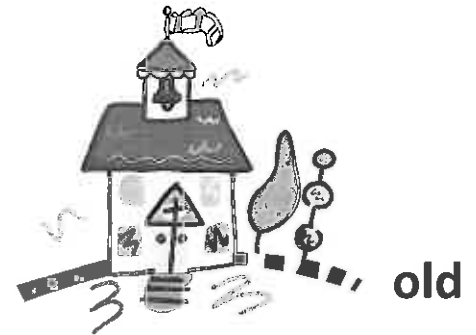


# SIGN UP FOR LOTTERY NOW!

3-Year-Old  
FULL DAY EXTENDED  
PRE-KINDERGARTEN



If you have a youngster who will be 3 years old by 12/1/19 and you are a resident of the Rondout Valley Central School District, they are eligible to participate in the 3-year-old *Full Day* Extended Pre-Kindergarten (EPK) 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. No transportation will be provided.

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

The lottery will be held at the District Office on May 10, 2019 at 4:00PM. All applications must be received by 12:00PM on May 8, 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 Malena x4846 or Louann x4863.

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**

**3-year-old Full Day Extended Pre-Kindergarten (EPK) Program**

Dear Parent/Guardian,

Attached you will find an application for anticipated Extended Pre-Kindergarten seats for the 2019-2020 academic year. Seats will be offered based on a public lottery to be held on **May 10, 2019 at 4:00 p.m. in the District Office.**

You must be a resident of the Rondout Valley School District  
Your child must be 3 years old on/before December 1, 2019.

**Complete all enclosed Forms.**

Return all forms to the Rondout Valley Central School District Office by 12:00PM on May 8, 2019.

Please review the enclosed information carefully.

All required documents must be received **no later than 12:00PM on May 8, 2019 at the District Office.**  
**(We must have an updated Physical form and Updated Immunizations before they can attend EPK.**  
**You can have your Dr. fax us confirmation of your scheduled appointment if it is after May 8, 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

**3 Year Old Full Day Extended Pre Kindergarten (EPK) Application**

2019-2020  
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 Extended Pre-Kindergarten 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*

**This Lottery Application and all enclosed Forms must be delivered to the Office of Pupil Personnel at the Rondout Valley Central School District Office by 12:00PM on May 8, 2019.**

**RONDOUT VALLEY CENTRAL SCHOOL DISTRICT  
3-YEAR-OLD EPK REGISTRATION FORM**

<b>Student First Name</b>		<b>Middle Name</b>	
<b>Student Last Name</b>			
<b>Physical Address</b> <small>(Street Address) (City) (State) (Zip)</small>			
<b>Mailing Address (if different)</b> <small>(PO Box Address) (City) (State) (Zip)</small>			
<b>Town/Village of Residence</b>		<b>Email Address:</b> Mother Father (Please circle one)	
<b>Father/Legal Guardian's Name:</b>		<b>Mother/Legal Guardian's Name:</b>	
<b>Student's Sex</b> M F	<b>Student's Date of Birth:</b>	<b>Special Programs/IEP:</b>	
<b>Student's Place of Birth</b> <small>(City) (State) (Zip)</small>			
<b>Number of years in US Schools:</b>		<b>What languages does the student understand?</b>	
<b>Home Language</b>	<b>What language does student:</b> Read  Write		
<b>Race (circle one)</b> Hispanic Non-Hispanic		<b>International Adoption?</b> YES NO	
		<b>Date of Adoption</b> _____	
<b>Ethnicity (circle one):</b> 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			<b>Date of 1<sup>st</sup> Polio Immunization:</b>
<b>RESIDENCY INFORMATION –( please circle one)</b> Student lives with: Both Parents Father Mother Legal Guardian Stepparent Relative Relationship: _____ Foster Home PLEASE NOTE PLACEMENT AGENCY & ADDRESS:			
<b>STUDENT LIVING ARRANGEMENTS</b>			
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**

*(Fill out employer information only for parent(s), Legal Guardian or Relative that student lives with)*

	<b>HOME#</b>	<b>WORK#</b>	<b>CELL#</b>
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**

	<b>Sex</b>	<b>Date of Birth</b>	<b>Attending Rondout?</b>	
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

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 Extended 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

3epk

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 May 8, 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 between 9/18-9/19 – (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 May 8, 2019. )

**NY State Immunization Requirements for School Entrance/Attendance**

<b>Vaccines</b>	<b>Pre-kindergarten</b> (Day Care, Nursery, Head Start, or Pre-K)	<b>Kindergarten</b>
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

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

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

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 EPK placement ONLY.**  
**You must return this application by May 8, 2019 to be considered for economically disadvantaged.**  
**You must fill out a new application in September and submit to Rondout Valley Food Service Department.**

**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"/>

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"/>

Total Household members (Children and Adults) \_\_\_\_\_

Total Adults \_\_\_\_\_

Total Children \_\_\_\_\_

**Last Four Digits of Social Security Number XXX-XX- \_\_\_\_\_**

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**

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

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

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

<b>Diabetes</b> <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> 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):**  <5<sup>th</sup>  5<sup>th</sup>-49<sup>th</sup>  50<sup>th</sup>-84<sup>th</sup>  85<sup>th</sup>-94<sup>th</sup>  95<sup>th</sup>-98<sup>th</sup>  99<sup>th</sup> and >

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

**PHYSICAL EXAMINATION/ASSESSMENT**

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>TESTS</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Other Pertinent Medical Concerns</b>
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: _____
<b>Lead Level Required Grades Pre- K &amp; K</b>			<b>Date</b>	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 10$ $\mu\text{g/dL}$				<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:	<b>Diagnoses/Problems (list)</b>	<b>ICD-10 Code</b>
	_____	_____
	_____	_____
	_____	_____

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	
<b>Scoliosis</b> Required for boys grade 9	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	
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				
<input type="checkbox"/> <b>Full Activity</b> without restrictions including Physical Education and Athletics.				
<input type="checkbox"/> <b>Restrictions/Adaptations</b> Use the Interscholastic Sports Categories (below) for Restrictions or modifications				
<input type="checkbox"/> <b>No Contact Sports</b> <b>Includes:</b> baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling				
<input type="checkbox"/> <b>No Non-Contact Sports</b> <b>Includes:</b> archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field				
<input type="checkbox"/> <b>Other Restrictions:</b>				
<input type="checkbox"/> <b>Developmental Stage for Athletic Placement Process ONLY</b> Grades 7 & 8 to play at high school level <b>OR</b> Grades 9-12 to play middle school level sports Student is at <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> <b>Accommodations:</b> 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				
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School attached</b>				
List medications taken at home:				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No				
HEALTH CARE PROVIDER				
Medical Provider Signature:			Date:	
Provider Name: <i>(please print)</i>			Stamp:	
Provider Address:				
Phone:				
Fax:				
<b>Please Return This Form To Your Child's School When Entirely Completed.</b>				