TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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

Checklist for Prekindergarten (4 year-olds)
Registration Applicants

Welcome to Troy Schools!

Attention Parent/Guardian: Your child must be age 4 by December 1, 2024 for the 2024-25 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)

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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 2024-2025 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
Sacred Heart - 308 Spring 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 <u>one</u> 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?____

☐SP ☐Summer Serv ***Office Use Only*** **Date: _____/_____/_____**

ID: _____ Home School: _____ School Enrolled: _____

Proof of Residency	Other Documents	Enrollment Exceptions
☐ National Grid Bill	☐ Photo ID	☐ Wynantskill student
☐ Lease	☐ Birth Certificate	☐ Permission Rcvd
☐ Notarized Landlord Letter	☐ DSS 299 – District: _____	☐ North Greenbush student
☐ Mortgage Statement	☐ Custody	☐ Permission Rcvd
☐ Other: _____	☐ Parent/Custodial Affidavits	☐ Employee's child
☐ McKinney-Vento	☐ Adoption	→ Employee ID: _____
	☐ Immunization	☐ Foreign Exchange
	☐ Physical	☐ Tuition Paying
	☐ 14 Day Letter	
	☐ Other: _____	

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

Child Pickup ☐ 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

Child Pickup ☐ 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 <u>ANY and ALL</u> 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

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 Student Registration Form

TROY CITY SCHOOL DISTRICT

PREKINDERGARTEN PROGRAM SITES

The following sites hold a Prekindergarten program in conjunction with the Troy City School District. Please note these are subject to change

1. School #2 470 Tenth Street	7:30 – 2:00	Head Start collaboration Additional Paperwork Required Parents transport
2. School #12 475 First Street	7:45 – 2:00	Parents transport Head Start Collaboration Additional Paperwork Required Tentative Afterschool Care option
3. School #12 475 First Street	8:15 – 1:30	Parents transport
4. Sacred Heart 308 Spring Avenue	8:00 – 1:00	Parents transport Wrap-around & After School Care option School Uniform
5. Sunnyside Day Care Center 9th and Ingalls Avenue	8:00 -1:00	Parents transport Afterschool Care option

Selection Criteria

TROY CITY SCHOOL DISTRICT

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.

	Selection Criteria	
	Troy School District- 4 year old Pre K	
	Criteria	**Point**
	4 years old by December 1 , 2024	10
	Both parents employed full time	20
	Domestic Violence	25
	Drug or Alcohol Abuse	10
	Foster Child	50
	Homeless	100
	Medical issue	15
	Receives Special Ed. Services	20
	Parent Incarcerated	10
	Parent attending college	15
	Parent attending High School	20
	Parent is actively seeking employment	15
	Parent is employed full time	25
	Parent is employed part time	10
	Parent needs interpreter	10
	Parent receives disability payment	15
	SSI	100
	TANF	100
	SNAP	100
	CPS Involvement	
	Total Points	

Prekindergarten Student Registration Form

TROY CITY SCHOOL DISTRICT

SITE REQUEST FORM

Child's Name: _____

Criteria for Acceptance:

- Child must reside within the Troy City School District.
- The child must be 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 March 7th. Applications will be selected at random to fill the available Pre K classrooms. You will be notified by mail of your child's placement. Every effort will be made on our part to grant you your Prekindergarten preference.

Additional Childcare

Wrap-around childcare is an option at some Pre K sites. This means that a parent can have the option of childcare before and/or after the Pre K day. However, the cost associated with the additional childcare is the responsibility of the parent or guardian.

Prekindergarten Student Registration Form

TROY CITY SCHOOL DISTRICT

CHILD PROFILE

Child's name _____

Language(s) spoken in the home _____

Is your child currently attending:

daycare_____ nursery school_____ or Head Start_____

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

_____

Does your child have any religious dietary needs?

_____

Mother's name_____Age_____Education_____
Phone: Home:_____ Cell:_____ Work:_____

Father's name _____ Age_____ Education_____
Phone: Home:_____ Cell:_____ Work:_____

Sitter's/Day Care Name _____

Address _____

Phone_____

Prekindergarten Student Registration Form

TROY CITY SCHOOL DISTRICT

CHILD RELEASE FORM

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

I hereby give the staff at _____ Pre K
(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:

Name	Phone Number	Relationship to Child
		Parent
		Parent

Prekindergarten Student Registration Form

TROY CITY SCHOOL DISTRICT

WALKING TRIP PERMISSION SLIP

I desire to have my child _____ go with the Prekindergarten on
(name of child)
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 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 (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.

_____ X _____
Date Signature of Parent/Guardian

_____
Please Print Name

TROY CITY SCHOOL DISTRICT

SCHOOL HEALTH SERVICES Entering Date_____ Grade_____ School_____ Sex_____

Student Name_____ Address _____ DOB_____ Place of Birth_____
Last First MI

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 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.

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

List any special medical problems or serious injuries or gym restrictions _____
Parent/Guardian Signature_____ Date _____

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

Home Language Questionnaire (HLQ)

STUDENT NAME:	
First Middle Last	
DATE OF BIRTH:	GENDER:
Month Day Year	❑ Male ❑ Female ❑ Non Binary
PARENT/PERSON IN PARENTAL RELATION INFO:	
Last Name First Name Relation to	

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 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?	❑ Mother _____ *specify*	❑ Father _____ *specify*	❑ Guardian(s) _____ *specify*
4. What language(s) does your child understand?	❑ English	❑ Other _____ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other _____ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other _____ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other _____ *specify*	❑ Does not write

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

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School *Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

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:**

ORAL INTERVIEW NECESSARY: ❑ **NO** ❑ **YES**

****DATE OF INDIVIDUAL INTERVIEW:**

MO DAY YR.

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:

MO. DAY YR.

PROFICIENCY LEVEL ACHIEVED ON NYSITELL:
☐☐ ENTERING ☐☐ EMERGING
☐☐ TRANSITIONING
☐☐ EXPANDING
☐☐ COMMANDING

FOR STUDENTS WITH DISABILITITES, LIST ACCOMODATIONS, 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

Prekindergarten Student Registration Form

TROY CITY SCHOOL DISTRICT

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?

_____

_____

TROY CITY SCHOOL DISTRICT

DO NOT RELEASE MEDIA FORM

2024-25 School Year

Return form to your school
ONLY IF YOU OBJECT
to your child's photo being published.

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.

TROY
CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

475 First Street
Troy, New York 12180

NETWORK COMPUTING AND INTERNET SAFETY POLICY 4526

USER ACKNOWLEGEMENT

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

TROY
CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

475 First Street
Troy, New York 12180

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.

Troy High School
Phone 328-5472
Fax 271-5164

Troy Middle School
Phone 328-5365
Fax 271-5492

Troy Community School
Phone 328-5025
Fax 328-5050

Carroll Hill
Phone 328-5703
Fax 274-4587

School 2
Phone 328-5603
Fax 271-5205

School 12
Phone 328-5025
Fax 203-6874

School 14
Phone 328-5803
Fax 274-0371

School 16
Phone 328-5103
Fax 328-5138

School 18
Phone 328-5501
Fax 328-5147

Pre-K
Phone 328-5012
Fax 328-5061

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)

Child's Name: Last First Middle

Birth Date: / / Month Day Year	Sex: ☐ Male ☐ Female	Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School Name: Grade

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

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

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

Parent's Signature **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.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE 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

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐Persistent ☐Other: ☐ Medication/Treatment Order Attached ☐Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐1 ☐2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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: ☐Yes ☐Not Done **Hypertension:** ☐Yes ☐Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

LaboratoryTesting	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**
☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ 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

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision	**With Correction** ☐Yes ☐No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail					☐

Notes

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐Pass ☐Fail	**Left** ☐Pass ☐Fail	**Referral** ☐Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK

☐ ***Family cardiac history reviewed –** required for Dominic Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **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 ☐

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

Paul Reinisch, Coordinator
Health, Physical Education
Recreation, Athletics & Safety
(518) 328-5417
I.G. Racela, MD, Medical Officer
(518) 328-5425

CONSENT TO ADMINISTER MEDICATION

Dear Parent/Guardian:

A list of medications, which will be available in your school's Health Office, are listed below. Due to New York State Education Department regulations, the following medications will only be administered with your health care provider's written order and your written permission.

Please have your health care provider check the medications appropriate for your child.
Only one student per form is allowed. 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**	_____
_____ **Hydrocortisone topical cream 1%**	_____
_____ **Benadryl Cream**	_____
_____ **Benzolkonium-antiseptic solution**	_____
_____ **Calamine – relieves itching**	_____
_____ **Orajel – oral pain relief**	_____
_____ **Vaseline Lotion and Ointment**	_____

Student Name_____ Date of Birth_____

School_____ Grade_____

PHYSICIAN SIGNS HERE

Health Care Provider's Signature_____ Phone#_____ Date_____

PARENT SIGNS HERE

Parent/Guardian's Signature_____ Phone#_____ Date_____

TROY
CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

Pupil Personnel Services
Donna Fitzgerald, Director
Pupil Personnel Services

475 First Street
Troy, New York 12180

(518) 328-5006 Director's Office
(518) 328-5075 Main Office
(518) 328-5060 Fax

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.

English - http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm.

Spanish-http://www.p12.nysed.gov/specialed/publications/policy/spanishparentguide.htm

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

New York State Migrant Education Program

Identification & Recruitment Office

Parent Survey

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provide 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 a few minutes to complete this questionnaire.

Has anyone in your family worked, or look 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 the 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 NO, please check this box ☐

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.