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

Registration Checklist for K-12 Registration Applicants

Welcome to the Troy City School District!

To register your child, a parent or guardian must be present with photo identification at the Central Registration Office located at School 12, 475 First Street.

Office hours are 7:30 am – 3:00 pm. During school breaks and summer, hours are 7:00 am – 2:00 pm.

All attached forms must be completed.

The following documents are also required for registration:

Required documents checklist:

- ☐ Health Certificate signed by a doctor
- ☐ Up-to-date immunization record
- ☐ Birth Certificate
- ☐ Proof of Residency (one of the following must be provided):
  - Utility bill or deposit (dated 30 days prior to registration)
  - Lease or rental agreement
  - Mortgage statement
  - 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)
- ☐ Photo identification of parent/guardian
- ☐ Dental Health Certificate (optional)

Your child’s registration will not be complete unless you have received verification from the Central Registration Department.

Questions? Contact Central 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

Elementary Schools:
School 2 – 470 Tenth Street
School 14 – 1700 Tibbits Avenue
School 16 – 40 Collins Avenue
School 18 – 412 Hoosick Street
Carroll Hill School – 112 Delaware Avenue

Troy Middle School
1976 Burdett Avenue

Troy High School
1950 Burdett Avenue
Housing Questionnaire

Name of School:______________________________________________ Grade:______

Name of Student:________________________________________________________________________

Last First Middle

Gender:□ Male □ Female □ Nonbinary Date of Birth: ____/____/______

Month Day Year

Address:_________________________________________________________ Zip Code:__________

Phone:___________________________________________________________

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

Where is the student currently living? Please check 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:________________________________________________________

Print name of Parent, Guardian or Student __________________________ 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                      Apartment/Floor   City           Zip

Household Phone Number: ___________________________   Is this a cell phone: ☐ Yes ☐ No

What language is spoken in the student’s home: ___________________________   Are translation services needed: ☐ Yes ☐ No

Ethnicity: Is the student Hispanic, Latino, or of Spanish origin? ☐ Yes, Hispanic ☐ No, not Hispanic

Race: Select one or more races from the following five racial groups
☐ Black ☐ White ☐ Asian American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

Gender: ☐ Male ☐ Female ☐ Nonbinary

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

Date of Birth: _______________ Place of Birth: _______________
City                          State                     Country

Has the student previously attended a school in Troy ☐ Yes ☐ No   If yes, what school: ___________________________

Registering for Grade: ___________   If applicable, what was the entry date into the USA? _______________________

Has the student attended school in the US ☐ Yes ☐ No   If yes, number of years enrolled in US schools: ____________

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

Office Use Only

☐ NCLB ☐ SP ☐ Summer Serv   Date: _____/_____/_______

ID: ____________________________________ Home School: ____________________ School Enrolled: ____________________

Documents provided to the district:
☐ Photo ID
☐ Proof of Residency
☐ National Grid Bill
☐ Lease
☐ Notarized Landlord Letter
☐ Mortgage Statement
☐ Other
☐ MCKINNEY-VENTO
☐ Lunch Form Completed
☐ Birth Certificate ☐ Passport ☐ Network Form
☐ Court Papers
☐ DSS 299-District__________
☐ Custody
☐ Parent/Custodial Affidavits
☐ Adoption

Enrollment Exceptions:
☐ School Choice ☐ Opt In
☐ Wynantskill student ☐ Permission Rcvd
☐ N. Greenbush student ☐ Permission Rcvd
☐ Employee’s child – District___________________ ☐ Emp ID
☐ Foreign Exchange
☐ Tuition Paying – District___________________

☐ Immunization ☐ 14 Day Letter
☐ Religious Exemption
☐ Physical
☐ Dental certificate
Parent/Guardian Information

Mother/Guardian: __________________________ / _______/ ______________________________
First Middle Initial Last
Relationship to child: □ Mother □ Stepmother □ Legal Guardian □ Foster Parent □ Other

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

Mailing Address if different from above: __________________________ / _______/ ______________________________
Street Apt/Flr City State Zip

Home Phone: ( _ ) ______________ Work Phone: ( _ ) ______________ Cell Phone: ( __ ) _______________
Email Address: ________________________ Phone call priority (1-3): Home_____ Work_____ Cell _____

Father/ Guardian: __________________________ / _______/ ______________________________
First Middle Initial Last
Relationship to child: □ Father □ Stepmother □ Legal Guardian □ Foster Parent □ Other

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

Mailing Address if different from above: __________________________ / _______/ ______________________________
Street Apt/Flr City State Zip

Home Phone: ( _ ) ______________ Work Phone: ( _ ) ______________ Cell Phone: ( __ ) _______________
Email Address: ________________________ Phone call priority (1-3): Home_____ Work_____ Cell _____

Other Children Living in the Household

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

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

Please list the names of ANY and ALL persons Troy City School District is allowed to contact or release your child to in case of an emergency, including illness, serious injury, early dismissal of school or an evacuation emergency.

Emergency Contact 1: Name: __________________________ Relationship to Student: ______________
Other than parent/guardian

Home Phone: ( _ ) ______________ Work Phone: ( _ ) ______________ Cell Phone: ( __ ) ______________
Address: __________________________________________________________

Emergency Contact 2: Name: __________________________ Relationship to Student: ______________
Other than parent/guardian

Home Phone: ( _ ) ______________ Work Phone: ( _ ) ______________ Cell Phone: ( __ ) ______________
Address: __________________________________________________________
Emergency Contact 2: Name: ______________________________ Relationship to Student: ____________

Other than parent/guardian

Home Phone: ( _ ) ______________ Work Phone: ( _ ) ______________ Cell Phone: ( __ ) ______________

Address: ____________________________________________________________________________

Additional Emergency Contacts:
___________________________________________________________________________________

Please answer the following only if the student relocated due to a Natural, Civil, or Health Disaster.

Please check one of the boxes below and provide the name of the crisis or disaster that led to the student relocating.

☐ Natural Disaster (Hurricanes, tropical storms, tornadoes, wildfire, landslides, tsunamis, sinkholes)
☐ Civil Disaster (War {asylee, refugee} fire accidents, industrial accidents)
☐ Health (Pandemics and epidemics)
☐ Other

Name of the crisis or disaster: ____________________________

Legal Information (If Applicable)

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

Who retains legal custody? ____________________________ Relationship to child____________________

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

☐ Legal guardianship document provided

Is the student in the care of a guardian(s) other than his/her mother or father? ☐ Yes ☐ No

If yes, name of legal guardian(s) ____________________________

Relationship to child_____________________________

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

Special Education Services

Does the student currently have an IEP (Individualized Education Plan) ☐ Yes ☐ No

Does your child receive any of the following type of services?

☐ Consultant Teacher ☐ Self-Contained Classroom ☐ Resource Room

☐ Out of District Class (BOCES or QUESTAR) ☐ Yes ☐ No

Related Services

☐ Speech and Language Therapy ☐ Occupational Therapy ☐ Physical Therapy

☐ Counseling ☐ Other, please describe________________________

Academic Intervention Services (AIS/Remedial)

☐ Math ☐ English Language Arts ☐ Science ☐ Social Studies

Other Services

☐ 504 Plan

☐ English as a Second Language (ESL) If yes how many years of service? ______

☐ Other __________________________

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

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

Other Information:

Has the family moved within the past three (3) years to obtain migratory employment? ☐ Yes ☐ No

*If yes, complete Migrant Education Form located at the end of the packet.

Parent Statement:

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

Parent or Guardian Signature X_________________________________________ Date________________

All documents are to be returned to:

Troy City School District Central Registration Office
School 12, 475 First St., Troy, NY 12180
Phone: (518) 328-5007 Fax: (518) 328-5061
Request for Records

I give permission for the release of information concerning my child

Student: ___________________________ Grade: _____ Date of Birth: ____________

Name of Former District: ___________________________ City: ___________ State: ______

Name of Former School: _______________________________ Phone: ______________

Address: __________________________________ Phone: ______________

Signature of Parent/Guardian X_________________________ Date: ____________

Office Use Only

<table>
<thead>
<tr>
<th>SCHOOL</th>
<th>ADDRESS</th>
<th>PHONE/FAX</th>
<th>CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Troy High School</td>
<td>1950 Burdett Avenue, Troy, NY 12180</td>
<td>P: (518) 328-5472</td>
<td>Guidance Office</td>
</tr>
<tr>
<td></td>
<td>Troy, NY 12180</td>
<td>F: (518) 271-5164</td>
<td></td>
</tr>
<tr>
<td>Troy Middle School</td>
<td>1976 Burdett Avenue, Troy, NY 12180</td>
<td>P: (518) 328-5365</td>
<td>Guidance Office</td>
</tr>
<tr>
<td></td>
<td>Troy, NY 12180</td>
<td>F: (518) 271-5492</td>
<td></td>
</tr>
<tr>
<td>Carroll Hill School</td>
<td>112 Delaware Avenue, Troy, NY 12180</td>
<td>P: (518) 328-5701</td>
<td>Kate Talham</td>
</tr>
<tr>
<td></td>
<td>Troy, NY 12180</td>
<td>F: (518) 274-4587</td>
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<td>School 2</td>
<td>470 Tenth Street, Troy, NY 12180</td>
<td>P: (518) 328-5601</td>
<td>Nickole Farnan</td>
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<tr>
<td></td>
<td>Troy, NY 12180</td>
<td>F: (518) 271-5205</td>
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<tr>
<td>School 14</td>
<td>1700 Tibbits Avenue, Troy, NY 12180</td>
<td>P: (518) 328-5801</td>
<td>Kristen Buffington</td>
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<td></td>
<td>Troy, NY 12180</td>
<td>F: (518) 274-0371</td>
<td></td>
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<td>School 16</td>
<td>40 Collins Avenue, Troy, NY 12180</td>
<td>P: (518) 328-5101</td>
<td>Secretary</td>
</tr>
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<td></td>
<td>Troy, NY 12180</td>
<td>F: (518) 274-4585</td>
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</tr>
<tr>
<td>School 18</td>
<td>412 Hoosick Street, Troy, NY 12180</td>
<td>P: (518) 328-5501</td>
<td>Emily Ruffinen</td>
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<td></td>
<td>Troy, NY 12180</td>
<td>F: (518) 274-4374</td>
<td></td>
</tr>
<tr>
<td>Central Registration</td>
<td>School 12, 475 First Street, Troy, NY 12180</td>
<td>P: (518) 328-5007</td>
<td>Central Registration Office</td>
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<td></td>
<td>Troy, NY 12180</td>
<td>F: (518) 328-5061</td>
<td></td>
</tr>
<tr>
<td>Special Education Department</td>
<td>School 12, 475 First Street, Troy, NY 12180</td>
<td>P: (518) 328-5075</td>
<td>Pupil Services Office</td>
</tr>
<tr>
<td></td>
<td>Troy, NY 12180</td>
<td>F: (518) 279-7600</td>
<td></td>
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Items Requested:

- Transcripts
- Current Report Cards
- Standardized Test Scores
- Regents Competency Test (RCT) results
- NYS Regents Scores
- NYS Regents Science Labs
- Birth Certificate
- NYS Proficiency Scores
- Cumulative Health Records/Immunizations
- Attendance Records
- Psychological Evaluations
- Disciplinary Records
- NYS ______ Grade Test Results
- Special Education Records, including most recent IEP

Thank you for your prompt attention to this matter
Parent Consent to Release Information
Medical Authorization Form

To Whom It May Concern:

In regard to my child: __________________________________________________

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

_____________________    X____________________________________
Date        Signature of Parent/Guardian

____________________________________
Please Print Name
## School Health Services

- **Entering Date**: 
- **Grade**: 
- **School**: 
- **Sex**: 

### Student Information
- **Student Name**: ____________________________
- **Address**: ____________________________
- **DOB**: ________
- **Place of Birth**: ____________________________

### Family Information
- **Mother's Name**: ____________________________
  - **Address (if different)**: ____________________________
  - **Home Phone**: __________
  - **Cell Phone**: __________
  - **Place of Employment**: ____________________________
  - **Phone**: ____________________________

- **Father's Name**: ____________________________
  - **Address (if different)**: ____________________________
  - **Home Phone**: __________
  - **Cell Phone**: __________
  - **Place of Employment**: ____________________________
  - **Phone**: ____________________________

- **Guardian/Step Parent**: ____________________________
  - **Address (if different)**: ____________________________
  - **Home Phone**: __________
  - **Cell Phone**: __________
  - **Place of Employment**: ____________________________
  - **Phone**: ____________________________

### Medical Information

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<th>Condition</th>
<th>No</th>
<th>Yes</th>
<th>Explain with Date/Medication</th>
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<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td>Anemia/Bleeding Disorder</td>
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<tr>
<td>Food</td>
<td></td>
<td>Yes</td>
<td>Sickle Cell</td>
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<tr>
<td>Bees</td>
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<td>Chronic Ear Infection</td>
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<tr>
<td>Environmental</td>
<td></td>
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<td>Hearing Loss</td>
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<tr>
<td>Medication</td>
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<td>Hearing Aid</td>
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<td>Eczema</td>
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<td></td>
<td>Speech Concerns</td>
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<tr>
<td>Asthma</td>
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<td></td>
<td>Vision Problems (Glasses/Contacts)</td>
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<tr>
<td>ADHD/ADD</td>
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<td>Loss of Vision</td>
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<tr>
<td>Behavior Concerns</td>
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<td>Bladder/Kidney Condition</td>
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<tr>
<td>Diabetes</td>
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<td></td>
<td>Absence of Kidney</td>
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<tr>
<td>Seizure Disorder (Epilepsy)</td>
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<td>Absence of Testicle</td>
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<td>Heart Murmur</td>
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<td>Arthritis</td>
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<tr>
<td>Cardiac Conditions/Surgery</td>
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<td>Fractures</td>
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<td>High/Low Blood Pressure</td>
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<td>Scoliosis</td>
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<tr>
<td>Fainting During Exercise</td>
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<td>Chicken Pox/Date</td>
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<tr>
<td>Head Injury</td>
<td></td>
<td></td>
<td>Surgery (Tonsils, Hernia)</td>
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<tr>
<td>Migraine Headaches</td>
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<td>Under Current Medical Care</td>
</tr>
</tbody>
</table>

### Additional Information

- **List any special medical problems or serious injuries or gym restrictions**: ____________________________
- **Parent/Guardian Signature**: ____________________________
- **Date**: ____________________________
Dear Parent or Person in Parental Relation:

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete these 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:**

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

**Date of Birth:**

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

**Gender:**

- Male
- Female

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

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

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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
   - Specify

2. What was the first language your child learned?
   - English
   - Other
   - Specify

3. What is the Home Language of each parent/guardian?
   - Parent 1
     - Specify
   - Parent 2
     - Specify
   - Guardian(s)
     - Specify

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

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

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

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

---

**School District Information:**

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

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

1
Home Language Questionnaire (HLQ) Page 2

### Educational History

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

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.
   
   Yes*  No  Not sure

   "If yes, please explain: ________________________________

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

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

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

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

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

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

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

   Month:  Day:  Year:

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

Relationship to student:  □ Parent  □ Other: __________________________

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

NAME: __________________________  POSITION: __________________________

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

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

NAME: __________________________  POSITION: __________________________

ORAL INTERVIEW NECESSARY:  □ No  □ Yes

**DATE OF INDIVIDUAL INTERVIEW: __________________________

<table>
<thead>
<tr>
<th>NO</th>
<th>DAY</th>
<th>YR</th>
</tr>
</thead>
</table>

OUTCOME OF INDIVIDUAL INTERVIEW:

□ ADMINISTER NYSITELL  □ ENGLISH PROFICIENT  □ REFER TO LANGUAGE PROFICIENCY TEAM

### NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: __________________________  POSITION: __________________________

DATE OF NYSITELL ADMINISTRATION: __________________________

<table>
<thead>
<tr>
<th>NO</th>
<th>DAY</th>
<th>YR</th>
</tr>
</thead>
</table>

PROFICIENCY LEVEL ACHIEVED ON NYSITELL:

□ ENTERING  □ EMERGING  □ TRANSITIONING  □ EXPANDING  □ COMMANDING

FOR STUDENTS WITH DISABILITIES LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:
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
Physical Examination Requirement

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

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

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

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

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

Thank you for your cooperation in this health endeavor.

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

Pre-K
Phone: 328-5436
Fax: 271-7692

School 2
Phone: 328-5620
Fax: 271-5205

School 12
Phone: 328-5025
Fax: 203-6874

School 14
Phone: 328-5025
Fax: 203-6874

School 16
Phone: 328-5120
Fax: 274-4585

School 18
Phone: 328-5120
Fax: 274-4585

Carroll Hill
Phone: 328-5720
Fax: 274-4587

Troy Middle School
Phone: 328-5436
Fax: 271-7692

Troy High School
Phone: 328-5425
Fax: 271-5174
Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

## Section 1. To be completed by Parent or Guardian (Please Print)

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<th>Child's Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
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<tbody>
<tr>
<td>Birth Date: / / (Month Day Year)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Sex: □ Male □ Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will this be your child's first oral health assessment? □ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School: __________________________</td>
<td>Grade</td>
<td></td>
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</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 __________________________ Date ____________

## Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of __________________________ on __________ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

□ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

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

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

<table>
<thead>
<tr>
<th>Dentist’s/ Dental Hygienist’s name and address (please print or stamp)</th>
<th>Dentist’s/Dental Hygienist’s Signature</th>
</tr>
</thead>
</table>

Optional Sections - If you agree to release this information to your child’s school, please initial here. □ Yes □ No

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

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

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

□ Yes □ No Dental Sealants Present

Other problems (Specify): ____________________________________________

II. Treatment Needs (check all that apply)

□ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

□ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

□ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

(3/2018)
### REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

**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</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ M</td>
<td>□ F</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School</th>
<th>Grade</th>
<th>Exam Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HEALTH HISTORY

#### Allergies

- [□] No
- [☐] Yes, indicate type

<table>
<thead>
<tr>
<th>Type</th>
<th>Medication/Treatment Order Attached</th>
<th>Anaphylaxis Care Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

#### Asthma

- [□] No
- [☐] Yes, indicate type

<table>
<thead>
<tr>
<th>Type</th>
<th>Intermittent</th>
<th>Persistent</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication/Treatment Order Attached</th>
<th>Asthma Care Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

#### Seizures

- [□] No
- [☐] Yes, indicate type

<table>
<thead>
<tr>
<th>Type</th>
<th>Date of last seizure</th>
<th>Seizure Care Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication/Treatment Order Attached</th>
<th>Seizure Care Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

#### Diabetes

- [□] No
- [☐] Yes, indicate type

<table>
<thead>
<tr>
<th>Type</th>
<th>Medication/Treatment Order Attached</th>
<th>Diabetes Medical Mgmt. Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

#### 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>Height</th>
<th>Weight</th>
<th>BP</th>
<th>Pulse</th>
<th>Respiration</th>
</tr>
</thead>
</table>

<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</td>
<td></td>
</tr>
<tr>
<td>☐ Lead Elevated &gt; 5 µg/dL</td>
<td></td>
</tr>
</tbody>
</table>

- [☐] System Review and Abnormal Findings Listed Below
- [☐] HEENT
- [☐] Lymph nodes
- [☐] Abdomen
- [☐] Extremities
- [☐] Skin
- [☐] Speech
- [☐] Dental
- [☐] Cardiovascular
- [☐] Back/Spine
- [☐] Social Emotional
- [☐] Neck
- [☐] Lungs
- [☐] Genitourinary
- [☐] Musculoskeletal

- [☐] Assessment/Abnormalities Noted/Recommendations:

<table>
<thead>
<tr>
<th>Diagnoses/Problems (list)</th>
<th>ICD-10 Code*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- [☐] 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></td>
<td></td>
</tr>
<tr>
<td>Color Perception Screening</td>
<td>[☐] Pass</td>
<td>[☐] Fail</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hearing: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.

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

Notes:

### 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 goggles, etc.) Use additional space below to explain.  *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

### MEDICATIONS

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

### IMMUNIZATIONS

- [☐] Record Attached  [☐] Reported in NYSIIS

### HEALTH CARE PROVIDER

- **Medical Provider Signature:**
- **Provider Name: (please print)**
- **Provider Address:**
- **Phone:**

**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

_____ Benzolkonium – 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_______________________________________________________________

Parent/Guardian’s Signature _________________________________________________________________

This form is to be completed by a physician, signed by parent, and returned to the Health Office
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 518-328-5075.
IDENTIFICATION & RECRUITMENT PARENT SURVEY

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

Please take few minutes to complete this questionnaire.

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

☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
☐ Work related to logging, harvesting, or initial processing of trees.
☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)

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

Parent/Guardian Name: _______________________________________________________

Home address: ______________________________________________________________

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

Previous Address: _____________________________________________________________

Student name: __________________________ Age _________ Grade _________

Student name: __________________________ Age _________ Grade _________

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