Checklist for PreKindergarten

Welcome to Troy Schools!

Registration Applicants

Your child must be age 4 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 submit 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.

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: Universal Pre K is dependent upon funding under the Troy Universal Pre K 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.

Arabic Interpreter: Nicole 518-431-9281
Spanish Interpreter: Lorely 518-416-6343

PreK Schools

School 2 – 470 Tenth Street
School 12 – 475 First Street
School 14 - 1700 Tibbits Avenue
School 16 - 40 Collins Avenue
Sacred Heart – 308 Spring Avenue
CEO – UTC -2331 Fifth Avenue
Sunnyside – 9th and Ingalls Avenue
Housing Questionnaire

Name of School: ___________________________________ Grade: __________

Name of Student: ___________________________________________________________

First          Last          Middle

Gender: ☐ Male ☐ Female

Date of Birth: ______/____/____

Address: __________________________________________ Zip: _______ Phone: __________

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

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

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

Name of Parent/Guardian or Student, please print

Signature of Parent/Guardian or Student

Date

X
STUDENT REGISTRATION FORM

STUDENT NAME:
_______________________/__________________/______________________________
First            Middle           Last

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

____________________________________

Address: __________________________
Street/Apt/Flr 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 □ Female

What language does the student speak and understand the most:

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

Has the student previously attended a school in Troy? □ Yes □ No

If yes, what school:

Registering for Grade:

Has the student attended school in the USA? □ Yes □ No

If yes, number of years enrolled in US schools:

Does the student have a parent/guardian on active duty in the Armed Forces? □ Yes □ No

Central Registration
475 First Street
Troy, New York 12180
(518) 328-5007
### Parent/Guardian Information

<table>
<thead>
<tr>
<th>Mother/Guardian</th>
<th>Father/Guardian</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First</strong></td>
<td><strong>First</strong></td>
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<td><strong>Middle Initial</strong></td>
<td><strong>Middle Initial</strong></td>
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<tr>
<td><strong>Last</strong></td>
<td><strong>Last</strong></td>
</tr>
</tbody>
</table>

#### Relationship to child
- [ ] Mother
- [ ] Step-parent
- [ ] Legal Guardian
- [ ] Foster Parent
- [ ] Other

#### Resides in Home
- [ ] Yes
- [ ] No
- [ ] Custodial Parent

#### 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: ____________________

#### Relationship to child
- [ ] Father
- [ ] Step-parent
- [ ] Legal Guardian
- [ ] Foster Parent
- [ ] Other

#### Resides in Home
- [ ] Yes
- [ ] No
- [ ] Custodial Parent

#### 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: ____________________

#### Enrollment Exceptions:
- [ ] School Choice
- [ ] opt In
- [ ] Wynantskill student
- [ ] N. Greenbush student
- [ ] Employee’s child – District
- [ ] Employee
- [ ] Tuition Paying – District
- [ ] Immunization
- [ ] 14 Day Letter
- [ ] Religious Exemption
- [ ] Physical
- [ ] Dental certificate

**Documents provided to the district:**
- [ ] Photo ID
- [ ] Proof of Residency
- [ ] National Grid Bill
- [ ] Lease
- [ ] Notarized Landlord Letter
- [ ] Mortgage Statement
- [ ] Other

**Parent/Custodial Affidavits**

**Birth Certificate**

**Passport**

**Court Papers**

**DSS 299-District**

**Custody**

**Parent/Custodial Affidavits**

**Adoption**

**Immunization**

**Religious Exemption**

**Mortgage Statement**

**opt In**

**Dental certificate**

**Adoption**

**Lease**

**Custody**

**Employee’s child**

**Permission Rcvd**

**Foreign Exchange**

**Permission Rcvd**

**NCLB**

**Summer Serv**

**Network Form**

**Office Use Only**

**Enrollment Exceptions:**

**MCKINNEY-VENTO**

**ID:** __________

**Home School:** __________

**School Enrolled:** __________

**District:** __________

**Email Address:** ____________________

**Home Phone:** (____) __________

**Mailing Address**

**Relationship to child**

**Resides in Home**

**Is to receive Correspondence**

**Mailing Address if different from above:**

**Relationship to child**

**Resides in Home**

**Is to receive Correspondence**

**Mailing Address if different from above:**

**Home Phone:** (____) __________

**Work Phone:** (____) __________

**Cell Phone:** (____) __________

**Email Address:** ____________________

**Permission Rcvd**

**NCLB**

**Summer Serv**

**Network Form**

**Office Use Only**

**Enrollment Exceptions:**

**MCKINNEY-VENTO**

**ID:** __________

**Home School:** __________

**School Enrolled:** __________

**District:** __________

**Email Address:** ____________________

**Home Phone:** (____) __________

**Mailing Address**

**Relationship to child**

**Resides in Home**

**Is to receive Correspondence**

**Mailing Address if different from above:**

**Relationship to child**

**Resides in Home**

**Is to receive Correspondence**

**Mailing Address if different from above:**

**Home Phone:** (____) __________

**Work Phone:** (____) __________

**Cell Phone:** (____) __________

**Email Address:** ____________________

**Permission Rcvd**

**NCLB**

**Summer Serv**

**Network Form**

**Office Use Only**

**Enrollment Exceptions:**

**MCKINNEY-VENTO**

**ID:** __________

**Home School:** __________

**School Enrolled:** __________

**District:** __________

**Email Address:** ____________________

**Home Phone:** (____) __________

**Mailing Address**

**Relationship to child**

**Resides in Home**

**Is to receive Correspondence**

**Mailing Address if different from above:**

**Relationship to child**

**Resides in Home**

**Is to receive Correspondence**

**Mailing Address if different from above:**

**Home Phone:** (____) __________

**Work Phone:** (____) __________

**Cell Phone:** (____) __________

**Email Address:** ____________________

**Permission Rcvd**

**NCLB**

**Summer Serv**

**Network Form**

**Office Use Only**

**Enrollment Exceptions:**

**MCKINNEY-VENTO**

**ID:** __________

**Home School:** __________

**School Enrolled:** __________

**District:** __________

**Email Address:** ____________________

**Home Phone:** (____) __________

**Mailing Address**

**Relationship to child**

**Resides in Home**

**Is to receive Correspondence**

**Mailing Address if different from above:**

**Relationship to child**

**Resides in Home**

**Is to receive Correspondence**

**Mailing Address if different from above:**

**Home Phone:** (____) __________

**Work Phone:** (____) __________

**Cell Phone:** (____) __________

**Email Address:** ____________________

**Permission Rcvd**

**NCLB**

**Summer Serv**

**Network Form**

**Office Use Only**

**Enrollment Exceptions:**

**MCKINNEY-VENTO**

**ID:** __________

**Home School:** __________

**School Enrolled:** __________

**District:** __________

**Email Address:** ____________________

**Home Phone:** (____) __________

**Mailing Address**

**Relationship to child**

**Resides in Home**

**Is to receive Correspondence**

**Mailing Address if different from above:**

**Relationship to child**

**Resides in Home**

**Is to receive Correspondence**

**Mailing Address if different from above:**

**Home Phone:** (____) __________

**Work Phone:** (____) __________

**Cell Phone:** (____) __________

**Email Address:** ____________________
Other Children Living in the Household – Please include children not of school age
الأطفال الآخرون الذين يعيشون في الأسرة - يرجى إدراج الأطفال الذين ليسوا في سن المدرسة

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.
يرجى ذكر أسماء أي وجميع الأشخاص المسموح لهم بالاتصال بطفلك أو إطلاق سراحه في حالة الطوارئ ، بما في ذلك المرض أو الإصابة الخطيرة أو الفصل المبكر من المدرسة أو حالة طوارئ الإخلاء.

**Emergency Contact 1**

Name: _______________________________ Relationship to Student: ___________________

Other than parent/guardian:  [ ]  شخص آخر غير ولي الأمر

Home Phone: (   )   Work Phone: (   )   Cell Phone: (   )

Address: _______________________________________________________

**Emergency Contact 2**

Name: _______________________________ Relationship to Student: ___________________

Other than parent/guardian:  [ ]  شخص آخر غير ولي الأمر

Home Phone: (   )   Work Phone: (   )   Cell Phone: (   )

Address: _______________________________________________________

**Emergency Contact 3**

Name: _______________________________ Relationship to Student: ___________________

Other than parent/guardian:  [ ]  شخص آخر غير ولي الأمر

Home Phone: (   )   Work Phone: (   )   Cell Phone: (   )

Address: _______________________________________________________

Additional Emergency Contacts:

____________________________________________________________________

____________________________________________________________________
If parents are divorced or separated, is there a court approved custody document?  
☐ Yes  ☐ No

Who retains legal custody of the child?  
☐ Yes  ☐ No

If yes, name of legal guardian(s) __________________________

Relationship to child __________________________

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?  
☐ Yes  ☐ No

- Academic Intervention Services (AIS/Remedial)
- Related Services
- Other, please describe ________________

District Class (BOCES or QUESTAR)  
☐ Yes  ☐ No

Other 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

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.

☐ Yes ☐ No

Parent or Guardian Signature ________________ Date ________________

Legal Information (If Applicable)  

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)  

Is the student currently having an IEP (Individualized Education Plan)?  
☐ Yes  ☐ No

Is the student in foster care?  
☐ Yes  ☐ No

Is there a court approved custody document?  
☐ Yes  ☐ No

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 or Guardian Signature ________________ Date ________________
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 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 if 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 Universal Prekindergarten program. I will also notify the district that my child has moved.

Signature of Parent/Guardian

____________________

Date

X

امضاء الأهل / ولي الأمر
Prekindergarten Student Registration Form

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 – 2:00
   Parents transport
   Head Start Collaboration
   Additional Paperwork Required
   Parents transport

3. School #14
   1700 Tibbits Avenue
   8:15 – 1:30
   Parents transport

4. CEO
   Fifth Avenue
   8:00 – 2:00
   Parents Transport
   Head Start Collaboration
   Additional Paperwork Required
   Parents transport

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

7. Sunnyside Day Care Center
   9th and Ingalls Avenue
   8:00 – 1:00
   Parents transport
   After School Care option

PREKINDERGARTEN PROGRAM SITES

المواقع التالية لديها برنامج الحضانة بالاشتراك مع مدرسة منطقة تروي:

1. المدرسة رقم 2
   470 Tenth Street
   7:30 – 2:00
   تعاون مسبق
   أوراق عمل إضافية
   النقل على الوالدين

2. المدرسة رقم 12
   475 First Street
   7:50 – 2:00
   النقل على الوالدين
   التعاون مسبق
   أوراق عمل إضافية
   النقل على الوالدين

3. المدرسة رقم 14
   1700 Tibbits Avenue
   8:15 – 1:30
   النقل على الوالدين

4. شارع خمسة
   Fifth Avenue
   8:00 – 2:00
   النقل على الوالدين
   التعاون مسبق
   أوراق عمل إضافية
   النقل على الوالدين

5. القلب المقدس
   308 Spring Avenue
   8:00 – 1:00
   النقل على الوالدين
   خيار الالتفاف والرعاية بعد المدرسة
   زي المدرسي مطلوب

6. المدرسة 16
   40 Collins Avenue
   7:30 – 1:00
   النقل على الوالدين

7. ساني سايد
   9th and Ingalls Avenue
   8:00 – 1:00
   النقل على الوالدين
   الرعاية بعد المدرسة
Child’s Name: __________________________________________________________

Criteria for Acceptance:
● Child must reside within the Troy City School District. يجب أن يقيم الطفل داخل المنطقة التعليمية لمدينة تروي
● The child must be 4 years of age on or before December 1st of the school year they are enrolling for. يجب أن يكون عمر الطفل 4 سنوات في أو قبل الأول من كانون الأول (ديسمبر) من العام الدراسي الذي يسجل فيه

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

Please rank order your top 5 choices below. يرجى ترتيب أفضل 5 اختيارات لك أدناه.

1. ______________________________________________
2. ______________________________________________
3. ______________________________________________
4. ______________________________________________
5. ______________________________________________

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

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.

Random Selection
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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.

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Prekindergarten Student Registration Form

CHILD PROFILE

Child’s name ________________________________

Language(s) spoken in the home ________________________________

Is your child currently attending:

daycare _____ nursery school_____ or Head Start____

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

______________________________________________________________

Does your child have any religious dietary needs?

______________________________________________________________

Mother’s name ___________________ Age ______ education ______
Phone: Home: __________ Cell: __________ Work: __________

Father’s name ___________________ Age ______ Education ______
Phone: Home: __________ Cell: __________ Work: __________

Sitter’s/Day Care Name __________________

Address ________________________________

Phone ________________________________
Prekindergarten Student Registration Form

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

I hereby give the staff at __________________________ (Name of school) 
permission to release my child __________________________ (Name of child) 
following person(s).  

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

Please Print Names of Authorized People:

الرجاء كتابة أسماء المفوضين:

الاسم  | رقم الهاتف | نوع القرابة |
<table>
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<td>Parent</td>
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<td>Parent</td>
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</tbody>
</table>

X

Parent Signature  Date
Prekindergarten Student Registration Form

استمارة تسجيل طالب الحضانة

TROY CITY SCHOOL DISTRICT

منطقة التعليمية لمدينة تروي

WALKING TRIP PERMISSION SLIP

قسيمة إذن رحلة المشي

I desire to have my child ____________________________ go with the Prekindergarten on ____________________________.

(roll call name of child)

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

__________________________

Parent Signature

__________________________

Date
Prekindergarten Student Registration Form
استمارة تسجيل طالب الحضانة
TROY CITY SCHOOL DISTRICT
المنطقة التعليمية لمدينة تروي

Parent Consent to Release Information
موافقة ولي الأمر على الإفصاح عن المعلومات
Medical Authorization Form
نموذج التفويض الطبي

To Whom It May Concern: 
إلى من يهمه الأمر

In regard to my (Son/Daughter): ____________________________
فيما يتعلق بـ أبني / ابنتي ____________________________
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.
حضرت أو فحست أو عالج طفلي لتزويد معلميه / موظفيها أو الموظفين ذوي الصلة بهم من (هو / هي) على اتصال يومي، مع أي وجميع المعلومات التي قد تكون ضرورية فيما يتعلق بحالته الجسدية السابقة أو الحالية والمعاملة المقدمة لذلك، إلى التأكد من أن موظفي المدرسة المذكورين على دراية كاملة بحالته / حالتها وحمايتها صحتهم وسلامتهم.

__________________________
Date 
التاريخ

X
Signature of Parent/Guardian
امضاء الأهل / ولي الأمر

__________________________
Please Print Name
يرجى كتابة الاسم
TROY CITY SCHOOL DISTRICT

SCHOOL HEALTH SERVICES

<table>
<thead>
<tr>
<th>Entering Date</th>
<th>Grade</th>
<th>School</th>
<th>Sex</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Student Name</th>
<th>Address</th>
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<table>
<thead>
<tr>
<th>DOB</th>
<th>Place of Birth</th>
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<table>
<thead>
<tr>
<th>Mother’s Name</th>
<th>Address (if different)</th>
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<table>
<thead>
<tr>
<th>Father’s Name</th>
<th>Address (if different)</th>
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<thead>
<tr>
<th>Guardian/Stepparent Name</th>
<th>Address (if different)</th>
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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.

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Explain with Date/Medication</th>
</tr>
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<tbody>
<tr>
<td>Anemia/Bleeding Disorder</td>
<td></td>
</tr>
<tr>
<td>Sickle Cell</td>
<td></td>
</tr>
<tr>
<td>Chronic Ear Infections</td>
<td></td>
</tr>
<tr>
<td>Hearing Loss</td>
<td></td>
</tr>
<tr>
<td>Speech Concerns</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>ADHD/ADD</td>
<td></td>
</tr>
<tr>
<td>Behavior Concerns</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Seizure Disorder (Epilepsy)</td>
<td></td>
</tr>
</tbody>
</table>

Has there ever been a family history of mental illness?

<table>
<thead>
<tr>
<th>N</th>
<th>Y</th>
<th>N</th>
<th>Y</th>
<th>N</th>
<th>Y</th>
<th>N</th>
<th>Y</th>
<th>N</th>
<th>Y</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
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</table>

15
<table>
<thead>
<tr>
<th>Condition</th>
<th>Arabic</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Murmur</td>
<td>تقبب في القلب</td>
<td>Arthritis</td>
</tr>
<tr>
<td>Cardiac Condition/Surgery</td>
<td>حالة / جراحة القلب</td>
<td>Fractures</td>
</tr>
<tr>
<td>High/Low Blood Pressure</td>
<td>ارتفاع / انخفاض ضغط الدم</td>
<td>Scoliosis</td>
</tr>
<tr>
<td>Fainting During Exercise</td>
<td>الإغماء أثناء التمرين</td>
<td>Chicken Pox/Date</td>
</tr>
<tr>
<td>Head Injury</td>
<td>إصابة بالرأس</td>
<td>Surgery (Tonsils, Hernia)</td>
</tr>
<tr>
<td>Migraine Headaches</td>
<td>صداع نصفي</td>
<td>Under Current Medical Care</td>
</tr>
</tbody>
</table>

List any special medical problems or serious injuries or gym restrictions

__________________________________________________________

Parent/Guardian Signature

Date

ملاحظات: ضع قائمة بأي مشاكل طبية خاصة أو إصابات خطيرة أو قيود الصالة الرياضية.
Dear Parent or Guardian:

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

Language Background
(Please check all that apply)

1. What language(s) is(are) spoken in the student's home or residence?

- English
- Other

(specify)

2. What was the first language your child learned?

- English
- Other

(specify)

3. What is the Home Language of each parent/guardian?

- Mother
- Father
- Guardian(s)

(specify)

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

- English
- Other

(specify)
5. What language(s) does your child speak? □ English □ Other (language): Specify □ Does not speak

6. What language(s) does your child read? □ English □ Other (language): Specify □ Does not read

7. What language(s) does your child write? □ English □ Other (language): Specify □ Does not write

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

SCHOOL DISTRICT INFORMATION:

Student ID number NYS student information system:

District Name (Number) & School

SCHOOL DISTRICT INFORMATION:

Date

Signature of Parent or of Person in Parental Relation

Relationship to student □ Mother □ Father □ Other

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

10a. Has your child ever been referred for a special education evaluation in the past? □ No □ Yes

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

10c. Does your child have an Individualized Education Program (IEP)? □ Yes □ No

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?

ما هي اللغة (اللغات) التي ترغب في تلقي المعلومات من المدرسة

Signature of Parent or of Person in Parental Relation

Relationship to student □ Mother □ Father □ Other

Date

التاريخ

السن

اليوم

الشهر

السنة

توفيق ولي الأمر أو الوصي

Month-Day-Year

Language of Student
# OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position:</th>
<th></th>
</tr>
</thead>
</table>

If an interpreter is provided, list name, position and credentials:

**NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position:</th>
<th></th>
</tr>
</thead>
</table>

**ORAL INTERVIEW NECESSARY:** □ No □ Yes

**DATE OF INDIVIDUAL INTERVIEW:**

<table>
<thead>
<tr>
<th>MO</th>
<th>DAY</th>
<th>YR.</th>
</tr>
</thead>
</table>

**OUTCOME OF INDIVIDUAL INTERVIEW:**

□ Administer NYSITELL

□ English proficient

□ Refer to Language Proficiency Team

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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position:</th>
<th></th>
</tr>
</thead>
</table>

**DATE OF NYSITELL ADMINISTRATION:**

□ Entering □ Emerging

**PROFICIENCY LEVEL ACHIEVED ON:**

□ Entering □ Emerging

**NYSITELL:**

□ Transferring □ Expanding □ Commanding

For students with disabilities, list accommodations, if any, administered in accordance with IEP pursuant to CSE recommendation:
Prekindergarten Student Registration Form

Number of people living in the household __________________

Single Parent Household ______ yes ______ no

Foster Child ______ yes ______ no

Non-English-Speaking Household ______ yes ______ no

Temporary Housing ______ yes ______ no

Parent/Guardian Working ______ yes ______ no

If yes, location and hours of work:

Parent/Guardian #1 __________________________________________

Parent/Guardian #2 __________________________________________

Parent/Guardian attending school ______ yes ______ no

Parent/Guardian on Unemployment ______ yes ______ no

Is your child covered by Medicaid ______ yes ______ no
DEVELOPMENTAL SCREENINGS

An outside approved agency may help assist with the Developmental Screenings for Troy City School District Pre K rooms. The screening is an informal assessment to identify possible developmental delays (speech, motor, educational and behavioral). Each child is seen individually by a teacher, speech therapist, or motor therapist. If any concerns do exist, a formal evaluation may be recommended. Please sign and date below for an outside approved agency to assist with your child’s screening.

Child’s Name: ____________________________________________

Child’s date of birth: ____________________________________________

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

Parent(s) Name: ____________________________________________

Telephone Number: ____________________________________________

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

X _____________________________

Parent or Guardian Signature

Date

التاريخ
Prekindergarten Student Registration Form

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 you child’s dislikes (food, activities, other)? __________________
_________________________________________________________________
_________________________________________________________________

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

 Conor H. Napper

Prekindergarten Enrollment Coordinator

475 First Street
Troy, New York 12180
2023-24 School Year
Return form to your school
إعاد الاستمارة إلى مدرستك

ONLY IF YOU OBJECT

لصورة طفلك التي يتم نشرها.

DO NOT RELEASE

الورقة الإعلامية

Please complete this form only if you OBJECT to the use of your child's photograph or video.
لإكمال هذا النموذج فقط إذا كنت تعترض على استخدام صورة طفلك أو مقطع فيديو.

Photographs and videos of our students may be used to promote programs and activities in print and online materials.
يمكن استخدام الصور ومقاطع الفيديو لطلابنا للترويج للبرامج والأنشطة في المواد المطبوعة وعبر الإنترنت.

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.
لا أرغب في أن يتم نشر صورة طفلي عبر الإنترنت على مواقع المنطقة أو في النشرة الإخبارية المطبوعة الخاصة بالمقاطعة.

DO NOT RELEASE:

☐ I do NOT wish my child to be photographed or videotaped by an outside agency (such as newspaper or television media).
لا أرغب في أن يتم تصوير طفلي أو تصويره بالفيديو من قبل وكالة خارجية (مثل الصحف أو وسائل الإعلام التلفزيونية).

ONLY IF YOU OBJECT

فقط إذا كنت تعترض على نشر صورة طفلك.
NETWORK COMPUTING AND INTERNET SAFETY POLICY 4526
شبكة الحوسبة وسياسة سلامة الإنترنت

USER ACKNOWLEDGEMENT
إقرار المستخدم

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.
بعد قراءة سياسة حوسبة الشبكات وأمان الإنترنت، يرجى طباعة اسمك وتوقيعك أدناه للإقرار بقبولك بقبول السياسة 4526 وشروطها. سيتم إصدار نسخة مع معرف المستخدم وكلمة المرور عند التوقيع.

USER’S NAME (please print): ____________________________________________
اسم المستخدم (يرجى طباعته)

BUILDING/SCHOOL: ________________________________
المبنى / المدرسة

USER’S ID NUMBER: ________________________________
 رقم هوية المستخدم

USER’S SIGNATURE: ________________________________________
توقيع المستخدم

PARENT’S SIGNATURE: X ________________________________________
توقيع ولي الأمر

DATE: ________________________________________________
التاريخ

PRINCIPAL/SUPERVISOR (please print): ________________________________
الرئيسي / المشرف (يرجى طباعته)

PHONE NUMBER: ________________________________________________
رقم الهاتف

PRINCIPAL/SUPERVISOR SIGNATURE: ________________________________
توقيع الرئيسي / المشرف

DATE: ________________________________________________
التاريخ

PLEASE REMOVE ACKNOWLEDGEMENT PAGE AND KEEP POLICY PORTION FOR YOUR RECORDS.
يرجى إزالة صفحة الإقرار واحتفظ بجزء السياسة لسجلاتك

FACULTY/STAFF: RETURN TO HUMAN RESOURCES
العودة إلى الموارد البشرية / الموظفين

STUDENTS: RETURN TO PRINCIPAL
العودة إلى المدرسة الرئيسية
Dear Parent /Guardian:

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

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

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

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

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

Thank you for your cooperation in this health endeavor.

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

Carroll Hill School 16
---
Pre-K School 18
---
School 2 Troy Middle School
---
School 12 Troy High School
---
School 14 Troy Community School

---

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Pre-K School 18
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School 2 Troy Middle School
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Carroll Hill School 16
---
Pre-K School 18
---
School 2 Troy Middle School
---
School 12 Troy High School
---
School 14 Troy Community School

---
DENTAL HEALTH CERTIFICATE - OPTIONAL

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started school, ask your dentist 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)**

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

School Name: __________________________

School Entry, K, 2, 4, 7, & 10.

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

**Parent's Signature**: __________________________

**Date**: __________________________

**Section 2. To be completed by the Dentist**

I. The Dental Health condition of _______________________________ on __________ (date of exam)

The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

- □ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.
- □ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

**Note**: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

**Dentist’s name and address (please print or stamp)**

**Dentist’s Signature**: __________________________

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

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

- □ Yes 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.
# HEALTH CERTIFICATE

## 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

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex: □ M □ F</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Exam Date:</td>
</tr>
</tbody>
</table>

### HEALTH HISTORY

<table>
<thead>
<tr>
<th>Allergies</th>
<th>□ No</th>
<th>□ Yes, Indicate Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Medication/Treatment Order Attached</td>
<td>□ Anaphylaxis Care Plan Attached</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Asthma</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Intermittent</td>
<td>□ Persistent</td>
</tr>
<tr>
<td>□ Medication/Treatment Order Attached</td>
<td>□ Asthma Care Plan Attached</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Seizures</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes, Indicate Type</td>
<td></td>
</tr>
<tr>
<td>□ Medication/Treatment Order Attached</td>
<td>□ Seizure Care Plan Attached</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diabetes</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes, Indicate Type</td>
<td></td>
</tr>
<tr>
<td>□ Medication/Treatment Order Attached</td>
<td>□ Diabetes Medical Mgmt. Plan Attached</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>BMI kg/m2</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Hyperlipidemia:</th>
<th>□ No</th>
<th>□ Yes</th>
<th>□ Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension:</td>
<td>□ No</td>
<td>□ Yes</td>
<td>□ Not Done</td>
</tr>
</tbody>
</table>

### PHYSICAL EXAMINATION/ASSESSMENT

<table>
<thead>
<tr>
<th>Height:</th>
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<th>BP:</th>
<th>Pulse:</th>
<th>Respiration:</th>
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</thead>
<tbody>
<tr>
<td>Laboratory Testing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>Negative</td>
<td>Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TB-PRN</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sickle Cell Screen-PRN</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Lead Level Required Grades Pre-K &amp; K</th>
<th>Date</th>
</tr>
</thead>
</table>

| □ Test Done | □ Lead Elevated >5 μg/dL |

| □ System Review and Abnormal Findings Listed Below |

<table>
<thead>
<tr>
<th>HEENT</th>
<th>□ Lymph nodes</th>
<th>□ Abdomen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>□ Cardiovascular</td>
<td>□ Back/Spine</td>
</tr>
<tr>
<td>Neck</td>
<td>□ Lungs</td>
<td>□ Genitourinary</td>
</tr>
</tbody>
</table>

| □ Assessment/Abnormalities Noted/Recommendations: |
| Diagnoses/Problems (list) | ICD-10 Code* |

| □ Additional Information Attached |

*Required only for students with an IEP receiving Medicaid
### SCREENINGS

<table>
<thead>
<tr>
<th>Vision (w/correction if prescribed)</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
<td>20/</td>
<td>□ Yes □ No</td>
<td>□</td>
</tr>
<tr>
<td>Near Vision Acuity</td>
<td>20/</td>
<td>20/</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Color Perception Screening</td>
<td>□ Pass □ Fail</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Pure Tone Screening</th>
<th>Right □ Pass □ Fail</th>
<th>Left □ Pass □ Fail</th>
<th>Referral □ Yes □ No</th>
<th>Not Done</th>
</tr>
</thead>
</table>

**Notes**

- Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7

### 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.
  - □ Other Restrictions:

- Developmental Stage for Athletic Placement Process **ONLY 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 Menstrual Cycle (if applicable): ____________

- □ Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggles, 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 NYSIS

### 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.*
CONSENT TO ADMINISTER MEDICATION
الموافقة على العلاج من قبل مقدم الرعاية

Dear Parent/Guardian
عزيزي 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.

قائمة 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 الكتابي.

Please have your health care provider check the medications appropriate for your child.
يرجى مطالبة مقدم الرعاية الصحي الخاص بك بفحص الأدوية المناسبة لطفلك.

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

Comments
تعليقات

____________________

_____ Acetaminophen – 325 mg – pain relief
مسكن للآلام - 325 ملغ - مسكن للآلام

_____ Acetaminophen – 80 mg – liquid/chewable-pain
سائل / ألم قابل للمضغ - 80 ملغ - مسكن للآلام

_____ Antacid – liquid - relief of upset stomach
مضاد للحموضة - سائل - يزيل اضطراب المعدة

_____ Hydrocortisone topical cream 1%
كريم موضعي هيدروكورتيزون 1%

_____ Benadryl Cream
كريم بينادريل

_____ Benzalkonium-antiseptic solution
محلول بنزالكينيون المطهر

_____ Calamine – relieves itching
كالامين - يخفف الحكة

____________________
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.

امتحان الأهل والأوصياء الأعزاء

توفر دائرة مدارس المدينة الموسعة في تروي خدمات وبرامج تعليمية خاصة للطلاب ذوي الإعاقة وفقًا للقوانين الفيدرالية وقوانين الولاية المعمول بها. يجوز لأي والد أو شخص على علاقة أبوية يشتبه في أن طفله / طفلها لديه إعاقة إحالة الطفل لجاهزات ل欢迎您 لROUGH L OASE PEOPLE'SPECTED التعليم الخاص للاهلية للحصول على خدمات وبرامج التعليم الخاص. يتوفر المزيد من المعلومات التفصيلية حول هذه العملية في دليل الوالدين للتعليم الخاص، والذي يتم نشره على موقع الويب الخاص بوزارة التعليم بولاية نيويورك باللغتين الإنجليزية والإسبانية


يجب على الوالدين أو الأشخاص الذين تربطهم علاقة أبوية الاتصال بمدير خدمات شؤون الموظفين بالمنطقة، دونا فيتزجيرالد، في المدرسة ٢١ على الرقم أعلاه.
Acceptance into the Troy City School District’s Prekindergarten for 4 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>
<th>معيار الاختيار</th>
<th>Point</th>
<th>النقط</th>
</tr>
</thead>
<tbody>
<tr>
<td>Troy School District- 4-year-old Pre K</td>
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<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Criteria</th>
<th>معايير</th>
<th>Point</th>
<th>النقط</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ 4 years old by December 1, 2023 4 سنوات بحلول 1 ديسمبر 2023</td>
<td>✔ سنوات بحلول 1 ديسمبر 2023</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Both parents employed full time كلا الوالدين يعملان بدوام كامل</td>
<td>كلا الوالدين يعملان بدوام كامل</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Domestic Violence العنف المنزلي</td>
<td>العنف المنزلي</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Drug or Alcohol Abuse تعاطي المخدرات أو الكحول</td>
<td>تعاطي المخدرات أو الكحول</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Foster Child ولد في التبني</td>
<td>ولد في التبني</td>
<td>50</td>
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<tr>
<td>Homeless بلا مأوى</td>
<td>بلا مأوى</td>
<td>100</td>
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<tr>
<td>Medical issue مشاكل صحية</td>
<td>مشاكل صحية</td>
<td>15</td>
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<tr>
<td>Receives Special Ed. Services يتلقى التعليم الخاصة</td>
<td>يتلقى التعليم الخاصة</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Parent Incarcerated خدمات الوالد المسجون</td>
<td>خدمات الوالد المسجون</td>
<td>10</td>
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</tr>
<tr>
<td>Parent attending college حضور ولي الأمر في الكلية</td>
<td>حضور ولي الأمر في الكلية</td>
<td>15</td>
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</tr>
<tr>
<td>Parent attending High School أحد الوالدين في المدرسة الثانوية</td>
<td>أحد الوالدين في المدرسة الثانوية</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Parent is actively seeking employmentوالد يسعى بنشاط للحصول على عمل</td>
<td>والد يسعى بنشاط للحصول على عمل</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Parent is employed full time الوالد يعمل بدوام كامل</td>
<td>الوالد يعمل بدوام كامل</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Parent is employed part time الوالد يعمل بدوام جزئي</td>
<td>الوالد يعمل بدوام جزئي</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Parent needs interpreter الوالد يحتاج إلى مترجم</td>
<td>الوالد يحتاج إلى مترجم</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Parent receives disability payment الوالد يتلقى مقدعات العجز</td>
<td>الوالد يتلقى مقدعات العجز</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>SSI</td>
<td>SSI</td>
<td>100</td>
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</tr>
<tr>
<td>TANF</td>
<td>TANF</td>
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</tr>
<tr>
<td>SNAP</td>
<td>SNAP</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>CPS Involvement مركز حماية الطفل</td>
<td>مركز حماية الطفل</td>
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<td></td>
</tr>
<tr>
<td>Total Points مجموع النقاط</td>
<td>مجموع النقاط</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 answer YES, please provide your contact information below:
إذا أجبت بنعم، فيرجى تقديم معلومات الاتصال الخاصة بك أدناه

Parent/Guardian Name
اسم ولي الأمر / الوصي:

Home address
عنوان المنزل:

Telephone number
رقم الهاتف: (______) _______ ______

Best time to be reached
أفضل وقت للوصول: ______ AM/PM

Previous Address
العنوان السابق:

Student name
اسم الطالب: ___________________________ Age _________ Grade ________

Student name
اسم الطالب: ___________________________ 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.

لإرسال هذه الإحالة، يرجى إرسال فاكس إلى الرقم أعلاه أو بالبريد إلى مكتب تحديد وتوظيف برنامج تعليم المهاجرين في نيويورك على العنوان أعلاه.