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, 2025 for the 2025-26 school year.

Please complete one Registration Packet for every child you are registering. Once you have completed the Registration Packet, please bring the packet and required documents, noted below, to the Central Registration Department.

A parent or guardian must be present with photo identification at the Central Registration Office located at School 12, 475 First Street

Office hours are 7:30 a.m. – 3:00 p.m. during school.
School breaks and summer office hours are 7:00 a.m. – 2:00 p.m.

Required documents checklist:

1. Health Certificate signed by a doctor
2. Up-to-date Immunization Record
3. Birth Certificate
4. Proof of Residency (one of the following must be provided)
    - Utility bill or deposit (dated 30 days prior to registration)
    - Lease or rental agreement
    - Mortgage Statement
    - Affidavit of Residence - * Only applies if parent lives in a dwelling that they do not lease or own in their name. The affidavit can be found at https://www.troycsd.org/district-services/registration/
5. Photo Identification of Parent/Guardian
6. Dental Health Certificate (optional)

NYS Prekindergarten Regulations. According to the revised New York State Prekindergarten Regulations 151-2.6 Admission Requirements for Children:

No child may participate in the Prekindergarten program unless:

(1) A report of a medical examination of the child signed by a physician is submitted within 30 days of admission which states that the child is free from contagious or communicable disease.

(2) The child has been immunized to the extent appropriate to his/her age in accordance with Section 2164 of the Public Health Law; or has been granted an exemption from such immunization.

Note: *Universal Pre-K is dependent upon funding under the Troy Universal Pre-K Grant from the New York State Education Department for the 2025-2026 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

Pre-K Schools
School 2 - 470 Tenth Street
School 12 - 475 First Street
Sacred Heart - 308 Spring Avenue
Sunnyside – 9th and Ingalls Avenue

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

Housing Questionnaire

Name of School: _____ Grade: _____

Name of Student: _____
Last *First* *Middle*

Gender: ☐ Male | ☐ Female | ☐ Nonbinary Date of Birth: ____/____/_____
Month Day Year

Address: _____/_____/_____/____/_____
Street *Apartment/Floor* *City* *State* *Zip*

Phone: (_____) - _____

The answer you give below will help the District determine what service 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: _____

_____ X _____
Print name of Parent/Guardian or Student *Parent/Guardian Signature or Student*

_____
Date

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

Student Registration Form

Student Name: _____/_____/_____
First *Middle* *Last*

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

Address: _____/_____/_____/____/_____
Street *Apartment/Floor* *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

What language does the student speak and understand the most? _____

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

Race: ☐ Black / African American

☐ White

☐ Asian

☐ American Indian or Alaska Native

☐ Native Hawaiian or other Pacific Islander

Gender: ☐ Male | ☐ Female | ☐ Nonbinary

Date of Birth: ____/____/____ Place of Birth: _____/_____/_____
Month Day Year *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? ____/____/____
Month Day Year

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

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

Parent / Guardian Information

Mother/Guardian: _____/_____/_____
First *Middle* *Last*

Relationship to child: ☐ Mother | ☐ Stepmother | ☐ Legal Guardian | ☐ Foster Parent | ☐ Other: _____

Resides in home?	Yes	No	Custodial parent?	Yes	No	Receive correspondence?	Yes	No	Child pickup?	Yes	No
	☐	☐		☐	☐		☐	☐		☐	☐

Mailing Address if different from above: _____/_____/_____/____/_____
Street *Apartment/Floor* *City* *State* *Zip*

Home Phone: (___) - _____ Work Phone: (___) - _____ Cell Phone: (___) - _____

Phone call priority (1 – 3): Home ____ Work ____ Cell ____

Email Address: _____ Email Type: ☐ Home | ☐ Work

Father/Guardian: _____/_____/_____
First *Middle* *Last*

Relationship to child: ☐ Father | ☐ Stepfather | ☐ Legal Guardian | ☐ Foster Parent | ☐ Other: _____

Resides in home?	Yes	No	Custodial parent?	Yes	No	Receive correspondence?	Yes	No	Child pickup?	Yes	No
	☐	☐		☐	☐		☐	☐		☐	☐

Mailing Address if different from above: _____/_____/_____/____/_____
Street *Apartment/Floor* *City* *State* *Zip*

Home Phone: (___) - _____ Work Phone: (___) - _____ Cell Phone: (___) - _____

Phone call priority (1 – 3): Home ____ Work ____ Cell ____

Email Address: _____ Email Type: ☐ Home | ☐ Work

Other Children Living in the Household:

Name: _____ Date of Birth: ____/____/____
Month Day Year
Gender: ☐ Male | ☐ Female | ☐ Nonbinary | Past Registrant? ☐ Yes | ☐ No

Name: _____ Date of Birth: ____/____/____
Month Day Year
Gender: ☐ Male | ☐ Female | ☐ Nonbinary | Past Registrant? ☐ Yes | ☐ No

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

Emergency Contacts

Please list the names of ANY and ALL persons the 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: _____/_____/_____/____/_____
Street *Apartment/Floor* *City* *State* *Zip*

Emergency Contact #2: Name: _____ Relationship to Student: _____
Other than parent/guardian

Home Phone: (___) - _____ Work Phone: (___) - _____ Cell Phone: (___) - _____

Address: _____/_____/_____/____/_____
Street *Apartment/Floor* *City* *State* *Zip*

Emergency Contact #3: Name: _____ Relationship to Student: _____
Other than parent/guardian

Home Phone: (___) - _____ Work Phone: (___) - _____ Cell Phone: (___) - _____

Address: _____/_____/_____/____/_____
Street *Apartment/Floor* *City* *State* *Zip*

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 (Hurricane, Tropical Storm, Tornado, Wildfire, Landslide, Tsunami, Sinkhole)

☐ Civil Disaster (War {asylee, refugee}, Fire Accidents, Industrial Accidents)

☐ Health (Pandemics and/or 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: _____

☐ 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 a copy of placement order (DSS-299)**

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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 flowing types 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 Registering For Pre-K

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, please complete the Migrant Education Form located at the end of the packet (page 31).

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.

X_____ _____

Parent or Guardian Signature *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

TROY
CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

Prekindergarten Student Registration Form

Troy City School District

ATTENDANCE EXPECTATIONS

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

- My child will be in school each day Prekindergarten is in session unless he or she is sick.
- If my child is not in attendance and is not sick, I understand that my child can be dropped from the program.
- I will send a written excuse each day my child is absent.
- If I can, I will call the Prekindergarten school/center to notify the school that my child will be absent.
- My child will be at school and picked up on time daily and will stay for the full Pre K program. I will sign my child in and out each day of the program. I understand that my child may be dropped from the program by not complying.
- My child will be dropped off at the start of the program and picked up at the end of the program. I understand that it is important for my child to be present for the entire day and by not complying my child may be dropped from the program.
- I understand it is my responsibility to be sure to give the Pre K teacher and staff updated phone numbers.
- I understand that if I move outside the Troy City School District area, my child will no longer be able to attend the Prekindergarten program. I will also notify the district that my child has moved.

X_____ _____

Parent or Guardian Signature *Date*

TROY
Today's Students. Tomorrow's Leaders.
CITY SCHOOL DISTRICT

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.

Troy School District: 4 year-old Pre-K		
✓	**Criteria**	**Point**
	4 years old by December 1st, 2025	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:	

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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 School** 308 Spring Avenue	8:00 – 1:00	Parent transport Wrap-around & After School Care option Uniforms required
5. **Sunnyside Day Care Center** 9th and Ingalls Avenue	8:00 – 1:00	Parents transport After School Care option

TROY
Today's Students. Tomorrow's Leaders.
CITY SCHOOL DISTRICT

Prekindergarten Student Registration Form

Troy City School District

SITE REQUEST FORM

Name of Child: _____
Last *First* *Middle*

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 are 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 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.

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

Prekindergarten Student Registration Form

Troy City School District

CHILD PROFILE

Name of Child: _____
Last *First* *Middle*

Language(s) spoken in the home: _____

Is your child currently attending: ☐ Daycare | ☐ Nursery school | ☐ Head Start

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

_____

Does your child have any religious dietary needs?

_____

Mother/Guardian: _____/_____/_____
First *Middle* *Last*

Home Phone: (___) - _____ Work Phone: (___) - _____ Cell Phone: (___) - _____

Age: _____ Education: _____

Father/Guardian: _____/_____/_____
First *Middle* *Last*

Home Phone: (___) - _____ Work Phone: (___) - _____ Cell Phone: (___) - _____

Age: _____ Education: _____

Babysitter or **Day Care Name:** _____

Address: _____/_____/_____/____/_____
Street *Apartment/Floor* *City* *State* *Zip*

Phone: (_____) - _____

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

Prekindergarten Student Registration Form

Troy City School District

CHILD RELEASE FORM

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

I hereby give the staff at _____ Pre-K permission to release my child
name of school

_____ to the following person(s).
name of child

X_____ _____
Parent or Guardian Signature *Date*

Please Print Names of Authorized People:

Name	Phone Number	Relationship to Child
		Parent

TROY
CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

Prekindergarten Student Registration Form

Troy City School District

WALKING TRIP PERMISSION SLIP

I desire to have my child, _____, go with the Prekindergarten
name of child

on all walking trips the class may take from September, 20___ to June, 20____. I shall be responsible for his/her actions while the class is taking the trip.

X_____ _____

Parent or Guardian Signature *Date*

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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, _____,
name of child *name of parent/guardian*

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 _____

Print name of Parent/Guardian or Student *Parent/Guardian Signature or Student*

_____

Date

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

School Health Services

Entering Date: _____ Grade: _____ School: _____ Sex: ____

Student Name: _____ Address: _____ D.O.B.: _____ Place of Birth: _____

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's 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.

	No	Yes	Explain with Date / Medication		No	Yes	Explain with Date / Medication
Allergies:				Anemia/Bleeding Disorder			
→ Food				Sickle Cell			
→ Bees				Chronic Ear Infection			
→ 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 of Kidney			
Seizure Disorder (Epilepsy)				Absence of Testicle			
Heart Murmur				Arthritis			
Cardiac Conditions/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, serious injuries, or gym restrictions: _____

X_____ _____
Parent or Guardian Signature *Date*

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

NYSED.gov

NEW YORK STATE EDUCATION DEPARTMENT
Emergent Multilingual Learners Language Profile for Prekindergarten Students

Dear Parent or Guardian,
Thank you for completing the Emergent Multilingual Learners Language Profile. This survey will assist your new school with valuable information about your child's experience with languages. Information gathered will assist Prekindergarten educators in delivering academically and linguistically relevant instruction that strengthens the language and literacy of all students.

THIS SECTION TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY AND MAINTAINED ON FILE
Date Profile Completed:
Student Name:
Gender:
Date of Birth:
District or Community Based Organization Name:
Student ID (if applicable):
Name of Person Administering Profile:
Title:

Parent or Person in Parental Relation Information

Name of parent or person in parental relation:

Relationship (to student) of person providing information for this profile: ☐ mother ☐ father ☐ other _____

In what language(s) would you like to receive information from the school? ☐ English ☐ other home language:

Language in the Home

1. In what language(s) do you (parents or guardians) speak to your child at home?

2. What is/are the primary language(s) of each parent/guardian in your home? (List all that apply.)

3. Is there a caretaker in the home? ☐ yes ☐ no

If yes, what language(s) does the caretaker speak most frequently?

4. What language(s) does your child understand?

5. In what language(s) does your child speak with other people?

6. Does your child have siblings? ☐ yes ☐ no

If yes, in what language(s) do the children speak with each other most of the time?

7a. At what age did your child begin to speak in short sentences? In what language?

7b. At what age did your child begin to speak in full sentences? In what language?

8. In what language does your child pretend play?

9. How has your child learned English so far (television shows, siblings, childcare, etc.)?

Language Outside the Home/Family

10. Has your child attended any nursery, Head Start or childcare program? ☐ yes ☐ no

If yes, in what language was the program conducted?

In what language does your child interact with other people in the nursery or childcare setting?

11. How would you describe your child's language use with friends?

Language Goals

12. What are your language goals for your child? For example, do you want child to become proficient in more than one language?

13. Have you exposed your child to more than one language to ensure that he or she is bilingual or multilingual? ☐ yes ☐ no

14. Does your child need to speak a language other than English in order to communicate with your relatives or extended family? ☐ yes ☐ no

If yes, in what language(s)?

Emergent Literacy

15. Does your child have books at home or does he or she read books from the library?

In what language(s) are these books read to him or her?

16a. Can your child name any letters or sounds in English? ☐ yes ☐ no

16b. Can your child recognize letters or symbols in another language? ☐ yes ☐ no

If yes, in what language(s)?
17a. Does your child pretend to read? ☐ yes ☐ no ☐ unsure If yes, in what language(s)? 17b. Does your child pretend to write? ☐ yes ☐ no ☐ unsure If yes, in what language(s)?
18. Does your child tell the stories from his/her favorite books or videos? ☐ yes ☐ no If yes, in what language(s)?
19. Does your child's childcare or nursery program describe goals for his or her learning? ☐ yes ☐ no If so, what goals do they describe?
20. Please describe anything special you did to prepare your child to begin Prekindergarten.

[i] For more information contact: the New York State Education Department Office of Early Learning at (518) 474-5807 or email OEL@nysed.gov or the New York State Education Department Office of Bilingual Education and World Languages at (518) 474 - 8775 or (718) 722-2445 or email OBEWL@nysed.gov.

TROY
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CITY SCHOOL DISTRICT

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 will help assist with the Developmental Screenings for Troy City School District Pre-K rooms. The screening is an informal assessment to identify possible developmental delays (speech, motor, educational and behavioral). Each child is seen individually by a teacher, speech therapist, or motor therapist. If any concerns do exist, a formal evaluation may be recommended. Please sign and date below for an outside approved agency to assist with your child's screening.

Child's Name: _____/_____/_____
First *Middle* *Last*

Child's Date of Birth: ____/____/_____
Month *Day* *Year*

Child's Gender: ☐ Male | ☐ Female

Parent(s) Name: _____

Phone: (_____) - _____

I give permission for my child, _____, to receive a developmental screening from an
name of child
out of district provider.

TROY
CITY SCHOOL DISTRICT
Today's Students. Tomorrow's Leaders.

Prekindergarten Student Registration Form

Troy City School District

Information Sheet

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

Parent/Guardian Name(s) _____

Email Address _____

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

_____

_____

Family Pets _____

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

_____

_____

What are you child's favorite snack foods?

_____

_____

What are your child's interests and what activities do they like to do?

_____

_____

What are your child's dislikes (food, activities, other)?

_____

_____

Do you have any behavioral concerns for your child?

_____

_____

_____

Anything else you would like to tell us about your child (i.e. medical concerns)?

_____

_____

DO NOT RELEASE MEDIA FORM

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

2025-26 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: _____/_____/_____
First *Middle* *Last*

Address: _____/_____/_____/____/_____
Street *Apartment/Floor* *City* *State* *Zip*

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.

X_____ _____
Parent or Guardian Signature *Date*

Networking Computing and Internet Safety Policy 4526

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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 issues 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

TROY
CITY SCHOOL DISTRICT
Today's Students. Tomorrow's Leaders.

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.

Pre-K
Phone: 328-5012
Fax: 328-5061

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

Carrol Hill School
Phone: 328-5703
Fax: 274-4587

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

Troy Middle School
Phone: 328-5365
Fax: 271-5492

Troy High School
Phone: 328-5472
Fax: 271-5164

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)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ 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 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.

Dentist's/ Dental Hygienist's name and address (please print or stamp)	**Dentist's/Dental Hygienist'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) ORa 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.

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:**

Laboratory Testing	Positive	Negative	Date	Lead Level Required for Pre-K & 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 Pre-K 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. <u>If Restrictions Apply</u> –** 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 <u>ONLY</u> 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.

Consent to Administer Medication

Paul Reinisch, Director
Health, Physical Education,
Recreation, Athletics, & Safety

Dr. John O'Bryan
Medical Director
Dear Parent/Guardian,
(518) 328-5425

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: ____/____/_____
Month Day Year

School: _____ Grade: _____

X_____ __
Health Care Provider Signature *Date*

X_____ __
Parent or Guardian Signature *Date*

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

Pupil Personnel Services
Donna Fitzgerald, Director
(518) 328-5075

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.

A Parent's Guide – https://www.nysed.gov/special-education/parents-guide-special-education

Parents or persons in parental relations should contact the District's Director of Pupil Personnel Services, Donna Fitzgerald, at School 12, 475 First Street, Troy, NY 12180, or by calling (518) 328-5075.

TROY CITY SCHOOL DISTRICT

Today's Students. Tomorrow's Leaders.

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.