Checklist for Prekindergarten Registration Applicants

Attention Parent/Guardian: Your child must be age 4 by December 1, 2021 for 2021-22 school year.

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 - all must include name of parent/guardian)
(5) Photo Identification of Parent/Guardian
(6) Dental Health Certificate (optional)

Central Registration. Parents/guardians will need to make an appointment to drop off registration paperwork at Central Registration (475 First Street) or it can be faxed or emailed. The registration packet and all required documents must be submitted with the application in order for Central Registration to process the application. Central Registration Hours: 7:30 a.m. to 3:00 p.m. / Summer hours 7:00 a.m. to 2:00 p.m. Summer hours are in effect during school breaks.
Registration Fax: (518) 271-5445 Email: reg@troycsd.org

NYS Prekindergarten Regulations. According to the revised New York State Prekindergarten Regulations 151-2.6 Admission Requirements for Children:

No child may participate in the Prekindergarten program unless:

(1) A report of a medical examination of the child signed by a physician is submitted within 30 days of admission which states that the child is free from contagious or communicable disease.
(2) The child has been immunized to the extent appropriate to his/her age in accordance with Section 2164 of the Public Health Law; or has been granted an exemption from such immunization.

Note: Universal Pre K is dependent upon funding under the Troy Universal Pre K Grant from the New York State Education Department for the 2021-2022 school year. The amount of funding received determines the number of Pre K slots.
Questions? Contact Juli at (518) 328-5436 or Registration at (518) 328-5007
Fax: (518) 271-5445 Email: reg@troycsd.org
Housing Questionnaire

Name of School: ___________________________________________ Grade: ______

Name of Student:
Last First Middle

Gender: □ Male  □ Female  Date of Birth: ______/_____/______
Month  Day  Year

Address: ______________________ Zip: ______  Phone: __________

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

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

□ In 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  ______________________
Name of Parent/Guardian or Student, please print  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: ____________________________ / ________ / ________ Apt/Fr __________ 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 Office Use Only Date: ________ / ________ / ________

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

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Prekindergarten Student Registration Form
TROY CITY SCHOOL DISTRICT

Attendance Expectations

I AGREE TO FOLLOW THE ATTENDANCE EXPECTATIONS OF THE TROY CITY SCHOOL DISTRICT UNIVERSAL PREKINDERGARTEN PROGRAM.

• My child will be in school each day Universal Prekindergarten is in session unless he or she is sick.

• If my child is not in attendance and is not sick, I understand that my child can be dropped from the program.

• I will send a written excuse each day my child is absent.

• If I can, I will call the Prekindergarten school/center to notify the school that my child will be absent.

• My child will be at school and picked up on time daily and will stay for the full Pre K program. I will sign my child in and out each day of the program. I understand that my child may be dropped from the program by not complying.

• My child will be dropped off at the start of the program and picked up at the end of the program. I understand that it is important for my child to be present for the entire day and by not complying my child may be dropped from the program.

• I understand it is my responsibility to be sure to give the Pre K teacher and staff updated phone numbers.

• I understand that if I move outside the Troy City School District area, my child will no longer be able to attend the Universal Prekindergarten program. I will also notify the district that my child has moved.

X

Signature of Parent/Guardian

Date
### Prekindergarten Program Sites

The following sites hold a Prekindergarten program in conjunction with the Troy City School District:

<table>
<thead>
<tr>
<th>Site</th>
<th>Hours</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. School #2</td>
<td>7:45 – 2:00</td>
<td>Head Start collaboration</td>
</tr>
<tr>
<td>470 Tenth Street</td>
<td></td>
<td>Additional Paperwork Required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parents transport</td>
</tr>
<tr>
<td>2. School #12</td>
<td>7:40 – 1:00</td>
<td>Parents transport</td>
</tr>
<tr>
<td>475 First Street</td>
<td>7:45 – 2:00</td>
<td>Head Start Collaboration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Additional Paperwork Required</td>
</tr>
<tr>
<td>3. School #14</td>
<td>7:45 – 1:00</td>
<td>Parents transport</td>
</tr>
<tr>
<td>1700 Tibbits Avenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. CEO</td>
<td>8:00 – 2:00</td>
<td>Parents Transport</td>
</tr>
<tr>
<td>Fifth Avenue</td>
<td></td>
<td>Head Start Collaboration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Additional Paperwork Required</td>
</tr>
<tr>
<td>6. Sacred Heart</td>
<td>8:00 – 1:00</td>
<td>Parents transport</td>
</tr>
<tr>
<td>308 Spring Avenue</td>
<td></td>
<td>Wrap-around &amp; After School Care option</td>
</tr>
<tr>
<td></td>
<td></td>
<td>School Uniform required</td>
</tr>
</tbody>
</table>
Prekindergarten Student Registration Form
TROY CITY SCHOOL DISTRICT

SITE REQUEST FORM

Child’s Name: ________________________________

Criteria for Acceptance:
- Child must reside within the Troy City School District.
- The child must be 4 years of age on or before December 1st of the school year they are enrolling for.

Preceding this page is a list of names and addresses of the Pre K providers within the Troy City School District. The hours of operation and what options the program has is listed.

Please rank order your top 5 choices below.
1. _______________________________________
2. _______________________________________
3. _______________________________________
4. _______________________________________
5. _______________________________________

Random Selection
New York State requires random selection of all Universal Prekindergarten programs. Applications will be accepted beginning February 22nd. Applications will be selected at random to fill the available Pre K classrooms. You will be notified by mail of your child’s placement. Every effort will be made on our part to grant you your Prekindergarten preference.

Additional Childcare
Wrap-around childcare is an option at some Pre K sites. This means that a parent can have the option of childcare before and/or after the Pre K day. However, the cost associated with the additional childcare is the responsibility of the parent or guardian.
Prekindergarten Student Registration Form
TROY CITY SCHOOL DISTRICT

CHILD PROFILE

Child's name ________________________________

Language(s) spoken in the home ________________________________

Is your child currently attending:
daycare_____ nursery school_____ or Head Start_____

Does your child have any special health challenges we should know about?

____________________________________________________________________________________

Does your child have any religious dietary needs?

____________________________________________________________________________________

Mother's name ___________________ Age _____ Education _____
Phone: Home: ___________ Cell: ___________ Work: ___________

Father's name ___________________ Age _____ Education _____
Phone: Home: ___________ Cell: ___________ Work: ___________

Sitter's/Day Care Name ____________________________________
Address ______________________________________
Phone ____________________________________
Prekindergarten Student Registration Form
TROY CITY SCHOOL DISTRICT

CHILD RELEASE FORM

Please indicate the names of the people who can pick up your child at dismissal time if you are unable to do so yourself. We will not release your child to any unauthorized person. Persons who pick up your child may be asked to show identification.

I hereby give the staff at _____________________________ Pre K
(name of school)
permission to release my child _____________________________ to the
(name of child)
following person(s).

X
Parent Signature

Date

Please Print Names of Authorized People:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Relationship to Child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Parent</td>
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<td>Parent</td>
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</tbody>
</table>
Prekindergarten Student Registration Form
TROY CITY SCHOOL DISTRICT

WALKING TRIP PERMISSION SLIP

I desire to have my child ________________________ go with the Prekindergarten on all walking trips the class may take from September, 20___ to June, 20___. I shall be responsible for his/her actions while the class is taking the trip.

X

Parent Signature

Date
Prekindergarten Student Registration Form
TROY CITY SCHOOL DISTRICT

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.

__________________________
Date

X
Signature of Parent/Guardian

__________________________
Please Print Name
## School Health Services

**Entering Date**

**Grade**

**School**

**Sex**

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Address (if different)</th>
<th>Home Phone</th>
<th>Cell Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td>MI</td>
<td></td>
</tr>
<tr>
<td>Mother's Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place of Employment</td>
<td>Phone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father's Name</td>
<td>Address (if different)</td>
<td>Home Phone</td>
<td>Cell Phone</td>
</tr>
<tr>
<td>Place of Employment</td>
<td>Phone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guardian/Step Parent Name</td>
<td>Address (if different)</td>
<td>Home Phone</td>
<td>Cell Phone</td>
</tr>
<tr>
<td>Place of Employment</td>
<td>Phone</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The answers to the questions on this form will be held in the School Health Office and will be kept confidential.

Has your child ever had the following? Please explain with date of onset, any "yes" answers.

<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>
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<tr>
<td>Food</td>
<td></td>
<td></td>
<td></td>
<td><strong>Sickle Cell</strong></td>
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<tr>
<td>Bees</td>
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<td></td>
<td></td>
<td><strong>Chronic Ear Infections</strong></td>
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<tr>
<td>Environmental</td>
<td></td>
<td></td>
<td></td>
<td><strong>Hearing Loss</strong></td>
<td></td>
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<tr>
<td>Medication</td>
<td></td>
<td></td>
<td></td>
<td><strong>Hearing Aid</strong></td>
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<tr>
<td>Eczema</td>
<td></td>
<td></td>
<td></td>
<td><strong>Speech Concerns</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td><strong>Vision Problems</strong></td>
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<tr>
<td>ADHD/ADD</td>
<td></td>
<td></td>
<td></td>
<td><strong>(Glasses, Contacts)</strong></td>
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<tr>
<td>Behavior Concerns</td>
<td></td>
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<td></td>
<td><strong>Loss of Vision</strong></td>
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<tr>
<td>Diabetes</td>
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<td></td>
<td><strong>Bladder/Kidney Condition</strong></td>
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<tr>
<td>Seizure Disorder (Epilepsy)</td>
<td></td>
<td></td>
<td></td>
<td><strong>Absence Kidney</strong></td>
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<tr>
<td>Heart Murmur</td>
<td></td>
<td></td>
<td></td>
<td><strong>Absence of Testicle</strong></td>
<td></td>
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<tr>
<td>Cardiac Condition/Surgery</td>
<td></td>
<td></td>
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<td><strong>Arthritis</strong></td>
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<tr>
<td>High/Low Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td><strong>Fractures</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Fainting During Exercise</td>
<td></td>
<td></td>
<td></td>
<td><strong>Scoliosis</strong></td>
<td></td>
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<tr>
<td>Head Injury</td>
<td></td>
<td></td>
<td></td>
<td><strong>Chicken Pox/Date</strong></td>
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<td></td>
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<tr>
<td>Migraine Headaches</td>
<td></td>
<td></td>
<td></td>
<td><strong>Surgery (Tonsils, Hernia)</strong></td>
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<td></td>
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<td></td>
<td></td>
<td><strong>Under Current Medical Care</strong></td>
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<td></td>
</tr>
</tbody>
</table>

List any special medical problems or serious injuries or gym restrictions

**Parent/Guardian Signature**

**Date**

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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.

**Student Name:**

- **First**
- **Middle**
- **Last**

**Date of Birth:**

- **Month**
- **Day**
- **Year**

**Gender:**

- Male
- Female

**Parent/Person in Parental Relation Info:**

- **Last Name**
- **First Name**
- **Relation to**

**Home Language Code**

**Language Background**

(Please check all that apply.)

1. What language(s) is(are) spoken in the student’s home or residence?

- English
- Other

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

6. What language(s) does your child read?

- English
- Other

7. What language(s) does your child write?

- English
- Other

---

**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:**

---

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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: ☐ Mother ☐ Father ☐ Other: __________

---

**OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ**

NAME: __________ Position: __________

If an interpreter is provided, list name, position and credentials:

**NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW**

NAME: __________ Position: __________

Oral interview necessary: ☐ No ☐ Yes

**DATE OF INDIVIDUAL INTERVIEW:** __________

**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: __________

Proficiency Level Achieved on NYSITELL:

☐ Exiting ☐ Emerging ☐ Transitioning ☐ Expanding ☐ Commanding

For students with disabilities, list accommodations, if any, administered in accordance with IEP pursuant to CSE recommendation.
Prekindergarten Student Registration Form

TROY CITY SCHOOL DISTRICT

HOUSEHOLD SURVEY

Number of people living in the household _____________________

Single Parent Household ______ yes ______ no

Foster Child ______ yes ______ no

Non-English Speaking Household ______ yes ______ no

Temporary Housing ______ yes ______ no

Parent/Guardian Working ______ yes ______ no

If yes, location and hours of work:

Parent/Guardian #1__________________________________________

Parent/Guardian #2__________________________________________

Parent/Guardian attending school ______ yes ______ no

Parent/Guardian on Unemployment ______ yes ______ no

Is your child covered by Medicaid ______ yes ______ no
DEVELOPMENTAL SCREENINGS

An outside approved agency may help assist with the Developmental Screenings for Troy City School District Pre K rooms. The screening is an informal assessment to identify possible developmental delays (speech, motor, educational and behavioral). Each child is seen individually by a teacher, speech therapist, or motor therapist. If any concerns do exist, a formal evaluation may be recommended. Please sign and date below for an outside approved agency to assist with your child’s screening.

Child’s Name: __________________________________________________________

Child’s date of birth: __________________________________________________

Child’s Gender: Male or Female (please circle)

Parent(s) Name: _______________________________________________________

Telephone Number: ____________________________________________________

I give permission for my child, ________________________________________, to receive a developmental screening from an out of district provider.

X
Parent or Guardian Signature ___________________________________________

Date ____________________________
Prekindergarten Student Registration Form
TROY CITY SCHOOL DISTRICT

Information Sheet

What do you want your child to be called at school?

Child’s birthday (M/D/Y):

Parent/Guardian Name(s):

Child’s Siblings (this will help us spell their names on their artwork):

Family Pets:

Email Address:

Child’s Allergies (please include food, animal or other allergies):

What are you child’s favorite snack foods?

What are your child’s interests?

What activities does your child like to do?

What are you child’s dislikes (food, activities, other)?

Anything else you would like to tell us about your child?
DO NOT RELEASE
MEDIA FORM

Please complete this form only if you OBJECT to the use of your child’s photograph or video.

Photographs and videos of our students may be used to promote programs and activities in print and online materials.

School ___________ Grade: ___________

Child’s Name: ____________________________________________

Address: ________________________________________________

Parent/Guardian Signature: _________________________________

DO NOT RELEASE:

☐ I do NOT wish my child’s photograph to appear online on District sites or in the District print newsletter.

DO NOT RELEASE:

☐ I do NOT wish my child to be photographed or videotaped by an outside agency (such as newspaper or television media).

ONLY IF YOU OBJECT to the release of your child’s photograph.
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.

USER’S NAME (please print): ___________________________________________

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.

FACULTY/STAFF: RETURN TO HUMAN RESOURCES
STUDENTS: RETURN TO PRINCIPAL

BOE Approved 2-1-12

20
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 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 who are entering the Troy City School District.

As part of your child’s education and in recognition of a desirable health practice, the annual health examination 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>Carroll Hill</th>
<th>School 16</th>
<th>School 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 328-5720</td>
<td>Phone 328-5120</td>
<td>Home 328-5025</td>
</tr>
<tr>
<td>Fax 274-4587</td>
<td>Fax 274-4585</td>
<td>Fax 203-6874</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-K</th>
<th>School 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 328-5012</td>
<td>Phone 328-5520</td>
</tr>
<tr>
<td>Fax 271-7692</td>
<td>Fax 274-4374</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>School 14</th>
<th>Troy High School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 328-5825</td>
<td>Phone 328-5425</td>
</tr>
<tr>
<td>Fax 274-0371</td>
<td>Fax 271-5174</td>
</tr>
</tbody>
</table>
DENTAL HEALTH CERTIFICATE - OPTIONAL

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination 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 dentist for an examination. If your child had a dental check-up before he/she started the school, ask your dentist 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)

Child's Name: Last  ______________  First  ______________  Middle  ______________
Birth Date: / /  ________________  Month Day Year
Sex: Male  ________________  Female
Will this be your child's first visit to a dentist?  Yes  ________________  No  ________________

School Name:  ________________  Grade  ________________
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  X  ___________________________  Date  ________________

Section 2. To be completed by the Dentist

I. The Dental Health condition of  ___________________________  on  ___________________________  (date of exam) The date of the exam 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 name and address (please print or stamp) Dentist'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 1/4 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):  ___________________________

III. 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 IN ENTIRETY BY PRIVATE HEALTH CARE 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

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

## HEALTH HISTORY

### Allergies
- □ No
- □ Medication/Treatment Order Attached
- □ Anaphylaxis Care Plan Attached
- □ Yes, indicate type: □ Food □ Insects □ Latex □ Medication □ Environmental

### Asthma
- □ No
- □ Medication/Treatment Order Attached
- □ Asthma Care Plan Attached
- □ Yes, indicate type: □ Intermittent □ Persistent □ Other:

### Seizures
- □ No
- □ Medication/Treatment Order Attached
- □ Seizure Care Plan Attached
- □ Yes, indicate type: □ Type: ____________
- □ Date of last seizure:

### Diabetes
- □ No
- □ Medication/Treatment Order Attached
- □ Diabetes Medical Mgmt. Plan Attached
- □ Yes, indicate type: □ Type 1 □ Type 2 □ HbA1c results: ____________
- □ Date Drawn: ____________

### 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-9th □ 90th-94th □ 95th-98th □ 99th and>

### Hyperlipidemia
- □ No □ Yes

### Hypertension
- □ No □ Yes

## PHYSICAL EXAMINATION/ASSESSMENT

### Height: ____________

### Weight: ____________

### BP:

### Pulse: ____________

### Respiration: ____________

<table>
<thead>
<tr>
<th>TESTS/PRN</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
<th>Other Pertinent Medical Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD/PRN</td>
<td></td>
<td></td>
<td></td>
<td>One Functioning: □ Eye □ Kidney □ Testicle</td>
</tr>
<tr>
<td>Sickle Cell Screen/PRN</td>
<td>□</td>
<td>□</td>
<td></td>
<td>□ Concussion – Last Occurrence: ____________</td>
</tr>
<tr>
<td>Lead Level Required Grades Pre-K &amp; K</td>
<td>Date</td>
<td></td>
<td>□ Mental Health: ____________</td>
<td></td>
</tr>
</tbody>
</table>

- □ Test Done □ Lead Elevated >10 μg/dl

- □ System Review and Exam Entirely Normal

## Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

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

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

- □ Additional Information Attached

Rev. 5/4/2018 Page 1 of 2
Name: ___________________________  DOB: ___________________________

**SCREENINGS**

<table>
<thead>
<tr>
<th>Vision</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
<td>20/</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>Distance Acuity With Lenses</td>
<td>20/</td>
<td>20/</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>Vision — Near Vision</td>
<td>20/</td>
<td>20/</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>Vision — Color</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>Right dB</td>
<td>Left dB</td>
<td>Referral</td>
<td></td>
</tr>
<tr>
<td>Pure Tone Screening</td>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>Scoliosis</td>
<td>Negative</td>
<td>Positive</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>Deviation Degree</td>
<td></td>
<td></td>
<td>Trunk Rotation Angle:</td>
<td></td>
</tr>
</tbody>
</table>

**Recommendations:**

- [ ] Full Activity without restrictions including Physical Education and Athletics.
- [ ] Restrictions/Adaptations
  - [ ] No Contact Sports
    - Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
  - [ ] No Non-Contact Sports
    - Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, skiing, swimming and diving, tennis, and track & field
- [ ] Other Restrictions:
  - [ ] Developmental Stage for Athlete Placement Process ONLY
    - Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports
    - Student is at Tanner Stage: I ☐ II ☐ III ☐ IV ☐ V ☐
- [ ] Accommodations: Use additional space below to explain
  - [ ] Brace*/Orthotic
  - [ ] Colostomy Appliance*
  - [ ] Hearing Aids
  - [ ] Insulin Pump/Insulin Sensor*
  - [ ] Medical/Prosthetic Device*
  - [ ] Pacemaker/Defibrillator*
  - [ ] Protective Equipment
  - [ ] Sport Safety Goggles
  - [ ] Other:

*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

List medications taken at home:

**IMMUNIZATIONS**

- [ ] Record Attached
- [ ] Reported In NYSIIS

Received Today: [ ] Yes [ ] No

**HEALTH CARE PROVIDER**

Medical Provider Signature: ___________________________  Date: ________

Provider Name: (please print) ___________________________  Stamp: ________

Provider Address: ________________________________________

Phone: ___________________________  Fax: ___________________________

Please return this form to your child’s school when entirely completed.

Rev. 5/4/2018  Page 2 of 2
CONSENT TO ADMINISTER MEDICATION

Dear Parent/Guardian:

A list of medications, which will be available in your school’s Health Office, are listed below. Due to 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.

Please have your health care provider check the medications appropriate for your child. Only one student per form is allowed. Each student must have this individual medication order on file. Please return the signed completed form to the Health Office of your school.

____ Acetaminophen – 325 mg – pain relief
____ Acetaminophen – 80 mg – liquid/chewable-pain
____ Antacid – liquid - relief of upset stomach
____ Hydrocortisone topical cream 1%
____ Benadryl Cream
____ Benzolonium-antiseptic solution
____ Calamine – relieves itching
____ Orajel – oral pain relief
____ Vaseline Lotion and Ointment

Comments

Student Name ___________________________ Date of Birth _____________

School ___________________________ Grade ___________

PHYSICIAN SIGNS HERE

Health Care Provider’s Signature ___________________________ Phone# _______ Date ______

PARENT SIGNS HERE

Parent/Guardian’s Signature ___________________________ Phone# _______ Date ______
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.