SCHODACK
CENTRAL SCHOOL DISTRICT

Dear Parents/Guardians,

We would like to take this opportunity to welcome your family to the Schodack Central School District. Kindergarten is an exciting time for children. The Schodack Central School District has a comprehensive process for registration. Children must be five years of age on or before December 1, in order to register for kindergarten in the upcoming school year.

Castleton Elementary School offers a full-day kindergarten program. During the screening process you will have the chance to meet teachers and ask questions about the upcoming school year.

If you have any questions regarding the registration process, please feel free to contact the District's Registrar, Jill Hanrahan at (518)732-2523 or the elementary building principal, Mr. Derby at (518)732-7755.

The Schodack Central School District welcomes you and encourages you to become actively involved in our school community. If you have questions, please do not hesitate to contact us.

Sincerely,

James Derby
CES Principal

Jill Hanrahan
District Registrar

SCHODACK CENTRAL SCHOOL DISTRICT

REGISTRATION CHECKLIST

Forms to be Provided/Completed for Registration

- **Registration Form**
- **2 Proofs of Residency (see attached note)**
- **Acceptable** proof of Birth Date**
- **Authorization for Release of Records and Information**
  - It would be very helpful to have a copy of current schedule or most recent progress or report card for scheduling purposes.
- **Health Registration Forms**
  - Health History form
  - SCSD Health Office emergency card
  - Student's Immunization record (official record signed by physician)This document may be faxed directly from the physician's office for your convenience
  - Physical/Health Appraisal Form
- **Documentation relating to Special Circumstance**
  - If you are not the natural parent but have legal guardianship of the student, please provide us with any available relevant documents or complete a Custody Affidavit.
  - If there are any other special circumstances such as: custody agreements, orders of protection, etc., please bring those documents with you. They will be copied and filed in the student's records. The schools cannot refuse to release a child to a parent/legal guardian unless there are court documents on file. A parent's written or verbal instructions are not sufficient.

If Relevant, Additional Documentation Needed for School Information

- **IEP (Individualized Education Plan) from previous school**
- **Home and Language Questionnaire**
- **Student Racial and Ethnic Identification**
- **Free/Reduced Lunch Forms**
- **HS Athletic Forms**
- **Others, please list: _____**

****birth certificate, passport, driver's license, state or government issued identification, school photo identification, consulate identification card, hospital or health records, military dependent identification card, documents issued by federal, state or local agencies, court orders or other court issued documents, Native American tribal document or records from non-profit international aid agencies and voluntary agencies.**

Schodack Central School District-Registration Form

Today's date: _____ Start date: _____

Student Information

Name:_____Gender: M F

Home Street Address: _____

Mailing address (if different): _____

Date of birth:_____Place of birth: _____ Home Phone: _____

Your answer below, for the living situation, will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act.

Where is the student living? (Circle one that applies) 1. Permanent housing (own/rent) 2. Shelter
3. with another family ("doubled up") 4. Hotel/Motel 5. Car, park, bus, train or campsite
6. Temporary living situation (please describe):_____

Is this child in foster care or under supervision of Social Services? YES NO
If yes, is the DSS-2999 form provided? YES NO

Are there custodial issues (court papers) regarding your child? YES NO ___attached

Last school attended: _____
School Name City/Town

Is your child under the Committee on Special Education (IEP)? Yes No
Does your child have a 504 Accommodation Plan? Yes No
Is your child receiving Academic Intervention Services? Yes No
Was your child ever retained? Yes No Grade____

Ethnicity: Is the child of Hispanic Origin: Yes/No
Race: choose all that apply: White Black Asian Pacific Islander American Indian Other

Parent/Guardian Information

Mother/Female Guardian: _____relationship to student: _____
Address: _____
Home #: _____ Cell #: _____ Work #: _____
Email address: _____

Father/Male Guardian: _____relationship to student: _____
Address: _____
Home #: _____ Cell #: _____ Work #: _____
Email address: _____
Parents marital Status: (please circle) married divorced single widow separated

Siblings

Name(s):_____DOB: _____ Grade: _____
Name(s):_____DOB: _____ Grade: _____
Name(s):_____DOB: _____ Grade: _____

Additional Household/Family Members

Name(s):_____

Office Use: CES Jr/Sr HS Grade:_____ Student ID #:_____ BUS: am:_____ pm:_____

SCHODACK
CENTRAL SCHOOL DISTRICT

Proof of Residency

Any two (2) of the following items must be provided to establish residency. Both are required within 3 days of registration.

- **Utility Bill-with current address and name of registrant**
- **House Deed**
- **Mortgage Statement**
- **Sale Contract/Homeowners agreement**
- **Property Tax Bill**
- **Lease Agreement**
- **Landlord Affidavit**
- **Driver's License with insurance card**

SCHODACK CENTRAL SCHOOL DISTRICT
1477 South Schodack Road
Castleton-on-Hudson, New York 12033

JASON M. CHEVRIER
Superintendent
518-732-2297

Schodack Central School District
Health Services

We would like to welcome you to the Schodack Central School District. In this packet you will find information and forms to be completed that will help us to ensure that your child will have a healthy experience at our school.

New York State Education Law requires that all newly entering students have up-to-date immunizations and a current physical. Attached are forms for your physician to complete. If needed, we can arrange for the physical to be done at school by the school doctor.

Also attached are a health history form for a parent/guardian to complete, information regarding medication at school, a medication administration form, and a Health Office Emergency Card to be completed by a parent/guardian. Should you need additional copies of any forms, they may be obtained through the school website, www.schodack.k12.ny.us.

For students in grades 7-12 that are interested in participating in sports, please check the athletic portion of the website.

Please feel free to contact us at any time if you have any health-related concerns or questions. We look forward to getting to know your child and to provide for their health needs throughout their school career.

Thank You.

Heather Brewer, RN (Castleton Elementary School) – 518-732-7946 or at hbrewer@schodack.k12.ny.us

Jeannette Stasack, RN (Maple Hill Jr./Sr. High School) – 518-732-7701 or at jstasack@schodack.k12.ny.us

CASTLETON ELEMENTARY SCHOOL
James Derby, Principal
518-732-7755

MAPLE HILL JR/SR HIGH SCHOOL
Robert Santarcangelo, Principal
518-732-7701

Health History to be Completed by Parent/Guardian

Has your child ever had: (please check)

STUDENT NAME_____

	Yes	No
Allergies:	____	____
Medication Allergy	____	____
Bee Sting Allergy	____	____
Food Allergy	____	____
Environmental	____	____
Seasonal/Hay fever	____	____
Diabetes	____	____
Missing organs (eye, kidney,testicle)	____	____
Bladder/Kidney problem or injury	____	____
Ear Problems/Hearing Loss	____	____
Eye Problems/Vision Loss	____	____
Ankle/Knee Pain/Injury	____	____
Neck/back Pain or Injury	____	____

	Yes	No
Elevated Blood Pressure	____	____
Head Injury/Concussion	____	____
Heart Problems/Murmur		
Chest Pains	____	____
Fainting Spells	____	____
Anxiety/Depression	____	____
Nose Bleeds/frequent or severe	____	____
Nose fracture	____	____
Injury to Spleen	____	____
Joint Sprain/Ligament tear		
Muscle Pull	____	____
Fracture-Dislocation Bones/Joints	____	____
Other Concern or Injury	____	____

If you answered "yes' to any of the above, please explain:_____

_____

Does Your Child Have Any of the Following:

Has your child ever had an illness, condition or injury that required him/her to go to the hospital, either as a patient overnight or in the emergency room for x-rays; required an operation; caused your child to miss a game or practice? Please explain:_____

_____

Has your child been ill for five (5) consecutive days? Yes____ No____ Please explain:_____

Is your child under medical care now? Yes____No____

Has your child taken any medication in the past year? Yes____ No____ If so, why?_____

Is your child taking medication now? Yes____ No____ If so, why?_____

Has your child ever fainted, felt dizzy or experienced chest pain during exercise? Yes____ No___
If so, explain_____

Has there ever been a sudden death in a family member under fifty (50) years of age? Yes___ No___

Does anyone in the child's family smoke? Yes___ No____ If so, whom?_____

Does your child have Orthodontic Appliances? (bridges, plates, capped teeth)? Yes____ No____

Does your child wear contact lenses or glasses? Yes____ No____

Since your child's last physical examination, has your child had any injury or medical illness? Yes___ No__
If so, please describe:_____

Date_____ Parent/guardian Signature_____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

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:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

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

Vision 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 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*:** 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.

Schodack Central School District – Health Office Emergency Card

Date _____

Name _____ Grade _____ DOB _____
Last First MI month/date/year

Student's Address _____ Student's Home Phone # _____

Parent/Guardian – Relationship (Mother, Stepmother, Guardian, Other):

Name _____ Cell Phone # _____
Last First

Address _____ Home Phone # _____

Place of Employment _____ Work Phone # _____

Email Address _____

Parent/Guardian – Relationship (Father, Stepfather, Guardian, Other):

Name _____ Cell Phone # _____
Last First

Address _____ Home Phone # _____

Place of Employment _____ Work Phone # _____

Email Address _____

Custodial concerns: _____ Yes _____ No (If yes, please furnish court papers)

Emergency contacts if needed:

	Name	Relationship	Home Phone	Cell Phone	Work Phone
1.					
2.					
3.					

Names and ages of school-age siblings: _____

_____

Names of other individuals residing at this address: _____

_____

Any childhood disease, injuries, operations or emotional concerns: _____

_____

Is there any specific information you would like the nurse to have in regards to your child? _____

_____

Family doctor: _____ Phone: _____

If your child must be taken to the hospital, which do you prefer? _____

Current medications: _____

Known allergies: _____

School personnel (teachers, aides and bus drivers, etc.) will be informed of medical information as needed. Confidentiality will be protected. I hereby give the school authorities permission to arrange for emergency medical treatment as needed if the parent/guardian is not available. Please call us if we can help you any time. Thank you!

Parent Signature _____

Date _____

Maple Hill Jr./Sr. High School 518-732-7701

Castleton Elementary School 518-732-7946

SCHODACK
CENTRAL SCHOOL DISTRICT

AUTHORIZATION FOR THE RELEASE OF STUDENT RECORDS

_____ (grade____) has begun the registration process in the Schodack CSD
(Student name)

PLEASE SEND US ANY OF THE FOLLOWING INFORMATION THAT MAY BE AVAILABLE:

1. **Academic Records**
2. **Attendance Records**
3. **Health and Immunization Records**
4. **Individual Education Program (IEP) or 504 Plan (Confidential)**
5. **Psychological test results**
6. **Standardized/State Test Results**
7. **Science Labs**

PLEASE FORWARD INFORMATION TO THE CIRCLED LOCATION BELOW:

CES	**Maple Hill Jr./Sr. HS**	**PPS**
Attn: Regina Maier	Attn: Mary Southard	Attn: Jill Hanrahan
(518)732-7755 rmaier@schodack.k12.ny.us	(518)732-7701 (518)732-0494(fax) msouthard@schodack.k12.ny.us	(518)732-2523 (518)732-2184(fax) jhanrahan@schodack.k12.ny.us

Thank you.

I hereby grant permission for _____fax # _____ to release all medical and school records for my child _____DOB_____.

_____
(Signature of Parent/Guardian)

For Office Use Only ***Request for Records Sent to Former School_____***
Date Initials

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: