Checklist for School 12 Prekindergarten (3-year-olds)

Welcome to the Troy School!

Attention Parent/Guardian: Your child must be age 3 by December 1, 2023 for the 2023-24 school year.

Please complete one Registration Packet for every child you are registering. Once you have completed the Registration Packet, please bring the packet and required documents, noted below, to the Central Registration Department.

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 a.m. – 3:00 p.m. during school. School breaks and summer office hours are 7:00 a.m - 2:00 p.m.

Required documents checklist:

1. Health Certificate signed by a doctor
2. Up-to-date immunization record
3. Birth Certificate
4. 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)
5. Photo identification of parent/guardian
6. Dental Health Certificate (optional)
NYS Prekindergarten Regulations. According to the revised 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 within 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 3 year olds is dependent upon funding under the Grant from the New York State Education Department for the 2023-2024 school year. The amount of funding received determines the number of Pre K slots.

Questions? Contact Juli 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

TROY SCHOOLS

PreK Locations:

School 2 - 470 Tenth Street
School 12 - 475 First Street
Sacred Heart School - 308 Spring Avenue
CEO- 5th Ave

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.
## Housing Questionnaire

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<th>Name of School</th>
<th>Grade</th>
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<tr>
<th>Name of Student</th>
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**Date of Birth:**

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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 _____________________________

<table>
<thead>
<tr>
<th>Name of Parent/Guardian or Student, please print</th>
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**Signature of Parent/Guardian or Student**

| _____________________________ |
| _____________________________ |

**Date**

| _____________________________ |
STUDENT REGISTRATION FORM

STUDENT NAME

_______________________ / ___________________ / ________________________________
First  /  Middle  /  Last  

Last Name of Parent/Guardian with whom student is living

_____________________________________

Address: _____________________ / ___________/________________
Street  /  Apt/Fm  /  City  /  NY  /  State  /  Zip

Household Phone Number: _____________________

Is this a cell phone:   Yes   No

What language is spoken in the student’s home: ___________

Are translation services needed:   Yes   No

Ethnicity: Is the student Hispanic, Latino, or of Spanish origin?

 Yes, Hispanic   No, not Hispanic

Race: Select one or more races from the following five racial groups

 Black   White   Asian   American Indian or Alaska Native   Native Hawaiian or other Pacific Islander

Gender:  Male: ذكر   Female: أنثى

What language does the student speak and understand the most: ___________________________

Date of Birth: _____/_____/_______ Place of Birth:

مكان الميلاد  /  City  /  State  /  Country

Has the student previously attended a school in Troy  Yes   No

If yes, what school ……………………………………………………………………………………………

Registering for Grade ……………………………………………………………………………………………

Has the student attended school in the USA  Yes   No

If yes, number of years enrolled in US schools …………………………………………………………………

Does the student have a parent/guardian on active duty in the Armed Forces?   Yes   No
NCLB  SP  Summer Serv

Office Use Only

Date: __/__/______

ID: ____________________ School Enrolled: ____________________

Home School: ____________________

Documents provided to the district:

- Photo ID
- Proof of Residency
- National Grid Bill
- Lease
- Notarized Landlord Letter
- Mortgage Statement
- Birth Certificate
- Court Papers
- Custody
- Parent/Custodial Affidavits
- Adoption
- Other: ____________________

Enrollment Exceptions:

- School Choice
- Opt In
- Wynantskill student
- Permission Rcvd
- N. Greenbush student
- Permission Rcvd
- Employee’s child – District
- Emp
- Foreign Exchange
- Tuition Paying – District
- Lunch Form Completed
- Network Form
- Immunization
- 14 Day Letter
- Religious Exemption
- Physical
- Dental certificate

Parent/Guardian Information

Mother/Guardian:

_________________________/_________/______________________________

First  Middle  Initial

Relationship to child:  Mother  Step-parent  Legal Guardian

Resides in Home:  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

Relationship to child:  Father  Step-parent  Legal Guardian

Other: ____________________
Resides in Home  ﯽ نعم  لا  ﯽ نعم  ﯽ لا  ﯽ لا
Is to receive Correspondence  ﯽ نعم  ﯽ لا
Mailing Address if different from above:

Email Address:

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

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:

Emergency Contact 2:

Emergency Contact 3:

Additional Emergency Contacts:

Address: ______________________________

Address: ______________________________

Address: ______________________________
Legal Information (If Applicable)

If parents are divorced or separated, is there a court approved custody document? □ Yes □ No
If wastewater, where has the court approval document?

Who retains legal custody of the child?

If joint, who has residential (primary physical) custody?

Legal guardianship document provided

Is the student in the care of a guardian(s) other than his/her mother or father? □ Yes □ No
If yes, name of legal guardian(s)

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
If no, please provide

Related Services

Academic Intervention Services (AIS/Remedial)

Other Services

If yes how many years of service?
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?

إذا كان طفلك يحتاج إلى تعليم خاص أو اللغة الإنجليزية كخدمات لغوية جديدة، فربما لا يذهب إلى المدرسة المنزلية. إذا كان ذلك ممكناً، فهل ترغب في أن يذهب أشقائه إلى نفس المدرسة؟

- 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 3 years to obtain migratory employment?

- Yes
- No

*If yes, complete the 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.

أشهد أن المعلومات الواردة أعلاه صحيحة وصحيفة. قد ينتج عن أي معلومات خاطئة بشأن الإقامة أن يتم محاسبتك لتغطية تكلفة التعليم و/أو الاستثناء من حضور منطقة مدارس تروي سيتي التعليمية.

**Parent or Guardian Signature**

 توقيع ولي الأمر أو الوصي

التاريخ

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) 328-5061
Prekindergarten Student Registration Form

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 dropped off at the start of the program and picked up at the end of 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 Universal Prekindergarten program.

Signature of Parent/Guardian: ____________________________
Date: ____________________
Acceptance into the Troy City School District’s Prekindergarten for the 3 year old program is based on need. Please put a check by each item that relates to your child.

<table>
<thead>
<tr>
<th>Selection Criteria</th>
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<tbody>
<tr>
<td>Troy School District- 3 year old Pre K</td>
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<tr>
<td>3 years old by December 1, 2023</td>
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<tr>
<td>Both parents employed full time</td>
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<tr>
<td>Domestic Violence</td>
</tr>
<tr>
<td>Drug or Alcohol Abuse</td>
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<tr>
<td>Foster Child</td>
</tr>
<tr>
<td>Homeless</td>
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<tr>
<td>Medical issue</td>
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<tr>
<td>Receives Special Ed. Services</td>
</tr>
<tr>
<td>Parent Incarcerated</td>
</tr>
<tr>
<td>Parent attending college</td>
</tr>
<tr>
<td>Parent attending High School</td>
</tr>
<tr>
<td>Parent is actively seeking employment</td>
</tr>
<tr>
<td>Parent is employed full time</td>
</tr>
<tr>
<td>Parent is employed part time</td>
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<tr>
<td>Parent needs interpreter</td>
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<tr>
<td>Parent receives disability payment</td>
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<td>SSI</td>
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<td>TANF</td>
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</tbody>
</table>
Prekindergarten Student Registration 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 2:00 – 7:30
   470 Tenth Street
   Head Start collaboration
   Additional Paperwork Required
   Parents transport
   School Uniform required

2. School 12: #2
   475 First Street
   2:00 – 7:50
   Parents transport
   Head Start Collaboration
   Additional Paperwork Required
   Parents transport

5. Sacred Heart
   308 Spring Avenue
   1:00 – 8:00
   Parents transport
   School Uniform 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.
Prekindergarten Student Registration Form

استمارة تسجيل طالب الحضانة

TROY CITY SCHOOL DISTRICT

المنطقة التعليمية لمدينة تروي

CHILD PROFILE

معلومات عن الطفل

Child’s name اسم الطفل__________________________________________

Language(s) spoken in the home اللغة (اللغات) التي يتم التحدث بها في المنزل________________________________________

Is your child currently attending هل يحضر طفلك حالياً:

daycare _____ nursery school _____ or Head Start_____

بداية رئيسية أو مدرسة حضانة رعاية نهارية

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

هل يعاني طفلك من أي تحديات صحية خاصة يجب أن معرفتها؟

____________________________________________________________

Does your child have any religious dietary needs؟

هل لطفلك أي احتياجات غذائية دينية؟

____________________________________________________________

Mother’s name اسم الأم________________________ Age العمر _______ education التعليم _______

Phone: Home:_____________ Cell:_____________ Work:____________

منزل الكليوي العمل

Father’s name اسم الأب________________________ Age العمر _______ Education التعليم _______

Phone: Home:_____________ Cell:_____________ Work:____________

منزل الكليوي العمل

Sitter’s/Day Care Name اسم المرشح / الرعاية النهارية____________________________________

Address عنوان____________________________________

Phone هاتف____________________________________
Prekindergarten Student Registration Form

CHILD RELEASE 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 the permission to release my child ____________________________ to the following person(s).

___________________________  ___________________________
Parent Signature  Date

Please Print Names of Authorized People

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

استمارة تسجيل طالب الحضانة

TROY CITY SCHOOL DISTRICT

المنطقة التعليمية لمدينة تروي

WALKING TRIP PERMISSION SLIP

قسيمة إذن رحلة المشي

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

all walking trips the class may take from September 20___ to June 20____.

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

Signature

Parent Signature

Date
Parent Consent to Release Information

Medical Authorization Form

To Whom It May Concern:

In regard to my (Son/Daughter): ____________________________

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

Date ____________________________

Signature of Parent/Guardian ____________________________

Please Print Name ____________________________
SCHOOL HEALTH SERVICES

Entering Date: ___________________________ Grade: ___________ School: ________________ Sex: ___________

Student Name: ___________________________ Address: ___________________________
                      Last                      First                      MI

DOB: _______________ Place of Birth: ___________________________

Mother’s Name: ___________________________ Address (if different): ___________________________ Home Phone: ___________________________
                      First                      Last                      Phone

Place of Employment: ___________________________ Phone: ___________________________

Father’s Name: ___________________________ Address (if different): ___________________________ Home Phone: ___________________________
                      First                      Last                      Phone

Place of Employment: ___________________________ Phone: ___________________________

Guardian/Step Parent Name: ___________________________ Address (if different): ___________________________ Home Phone: ___________________________
                      First                      Last                      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.

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<tr>
<th>Allergies</th>
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<th>Has your child ever had the following?</th>
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<tr>
<td><strong>Has your child ever had the</strong></td>
<td><strong>N</strong></td>
<td><strong>Y</strong></td>
<td><strong>Explain with Date/Medication</strong></td>
<td><strong>N</strong></td>
<td><strong>Y</strong></td>
<td><strong>Explain with Date/Medication</strong></td>
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<td>Allant</td>
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<td>Asthma</td>
<td>Vision Problems (Glasses, Contacts)</td>
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<td>ADHD/ADD</td>
<td>Loss of Vision</td>
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<td>Behavior Concerns</td>
<td>Bladder/Kidney Condition</td>
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<td>Diabetes</td>
<td>Absence Kidney</td>
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<td>Seizure Disorder (Epilepsy)</td>
<td>Absence of Testicle</td>
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<td>Heart Murmur</td>
<td>Arthritis</td>
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<tr>
<td>Cardiac Condition/Surgery</td>
<td>Fractures</td>
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<td>High/Low Blood Pressure</td>
<td>Scoliosis</td>
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<tr>
<td>Fainting During Exercise</td>
<td>Chicken Pox/Date</td>
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<tr>
<td>Head Injury</td>
<td>Surgery (Tonsils, Hernia)</td>
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<tr>
<td>Migraine Headaches</td>
<td>Under Current Medical Care</td>
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</tr>
</tbody>
</table>

List any special medical problems or serious injuries or gym restrictions

<table>
<thead>
<tr>
<th>Parent/Guardian Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________________</td>
<td>______</td>
</tr>
</tbody>
</table>

وضع قائمة بأي مشاكل طبية خاصة أو إصابات خطيرة أو قيود الصالة الرياضية

التوقيع ولي الأمر / الوصي

التاريخ
Home Language Questionnaire (HLQ)

**Student Name:** 

<table>
<thead>
<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
</table>

**Date of Birth:** 

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**Gender:** 

- [ ] Male
- [ ] Female

**Parent/Person in Parental Relation info:**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Relation to</th>
</tr>
</thead>
</table>

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.

**Home Language Code**

<table>
<thead>
<tr>
<th>Language Background</th>
<th>(Please check all that apply.)</th>
</tr>
</thead>
</table>

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
- Does not read

7. What language(s) does your child write?

- English
- Other
- Does not write

---

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

**School District Information:**

<table>
<thead>
<tr>
<th>District Name (Number) &amp; School Address</th>
</tr>
</thead>
</table>

**Student ID Number in NYS Student Information System:**

<table>
<thead>
<tr>
<th>Student ID Number</th>
<th>NYS Student Information System</th>
</tr>
</thead>
</table>

---

19
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.

10a. Has your child ever been referred for a special education evaluation in the past? □ No □ Yes "If yes, please complete 10b below."

10b. "If referred for an evaluation, has your child ever received any special education services in the past?"

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?

Signature of Parent or of Person in Parental Relation

Relationship to student: □ Mother □ Father □ Other □ 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: ___________________________

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: ___________________________

Proficiency Level Achieved on NYSITELL:

□ Entering □ Transitioning □ Emerging □ Commanding
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY,
ADMINISTERED IN
ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:
Prekindergarten Student Registration Form

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
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.

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

X

Parent or Guardian Signature

Date
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):
(Ashqay al-ittifal (si's'aduna dazzu fi tinjena azamanhum fi amalonymi 'alfaniya)
________________________________________________________________________
________________________________________________________________________

Family Pets ____________________________ (al-aiyinat al-alifia al-awaliyyah)

Email Address: _______________________________________________________

Child’s Allergies (please include food, animal or other allergies):
(Hassasiat al-ittifal (yurjii tismin al-tama im al-hiyan o hassasiyah al-akhir)
________________________________________________________________________
________________________________________________________________________

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)? _____________________
________________________________________________________________________
________________________________________________________________________

Anything 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.

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).

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

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).
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
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 continue to be encouraged. The examiner that is familiar with your child’s health history is able to give a more thorough physical. They can immediately advise you regarding any condition that might be found.

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

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

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

Thank you for your cooperation in this health endeavor.

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

Carroll Hill School
Phone 328-5720
Fax 274-4587

Pre-K
Phone 328-5436
Fax 271-7692

School 2
Phone 328-5620
Fax 271-5205

School 16
Phone 328-6120
Fax 274-4855

School 18
Phone 328-5520
Fax 274-4374

School 12
Home 328-5025
Fax 203-6874

School 14
Phone 328-5828
Fax 274-0371

Troy Middle School
Phone 328-5323
Fax 271-5175

Troy High School
Phone 328-5425
Fax 271-5174

Troy Community School
Phone 328-5025
Fax:328-5050
### Section 1. To be completed by Parent or Guardian (Please Print)

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>First Name</th>
<th>Last Name</th>
<th>Sex</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Male</td>
<td>/ /</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Female</td>
<td>Month Day Year</td>
</tr>
</tbody>
</table>

Will this be your child's first visit to a dentist? □ Yes □ No

### 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.

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

- [ ] 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.
**CONSENT TO ADMINISTER MEDICATION**

**الموافقة على العلاج من قبل مقدم الرعاية**

Dear Parent/Guardian

عزبي ولي الأمر / الوصي:

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.

طيف الأدوية، التي ستكون متاحة في مكتب الصحة بمدرستك، مذكورة أدناه. نظرًا للوائح وزارة التعليم في ولاية نيويورك، لن يتم إعطاء الأدوية التالية إلا بأمر مكتوب من مقدم الرعاية الصحية الخاص بك وإذن الكتفي.

Please have your health care provider check the medications appropriate for your child.

يرجى مطالبة مقدم الرعاية الصحية الخاص بك بفحص الأدوية المناسبة لطفلك.

Only one student per form is allowed. Each student must have this individual medication order on file.

نُسمح بطالب واحد فقط لكل نموذج. يجب أن يكون لكل طالب طلب الدواء الفردي هذا في الملف.

Please return the signed completed form to the Health Office of your school.

يرجى إعادة النموذج المكتمل الموقع إلى مكتب الصحة بمدرستك.

<table>
<thead>
<tr>
<th>Comments</th>
<th>تعليقات</th>
</tr>
</thead>
<tbody>
<tr>
<td>______ Acetaminophen – 325 mg – pain relief</td>
<td>مسكن للألم - 325 ملغ - مسكن</td>
</tr>
<tr>
<td>______ Acetaminophen – 80 mg – liquid/chewable-pain</td>
<td>سائل/ألبوميز للألم - 80 ملغ</td>
</tr>
<tr>
<td>______ Antacid – liquid - relief of upset stomach</td>
<td>مضاد للحموضة - سائل - يملأ الأمعاء</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 بنيزاكلوئون المطهر</td>
</tr>
<tr>
<td>______ Calamine – relieves itching</td>
<td>كالامين - يخفف الحكة</td>
</tr>
<tr>
<td>______ Orajel – oral pain relief</td>
<td>أوراجيل - لتخفيف الألم عن طريق الفم</td>
</tr>
<tr>
<td>______ Vaseline Lotion and Ointment</td>
<td>محلول وعسل فازلين</td>
</tr>
</tbody>
</table>

Student Name ___________________________ Date of Birth ___________________________

المدرسة ___________________________ الصف ___________________________

PHYSICIAN SIGNS HERE

الطبيب يوقع هنا

Health Care Providers Signature ___________________________ Date ___________________________

Phone ___________________________ # ___________________________

PARENT SIGNS HERE

والدين يوقع هنا

Parent/Guardian Signature ___________________________ Date ___________________________

Phone ___________________________ # ___________________________
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.

To provide a copy of the English and Spanish versions of the guide, please visit the following websites:


April 23, 2015