SIGN UP FOR LOTTERY NOW!

3-Year-Old
FULL DAY UNIVERSAL
PRE-KINDERGARTEN

If you have a youngster who will be 3 years old by 12/1/22 and you are a resident of the Rondout Valley Central School District, they are eligible to participate in the 3-year-old *Full Day* Universal Pre-Kindergarten program. We offer a free full day preschool experience 5 days a week from 9:00am to 2:00pm at the Brookside and Lederman Schools. No transportation will be provided.

Applications are available at the Rondout School District website and the District Office.

All applications must be recieved by 12:00PM on April 29, 2022 at the District Office. Lottery will be held May 10, 2022 at 4:30PM.

Openings are limited!

****All UPK programs pending Budget and Grant approvals****
Any questions please call #845-687-2400 Louann x4863.

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT
P.O. Box 9
Accord, New York 12404

Dr. Joseph Morgan
Superintendent of Schools
845-687-2400 Ext. 4802

Mrs. Lisa Pacht
Assistant Superintendent of Schools & Operations
845-687-2400 Ext. 4805

Mrs. Deana Rosinski
School Business Official
845-687-2400 Ext. 4812

Ms. Meg Braren
Director of Pupil Personnel Services
845-687-2400 Ext. 4863

SPRING 2022
3-year-old Full Day Universal Pre-Kindergarten Program

Dear Parent/Guardian,

Attached you will find an application for anticipated Universal Pre-Kindergarten seats for the 2022-2023 academic year. Seats will be offered based on a Zoom lottery to be held May 10, 2022 at 4:30pm. Access to Zoom Lottery will be on the Rondout Valley CSD website.

You must be a resident of the Rondout Valley School District
Your child must be **3** years old on/before December 1, 2022.

Complete all enclosed Forms.
Return all forms to the Rondout Valley Central School District Office by 12:00PM on April 29, 2022.

Please review the enclosed information carefully.
All required documents must be received **no later than 12:00PM on April 29, 2022 at the District Office.**
(We must have an updated Physical form and Updated Immunizations before they can attend UPK.
You can have your Dr. fax us confirmation of your scheduled appointment if it is after April 29, 2022.)

You may bring your required documents to the District Office and we will copy them for you, or they may be faxed to: Atten: UPKFD 845-687-0945

or mailed to: Rondout Valley CSD
DO-PPS-UPKFD
PO Box 9
Accord, NY 12404

Megan Braren
Director Pupil Personnel Services
845-687-2400
Ext. 4863

3 Year Old Full Day Universal Pre Kindergarten Application

2022-2023
Rondout Valley Central School District
Office of Pupil Personnel
P.O. Box 9
Accord, New York 12404

Name of Student: _____Male Female Non-Binary (Please Circle one)

Date of Birth: _____ ***Must be 3 years old on December 1, 2022***

Parent/Legal Guardian:_____Cell#:_____

Parent/Legal Guardian:_____Cell#: _____

Mailing Address:_____Home Phone #:_____

****Parents are responsible for transportation to ALL Universal Pre-Kindergarten programs****

The Brookside School in Cottekill on Lucas Ave.

Lederman Children's Center on Rt 213

Please indicate below your preference in rank order with:

1- being your first choice **2**- second choice

Brookside School _____ *before and after-care available**

Lederman Children's Center _____*before and after-care available**

****parent pays for before and after-care***

This Lottery Application and all enclosed Registration Forms must be delivered to the Office of Pupil Personnel at the Rondout Valley Central School District Office by 12:00PM on April 29, 2022.

3YO Full Day Universal Pre-Kindergarten lottery will take place on a Zoom to be held May 10, 2022 at 4:30pm. Access to Zoom will be on the Rondout Valley CSD website.

All UPK programs pending Budget and Grant approvals.

Due to NYS Immunization requirements we must ask for documentation.
All Preschoolers must be up to date on immunizations and Well Child exam before attending school.

***PLEASE NOTE: DOCUMENTS <u>REQUIRED</u> BY 12:00PM April 29, 2022**

1) 2 Proofs of Residency- copy of bill/receipt with parent name and physical address
2) Copy of Drivers License/photo ID
2) Copy of Birth Certificate
3) Copy of Shot Records
4) Copy of Physical Exam -physical must be done between 9/21 and 9/22 – (please take enclosed Health Assessment Form to your Doctor. You can have your Dr. fax us confirmation of your scheduled appointment if it is after April 29, 2022.)
5) Completed Registration Packet

See enclosed REGISTRATION CHECKLIST for More details

P.O. Box 9, 122 Kyserike Rd Accord, NY 12404

Rondout Valley Central School District

Welcome to the Rondout Valley Central School District!

REGISTRATION CHECKLIST

___ **Completed registration packet**

___ **Student's proof of age** – one photocopy of original document.
See list of admissible documents on the next page.

___ **Student's immunization record and recent physical** - Please give the enclosed School Health Examination form to your doctor to complete and sign. It should include information from a physical conducted within one year from your student's start date. You might need to provide your doctor's office with written consent to fax the document to RVCSD UPK: 845-687-0945. Or, you can bring the original form to your registration appointment. "My Chart" reports are not admissible. For more information regarding physical and immunization requirements for new students, please refer to the Health Office webpage on our website:
https://www.rondout.k12.ny.us/departments/health_office

___ **Parent/Guardian's proof of residence within the Rondout Valley Central School District** – one photocopy of 2 proofs of residency.
See list of admissible documents on the next pages. If you cannot provide proof of residency in your name, please call the Central Registration office prior to registering your child (845-687-2400 ext. 4814). An additional form may be required.

___ **Parent/Guardian's ID with name and picture –** one photocopy of original ID.
Parent/Guardian identification is required.

___ **Student's recent report card (*and* transcript for high school students)** – one copy. Academic records are not required for registration, but they quicken the admission process.

___ **IEP or 504 Plan** – Only applicable for students receiving special education services. If your child receives special education services by a district other than Rondout Valley, please provide one copy of your child's IEP or 504 Plan. It is not required for registration, but it quickens the admission process.

When the registration packet is complete and the documents described in the attached letter are collected, please return to the District Office

P.O. Box 9, 122 Kyserike Rd Accord, NY 12404
Rondout Valley Central School District

Dear Parent/Guardian:

Welcome to the Rondout Valley Central School District! The following documents are required when registering your child in the district.

PROOF OF RESIDENCY

Please submit evidence establishing your residency and your child's residency in the school district.

Evidence may include:

A copy of a residential lease, rental agreement, or proof of ownership of a house or condominium, such as a deed or mortgage statement

If you do not have the documentation listed above, the District will consider other forms of documentation. You must provide at least **two** documents as verification of residency, which may include, but are not limited to:

- pay stub
- income tax form
- utility or other bills
- membership documents based upon residency (e.g., library cards)
- voter registration document(s)
- official driver's license, learner's permit, or non-driver identification
- state or other government issued identification
- documents issued by federal, state, or local agencies (e.g., local social service agency, Office of Refugee Resettlement, etc.)
- evidence of custody of the child, including but not limited to, judicial custody orders or guardianship papers

If the student is age 17 or under and not living with a parent OR is living with a non-custodial parent, the District requires the parent/guardian(s) and person(s) in parental relation to the child to provide a **notarized** affidavit indicating that they are:

1) the person(s) in parental relation to the child, *over whom they have total and permanent custody and control,* and describing how they obtained total and permanent custody and control, whether through guardianship or otherwise; OR
2) the parent(s) with whom the child lawfully resides.

Legal documentation from the court that granted the guardianship/custody must be submitted.

The District will also accept other proof, such as documentation indicating that the child resides with a sponsor with whom the child has been placed by a federal agency (i.e., foster care).

PROOF OF AGE

Please provide documentation establishing your child's age.
Evidence may include:

1) a certified transcript of a birth certificate or record of baptism (including a certified transcript of a foreign birth certificate or record of baptism) giving the date of birth. *Information about replacing a birth certificate is available through the Village and Town Clerks where the birth occurred: https://ulstercountyny.gov/countyclerk/courtrecords.html*
2) Where such documentation is not available, a passport (including a foreign passport) may be used.

If the birth certificate or passport is not available, the District may consider certain other evidence, which has been in existence two years or more. An affidavit of age cannot be accepted as verification. Other evidence may include, but will not be limited to the following:

- official driver's license
- state or other government issued identification
- school photo identification with date of birth
- consulate identification card
- hospital or health records
- military dependent identification card
- documents issued by federal, state, or local agencies (e.g., local social service agency, Office of Refugee Resettlement, etc.)
- court orders or other court-issued documents
- Native American tribal document
- records from non-profit international aid agencies and voluntary agencies

EVIDENCE OF IMMUNIZATIONS & PHYSICAL

In accordance with New York State Department of Heath Immunization Bureau's Immunization Requirements for School Entrance/Attendance (NYS Public Health Law), the District must receive evidence that your child has been immunized. These records are necessary to ensure your child's continued attendance. *Ulster County Department of Public Health Immunization Clinic provides immunizations for children ages 18 years and younger. Information: https://ulstercountyny.gov/health/health-department-clinics*

Additionally, please provide record of the most recent physical examination your student has received. New York State mandates that each new student entering a public school is required to have a physical examination upon entering the District. A physical completed no more than twelve months before the first day of the school year in question will meet this requirement.

NOTICE OF RIGHTS REGARDING REFERRAL FOR EVALUATION FOR SPECIAL EDUCATION

If you suspect that your child is in need of special education services or programs, you may refer your child to the District's Committee on Special Education for evaluation. The referral should be made to Megan Braren, Director of Pupil Personnel Services, Rondout Valley Central School District, PO Box 9 Accord, New York 12404. The New York State Education Department website has information regarding this process and your rights. A copy of the Parent Guide to Special Education may be obtained from the following websites or upon your written request to the Committee on Special Education Chairperson.
http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm
http://www.p12.nysed.gov/specialed/publications/policy/spanishparentguide.htm
If you have any questions with respect to the foregoing, please contact the Pupil Personnel Services office at (845) 687-2400 ext. 4863.

P.O. Box 9, 122 Kyserike Rd Accord, NY 12404

Rondout Valley Central School District

REGISTRATION APPLICATION

STUDENT INFORMATION SCHOOL YEAR:_____

Student's Name: *First* *Middle* *Last*		
Student's Address:		
Birth Date: *mm / dd / yyyy*	☐ Male ☐ Female ☐ Non-Binary	**Entering Grade:**

Ethnic Origin: **(for statistical purposes only)**	**2. Please select one or more races from the following:** ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
1. Are you Hispanic/Latino? ☐ **Yes** ☐ **No**	

PARENT INFORMATION

Primary Phone:	**Primary Email:**

Parent/Guardian Name :*First* *Last*	**Cell:**
Complete Address:	☐ Male ☐ Female ☐ Non-Binary
	Home:
	Work:
Email Address:	**Relationship to student:** ☐ *Parent* ☐ *Grandparent* ☐ *relative* ☐ *Step-Parent* ☐ *Legal Guardian* ☐ *Other:*
Parent/Guardian Employer:	
Active Duty Armed Forces? Branch:	Entry Date:

Parent/Guardian Name:*First* *Last*	**Cell:**
Complete Address:	☐ Male ☐ Female ☐ Non-Binary
	Home:
	Work:
Email Address:	**Relationship to student:** ☐ *Parent* ☐ *Grandparent* ☐ *relative* ☐ *Step-Parent* ☐ *Legal Guardian* ☐ *Other:*
Parent/Guardian Employer:	
Active Duty Armed Forces? Branch:	Entry Date:

SCHOOL(S) PREVIOUSLY ATTENDED

Name of School	City/Town, State, Country	Grade(s)	Dates Attended

Is this student currently suspended from his/her most recent school? Yes No

CUSTODY INFORMATION

Information of Rights of Parent from the Family Education Rights and Privacy Act (FERPA): An education agency or institution shall give full rights under the Act to either parent, unless the agency or institution has been provided with evidence that there is a court order, State statute, or legally binding document relating to such matters as divorce, separation, or custody that specifically revokes the rights. (Authority: 20U.S.C 1232g)

- Please inform your school of changes in custodial arrangements. -

☐ Two Parents in Home ☐ Divorced/Separated ☐ Joint Custody ☐ Single Parent ☐ Sole Custody
☐ Custody Transfer (i.e. Adoption) ☐ Foster Placement (DDS-2999/3424 must be provided) ☐ Unaccompanied Youth

Custody paperwork provided during registration? ☐ Yes ☐ No

Restrictions of contact and/or information: ***Paperwork must be provided to Central Registration***

☐ No Restrictions for Parents/Guardians ☐ Custody Papers Specify Restriction ☐ Order of Protection
☐ Other Documentation, specify:_____ Expiration Date:_____
Person(s) Restricted:_____ Relationship to student:_____

SIBLING INFORMATION

Siblings Residing in the Home:

Last Name	First Name	Gender	DOB	Gr	Rondout Valley School
		☐ M ☐ F ☐ X			
		☐ M ☐ F ☐ X			
		☐ M ☐ F ☐ X			
		M F ☐ X			

STUDENT SUPPORT SERVICES

Does the student have an IEP: ☐ Yes ☐ No | Does the student have a 504 Plan: ☐ Yes ☐ No

P lease check any service the student currently receives:

☐ Remedial Reading ☐ Occupational Therapy ☐ School Counseling
☐ Remedial Math ☐ Physical Therapy ☐ Counseling from an Outside Agency
☐ ESOL ☐ Speech Therapy Name of Agency: _____

STUDENT'S PHYSICIAN INFORMATION

Name:	Phone:
Name of Practice:	
Address:	

Allergies/Health Concerns: _____

Required Medications: _____

If physical is not within one year, date of upcoming appointment:

EMERGENCY CONTACT INFORMATION * Parents/Guardians will be contacted first *

Name:	Cell:
Address:	**Alt. Phone:**
	Relationship to student:
	Permitted to pick up student: ☐ Yes ☐ No

Name:	Cell:
Address:	Alt. Phone:
	Relationship to student:
	Permitted to pick up student: ☐ Yes ☐ No

Print Name:_____ **Signature:**_____

Relationship to Student:_____ **Date:**_____

P.O. Box 9, 122 Kyserike Rd Accord, NY 12404

Rondout Valley Central School District

STUDENT'S NAME: ______________________________________

First *Middle* *Last*

ADDITIONAL EMERGENCY CONTACT INFORMATION

Name:	Cell:
Address:	☐ Home or ☐ Work Phone:
	Relationship to student:
	Permitted to pick up student: ☐ Yes ☐ No

Name:	Cell:
Address:	☐ Home or ☐ Work Phone:
	Relationship to student:
	Permitted to pick up student: ☐ Yes ☐ No

Name:	Cell:
Address:	☐ Home or ☐ Work Phone:
	Relationship to student:
	Permitted to pick up student: ☐ Yes ☐ No

Name:	Cell:
Address:	☐ Home or ☐ Work Phone:
	Relationship to student:
	Permitted to pick up student: ☐ Yes ☐ No

Name:	Cell:
Address:	☐ Home or ☐ Work Phone:
	Relationship to student:
	Permitted to pick up student: ☐ Yes ☐ No

Name:	Cell:
Address:	☐ Home or ☐ Work Phone:
	Relationship to student:
	Permitted to pick up student: ☐ Yes ☐ No

Name:	Cell:
Address:	☐ Home or ☐ Work Phone:
	Relationship to student:
	Permitted to pick up student: ☐ Yes ☐ No

Name:	Cell:
Address:	☐ Home or ☐ Work Phone:
	Relationship to student:
	Permitted to pick up student: ☐ Yes ☐ No

Print Name:______________________________ **Signature:**______________________________

Relationship to Student:______________________________ **Date:**______________________

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

Lissette Colón-Collins, Assistant 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 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.

Please write clearly when completing this section.

STUDENT NAME:		
First	*Middle*	*Last*

DATE OF BIRTH:			GENDER:
Month	*Day*	*Year*	❑ Male ❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to Student*

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 DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT

PO Box 9, Accord, NY 12404

Dr. Joseph Morgan
Superintendent of Schools
(845) 687-2400 Ext. 4802

Mrs. Lisa I. Pacht
Assistant Superintendent of Schools & Operations
(845) 687-2400 Ext. 4805

Mrs. Deanna Rosinski
School Business Official
(845) 687-2400 Ext. 4812

Ms. Megan Braren
Director of Pupil Personnel Services
(845) 687-2400 Ext. 4863

Dear Pre-Kindergarten Parent/Guardian,

We have the capability of sending phone calls, e-mails, and/or text messages to inform you of school delays, emergency closings, and upcoming events in the district. This is accomplished through an automated system which we use to contact parents, students, and staff. If you would like the district to register you for this service, please fill in this form and return it with your Universal Pre-Kindergarten application.

Thank you,
Superintendent Dr. Joseph Morgan

Parent/Guardian Name_____
Student Name _____

I would like the Rondout Valley Central School District to send me notifications about:

- Emergency Closings/Delays ____
- Upcoming Community Events ____

Please list information below regarding how you would like to receive the reminders. I prefer to receive notifications through a(n):

- Phone call @_____ @_____
- E-mail @_____ @_____
- Text message @_____ @_____

Should you have any questions, please contact Ms. Randi Chase in the *Technology Office* at the following phone number: **845-687-2400 extension 4851**.

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT
PO Box 9, Accord, NY 12404

Dr. Joseph Morgan
Superintendent of Schools
(845) 687-2400 Ext. 4802

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Ms. Megan Braren
Director of Pupil Personnel Services
(845) 687-2400 Ext. 4863

Dear Parent/Guardian,

Our district likes to celebrate student's achievements, activities, and opportunities by sharing them with our community. We do this in many ways, such as (but not limited to) school and/or district newsletters, the district's website, and the district's official social media sites.

Parents who **OBJECT** to the use of their child's name and/or photograph being used must send written notification to their child's building principal. Notification should be received by October 1. Unless otherwise directed, prior year's permission will be in effect until this date. Returning this form to your child's building principal will serve as written notification that you **OBJECT** to the use of your child's name and/or photograph being used.

No action is necessary if you grant permission for your child's name/photograph to be used as described above.

Please complete the following ONLY if you DENY permission for your child to be included.

- ☐ **I OBJECT** to the use of my child's name only, but a photograph/video alone is fine**.**
- ☐ **I OBJECT** to both my child's photograph/video and his/her name being used for any of the above uses.

If you return this form with neither of the above boxes checked, it will be understood that permission has been granted.

Child's Name: _____ Grade: _____

Parent Signature: _____ Date: _____

Parent Name (Print): _____

P.O. Box 9, 122 Kyserike Rd Accord, NY 12404

Rondout Valley Central School District

RESIDENCY QUESTIONNAIRE

Name of LEA RONDOUT VALLEY CENTRAL SCHOOL DISTRICT

Name of Student _____

Birth date: _____ Grade _____

Complete Address _____

Name of School _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. 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 one box.)

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____

☐ In permanent housing (check here if you own, lease, or share housing)

_____ _____

Print Name of Parent, Guardian, or Unaccompanied Youth

Signature of Parent, Guardian, or Unaccompanied Youth

_____

Date

P.O. Box 9, 122 Kyserike Rd Accord, NY 12404

Rondout Valley Central School District

MEDICAL INFORMATION

Name of School_____Grade_____ID# _____

Name of Student_____Date of Birth _____ Gender: _____
mm / dd / yyyy

Name of Parent/Guardian Completing Form _____

Parent/Guardian Name _____ _____ _____/_____
(Home address) *(Primary phone)* *(Secondary Phone)*

Parent/Guardian Name _____ _____ _____/_____
(Home address if different than above) *(Primary phone)* *(Secondary Phone)*

Physician's Name_____Physician's Phone _____

Dentist's Name _____ Dentist's Phone _____

1. Any known allergies to foods, bee/insect stings, latex, medicines, environmental, etc.? ❑ Describe reaction: (local swelling, hives, face swelling)_____ ❑ Are emergency medications required? **Yes** **No**	Yes	No
2. Sustained any injury or illness which required medical attention and/or hospitalization or surgery? If yes, your child may need to be cleared with a medical doctor's note to participate in sports/gym.	Yes	No
3. Is your child under a physician's care now for any existing problem? If yes, please explain below.	Yes	No
4. Absence or loss of function for eye, kidney, testicle, or other organ?	Yes	No
5. Requires any ongoing medication at home or school? Please list below.	Yes	No
6. Has asthma? If yes, are emergency meds required? **Yes** **No**	Yes	No
7. Had seizures, concussion, loss of consciousness, or has a neurological condition?	Yes	No
8. Has diabetes?	Yes	No
9. Has recurrent headaches? Explain below (frequency, intensity, any medication).	Yes	No
10. Complained of chest pain or fainting during physical exertion?	Yes	No
11. Has heart disease, murmur, or irregular heart beat?	Yes	No
12. Wears orthodontic braces? ❑ Is a specialized mouthpiece from an orthodontist required for sports/PE? **Yes** **No**	Yes	No
13. Had any teeth capped or replaced artificially?	Yes	No
14. Wears glasses? ❑ For sports? **Yes** **No** ❑ If yes, are glasses impact resistant? **Yes** **No** ❑ Contact lenses? **Yes** **No** If yes, how long?	Yes	No
15. Wears hearing aid devices? If yes, type?	Yes	No
16. Is there any medical condition or restriction which may be made worse by playing sports/PE?	Yes	No
17. Required by medical doctor to wear brace/support device to play sports/PE?	Yes	No
IF ANSWER IS YES TO ANY OF THE QUESTIONS ABOVE, EXPLAIN BY NUMBER AND GIVE DATE OF OCCURRENCE: _____ _____		

I certify that the above information is true and accurate and understand that it will be relied upon by the Rondout Valley Central School District. If medication is prescribed (only valid for current school year) on the health appraisal form completed by the health care provider, I authorize the school nurse to administer the prescribed medication as directed by the health care provider. I authorize the school nurse to contact the health care provider regarding information on this form and the health appraisal form for one calendar year from the date I signed below.

Parent/Legal Guardian Signature_____Date _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.

2021-22 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for **each** vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses** **or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]	**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses** **or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses** **or 2 doses** of **adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9, 10 and 11: 1 dose**	**2 doses** **or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.

   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.

   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 and 7: 10 years; minimum age for grades 8 through 12: 7 years)

   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.

   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2021-2022, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 and 7; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 8 through 12.

   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)

   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.

   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)

   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine

   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).

   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)

   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 and 8: 10 years; minimum age for grades 9 through 12: 6 weeks).

   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.

   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.

   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.

   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.

   d. If dose 1 was received at 15 months or older, only 1 dose is required.

   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)

   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.

   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.

   d. If one dose of vaccine was received at 24 months or older, no further doses are required.

   e. PCV is not required for children 5 years or older.

   f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE 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	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	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: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL				

☐ **System Review and Abnormal Findings Listed Below**

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

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
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 ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

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

☐ **Student is restricted from participation in:**

☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.

☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.

☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.

☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <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 Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.