



Dear Resident of the District:

Welcome to Schodack Central School District. Our district consists of two school buildings. Castleton Elementary School (CES) serves students in grades kindergarten-6. Maple Hill Jr./Sr. High School serves students in grades 7-12.

For any student, starting a new school environment can be stressful with new surroundings, new teachers and new friends. Our goal is to make this transition process as smooth as possible. Please take the time to review the registration packet. We ask for you to bring all necessary forms with you when you register. Our registration is a three-step process. The first step will be meeting with me to review all necessary documents. The second step, which often can be at the same time, will be a meeting at the actual building your child(ren) will be attending. The third step will be to establish residency (this needs to be completed three days of initial registration). Having all papers carefully filled out and with you will move the process along quickly.

Enclosed you will find a checklist of items required at the time of registration along with any forms you will need to fill out. Please call me when you are ready to register your child.

Sincerely,

Michele Reickert
District Registrar
518-732-2297 ext. 2310

SCHODACK CENTRAL SCHOOL DISTRICT

REGISTRATION CHECKLIST

Forms to be Provided/Completed for Registration
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- **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
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- **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: _____



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

Luz-Marina Lilchin, RN (Maple Hill Jr./Sr. High School) – 518-732-7701 or at llilchin@schodack.k12.ny.us

Health History to be Completed by Parent/Guardian

Has your child ever had: (please check)

STUDENT NAME _____

	Yes	No		Yes	No
Allergies:			Elevated Blood Pressure		
Medication Allergy			Head Injury/Concussion		
Bee Sting Allergy			Heart Problems/Murmur		
Food Allergy			Chest Pains		
Environmental			Fainting Spells		
Seasonal/Hay fever			Anxiety/Depression		
Diabetes			Nose Bleeds/frequent or severe		
Missing organs (eye, kidney, testicle)			Nose fracture		
Bladder/Kidney problem or injury			Injury to Spleen		
Ear Problems/Hearing Loss			Joint Sprain/Ligament tear		
Eye Problems/Vision Loss			Muscle Pull		
Ankle/Knee Pain/Injury			Fracture-Dislocation Bones/Joints		
Neck/back Pain or Injury			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 $\mu\text{g/dL}$	
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.					
If Restrictions Apply – Complete the information below					
☐ Student is restricted from participation in:					
☐ Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
☐ Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
☐ Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
☐ Other Restrictions:					
Developmental Stage for Athletic Placement Process <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: <i>(please print)</i>					
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 # _____

Address _____ Last First Home Phone # _____

Place of Employment _____ Work Phone # _____

Email Address _____

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

Name _____ Cell Phone # _____

Address _____ Last First 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 _____



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. Discipline Reports
7. Standardized/State Test Results
8. Science Labs

PLEASE FORWARD INFORMATION TO THE CIRCLED LOCATION BELOW:

CES	Maple Hill Jr./Sr. HS	PPS
Attn: Demi Wright	Attn: Kacey Feldman	
(518)732-7755 dwright@schodack.k12.ny.us	(518)732-7701 (518)732-0494(fax) kfeldman@schodack.k12.ny.us	(518)732-2523 (518)732-2184(fax)

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
Month	Day	Year
☐ Female		
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	☐ Parent 2	_____
	☐ Guardian(s)		_____
			specify
4. What language(s) does your child understand?	☐ English	☐ Other	_____
			specify
5. What language(s) does your child speak?	☐ English	☐ Other	_____ ☐ Does not speak
			specify
6. What language(s) does your child read?	☐ English	☐ Other	_____ ☐ Does not read
			specify
7. What language(s) does your child write?	☐ English	☐ Other	_____ ☐ Does not write
			specify

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? _____

Signature of Parent or of Person in Parental Relation

Month: Day: Year:

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: