SIGN UP FOR LOTTERY NOW!

4-Year-Old
FULL DAY EXTENDED
PRE-KINDERGARTEN

If you have a youngster who will be 4 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 4-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, Lederman and Ulster County Community College Children's Center 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 5:00PM. 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
4-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 5:00 p.m. in the District Office.**

You must be a resident of the Rondout Valley School District.
Your child must be **4** 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

Full Day 4 Year Old 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 3 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

UCCC Children's Center on Cottekill Road

Please indicate below your preference in rank order with:

1- first choice **2**- second choice **3**- third choice

Brookside School _____ *before and after-care available**

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

UCCC 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 by 12:00PM on May 8, 2019.

4-year-old Full Day Extended Pre-Kindergarten (EPK) lottery will take place on May 10, 2019 at 5:00 p.m. in the **District Office**.

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT
4-YEAR-OLD EPK REGISTRATION FORM

Student First Name	**Middle Name**	
Student Last Name		
Physical Address		
Mailing Address (if different)		
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		
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): 1 – 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	
(Fill out employer information only for parent(s), Legal Guardian or Relative that student lives with)	
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				

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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

4epk

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 and 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

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 (IVP 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.

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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
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

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
	$____ /____	$____ /____	$____ /____	$____ /____	☐
	$____ /____	$____ /____	$____ /____	$____ /____	☐
	$____ /____	$____ /____	$____ /____	$____ /____	☐
	$____ /____	$____ /____	$____ /____	$____ /____	☐
	$____ /____	$____ /____	$____ /____	$____ /____	☐
	$____ /____	$____ /____	$____ /____	$____ /____	☐
	$____ /____	$____ /____	$____ /____	$____ /____	☐
	$____ /____	$____ /____	$____ /____	$____ /____	☐
	$____ /____	$____ /____	$____ /____	$____ /____	☐

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: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached; ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached; ☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached; ☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached; ☐ 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-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
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle

☐ Concussion – Last Occurrence: _____

☐ Mental Health: _____

☐ Other:

☐ **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:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:	DOB:

SCREENINGS

Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ 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

☐ 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.

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: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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