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

Registration Checklist for K-12 Registration Applicants
قائمة مراجعة التسجيل لمقدمي طلبات التسجيل من روضة الأطفال إلى الصف الثاني عشر

Welcome to the Troy City School District!
مرحبًا بك في المنطقة التعليمية لمدينة تروي

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.
لتسجيل طفلك ، يجب أن يكون أحد الوالدين أو الوصي حاضرًا مع صورة هوية في مكتب التسجيل المركزى الموجود في على العنوان أعلاه

Office hours are 7:30 am – 3:00 pm. During school breaks and summer, hours are 7:00 am – 2:00 pm.
ساعات العمل ٠٣:٧ﺻﺑﺎﺣًﺎ – ٣ مسآء. خلال فترات الراحة المدرسية والصيف، تكون الساعات ٧ صبحة – ٢ مساءً

All attached forms must be completed.
يجب إكمال جميع النماذج المرفقة

The following documents are also required for registration:
المستندات الواقية أيضًا للتسجيل:

Required documents checklist:
قائمة التحقق من المستندات المطلوبة

- Health Certificate signed by a doctor
- شهادة صحية موقعة من الطبيب
- Up-to-date immunization record
- سجل تحقين حديث
- Birth Certificate
- شهادة الميلاد
- Proof of Residency (one of the following must be provided):
  - إثبات الإقامة (يجب تقديم واحد مما يلي)
  - Utility bill or deposit (dated 30 days prior to registration)
    - فاتورة أو ودية خدمات (مصدرة قبل ٣٠ يومًا من التسجيل)
  - Lease or rental agreement
    - عقد الإيجار أو السكن
  - Mortgage statement
    - بيان الرهن العقاري
  - 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)
    - تنصير الإقامة (يسري فقط إذا كان أحد الوالدين يعيش في مسكن لا يستطيعه أو يمتلكه بنفسه. يمكن العثور على الإقامة الخطية على الموقع أعلاه)
- Photo identification of parent/guardian
- تصدع صورة الوالد / الرامي
- Dental Health Certificate (optional)
- شهادة صحة الأسنان (اختياري)

Your child’s registration will not be complete unless you have received verification from the Central Registration Department.
لن يتمكن تسجيل طفلك إلا إذا تلقيت تأكيدًا من إدارة التسجيل المركزية

Questions? Contact Central Registration at (518) 328-5007
Fax: (518) 271-5445 Email: reg@troycsd.org
أسئلة؟ اتصل بالتسجيل المركزي

Arabic Interpreter: Nicole (518) 431-9281
المترجمة العربية: نيكول

Spanish Interpreter Loreley (518) 416-6343
الترجمة الإسبانية: لورلي

Elementary Schools: مدارس تروي
Troy Schools
School 2 – 470 Tenth Street
Troy Middle School مدرسة تروي المتوسطة
School 14 – 1700 Tibbits Avenue
1976 Burdett Avenue
School 16 – 40 Collins Avenue
المدرسة ١٤
School 18 – 412 Hoosick Street
المدرسة ١٦
Carroll Hill School – 112 Delaware Avenue
المدرسة ١٨

Troy High School مدرسة تروي الثانوية
1500 Burdett Avenue
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)

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#: 518-271-5445
Email: reg@troycsd.org

Special Education Department at 518-328-5075

Arabic Interpreter: Nicole 518-431-9281

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: ___________________________________________________________

First Name  Last Name  Middle Name

Gender:   Male   Female

Date of Birth: _______/_____/_____

Month  Day  Year

Address: __________________________________________ Zip: _______

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 ________________________________

Name of Parent/Guardian or Student, please print

________________________________________

Signature of Parent/Guardian or Student

X

________________________________________

Date
STUDENT REGISTRATION FORM

STUDENT NAME: _______________________/_____________________/____________________________
First                      Middle                      Last

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

Address: _______________________/ _______________________/ ____________________________
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

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

Date of Birth: ___/___/____ Place of Birth: ____________________________ ____________________________ ____________________________
Has the student previously attended a school in Troy?

Yes \( \Box \) No \( \Box \)

If yes, what school

Registering for Grade

Has the student attended school in the USA?

Yes \( \Box \) No \( \Box \)

If yes, number of years enrolled in US schools

Does the student have a parent/guardian on active duty in the Armed Forces?

Yes \( \Box \) No \( \Box \)

Office Use Only

ID: ____________________ Home School: ____________________School Enrolled: ____________________

Documents provided to the district:

- Photo ID
- Proof of Residency
- National Grid Bill
- Lease
- Notarized Landlord Letter
- Emp ID
- Mortgage Statement
- Other
- MCKINNEY-VENTO

Enrollment Exceptions:

- School Choice
- Opt In
- Wynantskill student
- Permission Rcvd
- N. Greenbush student
- Permission Rcvd
- Employee’s child – District

- Foreign Exchange
- Tuition Paying – District

- Lunch Form Completed
- Network Form

Parent/Guardian Information

Mother/Guardian: ____________________ ________________

First Middle Initial Last

Relationship to child

Mother \( \Box \) Step-parent \( \Box \) Legal Guardian \( \Box \) Foster Parent \( \Box \) Other ________________

Resides in Home Yes \( \Box \) No \( \Box \)

Is to receive Correspondence Yes \( \Box \) No \( \Box \)

Mailing Address if different from above: ____________________ ________________

City State Zip

Home Phone: (_______) ________________ Work Phone: (_______) ________________ Cell Phone: (_______) ________________
Email Address: ________________________________ Phone call priority (1-3): Home ____ Work ____ Cell ____

Father/Guardian:
________________________________________

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

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: _______________________

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

Address: ____________________________

Emergency Contact 2:

Name: ____________________________ Relationship to Student: _______________________

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? ___________________________

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

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

If yes, name of legal guardian(s): ___________________________

Is the student in foster care? Yes No

If yes, please provide copy of placement order (DSS-2999) if applicable.

Additional Services (If Applicable)

Special Education Services

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

Does your child receive any of the following type of services? Yes No

Speech and Language Therapy

Occupational Therapy

Physical Therapy

Counseling

Other, please describe: ___________________________
Academic Intervention Services (AIS/Remedial) (العلاج / خدمات التدخل الإكاديمي)

Math  الرياضيات
English Language Arts  اللغة الإنجليزية
Science  العلوم
Social Studies  الدراسات الاجتماعية

Other Services

- Math
- English Language Arts
- Science
- Social Studies

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?

If yes: ____________________________ Yes  نعم  NO  كلا

If registering for PREK – Is or will your child be receiving Summer Service this year?

IF REGISTERING FOR PREK:  هل سيترقد طفلك في الخصخصة الصيفية هذا العام أو سيترقد ذلك

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.

المعلومات الأخرى

Has the family moved within the past 3 years to obtain migratory employment?

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

* إذا كانت الإجابة بنعم ، أكمل نموذج تعليم المهاجرين الموجود في نهاية الخزمة.

Parent or Guardian Signature:  ____________________________________________________________________ Date: _____________________________

التاريخ
REQUEST FOR RECORDS
طلب السجلات

I give permission for the release of information concerning my child:
أعطي الإذن بالإفصاح عن المعلومات المتعلقة بطفلي:

Student: ___________________ Grade: _______ Date of Birth: ___________
طالب: _______________ الصف: _______ تاريخ الميلاد: ______________

Name of Former District: __________________ City: ___________ State: _________
اسم المنطقة السابقة: __________________ المدينة: ___________ الولاية: _________

Name of Former School: __________________ Phone: __________
اسم المدرسة السابقة: __________________ الهاتف: __________

Address: __________________ Fax: __________
العنوان: __________________ الفاكس: __________

Parent or Guardian Signature X Date __________
توقيع ولي الأمر أو الوصي التاريخ __________

Office Use Only
لاستخدام الجهة الرسمية فقط

REQUEST FOR RECORDS
طلب السجلات

Please send records to: ____________________________ Date sent: ______/_____/______
يرجى إرسال السجلات إلى: ____________________________ تاريخ الإرسال: ______/_____/______

<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 F: (518) 271-5164</td>
<td>Guidance Office</td>
</tr>
<tr>
<td>Troy Middle School</td>
<td>1976 Burdett Avenue, Troy, NY 12180</td>
<td>P: (518) 328-5365 F: (518) 271-5492</td>
<td>Guidance Office</td>
</tr>
<tr>
<td>Carroll Hill School</td>
<td>112 Delaware Avenue, Troy, NY 12180</td>
<td>P: (518) 328-5701 F: (518) 274-4587</td>
<td>Kate Talham</td>
</tr>
<tr>
<td>School 2</td>
<td>470 Tenth Street, Troy, NY 12180</td>
<td>P: (518) 328-5601 F: (518) 271-5205</td>
<td>Nickole Farnan</td>
</tr>
<tr>
<td>School 14</td>
<td>1700 Tibbits Avenue, Troy, NY 12180</td>
<td>P: (518) 328-5801 F: (518) 274-0371</td>
<td>Kristen Buffington</td>
</tr>
<tr>
<td>School 16</td>
<td>40 Collins Avenue, Troy, NY 12180</td>
<td>P: (518) 328-5101 F: (518) 274-4585</td>
<td>Tammie Hayner</td>
</tr>
<tr>
<td>School 18</td>
<td>412 Hoosick Street, Troy, NY 12180</td>
<td>P: (518) 328-5501 F: (518) 274-4374</td>
<td>Emily Ruffinen</td>
</tr>
<tr>
<td>Central Registration</td>
<td>School 12, 475 First St., Troy, NY 12180</td>
<td>P: (518) 328-5007 F: (518) 271-5445</td>
<td>Central Registration Office</td>
</tr>
<tr>
<td>Special Education</td>
<td>School 12, 475 First St., Troy, NY 12180</td>
<td>P: (518) 328-5075 F: (518) 279-7600</td>
<td>Pupil Services Office</td>
</tr>
<tr>
<td>Department</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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. شكرا لكم على اهتمامكم العاجل لهذه المسألة.
Parent Consent to Release Information

Moqafa'at Wali al-amr 'alal al-af'sath 'an al-mumulatan

Medical Authorization Form

Nmo'ozh al-tafa'iz al-ta'bi

To Whom It May Concern: إلی من يهمه الأمر

In regard to my (Son/Daughter): فيما يتعلق بـ ابنی/ ابنتی

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.

____________________________
Signature of Parent/Guardian

____________________________
Date

Please Print Name
**SCHOOL HEALTH SERVICES**

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

Student Name: ________________________ Address: _____________________________

Last Name: ___________________________ First Name: _______ MI: ________

DOB: _________________________ Place of Birth: _____________________________

Mother’s Name: ______________________ Address (if different): _____________________________ Home Phone: _______

Cell Phone: ______________________ Phone: _____________________________

Place of Employment: ______________________ Phone: _____________________________

Father’s Name: ______________________ Address (if different): _____________________________ Home Phone: _______

Cell Phone: ______________________ Phone: _____________________________

Place of Employment: ______________________ Phone: _____________________________

Guardian/Step Parent Name: ______________________ Address (if different): _____________________________ Home Phone: _______

Cell Phone: ______________________ 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>K</th>
<th>Explain with Date/Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALLERGIES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bees</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Environmental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eczema</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Has Your Child Ever Had the Following?**

<table>
<thead>
<tr>
<th>N</th>
<th>Y</th>
<th>Explain with Date/Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia/Bleeding Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Ear Infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Concerns</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Has your child ever had the following? Please explain with date of onset, any "yes" answers. /*
<table>
<thead>
<tr>
<th>Health Issue</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Vision Problems (Glasses, Contacts)</td>
</tr>
<tr>
<td>ADHD/ADD</td>
<td>Loss of Vision</td>
</tr>
<tr>
<td>Behavior Concerns</td>
<td>Bladder/Kidney Condition</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Absence Kidney</td>
</tr>
<tr>
<td>Seizure Disorder (Epilepsy)</td>
<td>Absence of Testicle</td>
</tr>
<tr>
<td>Heart Murmur</td>
<td>Arthritis</td>
</tr>
<tr>
<td>Cardiac Condition/Surgery</td>
<td>Fractures</td>
</tr>
<tr>
<td>High/Low Blood Pressure</td>
<td>Scoliosis</td>
</tr>
<tr>
<td>Fainting During Exercise</td>
<td>Chicken Pox/Date</td>
</tr>
<tr>
<td>Head Injury</td>
<td>Surgery (Tonsils, Hernia)</td>
</tr>
<tr>
<td>Migraine Headaches</td>
<td>Under Current Medical Care</td>
</tr>
</tbody>
</table>

List any special medical problems or serious injuries or gym restrictions

______________________________  ____________________________  
Parent/Guardian Signature      Date
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.

**Student Name**

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

**Date of Birth**

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

**Gender**

- [ ] Male
- [ ] Female

**Parent / Person in Parental Relation info**

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

**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?

<table>
<thead>
<tr>
<th>Language Options</th>
<th>Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
</tr>
<tr>
<td>Does not read</td>
<td>☐</td>
</tr>
</tbody>
</table>

Specify: [ ]

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

<table>
<thead>
<tr>
<th>Language Options</th>
<th>Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
</tr>
<tr>
<td>Does not write</td>
<td>☐</td>
</tr>
</tbody>
</table>

Specify: [ ]
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.

   □ No    □ Not sure    □ Yes  

   If yes, please explain: ____________________________

   How severe do you think these difficulties are?

   □ Minor    □ Somewhat severe    □ Severe

   □ Very severe

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

   *Please complete 10b below if yes.

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

   □ No    □ Yes  

   Type of services received: ____________________________

   If you marked Yes, indicate which services your child received: ____________________________

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 educational information from the school?

   ____________________________

Signature of Parent or of Person in Parental Relation: ____________________________

Date: ____________________________

Relationship to student: ____________________________

Official entry only - Name/Position of Personnel Administering HLQ:

Name: ____________________________

Position: ____________________________

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

Name: ____________________________

Position: ____________________________
**Date of Individual Interview:**

<table>
<thead>
<tr>
<th>MON</th>
<th>DAY</th>
<th>YR</th>
</tr>
</thead>
</table>

**Outcome of Individual Interview:**

- [ ] Administer NYSIETTLE
- [ ] Administer
- [ ] English Proficient
- [ ] English

**Interview:**

- [ ] Refer to Language Proficiency Test

---

**Name/Position of Qualified Personnel Administering NYSIETTLE**

<table>
<thead>
<tr>
<th>NAME:</th>
<th>POSITION:</th>
</tr>
</thead>
</table>

**Date of NYSIETTLE Administration:**

<table>
<thead>
<tr>
<th>PROFICIENCY LEVEL ACHIEVED ON</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENTERING</td>
</tr>
</tbody>
</table>

| M | O. | Da | YR |

**NYSIETTLE:**

**For Students with Disabilities, List Accommodations, if Any, Administered in Accordance with IEP Pursuant to CSE Recommendation:**

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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.

بعد قراءة سياسة حوسبة الشبكات وأمن الإنترنت، يرجى طباعة اسمك وتوقيعه أدناه للإقرار بقبولك

USER’S NAME (please print): ____________________________________

ADDRESS: ______________________________________________________

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.

PLEASE RETURN TO PRINCIPAL

STUDENTS: RETURN TO PRINCIPAL

BOE Approved 2-1-12
Dear Parent/Guardian

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

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

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

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

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

Thank you for your cooperation in this health endeavor.

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

Carroll Hill
Phone 328-5720
Fax 274-4587

Pre-K
Phone 328-5436
Fax 271-7692

School 16
Phone 328-5120
Fax 274-4585

School 17
Phone 328-5520
Fax 274-4374

School 18
Phone 328-5323
Fax 271-5175

School 19
Phone 328-5025
Fax 203-6874

School 20
Phone 328-5220
Fax 271-5205

School 21
Phone 328-5320
Fax 271-5175

School 22
Phone 328-5425
Fax 271-5174

Carroll Hill
School 16
School 17
School 18
School 19
School 20
School 21
School 22

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Phone 328-5320
Fax 271-5175

School 22
Phone 328-5425
Fax 271-5174
Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

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

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date</td>
<td>Sex</td>
<td>Will this be your child’s first visit to a dentist?</td>
</tr>
<tr>
<td>School Name</td>
<td></td>
<td>Yes</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 ___________________________ Date __________________

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

I. The dental health condition of ________________________ on __________________ (date of assessment)

- 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 schools does not preclude the student from attending school.

Dentist’s/Dental Hygienist’s name and address

<table>
<thead>
<tr>
<th>(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.

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.
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.

نظرًا لتغيير لوائح إدارة التعليم بولاية نيويورك، لن يتم إعطاء الأدوية التالية إلا بأمر مكتوب من مقدم الرعاية الصحية الخاص بك وإذكاك الكتابي. قائمة الأدوية، التي ستكون متاحة في مكتب الصحة بمدرستك، مذكورة أدناه. يرجى مطالبة مقدم الرعاية الصحية الخاص بك بخصوص الأدوية المناسبة لطفلك.

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.

طلب واحد فقط لكل طالب. يجب أن يكون لكل طالب طلب الدواء الفردي في هذا الملف. يرجى إعادة الاستمارة الموقعة والمكتوبة إلى مكتب الصحة في مدرستك.

**Comments**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Student Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen – 325 mg – pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>relief</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acetaminophen – 80 mg – liquid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>/chewable – pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antacid – liquid – relief of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>upset stomach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bacitracin topical ointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benadryl topical cream</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzolonium – antiseptic solution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calamine – relieves itching</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chloraseptic Spray</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough Drops (Middle &amp; High School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>students only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrocortisone topical cream 1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orajel – oral pain relief</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tums (Middle &amp; High School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>students only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaseline Lotion and Ointment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
April 23, 2015

Dear Parents/Guardians:

The Enlarged City School District of Troy provides special education services and programs to students with disabilities pursuant to applicable federal and state laws. Any parent or person in parental relation who suspects that his/her child has a disability may refer the child for an evaluation by the District’s Committee on Special Education (CSE) for eligibility for special education services and programs. More detailed information on this process is available in A Parent’s Guide to Special Education, which is published on the New York State Education Department’s website in English and Spanish.

Parents or persons in parental relation should contact the District’s Director of Pupil Personnel Services, Donna Fitzgerald, at School 12 475- First Street Troy, N.Y. 12180 or by calling 328-5075.
