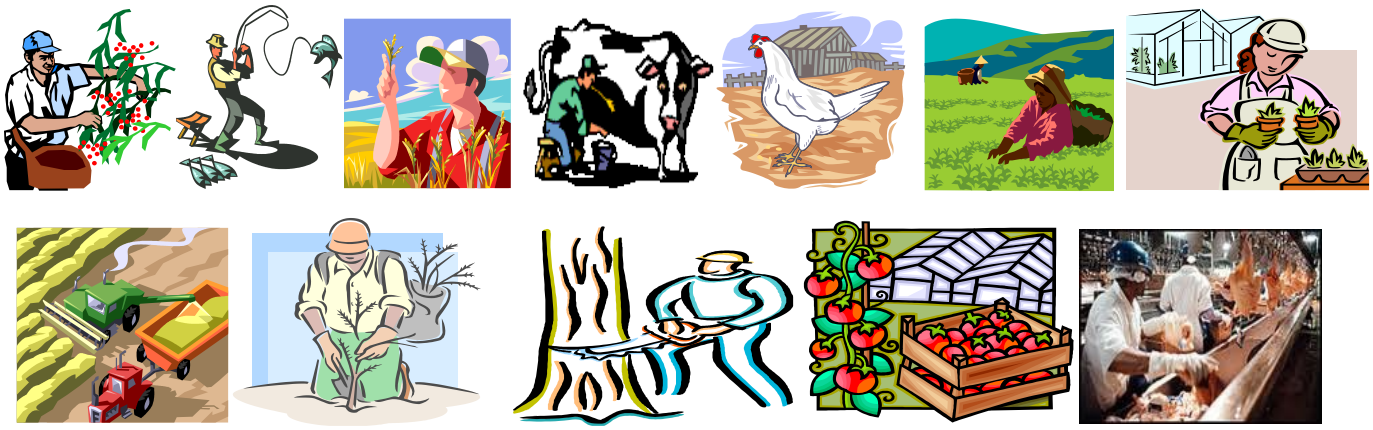
IDENTIFICATION & RECRUITMENT PARENT SURVEY

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.