

SIGN UP FOR LOTTERY NOW!

Full Day UNIVERSAL PRE-KINDERGARTEN



If you have a youngster who will be 3 years old by 12/1/18 and you are a resident of the Rondout Valley Central School District, they are eligible to participate in the *Full Day Universal Pre-Kindergarten (UPK)* program. We offer a free full day preschool experience 5 days a week from 9:00am to 2:00pm at the Brookside and Lederman Schools.

Applications are available at the Rondout School District website and the District Office.

The lottery will be held at the District Office on January 3, 2019 at 4:00PM. All applications must be received by 12:00PM on January 2, 2019 at the District Office.

Openings are limited!

*Families considered economically disadvantaged have priority per grant requirements. Any questions please call #687-2400 , and ask for Louann x4863 or Malena Callan x4846.

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT

P.O. Box 9
Accord, New York 12404

Dr. Joseph Morgan
Superintendent of Schools
845-687-2400 Ext. 4802

Dr. Timothy Wade
Deputy Superintendent
845-687-2400 Ext. 4863

Mrs. Lisa Pacht
Executive Director of Curriculum & Instruction
845-687-2400 Ext. 4805

Mrs. Debra Kosinski
School Business Administrator
845-687-2400 Ext. 4812

SPRING 2019 **Full Day Program**

Dear Parent/Guardian,

Attached you will find an application for anticipated Universal Pre-Kindergarten seats for the 2018-2019 academic year.

You must be a resident of the Rondout Valley School District
Your child must be 3 years old on/before December 1, 2018.

Complete all enclosed Forms.

Return all forms to the Rondout Valley Central School District Office by 12:00PM on January 2, 2019.

Please review the enclosed information carefully.

All required documents must be received **no later than 12:00PM on January 2, 2019 at the District Office.**

(We must have an updated Physical form and Updated Immunizations before they can attend UPK. You can have your Dr. fax us confirmation of your scheduled appointment if it is after January 2, 2019.)

You may bring your required documents to the District Office and we will copy them for you, or they may be faxed to: Atten: UPKFD 845-687-0945

or mailed to: Rondout Valley CSD
DO-PPS-UPKFD
PO Box 9
Accord, NY 12404

Robin Doick
CSE/CPSE Chairperson
Pupil Personnel Services
845-687-2400 Ext. 4863

Full Day 3 Year Old Pre Kindergarten Application

2018-2019
Rondout Valley Central School District
Office of Pupil Personnel
P.O. Box 9
Accord, New York 12404

Name of Student: _____ Male/Female (Please Circle one)

Date of Birth: _____

Father/Legal Guardian: _____ Cell#: _____

Mother/Legal Guardian: _____ Cell#: _____

Mailing Address: _____ Home Phone #: _____

We have 2 schools participating in our Full Day Universal Prekindergarten program:

The Brookside School in Cottekill on Lucas Ave.

Lederman Children's Center on Rt 213

Please indicate below your preference in rank order with:

1- being your first choice **2-** second choice

Brookside School _____ *before and after-care available**
Lederman Children's Center _____ *before and after-care available**

**parent pays for before and after-care*

**RONDOUT VALLEY CENTRAL SCHOOL DISTRICT
UPK REGISTRATION FORM**

Student First Name		Middle Name	
Student Last Name			
Physical Address (Street Address) (City) (State) (Zip)			
Mailing Address (if different) (PO Box/address) (City) (State) (Zip)			
Town/Village of Residence		Email Address: Mother Father (Please circle one)	
Father/Legal Guardian's Name:		Mother/Legal Guardian's Name:	
Student's Sex M F	Student's Date of Birth:	Special Programs/IEP:	
Student's Place of Birth (City) (State) (Zip)		Date of Entry (if not born in US)	Country of Origin
Number of years in US Schools:		What languages does the student understand?	
Home Language	What language does student: Read Write		
Race (circle one) Hispanic Non-Hispanic		International Adoption? YES NO	
		Date of Adoption _____	
Ethnicity (circle one): I – American Indian or Native America A – Asian B- Black or African American H – Hispanic or Latino P – Native American or other Pacific Islander W - White			Date of 1st Polio Immunization:
RESIDENCY INFORMATION –(please circle one) Student lives with: Both Parents Father Mother Legal Guardian Stepparent Relative Relationship: _____ Foster Home PLEASE NOTE PLACEMENT AGENCY & ADDRESS:			
STUDENT LIVING ARRANGEMENTS			
Is the student homeless?		YES	NO
Is the student living in a shelter:.....		YES	NO
Is the student living with relatives due to lack of housing?.....		YES	NO
Is the student living in an abandoned apartment/building?.....		YES	NO
Is the student living in a motel/hotel?.....		YES	NO
Is the student living in a campground, car, train/bus station or other similar situation due to lack of alternative, adequate housing?.....		YES	NO
Is the student temporarily housed in a shelter awaiting OCF'S permanent foster care placement?.....		YES	NO

TELEPHONE NUMBERS			
<i>(Fill out employer information only for parent(s), Legal Guardian or Relative that student lives with)</i>			
	HOME#	WORK#	CELL#
Father			
Father's Employer			
Mother			
Mother's Employer			
Guardian			
Guardian's Employer			
Relative			
Relative's Employer			
****EMERGENCY NUMBERS****			
Name		Relationship	
Address		Permission to pick up student: YES NO	
Phone #		Cell #	

OTHER CHILDREN				
	Sex	Date of Birth	Attending Rondout?	
Brother's Names			Yes	No
Sister's Names				

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT

P.O. Box 9
Accord, New York 12404

Dr. Joseph Morgan
Superintendent of Schools
845-687-2400 Ext. 4802

Dr. Timothy Wade
Deputy Superintendent
845-687-2400 Ext. 4863

Mrs. Lisa Pacht
Executive Director for Curriculum & Instruction
845-687-2400 Ext. 4805

Mrs. Debra Kosinski
School Business Administrator
845-687-2400 Ext. 4812

PARENTAL PERMISSION FOR USE OF STUDENT NAMES, PHOTOGRAPHS & VIDEO

Dear Parent/Guardian,

The Rondout Valley Central School District is changing its practice of publishing student names, photographs and videos. From here forward, the district will publish names, photographs and videos of students unless parents/guardians have completed and returned the following form expressing that they **do not give consent** to publish his or her child's name, photograph or video. Student names, photographs and videos will be used only for educational and/or public relations purposes, in newsletters, on the district website, etc. and student names will not be used together with their photo or video.

OPT OUT FORM

I, _____, the parent/legal guardian of student
(Please print parent/guardian's name)

_____, **DO NOT** give my permission to the Rondout Valley
(Please print student's name)

Central School District to use my child's name, photograph or video.

Full Parent/Guardian Signature

Date

/rc upk

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT

P.O. Box 9
Accord, New York 12404

Dr. Joseph Morgan
Superintendent of Schools
845-687-2400 Ext. 4802

Dr. Timothy Wade
Deputy Superintendent
845-687-2400 Ext. 4863

Mrs. Lisa Pacht
Executive Director for Curriculum & Instruction
845-687-2400 Ext. 4805

Mrs. Debra Kosinski
School Business Administrator
845-687-2400 Ext. 4812

Dear Pre-Kindergarten Parent/Guardian,

We have the capability of sending phone calls, e-mails, and/or text messages to inform you of school delays, emergency closings, and upcoming events in the district. This is accomplished through an automated system which we use to contact parents, students, and staff. If you would like the district to register you for this service, please fill in this form and return it with your Universal Pre-Kindergarten application.

Parent/Guardian Name _____

Student Name _____

I would like the Rondout Valley Central School District to send me notifications about:

- Emergency Closings/Delays _____
- Upcoming Community Events _____

Please check all that apply below regarding how you would like to receive the reminders. I prefer to receive notifications through a(n):

- Phone call @ _____
- E-mail @ _____
- Text message @ _____

Should you have any questions, please contact Ms. Randi Chase in the *Technology Office* at the following phone number: **845-687-2400 extension 4851.**

Thank you,
Superintendent, Dr. Joseph Morgan

upk

Due to NYS Immunization requirements we must ask for documentation.
All Preschoolers must be up to date on immunizations and Well Child exam before attending school.

***PLEASE NOTE: DOCUMENTS REQUIRED BY 12:00PM January 2, 2019**

- 1) Proof of Residency- copy of bill/receipt with parent name and physical address
- 2) Copy of Birth Certificate
- 3) Copy of Shot Records
- 4) Copy of Physical Exam -physical must be done after 9/5/17 – (please take enclosed Health Assessment Form to your Doctor. You can have your Dr. fax us confirmation of your scheduled appointment if it is after January 2, 2019.)

NY State Immunization Requirements for School Entrance/Attendance

Vaccines	Pre-kindergarten (Day Care, Nursery, Head Start, or Pre-K)	Kindergarten
Diphtheria and Tetanus Toxoid-Containing Vaccine and Pertussis Vaccine (DTaP/ DTP/Tdap)	4 doses	4-5 doses (See footnote 2ab)
Polio (IPV or OPV)	3 doses	3- 5 doses (See footnote 4ac)
Measles, Mumps and Rubella(MMR)	1 dose (See footnote 5a-d)	2 dose
Hepatitis B	3 doses (See footnote 6a)	3 doses
Varicella(Chickenpox)	1 dose (See footnote 7ab)	2 doses
Haemophilus influenzae type b conjugated vaccine (Hib)	1-4 doses (See footnote 9a-d)	Not applicable
Pneumococcal Conjugate Vaccine (PCV)	1-4 doses (See footnote 10a)	Not applicable

2. a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. b. If the fourth dose of DTaP was administered at 4 years or older, the fifth (booster) dose of DTaP vaccine is not required..

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)

a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months) a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

c. Mumps: One dose is required for prekindergarten and grades 11 and 12. Two doses are required for grades kindergarten through 10.

d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine

a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)

a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.

c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.

d. If dose 1 was received at 15 months or older, only 1 dose is required.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)

a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT
PO Box 9, Accord, NY 12404

Dr. Joseph Morgan
Superintendent of Schools
(845) 687-2400, Ext. 4802

Dr. Timothy Wade
Deputy Superintendent
(845) 687-2400, Ext. 4863

Mrs. Lisa I. Pacht
Executive Director of Curriculum & Instruction
(845) 687-2400, Ext. 4805

Mrs. Debra Kosinski
School Business Administrator
(845) 687-2400, Ext. 4812

Preschool Home Language Survey

PLEASE PRINT

Child's name: _____ Date of birth: _____
(first) (middle) (last)

Date of school entrance: _____

Person completing the survey: Mother Father Grandparent Guardian Other

Please tell us about your child:

1. What language did the child learn when he/she first began to talk? _____
2. What language does the family speak at home most of the time? _____
3. What language (s) does the primary caregiver (s) speak to the child most of the time? _____
4. What language (s) does the child speak to his/her primary caregiver (s) most of the time? _____
5. What language (s) does the child speak to his/her brothers and sisters most of the time? _____
6. What language does the child speak to his/her friends most of the time? _____
7. What name do you use for your child (if different from above)? _____

We are using this application for Full Day UPK placement ONLY
You must return this application by January 2, 2019
To be considered for economically disadvantaged

If you currently are approved for Free/Reduced lunch please just check the box and sign below. No need to fill out the household information.

Yes, I have a school age student that attends Rondout Valley CSD and currently is approved for Free/Reduced lunch.

Parent Signature: _____

2018-2019 Application for Free and Reduced Price School Meals/Milk

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

Student Name	School	Grade/Teacher	Foster child	Homeless Migrant, Runaway
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

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 4, and sign the application.
 Name: _____ CASE # _____

3. Report all income for ALL Household Members (Skip this step if you answered 'yes' to step 2)

All Household Members (including yourself and all children that have income).

List all Household members not listed in Step 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any other source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Household member	Earnings from work before deductions Amount/How often	Child Support, Alimony Amount/How Often	Pensions, Retirement Payments Amount/How Often	Other Income, Social Security Amount/How Often	No Income
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>

Total Household members (Children and Adults) _____

Last Four Digits of Social Security Number XXX-XX- ____ _

Total Adults _____

Total Children _____

Please Circle one I do I do not have a Social Security number

4. Signature: An adult household member must sign this application and provide the last four digits of their Social Security Number (SS#), or circle the "I do or I do not have a SS# box" before it can be approved.

I certify (promise) that all of the information on this application is true and that all income is reported. I understand that the information is being given so the school will get 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 Phone: _____ Work Phone: _____ Home Address: _____

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

Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Anaphylaxis Care Plan Attached <input type="checkbox"/> Environmental
---	---	---

Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	<input type="checkbox"/> Asthma Care Plan Attached
--	--	--

Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type: _____	<input type="checkbox"/> Seizure Care Plan Attached Date of last seizure: _____
--	--	--

Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____ Date Drawn: _____	<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/m2 **Percentile (Weight Status Category):** <5th 5th-49th 50th-84th 85th-94th 95th-98th 99th and >

Hyperlipidemia: No Yes **Hypertension:** No Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

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

<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	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name:	DOB:
-------	------

SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis	Negative	Positive	Referral	
Required for boys grade 9 And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

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

Full Activity without restrictions including Physical Education and Athletics.

Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications

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 Athletic 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

<input type="checkbox"/> Brace*/Orthotic	<input type="checkbox"/> Colostomy Appliance*	<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Insulin Pump/Insulin Sensor*	<input type="checkbox"/> Medical/Prosthetic Device*	<input type="checkbox"/> Pacemaker/Defibrillator*
<input type="checkbox"/> Protective Equipment	<input type="checkbox"/> Sport Safety Goggles	<input type="checkbox"/> Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

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: <i>(please print)</i>	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child’s School When Entirely Completed.