



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, Michele Reickert at (518)732-2297 ext. 2310 or the elementary building principal, Mrs. Sullivan 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,

Megan Sullivan  
CES Principal

Michele Reickert  
District Registrar

# SCHODACK CENTRAL SCHOOL DISTRICT

## REGISTRATION CHECKLIST

|                                                        |
|--------------------------------------------------------|
| <b>Forms to be Provided/Completed for Registration</b> |
|--------------------------------------------------------|

- **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.

|                                                                            |
|----------------------------------------------------------------------------|
| <b>If Relevant, Additional Documentation Needed for School Information</b> |
|----------------------------------------------------------------------------|

- **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](http://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](mailto: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](mailto: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: <input type="checkbox"/> Female <input type="checkbox"/> Male | Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X |            |
| School:                                                                              | Grade:                                                                                                                                       | Exam Date: |

### HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

|                                    |                                                                                                                                                                                                                              |
|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Allergies | Type:<br><input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached                                                                                                |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other:<br><input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached |
| <input type="checkbox"/> Seizures  | Type: Date of last seizure:<br><input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached                                                                              |
| <input type="checkbox"/> Diabetes  | Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2<br><input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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/m<sup>2</sup>

**Percentile (Weight Status Category):** ☐ < 5<sup>th</sup> ☐ 5<sup>th</sup>- 49<sup>th</sup> ☐ 50<sup>th</sup>- 84<sup>th</sup> ☐ 85<sup>th</sup>- 94<sup>th</sup> ☐ 95<sup>th</sup>- 98<sup>th</sup> ☐ 99<sup>th</sup> and >

**Hyperlipidemia:** ☐ Yes ☐ Not Done

**Hypertension:** ☐ Yes ☐ Not Done

### PHYSICAL EXAMINATION/ASSESSMENT

|                           |                          |                          |               |                                                                                                     |             |
|---------------------------|--------------------------|--------------------------|---------------|-----------------------------------------------------------------------------------------------------|-------------|
| <b>Height:</b>            | <b>Weight:</b>           | <b>BP:</b>               | <b>Pulse:</b> | <b>Respirations:</b>                                                                                |             |
| <b>Laboratory Testing</b> | <b>Positive</b>          | <b>Negative</b>          | <b>Date</b>   | <b>Lead Level</b><br>Required for PreK & K                                                          | <b>Date</b> |
| TB- PRN                   | <input type="checkbox"/> | <input type="checkbox"/> |               | <input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$ |             |
| Sickle Cell Screen-PRN    | <input type="checkbox"/> | <input type="checkbox"/> |               |                                                                                                     |             |

☐ System Review Within Normal Limits

☐ Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

|                                        |                                         |                                          |                                       |                                           |
|----------------------------------------|-----------------------------------------|------------------------------------------|---------------------------------------|-------------------------------------------|
| <input type="checkbox"/> HEENT         | <input type="checkbox"/> Lymph nodes    | <input type="checkbox"/> Abdomen         | <input type="checkbox"/> Extremities  | <input type="checkbox"/> Speech           |
| <input type="checkbox"/> Dental        | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Back/Spine/Neck | <input type="checkbox"/> Skin         | <input type="checkbox"/> Social Emotional |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Lungs          | <input type="checkbox"/> Genitourinary   | <input type="checkbox"/> Neurological | <input type="checkbox"/> 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:                         |                          |
| <b>SCREENINGS</b>                                                                                                                                                                                                                                                 |                                                                                 |                                                                         |                                                                                      |                              |                          |
| Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11                                                                                                                                                                                              |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>Vision Screening</b>                                                                                                                                                                                                                                           | <b>With Correction</b> <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Right</b>                                                            | <b>Left</b>                                                                          | <b>Referral</b>              | <b>Not Done</b>          |
| Distance Acuity                                                                                                                                                                                                                                                   |                                                                                 | 20/                                                                     | 20/                                                                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> |
| Near Vision Acuity                                                                                                                                                                                                                                                |                                                                                 | 20/                                                                     | 20/                                                                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> |
| Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail                                                                                                                                                                            |                                                                                 |                                                                         |                                                                                      |                              | <input type="checkbox"/> |
| Notes                                                                                                                                                                                                                                                             |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>Hearing Screening:</b> 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.                                                                                              |                                                                                 |                                                                         |                                                                                      |                              | <b>Not Done</b>          |
| Pure Tone Screening                                                                                                                                                                                                                                               | <b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail        | <b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail | <b>Referral</b> <input type="checkbox"/> Yes                                         |                              | <input type="checkbox"/> |
| Notes                                                                                                                                                                                                                                                             |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>Scoliosis Screening:</b> Boys grade 9, Girls grades 5 & 7                                                                                                                                                                                                      |                                                                                 | <b>Negative</b>                                                         | <b>Positive</b>                                                                      | <b>Referral</b>              | <b>Not Done</b>          |
|                                                                                                                                                                                                                                                                   |                                                                                 | <input type="checkbox"/>                                                | <input type="checkbox"/>                                                             | <input type="checkbox"/> Yes | <input type="checkbox"/> |
| <b>FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK</b>                                                                                                                                                                                            |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>*Family cardiac history reviewed</b> – required for Dominic Murray Sudden Cardiac Arrest Prevention Act                                                                                                                               |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b>                                                                                                                                                                   |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>If Restrictions Apply</b> – Complete the information below                                                                                                                                                                                                     |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Student is restricted from participation in:</b>                                                                                                                                                                                      |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.                                                                   |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.                                                                                                                                                              |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.                                                                                                               |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Other Restrictions:</b>                                                                                                                                                                                                               |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level. |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V                                                                                                   |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Other Accommodations*:</b> 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.                                                                                                                             |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>MEDICATIONS</b>                                                                                                                                                                                                                                                |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> Order Form for medication(s) needed at school attached                                                                                                                                                                                   |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>COMMUNICABLE DISEASE</b>                                                                                                                                                                                                                                       |                                                                                 |                                                                         | <b>IMMUNIZATIONS</b>                                                                 |                              |                          |
| <input type="checkbox"/> Confirmed free of communicable disease during exam                                                                                                                                                                                       |                                                                                 |                                                                         | <input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS |                              |                          |
| <b>HEALTHCARE PROVIDER</b>                                                                                                                                                                                                                                        |                                                                                 |                                                                         |                                                                                      |                              |                          |
| Healthcare Provider Signature:                                                                                                                                                                                                                                    |                                                                                 |                                                                         |                                                                                      |                              |                          |
| Provider Name: <i>(please print)</i>                                                                                                                                                                                                                              |                                                                                 |                                                                         |                                                                                      |                              |                          |
| Provider Address:                                                                                                                                                                                                                                                 |                                                                                 |                                                                         |                                                                                      |                              |                          |
| Phone:                                                                                                                                                                                                                                                            |                                                                                 |                                                                         | Fax:                                                                                 |                              |                          |
| <b>Please Return This Form to Your Child's School Health Office When Completed.</b>                                                                                                                                                                               |                                                                                 |                                                                         |                                                                                      |                              |                          |

**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 \_\_\_\_\_



**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: Demi Wright                           | Attn: Kacey Feldman                                                |                                     |
| (518)732-7755<br>dwright@schodack.k12.ny.us | (518)732-7701<br>(518)732-0494(fax)<br>kfeldman@schodack.k12.ny.us | (518)732-2523<br>(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.*

|                                                 |            |                               |
|-------------------------------------------------|------------|-------------------------------|
| <b>STUDENT NAME:</b>                            |            |                               |
|                                                 |            |                               |
| First                                           | Middle     | Last                          |
| <b>DATE OF BIRTH:</b>                           |            | <b>GENDER:</b>                |
|                                                 |            | <input type="checkbox"/> Male |
| Month                                           | Day        | Year                          |
| <input type="checkbox"/> Female                 |            |                               |
| <b>PARENT/PERSON IN PARENTAL RELATION INFO:</b> |            |                               |
|                                                 |            |                               |
| 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? | <input type="checkbox"/> English     | <input type="checkbox"/> Other    | _____                                   |
|                                                                        |                                      |                                   | specify                                 |
| 2. What was the first language your child learned?                     | <input type="checkbox"/> English     | <input type="checkbox"/> Other    | _____                                   |
|                                                                        |                                      |                                   | specify                                 |
| 3. What is the Home Language of each parent/guardian?                  | <input type="checkbox"/> Parent 1    | <input type="checkbox"/> Parent 2 | _____                                   |
|                                                                        | <input type="checkbox"/> Guardian(s) |                                   | _____                                   |
|                                                                        |                                      |                                   | specify                                 |
| 4. What language(s) does your child understand?                        | <input type="checkbox"/> English     | <input type="checkbox"/> Other    | _____                                   |
|                                                                        |                                      |                                   | specify                                 |
| 5. What language(s) does your child speak?                             | <input type="checkbox"/> English     | <input type="checkbox"/> Other    | <input type="checkbox"/> Does not speak |
|                                                                        |                                      |                                   | specify                                 |
| 6. What language(s) does your child read?                              | <input type="checkbox"/> English     | <input type="checkbox"/> Other    | <input type="checkbox"/> Does not read  |
|                                                                        |                                      |                                   | specify                                 |
| 7. What language(s) does your child write?                             | <input type="checkbox"/> English     | <input type="checkbox"/> Other    | <input type="checkbox"/> 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: