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

Welcome to Troy Schools!

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) 328-5061 Email: reg@troycsd.org

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

**TROY SCHOOLS**

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

**PLEASE NOTE, IF STUDENTS WANT TO CONTINUE ON TO THE 4 YEAR OLD PK 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

Name of School: ___________________________ Grade: _________

Name of Student: _______________________________________________________________

Last    First    Middle

Gender: □ Male  □ Female  □ Non Binary Date of Birth: _____/____/_____

Month     Day     Year

Address: ____________________________ Zip: _______ Phone: _______________

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

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

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

_____________________________________  X  ____________________________________
Name of Parent/Guardian or Student, please print  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: _______________________________/ ____________/________________   NY   ______________

Street       Apt/Flr       City                     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 □ Non Binary 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

Did the student take any final High School level exam(s) out of state while his/her guardian was in the military? ____

□ NCLB   □ SP   □ Summer Serv

Office Use Only          Date: _____/_____/_______

ID: ________________   Home School: ________________ School Enrolled: ________________

Documents provided to the district:

□ Photo ID

□ Proof of Residency

□ National Grid Bill

□ Lease

□ Notarized Landlord Letter

□ Mortgage Statement

□ Other __________________

□ MCKINNEY-VENTO

□ Birth Certificate          □ Passport

□ Court Papers

□ DSS 299-District__________

□ Custody

□ Parent/Custodial Affidavits

□ Adoption

Enrollment Exceptions:

□ School Choice           □ Opt In

□ Wynantskill student    □ Permission Rcvd

□ N. Greenbush student   □ Permission Rcvd

□ Employee’s child – District__________ □ Emp ID

□ Foreign Exchange

□ Tuition Paying – District

□ Lunch Form Completed

□ Network Form

□ Immunization            □ 14 Day Letter

□ Religious Exemption

□ Physical

□ Dental certificate
Parent/Guardian Information

Mother/Guardian: ___________________________ / ___________/ ______________________________
First                          Middle Initial                        Last

Relationship to child: □ Mother  □ Step-parent  □ Legal Guardian  □ Foster Parent  □ Other__________________________

Resides in Home  □ Yes  □ No  Custodial Parent  □ Yes  □ No  Is to receive Correspondence  □ Yes  □ No

Mailing Address if different from above: ___________________________ / ___________/ ______________________________
Street                Apt/Flr               City                        State             Zip

Home Phone: (____) ______________ Work Phone: (____) ______________ Cell Phone: (____) _______________

Email Address: ___________________________ Phone call priority (1-3): Home_____ Work_____ Cell_____

Father/Guardian: ___________________________ / ___________/ ______________________________
First                          Middle Initial                        Last

Relationship to child: □ Father  □ Step-parent  □ Legal Guardian  □ Foster Parent  □ Other__________________________

Resides in Home  □ Yes  □ No  Custodial Parent  □ Yes  □ No  Is to receive Correspondence  □ Yes  □ No

Mailing Address if different from above: ___________________________ / ___________/ ______________________________
Street                Apt/Flr               City                        State             Zip

Home Phone: (____) ______________ Work Phone: (____) ______________ Cell Phone: (____) _______________

Email Address: ___________________________ Phone call priority (1-3): Home_____ Work_____ Cell_____

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

Name: ___________________________________________ Date of Birth: _____/_______/______
Gender: □ Male  □ Female  Past Registrant  □ Yes  □ No

Name: ___________________________________________ Date of Birth: _____/_______/______
Gender: □ Male  □ Female  Past Registrant  □ Yes  □ No
Please list the names of ANY and ALL persons Troy City School District is allowed to contact or release your child to in case of an emergency, including illness, serious injury, early dismissal of school or an evacuation emergency.

**Emergency Contact 1:**
Name: ________________________  Relationship to Student: ____________________  
Other than parent/guardian
Home Phone: (   _    ) ______________  Work Phone: (   _    ) ______________  Cell Phone: (   _    ) ______________
Address: _________________________________________________________

**Emergency Contact 2:**
Name: ________________________  Relationship to Student: ____________________  
Other than parent/guardian
Home Phone: (   _    ) ______________  Work Phone: (   _    ) ______________  Cell Phone: (   _    ) ______________
Address: _________________________________________________________

**Emergency Contact 3:**
Name: ________________________  Relationship to Student: ____________________  
Other than parent/guardian
Home Phone: (   _    ) ______________  Work Phone: (   _    ) ______________  Cell Phone: (   _    ) ______________
Address: _________________________________________________________

**Additional Emergency Contacts:** ___________________________________________________________
Legal Information (If Applicable)
If parents are divorced or separated, is there a court approved custody document? ☐ Yes ☐ No
Who retains legal custody? _____________________________ Relationship to child _______________________
☐ Legal guardianship document provided

Is the student in the care of a guardian(s) other than his/her mother or father? ☐ Yes ☐ No
If yes, name of legal guardian(s) _____________________________ Relationship to child _______________________

Is the student in foster care? ☐ Yes ☐ No
If yes, please provide copy of placement order (DSS-2999)

Additional Services (If Applicable)

Special Education Services
Does the student currently have an IEP (Individualized Education Plan) ☐ Yes ☐ No
Does your child receive any of the following type of services?
☐ Consultant Teacher ☐ Self-Contained Classroom ☐ Resource Room
☐ Out of District Class (BOCES or QUESTAR) ☐ Yes ☐ No

Related Services
☐ Speech and Language Therapy ☐ Occupational Therapy ☐ Physical Therapy
☐ Counseling ☐ Other, please describe ____________________________

Academic Intervention Services (AIS/Remedial)
☐ Math ☐ English Language Arts ☐ Science ☐ Social Studies

Other Services
☐ 504 Plan
☐ English as a New Language (ENL) If yes how many years of service? _________
☐ Other ____________________________

If your child requires special education or English as a new language services, he or she may not be attending their home school. If it is feasible, do you wish for siblings to attend the same school? ☐ YES ☐ NO

IF REGISTERING FOR PREK –Is or will your child be receiving Summer Service this year? ☐ Yes ☐ No

Other Information
Has the family moved within past 3 years to obtain migratory employment? _______ Yes _______ No
● If yes, complete Migrant Education Form located at the end of the packet.

Parent Statement:
I certify that the above information is true and correct. Any misinformation regarding residency may result in being billed to cover the cost of instruction and/or exclusion from attending the Troy City School District.

Parent or Guardian Signature
X _____________________________ Date _______________

All documents are to be returned to:
Troy City School District Central Registration Office
School 12 475 First St., Troy, NY 12180
Phone: (518) 328-5007 Fax: (518) 328-5061
Prekindergarten Student Registration Form
TROY CITY SCHOOL DISTRICT

Attendance Expectations

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

- My child will be in school each day Prekindergarten is in session unless he or she is sick.

- If my child is not in attendance and is not sick, I understand that my child can be dropped from the program.

- I will send a written excuse each day my child is absent.

- If I can, I will call the Prekindergarten school/center to notify the school that my child will be absent.

- My child will be at school and picked up on time daily and will stay for the full Pre K program. I will sign my child in and out each day of the program. I understand that my child may be dropped from the program by not complying.

- My child will be dropped off at the start of the program and picked up at the end of the program. I understand that it is important for my child to be present for the entire day and by not complying my child may be dropped from the program.

- I understand it is my responsibility to be sure to give the Pre K teacher and staff updated phone numbers.

- I understand that if I move outside the Troy City School District area, my child will no longer be able to attend the Prekindergarten program. I will also notify the district that my child has moved.

X

Signature of Parent/Guardian

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 years old by December 1, 2023</td>
<td>10</td>
</tr>
<tr>
<td>Both parents employed full time</td>
<td>20</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>25</td>
</tr>
<tr>
<td>Drug or Alcohol Abuse</td>
<td>10</td>
</tr>
<tr>
<td>Foster Child</td>
<td>50</td>
</tr>
<tr>
<td>Homeless</td>
<td>100</td>
</tr>
<tr>
<td>Medical issue</td>
<td>15</td>
</tr>
<tr>
<td>Receives Special Ed. Services</td>
<td>20</td>
</tr>
<tr>
<td>Parent Incarcerated</td>
<td>10</td>
</tr>
<tr>
<td>Parent attending college</td>
<td>15</td>
</tr>
<tr>
<td>Parent attending High School</td>
<td>20</td>
</tr>
<tr>
<td>Parent is actively seeking employment</td>
<td>15</td>
</tr>
<tr>
<td>Parent is employed full time</td>
<td>25</td>
</tr>
<tr>
<td>Parent is employed part time</td>
<td>10</td>
</tr>
<tr>
<td>Parent needs interpreter</td>
<td>10</td>
</tr>
<tr>
<td>Parent receives disability payment</td>
<td>15</td>
</tr>
<tr>
<td>SSI</td>
<td>100</td>
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<tr>
<td>TANF</td>
<td>100</td>
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<tr>
<td>SNAP</td>
<td>100</td>
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<tr>
<td>CPS Involvement</td>
<td></td>
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<tr>
<td>Total Points</td>
<td></td>
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</tbody>
</table>
Prekindergarten Student Registration Form
TROY CITY SCHOOL DISTRICT
SITE REQUEST FORM

Child’s Name: __________________________________________________________

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

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

Please rank order your program site choices below.

1. ________________________________________________________________
2. ________________________________________________________________
3. ________________________________________________________________

PREKINDERGARTEN PROGRAM SITES FOR THREE YEAR OLDS

1. School #2 7:30 – 2:00
   470 Tenth Street
   Head Start collaboration
   Additional Paperwork Required
   Parents transport

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

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

4. Sacred Heart School 8:00 – 1:00
   Parent Transport
   Uniforms Required

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

Additional Childcare
Wrap-around childcare is an option at some Pre K sites. This means that a parent can have the option of childcare before and/or after the Pre K day. However, the cost associated with the additional childcare is the responsibility of the parent or guardian.
Prekindergarten Student Registration Form
TROY CITY SCHOOL DISTRICT

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
TROY CITY SCHOOL DISTRICT

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 permission to release my child ________________________ to the following person(s).

X

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>
<tr>
<td></td>
<td></td>
<td>Parent</td>
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<td>Parent</td>
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<td>Parent</td>
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</tbody>
</table>
WALKING TRIP PERMISSION SLIP

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

X__________________________
Parent Signature

__________________________
Date
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

X _______________________________________
Signature of Parent/Guardian

________________________________________
Please Print Name
**TROY CITY SCHOOL DISTRICT**

**SCHOOL HEALTH SERVICES**

<table>
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<tr>
<th>Entering Date</th>
<th>Grade</th>
<th>School</th>
<th>Sex</th>
</tr>
</thead>
</table>

**Student Name:** ____________________________________________  **Address:** ____________________________  **DOB:** ____________  **Place of Birth:** ____________

**Last** | **First** | **MI**

**Mother’s Name:** ____________________________________________  **Address (if different):** ____________________________  **Home Phone:** ____________  **Cell Phone:** ____________

**Father’s Name:** ____________________________________________  **Address (if different):** ____________________________  **Home Phone:** ____________  **Cell Phone:** ____________

**Guardian/Step Parent Name:** ____________________________  **Address (if different):** ____________________________  **Home Phone:** ____________  **Cell Phone:** ____________

**Place of Employment:** ____________________________________________  **Phone:** ____________

The answers to the questions on this form will be held in the School Health Office and will be kept confidential.

Has your child ever had the following? Please explain with date of onset, any “yes” answers.

<table>
<thead>
<tr>
<th>Has Your Child Ever Had the Following?</th>
<th>N</th>
<th>Y</th>
<th>Explain with Date/Medication</th>
<th>Has Your Child Ever Had the Following?</th>
<th>N</th>
<th>Y</th>
<th>Explain with Date/Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALLERGIES</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>Anemia/Bleeding Disorder</strong></td>
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<tr>
<td>Food</td>
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<td><strong>Sickle Cell</strong></td>
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<tr>
<td>Bees</td>
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<td></td>
<td><strong>Chronic Ear Infections</strong></td>
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<tr>
<td>Environmental</td>
<td></td>
<td></td>
<td></td>
<td><strong>Hearing Loss</strong></td>
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<tr>
<td>Medication</td>
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<td></td>
<td><strong>Hearing Aid</strong></td>
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<tr>
<td>Eczema</td>
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<td></td>
<td><strong>Speech Concerns</strong></td>
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<tr>
<td>Asthma</td>
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<td></td>
<td></td>
<td><strong>Vision Problems</strong></td>
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<tr>
<td>(Glasses, Contacts)</td>
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<td><strong>Loss of Vision</strong></td>
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<tr>
<td>ADHD/ADD</td>
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<td></td>
<td><strong>Bladder/Kidney Condition</strong></td>
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<tr>
<td>Behavior Concerns</td>
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<td></td>
<td><strong>Absence Kidney</strong></td>
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<tr>
<td>Diabetes</td>
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<td></td>
<td><strong>Absence of Testicle</strong></td>
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<tr>
<td>Seizure Disorder (Epilepsy)</td>
<td></td>
<td></td>
<td></td>
<td><strong>Arthritis</strong></td>
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<tr>
<td>Heart Murmur</td>
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<td></td>
<td><strong>Fractures</strong></td>
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<td></td>
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<tr>
<td>Cardiac Condition/Surgery</td>
<td></td>
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<td></td>
<td><strong>Scoliosis</strong></td>
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<tr>
<td>High/Low Blood Pressure</td>
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<td><strong>Chicken Pox/Date</strong></td>
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<tr>
<td>Fainting During Exercise</td>
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<td></td>
<td><strong>Surgery (Tonsils, Hernia)</strong></td>
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<td></td>
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<tr>
<td>Head Injury</td>
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<td><strong>Under Current Medical Care</strong></td>
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<tr>
<td>Migraine Headaches</td>
<td></td>
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<td><strong>Date</strong></td>
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</tr>
</tbody>
</table>

List any special medical problems or serious injuries or gym restrictions ____________________________________________

**Parent/Guardian Signature** ____________________________________________  **Date** ____________________________
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.

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### Home Language Questionnaire (HLQ)

<table>
<thead>
<tr>
<th>S T U D E N T N A M E :</th>
</tr>
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<tbody>
<tr>
<td>First</td>
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<table>
<thead>
<tr>
<th>D A T E O F B I R T H :</th>
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<tbody>
<tr>
<td>Month</td>
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</table>

<table>
<thead>
<tr>
<th>G E N D E R :</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Male</td>
</tr>
<tr>
<td>❑ Female</td>
</tr>
<tr>
<td>❑ Non Binary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>P A R E N T / P E R S O N I N P A R E N T A L R E L AT I O N I N F O :</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
</tr>
</tbody>
</table>

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### 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
   specify
   ❑ Father
   specify
   ❑ Guardian(s)
   specify

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

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

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

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

---

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

<table>
<thead>
<tr>
<th>S C H O O L D I S T R I C T I N F O R M A T I O N :</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Name (Number) &amp; School</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S T U D E N T I D N U M B E R I N N Y S S T U D E N T I N F O R M A T I O N S Y S T E M :</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student ID Number</td>
</tr>
<tr>
<td>Address</td>
</tr>
</tbody>
</table>

---

[16]
## 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.
   
<table>
<thead>
<tr>
<th>Yes*</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

   *If yes, please explain: __________________________

   How severe do you think these difficulties are?  ☐ Minor  ☐ Somewhat severe  ☐ Very severe

10a. Has your child ever been referred for a special education evaluation in the past?  ☐ No  ☐ Yes*  *Please complete 10b below

10b. *If referred for an evaluation, has your child ever received any special education services in the past?  
   
<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

   Type of services received: __________________________

   Age at which services received (Please check all that apply):

<table>
<thead>
<tr>
<th>Birth to 3 years (Early Intervention)</th>
<th>3 to 5 years (Special Education)</th>
<th>6 years or older (Special Education)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

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

   __________________________

   Signature of Parent or of Person in Parental Relation  Date

   Relationship to student:  ☐ Mother  ☐ Father  ☐ Other: __________________________
Prekindergarten Student Registration Form
TROY CITY SCHOOL DISTRICT

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
DEVELOPMENTAL SCREENINGS

An outside approved agency will 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
Prekindergarten Student Registration Form
TROY CITY SCHOOL DISTRICT

Information Sheet

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

Child’s birthday (M/D/Y):_____________________________________________

Parent/Guardian Name(s):_____________________________________________

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

________________________________________________________________
________________________________________________________________

Family Pets: ________________________________________________________

Email Address: _____________________________________________________

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

________________________________________________________________
________________________________________________________________

What are you child’s favorite snack foods?

________________________________________________________________
________________________________________________________________

What are your child’s interests?

________________________________________________________________
________________________________________________________________

What activities does your child like to do?

________________________________________________________________
________________________________________________________________

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

________________________________________________________________
________________________________________________________________

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

________________________________________________________________
________________________________________________________________

________________________________________________________________

________________________________________________________________
DO NOT RELEASE
MEDIA FORM

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

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

School __________     Grade:     ______________

Child’s Name: ___________________________________________________

Address: _______________________________________________________

Parent/Guardian Signature: _______________________________________

DO NOT RELEASE:

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

DO NOT RELEASE:

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

ONLY IF YOU OBJECT to the release of your child’s photograph.
NETWORK COMPUTING AND
INTERNET SAFETY POLICY 4526

USER ACKNOWLEDGEMENT
After reading the Networking Computing and Internet Safety Policy, please print and sign your name below acknowledging that you accept Policy 4526 and its terms. A copy with your User ID and Password will be issued to you when signed.

USER’S NAME (please print):
______________________________________

BUILDING/SCHOOL: ________________________________________

USER’S ID NUMBER: _______________________________________

USER’S SIGNATURE: ________________________________________

PARENT’S SIGNATURE: X _____________________________________

DATE: _____________________________________________________

PRINCIPAL/SUPERVISOR (please print): _________________________

PHONE NUMBER: ___________________________________________

PRINCIPAL/SUPERVISOR SIGNATURE: _________________________

DATE: _____________________________________________________

PLEASE REMOVE ACKNOWLEDGEMENT PAGE AND
KEEP POLICY PORTION FOR YOUR RECORDS.

FACULTY/STAFF: RETURN TO HUMAN RESOURCES
STUDENTS: RETURN TO PRINCIPAL

BOE Approved 2-1-12
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.

<table>
<thead>
<tr>
<th>Carroll Hill</th>
<th>School 16</th>
<th>School 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 328-5720</td>
<td>Phone 328-5120</td>
<td>Phone 328-5025</td>
</tr>
<tr>
<td>Fax 274-4587</td>
<td>Fax 328-5146</td>
<td>Fax 203-6874</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-K</th>
<th>School 18</th>
<th>Troy Community School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 328-5012</td>
<td>Phone 328-5520</td>
<td>Phone: 328-5025</td>
</tr>
<tr>
<td>Fax 328-5061</td>
<td>Fax 274-4585</td>
<td>Fax:328-5050</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School 2</th>
<th>Troy Middle School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 328-5620</td>
<td>Phone 328-5323</td>
</tr>
<tr>
<td>Fax 271-5205</td>
<td>Fax 271-5175</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School 14</th>
<th>Troy High School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 328-5825</td>
<td>Phone 328-5425</td>
</tr>
<tr>
<td>Fax 274-0371</td>
<td>Fax 271-5174</td>
</tr>
</tbody>
</table>
**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 the 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: Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date: / /</td>
<td>Sex: □ Male</td>
<td>Will this be your child's first visit to a dentist? □ Yes □ No</td>
</tr>
<tr>
<td>Month Day Year</td>
<td>□ Female</td>
<td></td>
</tr>
</tbody>
</table>

School Name:  
Grade  

Have you noticed any problem in the mouth that interferes with your child’s ability to chew, speak or focus on school activities? □ Yes □ No

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

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

Parent’s Signature__________________  Date ____________________

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

I. The Dental Health condition of _______________________________ on _________________ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

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

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

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

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

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

- Yes □ No Caries Experience/Restoration History – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

- Yes □ No Untreated Caries – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

- Yes □ No Dental Sealants Present

Other problems (Specify):_______________________________________________________________________________

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

- □ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
- □ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
- □ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.
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>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes, indicate type</td>
<td>Type:</td>
</tr>
<tr>
<td>☐ Medication/Treatment Order Attached</td>
<td>☐ Anaphylaxis Care Plan Attached</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Asthma</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes, indicate type</td>
<td>☐ Intermittent ☐ Persistent ☐ Other:</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>Type:</td>
</tr>
<tr>
<td>☐ Medication/Treatment Order Attached</td>
<td>Date of last seizure:</td>
</tr>
<tr>
<td>☐ Seizure Care Plan Attached</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diabetes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes, indicate type</td>
<td>Type: ☐ 1 ☐ 2</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, 5x Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.

BMI kg/m²

<table>
<thead>
<tr>
<th>Percentile (Weight Status Category): ☐ &lt;5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and&gt;</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hyperlipidemia: ☐ No ☐ Yes ☐ Not Done</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hypertension: ☐ No ☐ Yes ☐ Not Done</th>
</tr>
</thead>
</table>

### PHYSICAL EXAMINATION/ASSESSMENT

<table>
<thead>
<tr>
<th>Laboratory Testing</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB-PRN</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Screen-PRN</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lead Level Required Grades Pre-K &amp; K</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Test Done ☐ Lead Elevated &gt; 5 µg/dL</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>☐ System Review and Abnormal Findings Listed Below</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ HEENT ☐ Lymph nodes ☐ Abdomen ☐ Extremities ☐ Speech</td>
</tr>
<tr>
<td>☐ Dental ☐ Cardiovascular ☐ Back/Spine ☐ Skin ☐ Social Emotional</td>
</tr>
<tr>
<td>☐ Neck ☐ Lungs ☐ Genitourinary ☐ Neurological ☐ Musculoskeletal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>☐ Assessment/Abnormalities Noted/Recommendations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Diagnoses/Problems (list) ☐ ICD-10 Code*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>☐ Additional Information Attached</th>
</tr>
</thead>
</table>

*Required only for students with an IEP receiving Medicaid
Name: 

DOB: 

### 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>☐ Yes ☐ No</td>
<td>☐</td>
</tr>
<tr>
<td>Color Perception Screening</td>
<td>☐ Pass ☐ Fail</td>
<td></td>
<td>☐ Yes ☐ No</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.

**Not Done**

### Pure Tone Screening

<table>
<thead>
<tr>
<th>Right</th>
<th>☐ Pass ☐ Fail</th>
<th>Left</th>
<th>☐ Pass ☐ Fail</th>
<th>Referral</th>
<th>☐ Yes ☐ No</th>
</tr>
</thead>
</table>

**Notes**

### Scoliosis

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

<table>
<thead>
<tr>
<th>Negative</th>
<th>Positive</th>
<th>☐ Yes ☐ No</th>
</tr>
</thead>
</table>

**Not Done**

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

☐ Student may participate in all activities without restrictions.

☐ Student is restricted from participation in:

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

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


☐ 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 Menses (if applicable) : ____________

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

### MEDICATIONS

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

### IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

### HEALTH CARE PROVIDER

Medical Provider Signature: 

Provider Name: *(please print)*

Provider Address: 

Phone: 

Fax: 

Please Return This Form To Your Child’s School When Completed.
Dear Parent/Guardian:

Due to a change in 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. A list of medications, which will be available in your school’s Health Office, are listed below. Please have your health care provider check the medications appropriate for your child.

Only one student per form. Each student must have this individual medication order on file. Please return the signed, completed form to the Health Office of your school.

Comments

____ Acetaminophen – 325 mg – pain relief
____ Acetaminophen – 80 mg – liquid/chewable – pain
____ Antacid – liquid – relief of upset stomach
____ Bacitracin topical ointment
____ Benadryl topical cream
____ Benzolonium – antiseptic solution
____ Calamine – relieves itching
____ Chloraseptic Spray
____ Cough Drops *(Middle & High School students only)*
____ Hydrocortisone topical cream 1%
____ Orajel – oral pain relief
____ Tums *(Middle & High School students only)*
____ Vaseline Lotion and Ointment

Student Name __________________________________________         Date of Birth _________________

School ______________________________________   Grade _______________

Health Care Provider’s Signature_______________________________________________________________

Health Care Provider’s Telephone # _______________

Parent/Guardian’s Signature _________________________________________________________________

This form is to be completed by a physician, signed by parent, and returned to the Health Office
April 23, 2015

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
NEW YORK STATE MIGRANT EDUCATION PROGRAM
IDENTIFICATION & RECRUITMENT OFFICE
PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, regardless of their nationality or legal status. This program is free of charge to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take few minutes to complete this questionnaire.

Has anyone in your family worked, or looked for work at the following occupations during the past 3 years?

☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)

☐ Work related to logging, harvesting, or initial processing of trees.

☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)

If you answer YES, please provide your contact information below:

Parent/Guardian Name: ____________________________________________

Home address: ____________________________________________________

Telephone number: (____)-_______-_______ Best time to be reached: _____ AM/PM

Previous Address: _________________________________________________

Student name: ___________________ Age _______ Grade_______

Student name: ___________________ Age _______ Grade_______

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