Checklist for Prekindergarten Registration Applicants

Welcome to Troy Schools!

Attention Parent/Guardian: 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 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: 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.

Questions? Contact the Pre K Office at (518) 328-5012 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
- School 14 - 1700 Tibbits Avenue
- School 16 - 40 Collins Avenue (At School 12 for 2023-2024)
- Sacred Heart - 308 Spring Avenue
- CEO - UTC - 2331 Fifth Avenue
- Sunnyside – 9th and Ingalls Avenue
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

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 ______________________
If joint, who has residential (primary physical) custody? ____________________________
□ Legal guardianship document provided
Is the student in the care of a guardian(s) other than his/her mother or father? □ Yes □ No
If yes, name of legal guardian(s) __________________________ 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 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 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 Universal Prekindergarten program. I will also notify the district that
  my child has moved.

X _____________________________________ _______________________
Signature of Parent/Guardian          Date
PREKINDERGARTEN PROGRAM SITES
The following sites hold a Prekindergarten program in conjunction with the Troy City School District:

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

2. School #12
   475 First Street
   7:30 – 1:00
   Parents transport
   Head Start Collaboration
   Additional Paperwork Required

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

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
   (at School 12 for the 2023-2024 school year)
   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
Child’s Name: __________________________________________________________

Criteria for Acceptance:
- Child must reside within the Troy City School District.
- The child must be 4 years of age on or before December 1st of the school year they are enrolling for.

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.

1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________
4. __________________________________________________________
5. __________________________________________________________

Random Selection
New York State requires random selection of all Universal Prekindergarten programs. Applications will be accepted beginning February 27th. 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____________________________________
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 (name of school) permission to release my child ________________________ to the (name of child) 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>
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<td>Parent</td>
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<td>Parent</td>
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</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
Prekindergarten Student Registration Form
TROY CITY SCHOOL DISTRICT

Parent Consent to Release Information
Medical Authorization Form

To Whom It May Concern:

In regard to my (Son/Daughter): __________________________

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

______________________________  ______________________________
Date                                              Signature of Parent/Guardian

______________________________
Please Print Name
TROY CITY SCHOOL DISTRICT  
SCHOOL HEALTH SERVICES

Student Name_____________________________________ Address _________________________ DOB_____________ Place of Birth______

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Mother’s Name _____________________________________ Address (if different)___________________________ Home Phone:____________ Cell Phone:_______
Place of Employment __________________________________Phone_______________________________

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Father’s Name _____________________________________ Address (if different)___________________________ Home Phone:____________ Cell Phone:______
Place of Employment __________________________________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>
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<tbody>
<tr>
<td><strong>ALLERGIES</strong></td>
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<td><strong>Anemia/Bleeding Disorder</strong></td>
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<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><strong>Chronic Ear Infections</strong></td>
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<tr>
<td>Environmental</td>
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<td><strong>Hearing Loss</strong></td>
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<tr>
<td>Medication</td>
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<td><strong>Hearing Aid</strong></td>
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<tr>
<td>Eczema</td>
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<td><strong>Speech Concerns</strong></td>
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<tr>
<td>Asthma</td>
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<td><strong>Vision Problems</strong></td>
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<td>(Glasses, Contacts)</td>
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<td>ADHD/ADD</td>
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<td><strong>Loss of Vision</strong></td>
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<tr>
<td>Behavior Concerns</td>
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<td><strong>Bladder/Kidney Condition</strong></td>
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<tr>
<td>Diabetes</td>
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<td><strong>Absence Kidney</strong></td>
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<tr>
<td>Seizure Disorder (Epilepsy)</td>
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<td><strong>Absence of Testicle</strong></td>
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<td>Heart Murmur</td>
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<td><strong>Arthritis</strong></td>
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<tr>
<td>Cardiac Condition/Surgery</td>
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<td><strong>Fractures</strong></td>
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<tr>
<td>High/Low Blood Pressure</td>
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<td><strong>Scoliosis</strong></td>
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<tr>
<td>Fainting During Exercise</td>
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<td><strong>Chicken Pox/Date</strong></td>
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<tr>
<td>Head Injury</td>
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<td><strong>Surgery (Tonsils, Hernia)</strong></td>
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<tr>
<td>Migraine Headaches</td>
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<td><strong>Under Current Medical Care</strong></td>
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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.

---

**Home Language Questionnaire (HLQ)**

**Student Name:**

First  Middle  Last

**Date of Birth:**

Month  Day  Year

**Gender:**

- [ ] Male
- [ ] Female
- [ ] Non Binary

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

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<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Relation to</th>
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**Home Language Code**

---

**Language Background**

*(Please check all that apply.)*

1. **What language(s) is(are) spoken in the student's home or residence?**
   - [ ] English
   - [ ] Other

2. **What was the first language your child learned?**
   - [ ] English
   - [ ] Other

3. **What is the Home Language of each parent/guardian?**
   - [ ] Mother
   - [ ] Father
   - [ ] Guardian(s)

4. **What language(s) does your child understand?**
   - [ ] English
   - [ ] Other

5. **What language(s) does your child speak?**
   - [ ] English
   - [ ] Other
   - [ ] Does not speak

6. **What language(s) does your child read?**
   - [ ] English
   - [ ] Other
   - [ ] Does not read

7. **What language(s) does your child write?**
   - [ ] English
   - [ ] Other
   - [ ] Does not write

---

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

**School District Information:**

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

District Name (Number)  School  Address
### Educational History

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

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

   - Yes*  
   - No  
   - Not sure

   "If yes, please explain: ____________________________"

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

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

10b. *If referred for an evaluation, has your child ever received any special education services in the past?  
- No  
- Yes – Type of services received: ____________________________

Age at which services received (Please check all that apply):
- Birth to 3 years (Early Intervention)  
- 3 to 5 years (Special Education)  
- 6 years or older (Special Education)

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

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

   ____________________________

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

   Month:  Day:  Year:  

**Signature of Parent or of Person in Parental Relation**

Date  

Relationship to student:  
- Mother  
- Father  
- Other: ____________________________

---

**OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ**

**NAME:**  
**POSITION:**

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

---

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

**NAME:**  
**POSITION:**

Optional Interview Necessary:  
- No  
- Yes

**Date of Individual Interview:**

**Outcome of Individual Interview:**
- Administer NYSITELL  
- English Proficient  
- Refer to Language Proficiency Team

---

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

**NAME:**  
**POSITION:**

Proficiency Level

**Date of NYSITELL Administration:**

Achieved on NYSITELL:  
- Entering  
- Emerging  
- Transitioning  
- Expanding  
- Commanding

For students with disabilities, list accommodations, if any. Administered in accordance with IEP pursuant to CSE recommendation:

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**OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ**

**NAME:**  
**POSITION:**

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

---

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

**NAME:**  
**POSITION:**

Optional Interview Necessary:  
- No  
- Yes

**Date of Individual Interview:**

**Outcome of Individual Interview:**
- Administer NYSITELL  
- English Proficient  
- Refer to Language Proficiency Team

---

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

**NAME:**  
**POSITION:**

Proficiency Level

**Date of NYSITELL Administration:**

Achieved on NYSITELL:  
- Entering  
- Emerging  
- Transitioning  
- Expanding  
- Commanding

For students with disabilities, list accommodations, if any. Administered in accordance with IEP pursuant to CSE recommendation:
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 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
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?
__________________________________________________________________
__________________________________________________________________
2023-24 School Year
Return form to your school
ONLY IF YOU OBJECT
to your child’s photo being published.

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
PHYSICAL EXAMINATION REQUIREMENT

Dear Parent /Guardian:

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

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

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

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

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

Thank you for your cooperation in this health endeavor.

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

Carroll Hill
Phone 328-5720
Fax 274-4587

School 16
Phone 328-5120
Fax 328-5146

School 12
Phone 328-5025
Fax 203-6874

Pre-K
Phone 328-5012
Fax 328-5061

School 18
Phone 328-5525
Fax 274-4585

Troy Community School
Phone: 328-5025
Fax: 328-5050

School 2
Phone 328-5620
Fax 271-5205

Troy Middle School
Phone 328-5323
Fax 271-5175

School 14
Phone 328-5825
Fax 274-0371

Troy High School
Phone 328-5425
Fax 271-5174
DENTAL HEALTH CERTIFICATE - OPTIONAL

Parent/Guardian: New York State law (Chapter 281) permits schools to request 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>□ Female</td>
</tr>
<tr>
<td></td>
<td>Will this be your child’s first visit to a dentist? □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>School Name:</td>
<td>Grade</td>
</tr>
</tbody>
</table>

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 X ____________________________ 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.
**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 □ No</th>
<th>□ Yes, indicate type</th>
<th>Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ Medication/Treatment Order Attached □ Anaphylaxis Care Plan Attached</td>
</tr>
<tr>
<td>Asthma □ No</td>
<td>□ Yes, indicate type</td>
<td>□ Intermittent □ Persistent □ Other:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Medication/Treatment Order Attached □ Asthma Care Plan Attached</td>
</tr>
<tr>
<td>Seizures □ No</td>
<td>□ Yes, indicate type</td>
<td>Type:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Medication/Treatment Order Attached</td>
</tr>
<tr>
<td>Diabetes □ No</td>
<td>□ Yes, indicate type</td>
<td>Type: □ 1 □ 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Medication/Treatment Order Attached □ 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.

**BMI** ______ kg/m²

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

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

**PHYSICAL EXAMINATION/ASSESSMENT**

<table>
<thead>
<tr>
<th>Laboratory Testing</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
<th>List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB-PRN</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Screen-PRN</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Lead Level Required Grades Pre-K & K** □ Test Done □ Lead Elevated > 5 µg/dL

□ System Review and Abnormal Findings Listed Below

- □ HEENT □ Lymph nodes □ Abdomen □ Extremities □ Speech
- □ Dental □ Cardiovascular □ Back/Spine □ Skin □ Social Emotional
- □ Neck □ Lungs □ Genitourinary □ Neurological □ Musculoskeletal
- □ Assessment/Abnormalities Noted/Recommendations: Diagnoses/Problems (list) ICD-10 Code*

□ Additional Information Attached

*Required only for students with an IEP receiving Medicaid
**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</td>
<td>□ No</td>
</tr>
<tr>
<td>Near Vision Acuity</td>
<td>20/</td>
<td>20/</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Color Perception Screening</td>
<td>□ Pass □ Fail</td>
<td></td>
<td>□ Yes</td>
<td>□ No</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.
- **Pure Tone Screening**
  - Right □ Pass □ Fail
  - Left □ Pass □ Fail
  - Referral □ Yes □ No

**Notes**

- **Scoliosis**: Screen Boys in grade 9, and Girls in grades 5 & 7
  - Negative □ Positive □ Referral □ Yes □ No □ 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.
  - **Non-Contact Sports**: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
  - □ 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:
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
_____ Benzalkonium – 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 _______________

PHYSICIAN SIGNS HERE

Health Care Provider’s Signature __________________ __________________ signature date
Health Care Provider’s Telephone # _____________________________

PARENT SIGNS HERE

Parent/Guardian’s Signature __________________ __________________ signature date

This form is to be completed by a physician, signed by parent, and returned to the Health Office.
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.
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>Criteria</th>
<th>Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 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>
</tr>
<tr>
<td>TANF</td>
<td>100</td>
</tr>
<tr>
<td>SNAP</td>
<td>100</td>
</tr>
<tr>
<td>CPS Involvement</td>
<td></td>
</tr>
<tr>
<td>Total Points</td>
<td></td>
</tr>
</tbody>
</table>
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.