Registration Checklist for K - 12

Welcome to Troy Schools!

In order to register your child, a parent or guardian must be present with photo identification at Central Registration Office located at School 12, 475 First Street. Office hours 7:30 am to 3:00 pm/Summer hours 7:00 am to 2:00 pm. Summer Hours are in effect during school breaks.

All attached forms must be completed.

The following documents are also required for registration:

**Required documents checklist**

1. Health Certificate signed by a doctor
2. Up-to-date Immunization Record
3. Birth Certificate
4. Proof of Residency (mortgage statement, lease, electric bill within 30 days or district residency form with the name of parent/guardian – all must include name of parent/guardian)
5. Photo Identification of Parent/Guardian
6. Dental Health Certificate (optional)

**Questions?** Contact Central Registration at 518-328-5007
Fax# 518-271-5445 email: reg@troycsd.org

**Se habla español:** 518-629-5757  Arabic Interpreter: 518-431-9281

**TROY SCHOOLS**

**Elementary Schools**
- School 2 – 470 Tenth Street
- School 14 – 1700 Tibbits Avenue
- School 16 – 40 Collins Avenue
- School 18 -412 Hoosick Street
- Carroll Hill School – 112 Delaware Avenue

**Troy Middle School**
1976 Burdett Avenue

**Troy High School**
1950 Burdett Avenue
Central Registration
475 First Street
Troy, New York 12180
(518) 328-5007

Housing Questionnaire

Name of School: ___________________________ Grade: __________

Name of Student: ___________________________

Last First Middle

Gender: □ Male □ Female Date of Birth: __________/________/________

Month Day Year

Address: _____________________________________________ Zip: ______ Phone: __________

The answer you give below will help the District determine what services you or your child may be able to receive under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don’t have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? – Please check one box.

□ In permanent housing
□ In a shelter
□ In a motel/hotel
□ With another family or person because of loss of housing or economic hardship
□ In a car, park, bus, train, or campsite
□ Other temporary living situation __________________________

_________________________ X __________________________
Print name of Parent, Guardian or Student Signature of Parent/Guardian or Student

_________________________
Date
STUDENT REGISTRATION FORM

STUDENT NAME: ______________________ / __________________/ __________________
First       Middle       Last

Last Name of Parent/Guardian with whom student is living: ____________________________________________

Address: ____________________________________________
           Street / Apt/Flr / City / NY State / Zip
Household Phone Number: ____________________________ Is this a cell phone: ☐ Yes ☐ No

What language is spoken in the student’s home: __________________________ Are translation services needed: ☐ Yes ☐ No

Ethnicity: Is the student Hispanic, Latino, or of Spanish origin? ☐ Yes, Hispanic ☐ No, not Hispanic

Race: Select one or more races from the following five racial groups
☐ Black  ☐ White  ☐ Asian  ☐ American Indian or Alaska Native  ☐ Native Hawaiian or other Pacific Islander

Gender: ☐ Male  ☐ Female  What language does the student speak and understand the most: __________________________

Date of Birth: ____/____/_______ Place of Birth: __________________________________________

City State Country

Has the student previously attended a school in Troy ☐ Yes ☐ No If yes, what school: __________________________

Registering for Grade: __________________________

Has the student attended school in the USA: ☐ Yes ☐ No If yes, number of years enrolled in US schools: _____

Does the student have a parent/guardian on active duty in the Armed Forces? ☐ Yes ☐ No

Did the student take any final High School level exam(s) out of state while his/her guardian was in the military? ______

☐ NCLB  ☐ SP  ☐ Summer Serv

ID: __________________________ Home School: __________________________ School Enrolled: __________________________

Documents provided to the district:
☐ Photo ID
☐ Proof of Residency
☐ National Grid Bill
☐ Lease
☐ Notarized Landlord Letter
☐ Mortgage Statement
☐ Other
☐ MCKINNEY-VENTO

☐ Birth Certificate  ☐ Passport
☐ Court Papers
☐ DSS 299-District
☐ Custody
☐ Parent/Custodial Affidavits
☐ Adoption

Enrollment Exceptions:
☐ School Choice  ☐ Opt In
☐ Wynantskill student  ☐ Permission Rcvd
☐ N. Greenbush student  ☐ Permission Rcvd
☐ Employee’s child – District  ☐ Emp ID
☐ Foreign Exchange
☐ Tuition Paying – District

☐ Lunch Form Completed
☐ Network Form

☐ Immunization  ☐ 14 Day Letter
☐ Religious Exemption
☐ Physical
☐ Dental certificate
Parent/Guardian Information

Mother/Guardian: / / First Middle Initial Last

Relationship to child: ☐ Mother ☐ Step-parent ☐ Legal Guardian ☐ Foster Parent ☐ Other

Resides in Home ☐ Yes ☐ No Custodial Parent ☐ Yes ☐ No Is to receive Correspondence ☐ Yes ☐ No

Mailing Address if different from above: / / Street Apt/Flr City State Zip

Home Phone: (___) Work Phone: (___) Cell Phone: (___)

Email Address: Phone call priority (1-3): Home Work Cell

Father/Guardian: / / First Middle Initial Last

Relationship to child: ☐ Father ☐ Step-parent ☐ Legal Guardian ☐ Foster Parent ☐ Other

Resides in Home ☐ Yes ☐ No Custodial Parent ☐ Yes ☐ No Is to receive Correspondence ☐ Yes ☐ No

Mailing Address if different from above: / / Street Apt/Flr City State Zip

Home Phone: (___) Work Phone: (___) Cell Phone: (___)

Email Address: Phone call priority (1-3): Home Work Cell

Other Children Living in the Household—Please include children not of school age

Name: __________________________ Date of Birth: ___/___/___
Gender: ☐ Male ☐ Female Past Registrant ☐ Yes ☐ No

Name: __________________________ Date of Birth: ___/___/___
Gender: ☐ Male ☐ Female Past Registrant ☐ Yes ☐ No

Please list the names of ANY and ALL persons Troy City School District is allowed to contact or release your child to in case of an emergency, including illness, serious injury, early dismissal of school or an evacuation emergency.

Emergency Contact 1: Name: __________________________ Relationship to Student: __________________________

Other than parent/guardian

Home Phone: (___) Work Phone: (___) Cell Phone: (___)

Address: __________________________

Emergency Contact 2: Name: __________________________ Relationship to Student: __________________________

Other than parent/guardian

Home Phone: (___) Work Phone: (___) Cell Phone: (___)

Address: __________________________
Emergency Contact 3: Name: ____________________________  Relationship to Student: ____________________________

Other than parent/guardian

Home Phone: (____)  Work Phone: (____)  Cell Phone: (____)

Address: ____________________________

Additional Emergency Contacts: ____________________________

Legal Information (If Applicable)
If parents are divorced or separated, is there a court approved custody document? □ Yes  □ No
Who retains legal custody? ____________________________________________  Relationship to child __________

If joint, who has residential (primary physical) custody? ____________________________________________
□ Legal guardianship document provided
Is the student in the care of a guardian(s) other than his/her mother or father? □ Yes  □ No
If yes, name of legal guardian(s) ____________________________________________  Relationship to child __________

Is the student in foster care? □ Yes  □ No  If yes, please provide copy of placement order (DSS-2999)

Additional Services (If Applicable)
Special Education Services
Does the student currently have an IEP (Individualized Education Plan) □ Yes  □ No
Does your child receive any of the following type of services?
□ Consultant Teacher  □ Self-Contained Classroom  □ Resource Room
□ Out of District Class (BOCES or QUESTAR)  □ Yes  □ No

Related Services
□ Speech and Language Therapy  □ Occupational Therapy  □ Physical Therapy
□ Counseling  □ Other, please describe ____________________________________________

Academic Intervention Services (AIS/Remedial)
□ Math  □ English Language Arts  □ Science  □ Social Studies

Other Services
□ 504 Plan
□ English as a New Language (ENL)  If yes how many years of service? _________
□ Other ____________________________________________

If your child requires special education or English as a new language services, he or she may not be attending their home school. If it is feasible, do you wish for siblings to attend the same school?  □ YES  □ NO

IF REGISTERING FOR PREK – Is or will your child be receiving Summer Service this year □ Yes  □ No

Parent Statement:
I certify that the above information is true and correct. Any misinformation regarding residency may result in being billed to cover the cost of instruction and/or exclusion from attending the Troy City School District.

Parent or Guardian Signature  X  Date ____________________________

All documents are to be returned to:
Troy City School District Central Registration Office
School 12, First Floor  475 First St., Troy, NY 12180
Phone: (518) 328-5007  Fax: (518) 271-5445
REQUEST FOR RECORDS

I give permission for the release of information concerning my child:

Student: ___________________________  Grade: _______________  Date of Birth: _______________

Name of Former District: ___________________________  City: _______________  State: _______________

Name of Former School: ___________________________  Phone: ___________________________

Address: ___________________________  Fax: ___________________________

Signature of Parent/Guardian X  Date: _______________

Office Use Only

REQUEST FOR RECORDS

Please send records to: ___________________________  Date sent: __/__/__

<table>
<thead>
<tr>
<th>√</th>
<th>SCHOOL</th>
<th>ADDRESS</th>
<th>PHONE/FAX</th>
<th>CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Troy High School</td>
<td>1950 Burdett Avenue 19750 Burdett Avenue</td>
<td>P: (518) 328-5472 F: (518) 271-5164</td>
<td>Guidance Office</td>
</tr>
<tr>
<td></td>
<td>Troy Middle School</td>
<td>Troy, NY 12180</td>
<td></td>
<td>Guidance Office</td>
</tr>
<tr>
<td></td>
<td>Carroll Hill School</td>
<td>112 Delaware Avenue 112 Delaware Avenue</td>
<td>P: (518) 328-5701 F: (518) 271-5492</td>
<td>Kate Talham</td>
</tr>
<tr>
<td></td>
<td>School 2</td>
<td>470 Tenth Street 470 Tenth Street</td>
<td>P: (518) 328-5601 F: (518) 271-5205</td>
<td>Nickole Farnan</td>
</tr>
<tr>
<td></td>
<td>School 14</td>
<td>1700 Tibbits Avenue 1700 Tibbits Avenue</td>
<td>P: (518) 328-5801 F: (518) 274-0371</td>
<td>Secretary</td>
</tr>
<tr>
<td></td>
<td>School 16</td>
<td>40 Collins Avenue 40 Collins Avenue</td>
<td>P: (518) 328-5101 F: (518) 274-4585</td>
<td>Latonia Berkley</td>
</tr>
<tr>
<td></td>
<td>School 18</td>
<td>412 Hoosick Street 412 Hoosick Street</td>
<td>P: (518) 328-5501 F: (518) 274-4374</td>
<td>Emily Ruffinen</td>
</tr>
<tr>
<td></td>
<td>Central Registration</td>
<td>School 12 475 First St. School 12 475 First St.</td>
<td>P: (518) 328-5007 F: (518) 271-5445</td>
<td>Central Registration Office</td>
</tr>
<tr>
<td></td>
<td>Special Education Department</td>
<td>School 12 475 First St. School 12 475 First St.</td>
<td>P: (518) 328-5075 F: (518) 279-7600</td>
<td>Pupil Services Office</td>
</tr>
</tbody>
</table>

Items Requested:
- Transcripts
- Current Report Cards
- Standardized Test Scores
- Regents Competency Test (RCT) Results
- NYS Regents Scores
- NYS Regents Science Labs
- Birth Certificate
- NYS Proficiency Scores
- Cumulative Health Records/Immunizations
- Attendance Records
- Psychological Evaluations
- Disciplinary Records
- NYS Grade Test Results
- Special Education Records, including most recent IEP
Thank you for your prompt attention to this matter.

Parent Consent to Release Information
Medical Authorization Form

To Whom It May Concern:

In regard to my (Son/Daughter): ____________________________

I, ____________________________, hereby authorize any physician or nurse who has attended, examined, or treated my child to furnish his/her teachers or pertinent staff with whom (he/she) comes in daily contact, with any and all information which may be necessary regarding (his/her) past or present physical condition and treatment rendered therefore, to ensure that said school personnel are fully cognizant of his/her condition and to safeguard their health and safety.

[Signature]
Signature of Parent/Guardian

Date

Please Print Name
<table>
<thead>
<tr>
<th>Has Your Child Ever Had the Following?</th>
<th>N</th>
<th>Y</th>
<th>Explain with Date/Medication</th>
<th>Has Your Child Ever Had the Following?</th>
<th>N</th>
<th>Y</th>
<th>Explain with Date/Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALLERGIES</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>Anemia/Bleeding Disorder</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td></td>
<td></td>
<td></td>
<td><strong>Sickle Cell</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bees</td>
<td></td>
<td></td>
<td></td>
<td><strong>Chronic Ear Infections</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td></td>
<td></td>
<td></td>
<td><strong>Hearing Loss</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td></td>
<td></td>
<td></td>
<td><strong>Hearing Aid</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eczema</td>
<td></td>
<td></td>
<td></td>
<td><strong>Speech Concerns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td><strong>Vision Problems (Glasses, Contacts)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADHD/ADD</td>
<td></td>
<td></td>
<td></td>
<td><strong>Loss of Vision</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior Concerns</td>
<td></td>
<td></td>
<td></td>
<td><strong>Bladder/Kidney Condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td><strong>Absence Kidney</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizure Disorder (Epilepsy)</td>
<td></td>
<td></td>
<td></td>
<td><strong>Absence of Testicle</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Murmur</td>
<td></td>
<td></td>
<td></td>
<td><strong>Arthritis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Condition/Surgery</td>
<td></td>
<td></td>
<td></td>
<td><strong>Fractures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High/Low Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td><strong>Scoliosis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fainting During Exercise</td>
<td></td>
<td></td>
<td></td>
<td><strong>Chicken Pox/Date</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Injury</td>
<td></td>
<td></td>
<td></td>
<td><strong>Surgery (Tonsils, Hernia)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine Headaches</td>
<td></td>
<td></td>
<td></td>
<td><strong>Under Current Medical Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

List any special medical problems or serious injuries or gym restrictions

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

<table>
<thead>
<tr>
<th>STUDENT NAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
</tr>
<tr>
<td>DATE OF BIRTH:</td>
</tr>
<tr>
<td>Month</td>
</tr>
<tr>
<td>PARENT/PERSON IN PARENTAL RELATION INFO:</td>
</tr>
<tr>
<td>Last Name</td>
</tr>
</tbody>
</table>

**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

2. What was the first language your child learned?
   - [ ] English
   - [ ] Other

3. What is the Home Language of each parent/guardian?
   - [ ] Mother
   - [ ] Father
   - [ ] Guardian(s)

4. What language(s) does your child understand?
   - [ ] English
   - [ ] Other

5. What language(s) does your child speak?
   - [ ] English
   - [ ] Other
   - [ ] Does not speak

6. What language(s) does your child read?
   - [ ] English
   - [ ] Other
   - [ ] Does not read

7. What language(s) does your child write?
   - [ ] English
   - [ ] Other
   - [ ] Does not write

---

**THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:**

**SCHOOL DISTRICT INFORMATION:**

| District Name | Number & School | Address |

**STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:**

---
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:
   □ 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?

Name of Parent or of Person in Parental Relation

Relationship to student: □ Mother □ Father □ Other: __________

Month: __________ Day: __________ Year: __________

---

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: __________________________

OUTCOME OF:
□ ADMINISTER NYSTELL
□ INDIVIDUAL ENGLISH PROFICIENT
□ INTERVIEW REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSTELL

Name: __________________________ Position: __________________________

Date of NYSTELL Administration:

Proficiency Level: □ ENTERING □ EMERGING □ TRANSITIONING □ EXPANDING □ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:
NETWORK COMPUTING AND
INTERNET SAFETY POLICY 4526

USER ACKNOWLEDGEMENT
After reading the Networking Computing and Internet Safety Policy, please print and sign your name below acknowledging that you accept Policy 4526 and its terms. A copy with your User ID and Password will be issued to you when signed.

STUDENTS NAME: ______________________________________________________

BUILDING/SCHOOL: ____________________________________________________

USER'S ID NUMBER: ____________________________________________________

USER'S SIGNATURE: _____________________________________________________

PARENT'S SIGNATURE: X _________________________________________________

DATE: __________________________________________________________________

PRINCIPAL/SUPERVISOR (please print): _____________________________________

PHONE NUMBER: _______________________________________________________

PRINCIPAL/SUPERVISOR SIGNATURE: ____________________________________

DATE: __________________________________________________________________

PLEASE REMOVE ACKNOWLEDGEMENT PAGE AND
KEEP POLICY PORTION FOR YOUR RECORDS.

STUDENTS: RETURN TO PRINCIPAL
BOE Approved 2-1-12

11
PHYSICAL EXAMINATION REQUIREMENT

Dear Parent/Guardian:

New York State Education Law requires that all children attending school in New York State have a physical examination and dental screening at the following grade levels: Pre K, Kindergarten, 1st grade, 3rd grade, 5th grade, 7th grade, 9th grade and 11th grade, and all new students entering into the Troy City School District.

As part of your child’s education and in recognition of a desirable health practice, the annual health examinations by your health care providers continue to be encouraged. The examiner that is familiar with your child’s health history is able to give a more thorough physical. They can immediately advise you regarding any condition that might be found.

If your child has had a physical in the past year or you plan to have your child examined by his/her own doctor, please have the Health Certificate filled out by the doctor and returned to school.

When we require that your child have a physical examination, we will be requesting a dental certificate as well. There is a sample certificate available for you to take to your child’s dentist. Once it is completed, it should be returned to the School Nurse as it will be filed in your child’s Cumulative Health Record.

Please call the school’s health office if you have any questions or concerns.

Thank you for your cooperation in this health endeavor.

Please return the completed form to the Health Office of your child’s school.

<table>
<thead>
<tr>
<th>School 12</th>
<th>School 16</th>
<th>Carroll Hill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 328-5025</td>
<td>Phone 328-5120</td>
<td>Phone 328-5720</td>
</tr>
<tr>
<td>Fax 203-6874</td>
<td>Fax 274-4585</td>
<td>Fax 274-4587</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School 18</th>
<th>Pre-K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 328-5520</td>
<td>Phone 328-5436</td>
</tr>
<tr>
<td>Fax 274-4374</td>
<td>Fax 271-7692</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Troy Middle School</th>
<th>School 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 328-5323</td>
<td>Phone 328-5620</td>
</tr>
<tr>
<td>Fax 271-5175</td>
<td>Fax 271-5205</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Troy High School</th>
<th>School 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 328-5425</td>
<td>Phone 328-5825</td>
</tr>
<tr>
<td>Fax 271-5174</td>
<td>Fax 274-0371</td>
</tr>
</tbody>
</table>
Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birth Date</th>
<th>Sec</th>
<th>Will this be your child's first oral health assessment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ / / Year</td>
<td>€Male</td>
<td>€Yes €No</td>
</tr>
<tr>
<td></td>
<td>€Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School: Name</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? €Yes €No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of __________________ on __________ (date of assessment)

The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).

€Yes €No Caries Experience/Restoration History — Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

€Yes €No Untreated Caries — Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

€Yes €No Dental Sealants Present

Other problems (Specify):

II. Treatment Needs (check all that apply)

€ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

€ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

€ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.
REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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

<table>
<thead>
<tr>
<th>STUDENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Sex: □ M □ F</td>
</tr>
<tr>
<td>DOB:</td>
</tr>
<tr>
<td>School:</td>
</tr>
<tr>
<td>Grade:</td>
</tr>
<tr>
<td>Exam Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies □ No</td>
</tr>
<tr>
<td>□ Yes, indicate type</td>
</tr>
<tr>
<td>Type:</td>
</tr>
<tr>
<td>□ Medication/Treatment Order Attached</td>
</tr>
<tr>
<td>□ Anaphylaxis Care Plan Attached</td>
</tr>
<tr>
<td>Asthma □ No</td>
</tr>
<tr>
<td>□ Yes, indicate type</td>
</tr>
<tr>
<td>□ Intermittent</td>
</tr>
<tr>
<td>□ Persistent</td>
</tr>
<tr>
<td>□ Other:</td>
</tr>
<tr>
<td>□ Medication/Treatment Order Attached</td>
</tr>
<tr>
<td>□ Asthma Care Plan Attached</td>
</tr>
<tr>
<td>Seizures □ No</td>
</tr>
<tr>
<td>□ Yes, indicate type</td>
</tr>
<tr>
<td>Date of last seizure:</td>
</tr>
<tr>
<td>□ Medication/Treatment Order Attached</td>
</tr>
<tr>
<td>□ Seizure Care Plan Attached</td>
</tr>
<tr>
<td>Diabetes □ No</td>
</tr>
<tr>
<td>□ Yes, indicate type</td>
</tr>
<tr>
<td>Type: □ 1 □ 2</td>
</tr>
<tr>
<td>□ Medication/Treatment Order Attached</td>
</tr>
<tr>
<td>□ Diabetes Medical Mgmt. Plan Attached</td>
</tr>
</tbody>
</table>

Risk Factors for Diabetes or Pre-Diabetes: Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.

BMI ________ kg/m2

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

Hyperlipidemia: □ No □ Yes □ Not Done

Hypertension: □ No □ Yes □ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

<table>
<thead>
<tr>
<th>Laboratory Testing</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
<th>List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB-PRN</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Screen-PRN</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Level Required Grades Pre- K &amp; K</td>
<td>Date</td>
<td>□ Test Done</td>
<td>□ Lead Elevated &gt; 5 µg/dL</td>
<td></td>
</tr>
</tbody>
</table>

□ System Review and Abnormal Findings Listed Below

□ HEENT □ Dental □ Neck □ Lymph nodes □ Cardiovascular □ Lungs □ Abdomen □ Back/Spine □ Genitourinary □ Extremities □ Skin □ Neurological □ Speech □ Social Emotional □ Musculoskeletal

□ Assessment/Abnormalities Noted/Recommendations: Diagnoses/Problems (list) ICD-10 Code*

□ Additional Information Attached

*Required only for students with an IEP receiving Medicaid
<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
</tr>
</thead>
</table>

### SCREENINGS

<table>
<thead>
<tr>
<th>Vision (w/correction if prescribed)</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
<td>20/</td>
<td>□ Yes □ No</td>
<td>□</td>
</tr>
<tr>
<td>Near Vision Acuity</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Color Perception Screening</td>
<td>□ Pass □ Fail</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes**

**Hearing** Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.

<table>
<thead>
<tr>
<th>Pure Tone Screening</th>
<th>Right</th>
<th>Pass</th>
<th>Fail</th>
<th>Left</th>
<th>Pass</th>
<th>Fail</th>
<th>Referral</th>
<th>Yes</th>
<th>No</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td></td>
<td></td>
<td>□</td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td>□</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes**

<table>
<thead>
<tr>
<th>Scoliosis Screen Boys in grade 9, and Girls in grades 5 &amp; 7</th>
<th>Negative</th>
<th>Positive</th>
<th>Referral</th>
<th>Yes</th>
<th>No</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>□ Yes □ No</td>
<td>□</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- □ Student may participate in all activities without restrictions.
- □ Student is restricted from participation in:
  - **Contact Sports**: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
  - **Limited Contact Sports**: Baseball, Fencing, Softball, and Volleyball.
  - **Non-Contact Sports**: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
  - □ Other Restrictions:

**Developmental Stage for Athletic Placement Process ONLY required** for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.

- **Tanner Stage**: □ I □ II □ III □ IV □ V
- **Age of First Menses (if applicable)**: ____________

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

### MEDICATIONS

- □ Order Form for Medication(s) Needed at School Attached

### IMMUNIZATIONS

- □ Record Attached □ Reported in NYSIIS

### HEALTH CARE PROVIDER

- **Medical Provider Signature:**
- **Provider Name**: *(please print)*
- **Provider Address:**
- **Phone:**
- **Fax:**

*Please Return This Form To Your Child’s School When Completed.*
Dear Parent/Guardian:

Due to a change in New York State Education Department regulations, the following medications will only be administered with your health care provider’s written order and your written permission. A list of medications, which will be available in your school’s Health Office, are listed below.

**Please have your health care provider check the medications appropriate for your child.** Only one student per form. Each student must have this individual medication order on file.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen - 325 mg - pain relief</td>
<td></td>
</tr>
<tr>
<td>Acetaminophen - 80 mg - liquid/chewable - pain</td>
<td></td>
</tr>
<tr>
<td>Antacid - liquid - relief of upset stomach</td>
<td></td>
</tr>
<tr>
<td>Bacitracin topical ointment</td>
<td></td>
</tr>
<tr>
<td>Benadryl topical cream</td>
<td></td>
</tr>
<tr>
<td>Benzolalkonium - antiseptic solution</td>
<td></td>
</tr>
<tr>
<td>Calamine - relieves itching</td>
<td></td>
</tr>
<tr>
<td>Chloraseptic Spray</td>
<td></td>
</tr>
<tr>
<td>Cough Drops</td>
<td></td>
</tr>
<tr>
<td>Hydrocortisone topical cream 1%</td>
<td></td>
</tr>
<tr>
<td>Orajel - oral pain relief</td>
<td></td>
</tr>
<tr>
<td>Tums</td>
<td></td>
</tr>
<tr>
<td>Vaseline Lotion and Ointment</td>
<td></td>
</tr>
</tbody>
</table>

**Student Name ____________________________**  **Date of Birth ___________**  **Grade ______**

Date ______  Health Care Provider’s Signature ____________________________  Telephone # ____________

PHYSICIAN SIGNS HERE

* Please print or stamp name ____________________________

Date ______  Parent/Guardian’s Signature ____________________________  Telephone # ____________

PARENT SIGNS HERE
April 23, 2015

Dear Parents/Guardians:

The Enlarged City School District of Troy provides special education services and programs to students with disabilities pursuant to applicable federal and state laws. Any parent or person in parental relation who suspects that his/her child has a disability may refer the child for an evaluation by the District’s Committee on Special Education (CSE) for eligibility for special education services and programs. More detailed information on this process is available in *A Parent’s Guide to Special Education*, which is published on the New York State Education Department’s website in English and Spanish.


Parents or persons in parental relation should contact the District’s Director of Pupil Personnel Services, Donna Fitzgerald, at School 12 475- First Street Troy, N.Y. 12180 or by calling 328-5075.
2020-2021 Community Eligibility Provision (CEP)/Provision 2 Non-base Year
Household Income Eligibility Form

The Enlarged City School District of Troy is participating in the Community Eligibility Provision (CEP) or Provision 2 in a non-base year. All children in the school will receive meals/milk at no charge regardless of household income or completion of this form. This form is to determine eligibility for additional State and Federal program benefits that your child(ren) may qualify for. Read the instructions on the back, complete only one form for your household, sign your name and return it to the school named above. Call 518-328-5005 if you need help.

1. List all children in your household who attend school:

<table>
<thead>
<tr>
<th>Student Name</th>
<th>School</th>
<th>Grade/Teacher</th>
<th>Foster Child</th>
<th>No Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. Skip to Part 5, and sign the application.

Name: _____________________________  CASE #: ________________________

3. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box. If you have listed a foster child above, you must report their personal income.

<table>
<thead>
<tr>
<th>Name of household member</th>
<th>Earnings from work before deductions</th>
<th>Child Support, Alimony</th>
<th>Pensions, Retirement Payments</th>
<th>Other Income, Social Security</th>
<th>No Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td></td>
</tr>
</tbody>
</table>

4. Household Size: __________________________ (Include in this number: yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living in your household.)

5. Signature: An adult household member must sign this application.

I certify (promise) that all the information on this application is true and that all income is reported. I understand that the Information is being given so the school may receive federal funds. The school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and Federal laws, and my children may lose meal benefits.

Signature: ___________________________________________  DATE: ____________

Email Address: ______________________________________  Home Address: __________________________

Home Phone: ___________________________  Work Phone: ___________________________

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

___ SNAP/TANF/Foster
___ Income Household: Total Household Income/How Often: $_____ / _______ Household Size: ________
___ Free Eligibility  ___ Reduced Eligibility  ___ Denied Eligibility

___ Signature of Reviewing Official ____________
PART 1
ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE FORM FOR YOUR HOUSEHOLD.
(1) Print the names of the children, including foster children, for whom you are applying on one form.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, and check the box for each child with no income.

PART 2
HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 5.
(1) List a current SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families) or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. Do not use the 16-digit number on your benefit card. The case number is provided on your benefit letter.
(2) An adult household member must sign the form in PART 5. SKIP PART 3 and 4 - Do not list names of household members or income if you list a SNAP, TANF or FDPIR number.

PARTS 3, 4 & 5
ALL OTHER HOUSEHOLDS MUST COMPLETE ALL OF PARTS 3, 4 AND 5.
(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box. The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should not be considered as income for this program.

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children’s Health Insurance Program (CHIP). In order to determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

PRIVACY ACT STATEMENT

The Enlarged City School District of Troy is committed to maintaining the privacy of our students and families and the confidentiality of sensitive personal information. The information you have provided on this form will be used only for the purpose(s) stated above and will otherwise be maintained by the District in confidence in accordance with the applicable provisions of the Federal Educational Rights and Privacy Act (FERPA) and the privacy protections of Public Officers Law section 69.