HERRICKS PUBLIC SCHOOLS

Education Today
Knowledge Forever

Welcome to Herricks UFSD

Dear Parent/Person in Parental Relation,

Attached is a packet of materials needed in order to register your child.

Please call Pat Lewis, Registration Department, at 516-305-8987 for an appointment or if you have any questions regarding registration. Hours of registration are Monday through Friday from 9:00 a.m. to 3:30 p.m.

Thank you for your cooperation.

♦ HERRICKS PUBLIC SCHOOLS ♦ 999-B HERRICKS ROAD ♦
NEW HYDE PARK ♦ NEW YORK 11040

Registration/Status Form Starting Date:_____

For Office Use Only

Proof of Residence	***Residence***	***General Information***	***Transportation***	***School to Attend***
Moving into district ☐ Moving within district ☐ Living with _____	New Home ☐ Renting ☐	Birth Certificate ☐ Passport ☐ Other ☐ Immunization ☐ Medical ☐	Walker ☐ Rider ☐	Center Street ☐ Denton Avenue ☐ Searingtown ☐ Middle School ☐ High School ☐

STUDENT INFORMATION: (Please type or print legibly with a ball point pen.)

Last Name:	First Name:		Middle Name/Initial:
Address:	Town:		Zip:
Date of Birth:	Gender:	Race/Ethnicity:	Grade:
Birthplace:	Telephone Number:		
Previous Address:	Town:	State:	Zip:

DOES YOUR CHILD HAVE A DISABILITY? ☐ YES ☐ NO

HAS YOUR CHILD RECEIVED TITLE I SERVICES IN THE PAST? ☐ YES ☐ NO

1. Is the student currently living in permanent housing? ☐ YES ☐ NO

   If you answered "Yes" please proceed to Page 2.
   If you answered "No" please proceed to Question 2.

2. If the student is not currently living in permanent housing, where is the student currently living?

   - ☐ In a shelter
   - ☐ With another family or other person on a temporary basis because of an involuntary loss of housing or as a result of economic hardship
   - ☐ In a hotel/motel
   - ☐ In a car, park, bus, train or campsite
   - ☐ Other temporary living situation (Please describe): _____
     _____

Please be advised that if the student is living in temporary housing, the District may conduct a home visit if it so chooses. However, please also be advised that the District cannot contact a landlord or building superintendent to verify a student's housing status.

The answer you give above will 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 do not have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificates. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

*****The District's homeless liaison is Jaclyn Mirabile, Social Worker, 516-305-8432.

PARENT(S)/ PERSON(S) IN PARENTAL RELATION:

PARENT 1:	**PARENT 2:**
CHECK ALL THAT APPLY: ☐ FATHER ☐ MOTHER ☐ PERSON(S) IN PARENTAL RELATION ☐ CUSTODIAL PARENT ☐ FOSTER PARENT NAME: _____ LAST FIRST MI BIRTHPLACE: _____ BUSINESS TELEPHONE: _____ CELL TELEPHONE: _____ E-MAIL ADDRESS: _____	CHECK ALL THAT APPLY: ☐ FATHER ☐ MOTHER ☐ PERSON(S) IN PARENTAL RELATION ☐ CUSTODIAL PARENT ☐ FOSTER PARENT NAME: _____ LAST FIRST MI BIRTHPLACE: _____ BUSINESS TELEPHONE: _____ CELL TELEPHONE: _____ E-MAIL ADDRESS: _____

PARENT(S)/ PERSON(S) IN PARENTAL RELATION WITH WHOM STUDENT DOES *NOT* RESIDE:

PARENT 1:	**PARENT 2:**
CHECK ALL THAT APPLY: ☐ FATHER ☐ MOTHER ☐ PERSON(S) IN PARENTAL RELATION ☐ CUSTODIAL PARENT ☐ FOSTER PARENT NAME: _____ LAST FIRST MI BIRTHPLACE: _____ BUSINESS TELEPHONE: _____ CELL TELEPHONE: _____ E-MAIL ADDRESS: _____	CHECK ALL THAT APPLY: ☐ FATHER ☐ MOTHER ☐ PERSON(S) IN PARENTAL RELATION ☐ CUSTODIAL PARENT ☐ FOSTER PARENT NAME: _____ LAST FIRST MI BIRTHPLACE: _____ BUSINESS TELEPHONE: _____ CELL TELEPHONE: _____ E-MAIL ADDRESS: _____

EMERGENCY CONTACT (PERSON TO CALL WHEN PARENT/GUARDIAN CANNOT BE REACHED)

Name	Home Phone	Cell Phone	Work Phone	Relationship to Child
Name	Home Phone	Cell Phone	Work Phone	Relationship to Child
Name	Home Phone	Cell Phone	Work Phone	Relationship to Child

OTHER CHILDREN IN FAMILY:

NAME	GENDER	RELATIONSHIP	DATE OF BIRTH (IF MINOR)	GRADE

OTHER FAMILIES LIVING AT THIS ADDRESS:

NAME	GENDER	RELATIONSHIP	DATE OF BIRTH (IF MINOR)	GRADE

I certify, under penalty of law, that the above statements are true. I further certify that I do not maintain a residence outside the boundaries of the Herricks School District. I understand that if the above mentioned child(ren) is (are) found not to be a legitimate resident(s) of the Herricks Union Free School District that "I WILL BE LEGALLY RESPONSIBLE FOR AND WILL PAY THE SCHOOL DISTRICT'S ANNUAL TUITION RATE PER CHILD, RETROACTIVE TO THE FIRST DAY OF ADMISSION, ALONG WITH ANY COSTS ASSOCIATED WITH ENROLLING MY CHILD."

I also realize that theft of governmental services is a crime punishable under the State Penal Law and that a false statement made in connection with this application will make me liable to criminal prosecution. I further understand that it is my responsibility to notify the school district if I change my residence.

I have been informed that the school district may make unannounced home visits for the purpose of residence verification.

☐ *(Please initial) I have read and understand the above.*

Signature of Parent/Person in Parental Relation:_____ Date:_____

Registered by: _____ Date: _____

Form 1000 - **USE WHEN A HOMEOWNER OR RENTER IS REGISTERING HIS/HER OWN CHILD.**

Herricks Public Schools
New Hyde Park, NY 11040

Upon request, your child shall be enrolled and begin attendance on the next school day (unless a determination of non-residency is made on the date of request). The contents of this packet must be completed as soon as practical, but no later than three business days after the child's enrollment. The District will provide you with its residency determination within three business days of your child's enrollment. However, if you submit the contents of this packet on the third business day after your child's enrollment, the District will provide its residency determination on the fourth business day.

Please call 516 305-8987 to discuss interest in enrolling your child.

PROOF OF HOME OWNERSHIP OR RENTAL REQUIRED:

HOMEOWNER	**RENTER**
☐ Deed *OR* Tax Bill *OR* Mortgage Statement *OR* ☐ Statement by a third party relating to parent(s) or person(s) in parental relation's presence in the district	☐ Lease *OR* Landlord / tenant forms signed by owner and tenant.

Note: the District reserves the right to differentiate the weight given to each piece of documentation submitted as it determines is necessary. As an applicant, you should submit documentation that is most likely to prove your residency within the District.

AND THREE (3) PROOFS OF DISTRICT RESIDENCY:

NON-EXHAUSTIVE LIST OF ALTERNATE PROOF OF RESIDENCY (3 required)

- ☐ Current telephone bill showing name and address
- ☐ Current PSEG or National Grid statement with your name and address
- ☐ Driver's License and Car Insurance Identification Card
- ☐ Canceled Bank Check with printed name and address
- ☐ Pay Stub – showing a printed name and address within the district
- ☐ Moving bill from a commercial moving company
- ☐ Attorney statement – stating that he certifies that the individual resides at a specific address within the Herricks School District
- ☐ Current Tax Return or W-2 issued from Internal Revenue Service (printed name and address)
- ☐ Post Office confirmation stating change of address
- ☐ Court issued documentation (current name and address)
- ☐ Other proofs as may be appropriate. Acceptance of such other proofs shall be at the discretion of the District.

AND

- ☐ Student's original Birth Certificate (with raised seal) or record of baptism. If either is unavailable, the student may provide his or her passport (including a foreign passport). If all of the aforementioned documentation is unavailable, then the District may request additional documentary evidence.
- ☐ Affidavit from parent/person in parental relation evidencing relationship with child. (Parent/person in parental relation may submit alternative documentation as it deems necessary).
- ☐ Medical Records including Immunization
- ☐ Report Cad from previous school

The submission of false information or false statements in this application to the School District is a violation of the New York Penal Code 175.30 and is punishable by a fine and imprisonment of up to one year in jail.
In addition, the District will pursue action for tuition reimbursement against anyone whose false information results in the enrollment of students into the school district, who are not legal residents of the district.
01/23

HERRICKS PUBLIC SCHOOLS

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Parent's Statement Residency Affidavit

TO THE BOARD OF EDUCATION OF THE HERRICKS UNION FREE SCHOOL DISTRICT

This is to certify that I, _____

1. I understand that this statement is being made UNDER THE PENALTIES OF PERJURY, so that _____ may be admitted to the schools of the Herricks Public Schools.
(Name of Child)

2. I reside in the home of _____
(Homeowners Name)

_____
(Homeowners Address)

as my legal residence. I further certify that I do not maintain another residence outside the boundaries of the Herricks School District.

I understand that if the above mention child(ren) is (are) found not to be a legitimate residents of the Herricks Union Free School District, that I WILL BE LEGALLY RESPONSIBLE FOR AND WILL PAY THE SCHOOL DISTRICT'S ANNUAL TUITION RATE PER CHILD, RETROACTIVE TO THE FIRST DAY OF ADMISSION, ALONG WITH ANY COSTS ASSOCIATED WITH ENROLLING YOUR CHILD". I also realize that theft of governmental services is a crime punishable under the State Penal Law and that a false statement made in connection with this application will make me liable to criminal prosecution. I have been informed that the school district will make unannounced home visits for purposes of residency verification.

I further understand that if I move out of the home listed above, I will immediately notify the school district.

I have been informed that the school district may make unannounced home visits for the purpose of residence verification. I have read and understood the above. [ ] YES

_____
Signature of Parent/Person in Parental Relation

Sworn to before me this _____ day of _____, 20____

_____
Notary Public

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Elisa Alvarez, Associate Commissioner Office of
Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Person in Parental Relation:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

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

HOME LANGUAGE CODE _____

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other	_____ *specify*	
2. What was the first language your child learned?	❑ English	❑ Other	_____ *specify*	
3. What is the Home Language of each parent/guardian?	❑ Parent 1 _____ *specify*		❑ Parent 2 _____ *specify*	
	❑ Guardian(s) _____ *specify*			
4. What language(s) does your child understand?	❑ English	❑ Other	_____ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other	_____ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other	_____ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other	_____ *specify*	❑ Does not write

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: ❑ Parent ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

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

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

NAME: _____ **POSITION:** _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

****DATE OF INDIVIDUAL INTERVIEW:** _____ (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 DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

HERRICKS PUBLIC SCHOOLS

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Pupil Personnel Services

Dr. Thomas Sposato, PPS Director
tsposato@herricks.org

Eleni Chronas, PPS Assistant Director
echronas@herricks.org

Dear Parents/Person in Parental Relations,

Please note that the school district is required to inform all parents of children entering our schools of their child's rights with respect to special education.

In accordance with federal and state regulations, the Herricks School District provides appropriate special education services to students with educational disabilities. Any parents who suspect that their child may have an educational disability may make a written referral to the school's Principal or to Dr. Thomas Sposato, Director of Pupil Services, 999-B Herricks Road, New Hyde Park, NY 11040.

The law concerning special education is known as The Individuals with Disabilities Education Act (IDEA). The New York State Education Department's handbook on special education can be found at the following link:
http://www.p12.nysed.gov/specialed/publications/policy/parentsguide.pdf

Before referring a student who is not currently enrolled in the Herricks School District, the parent/guardian must contact the Central Registration Office at (516) 305-8900 to arrange an appointment. Forms and other details are available on the district website at:
www.herricks.org

Parents who suspect that their child under the age of 3 may need special education services should contact the Nassau County Department of Health Early Intervention Program at (516) 227-8661.

Sincerely,

Dr. Thomas Sposato
Director of Pupil Personnel Services

HERRICKS PUBLIC SCHOOLS

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Questionnaire for Children with Special Needs

Name of Child _____ School _____

Does your child have any handicapping conditions? ☐ Yes ☐ No

Has your child received any special education services? ☐ Yes ☐ No

If yes, what services has your child received?

_____

_____

_____

Does your child have a current IEP (Individualized Education Program)? ☐ Yes ☐ No

_____
Mother / Person in Parental Relation
(Please print)

_____
Father / Person in Parental Relation
(Please print)

Address: _____

_____

Home Telephone Number: _____

Business Number: _____

Cellphone Number: _____

12/19

HERRICKS PUBLIC SCHOOLS

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NAME AND ADDRESS OF SCHOOL STUDENT LAST ATTENDED.

Re: Child's name _____

Child's Birth Date _____

Please be informed that the above captioned child is a former student in your school. This student has entered Grade _____ in the Herricks School District.

Please forward the following information to the school indicated below:

A. Transfer Card
B. Report Card(s)
C. Scholastic Record (including NYS Required Elem/MS Science Investigations, if applicable)
D. Standardized Testing Record
E. Health Record
F. CSE Records (if applicable)

CENTER STREET SCHOOL **240 Center Street** **Williston Park, NY 11596**	**DENTON AVENUE SCHOOL** **1050 Denton Ave** **New Hyde Park, NY 11040**	**SEARINGTOWN SCHOOL** **106 Beverly Drive** **Albertson, NY 11507**	**HERRICKS MIDDLE SCHOOL** **7 Hilldale Drive** **Albertson, NY 11507**	**HERRICKS HIGH SCHOOL** **100 Shelter Rock Road** **New Hyde Park, NY 11040**
Attn: Nickie Barbarino	Attn: Sheila Condron	Attn: Judy Ruffino	Attn: Guidance Department	Attn: Guidance Department
Phone: 516-305-8333	Phone: 516-305-8433	Phone: 516-305-8533	Phone: 516-305-8657	Phone: 516-305-8757
Fax: 516-739-4739	Fax: 516-739-4754	Fax: 516-248-3277	Fax: 516-739-4738	Fax: 516-739-4741

Any further information will be greatly appreciated.

Ms. K. Elizabeth Guercin
Assistant Superintendent for Curriculum and Instruction

_____ _____
Signature of Parent / Guardian Date

_____
PRINT Name of Parent / Guardian

HERRICKS PUBLIC SCHOOLS

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NOTIFICATION OF RIGHTS UNDER THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT

This is to advise you of your rights with respect to the school records relating to (your son) (your daughter) (you) pursuant to the Federal "Family Educational Rights and Privacy Act of 1974."

Parents of a student under 18, or a student 18 or older, have a right to inspect and review any and all official records, files, and data directly related to their children, including all material that is incorporated into each student's cumulative record folder, and intended for school use or to be available to parties outside the school or school system, and specifically including, but not necessarily limited to, identifying data, academic work completed, level of achievement (grades, standardized achievement test scores), attendance data, scores on standardized intelligence, aptitude, and psychological tests, interest inventory results, health data, family background information, teacher or counselor ratings and observations, and verified reports of serious or recurrent behavior patterns.

A parent of a student under 18 years of age or a student 18 years of age or older shall make a request for access to a child's (his/her own) school records, in writing, to the Elementary Principal of the building to which such student is assigned or the Guidance Counselor in the Secondary School. Upon receipt of such request, arrangements shall be made to provide access to such records within a reasonable period of time, but in no case, no more than forty-five (45) days after the request has been received.

If information contained in the student's record is believed to be inaccurate or misleading, the parent or eligible student should write the Principal, clearly identify the part of the record they want changed, and specify why it is inaccurate or misleading. If the district decides not to amend the record as requested, the parent or eligible student will be notified of the decision and advised of their right to a hearing regarding the request for amendment additional information regarding the hearing procedures will be provided to the parent or eligible student when notified of the right to a hearing.

Student records and any material contained therein which is personally identifiable are confidential and may not be released or made available to persons other than parents or student without the written consent of such parents or student. There are a number of exceptions to this rule, such as other school employees and officials, and certain State and Federal officials, who have a legitimate educational need for access to such records in the course of their employment in addition, the district will disclose, upon request, education records to officials of another school district in which a student seeks or intends to enroll.

Objection to Release of Directory Information Designations

The Board of Education of the Herricks U.F.S.D. has designated certain categories of student information as "directory information." Directory information includes a student's name, address, telephone number, and photograph.

A parent/guardian or eligible student will have 14 days to notify the district of any objections they have to any of the "directory information" designations. For your convenience, you may note your objections to the release of directory information on this form and return it to the Building Principal.

[ ] Please do not release directory information without my prior consent.

_____ _____

Name of Student Name of Parent/Person in Parental Relation

HERRICKS PUBLIC SCHOOLS

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Disclosure Use of Student Images and Student Works

Please be advised that the Herricks Union Free School District frequently has the opportunity to publicize students and/or their awards, honors, artwork, activities, etc. In addition, media outlets on occasion request student information including photos and creative works for use in connection with news about the District or its students. Based on the foregoing, the District reserves the right to display, disclose, publish, distribute, post, share or otherwise make available to the public, certain information.

If you choose to prohibit the disclosure of such information, please complete the form below.

I _____, the undersigned student at least 18 years of age / the parent and/or person in parental relation of

_____, a student who is attending a school in the Herricks Union Free School District, deny permission for the student named above to have any information publicized.

Please sign only if you are denying permission to have any information publicized.

Sign: _____ Date:_____

Parent/Person in Parental Relation
is Under 18 Years of Age

If student is 18 years of age or older:

Sign: _____ Date: _____

Please note, that your preference regarding the Disclosure of Student Images and Works is separate from your preference regarding the District's Disclosure of Directory Information as set forth in the accompanying FERPA notification form.

HERRICKS PUBLIC SCHOOLS

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Student Use of Computers in the Herricks Public Schools

Policy

The Board of Education of the Herricks Union Free School District (the Board) believes that providing access to computers is an integral part of a contemporary education. As possible, technology devices, computers and computer networks will be made available to students.

When a student accesses computers, computer systems, and computer networks owned or operated by the Herricks Union Free School District, he or she assumes certain responsibilities and obligations. Access of this type is subject to school policies and local, state, and federal laws. The Board expects that student use of computers will be ethical and will reflect academic honesty. Students must demonstrate respect for property, ownership of data, system security mechanisms, and rights to privacy.

The Board of Education considers any violation of appropriate use principles or guidelines to be a serious offense and reserves the right to copy and examine any files or information that may suggest that a student is using school computer systems inappropriately. Violators are subject to disciplinary action by school officials. Offenders may also be prosecuted under laws including, but not limited to, the Privacy Protection Act of 1974, the Computer Fraud and Abuse Act of 1986, the Computer virus Eradication Act of 1989, and the Electronic Communications Privacy Act.

The Superintendent will develop guidelines for the appropriate use of the district's computer resources.

Student Agreement Form

This form must be completed each year and kept on file in the Principal's Office.

_____ _____ _____
Student's Name Grade Building

I have read and understand the computer use policy for the Herricks Union Free School District as noted in Policy 4526. I agree to abide by this policy at all times while using computers or computer resources provided by the Herricks Union Free School District.

_____ _____
Student's Signature Parent / Person in Parental Relation

_____
Date

09/19

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM (FORM A)

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

STUDENT INFORMATION

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 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:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

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

Notes

Hearing Screening: 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 Dominick 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*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

*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.

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) 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.

HERRICKS PUBLIC SCHOOLS
STUDENT HEALTH HISTORY

Name of Student: _____ Grade: _____ D.O.B.: _____

PLEASE NOTE: Health information will be shared with staff on a need to know basis only.

1. DEVELOPMENTAL HISTORY – Were there any problems during …..

Check	YES	NO	*Explanation if "YES"*
a. Pregnancy			
b. Labor and delivery			
c. Infant's early months			
d. Child's early years			

2. Has your child had any …

Check	YES	NO	*Explanation if "YES"*
a. Serious medical conditions			
b. Serious illness			
c. Serious injuries			
d. Hospitalizations			
e. Surgery/operations			

3. Has your child had …

Check	YES	NO	*Explanation if "YES"*
a. Chickenpox			
b. Hepatitis			
c. Meningitis			
d. Mononucleosis			
e. Pneumonia			
f. Rheumatic Fever			
g. Tuberculosis			
h. Strep			
i. Lyme Disease			
j. Any other communicable disease			Disease: Date:

4. Does your child have any history of ….

Check one:	*YES*	*NO*
a. Allergies (to medications, food, insect bites, bee sting, other)		
b. Asthma		
c. Bleeding disorder		
d. Bowel problems		
e. Cardiac (heart) condition		
f. Congenital (birth) defects		
g. Convulsions, epilepsy, or seizures		
h. Ear condition or infections, fluid in ear three (3) times or more		
i. Eczema, psoriasis or any other skin condition		
j. Genital defect/condition		
k. Hearing problems		
l. Kidney or urinary problems		
m. Muscular problems or diseases		
n. Neurological problems or diseases		
o. Orthopedic problems or diseases		
p. Speech problem		
q. Vision problem, or wear glasses, contacts (give reason and when worn)		
r. Any condition currently under the care of a doctor		
s. Any condition for which a doctor has advised student not to participate fully in physical education		
t. Need to take daily medications		
u. Need to take emergency medication		

Please provide an explanation for any "YES" responses to question No. 4.
If additional space is needed, please attach a separate sheet to this form.

Questions letter _____: Explanation:

_____
_____
_____

Questions letter _____: Explanation:

_____
_____
_____

Questions letter _____: Explanation:

_____
_____
_____

5. Has your child received any medical or other evaluation, the findings of which could help school personnel in meeting his/her health or educational needs?

_____
_____
_____
_____

6. Do you have any concerns about your child's developmental behavior or emotional well-being which the school should be aware?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Information on this form may be shared with appropriate personnel for health and educational purposes.

Parent/Person in Parental Relation Signature: _____

Date: _____