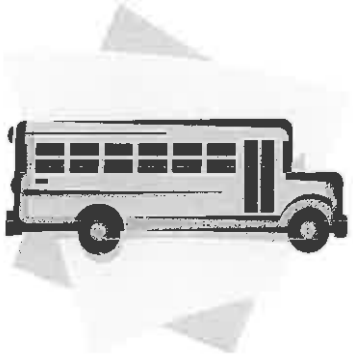
SIGN UP FOR LOTTERY NOW!

Full Day
UNIVERSAL
PRE-KINDERGARTEN

If you have a youngster who will be 4 years old by 12/1/19 and you are a resident of the Kerhonkson Elementary School, 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 Kerhonkson Elementary School. No before or after care provided for UPK students at the Kerhonkson Elementary School. Busing will be provided at designated pickup points.



Applications are available at:
The Kerhonkson Elementary School or go to the Rondout website and click on the Kerhonkson School Home page.
Lottery will be 5/7/19 at the District Office
Openings are limited!*

***Families considered economically disadvantaged have priority per grant requirements.**
Any questions please call #845-687-2400 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
Full Day Program at Kerhonkson Elementary School

Dear Parent/Guardian,

Attached you will find a lottery application for anticipated Universal Pre-Kindergarten (UPK) seats for the 2019-2020 academic year. Seats will be offered based on a public lottery to be held on May 7, 2019 at 5:00 p.m. at the **District Office**.

You must be a resident of the Kerhonkson Elementary School in the Rondout School District
Your child must be **4** years old on/before December 1, 2019.
Kerhonkson UPK will be from 9:00am-2:00pm
There is no before or after care for UPK students at the Kerhonkson Elementary School.

Complete all enclosed Forms.
Return all forms to the Rondout Valley Central School District Office by 12:00 p.m. on May 3, 2019.

Please review the enclosed information carefully.
All required documents must be received **no later than May 3, 2019.**
(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 May 3, 2019)

If your child does not make it into the Kerhonkson Full Day lottery, he/she will automatically be placed into the 4-year-old Full Day Lottery for Ulster County Community College, Brookside School and Lederman Children's Center lottery to be held on May 10, 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: UPKFDK 845-687-0945

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

Full Day lottery for Kerhonkson Elementary is May 7, 2019 at 5:00 p.m. in the District Office.
4-year-old Pre-Kindergarten lottery will take place on May 10, 2019 at 5:00 p.m. in the District Office. All are welcome to attend the lottery on although your presence is not required.

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

Full Day Pre Kindergarten Kerhonkson Lottery 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: _____ ***Must be 4 years old on December 1, 2019***

Father/Legal Guardian: _____ Cell#: _____

Mother/Legal Guardian: _____ Cell#: _____

Mailing Address: _____ Home Phone #: _____

After the Full Day Lottery: If your child does not make it into the Kerhonkson Full Day lottery, he/she will automatically be placed into the 4-year-old Full Day EPK lottery for Ulster County Community College, Brookside School and Lederman Children's Center lottery to be held on May 10, 2019.

If your child does not make it into the 4-year-old Full Day Extended Pre-Kindergarten (EPK) lottery, he/she will be automatically entered into the Half-Day Universal Pre-Kindergarten (UPK) lottery to be held on May 16, 2019 at 5:00 p.m.

We have 3 schools participating in our Full Day Extended Pre-Kindergarten program:

The Brookside School in Cottekill on Lucas Ave.
Ulster County Community College Children's Center on Cottekill 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 **3**- third choice

Brookside School	_____	Wrap around available*
UCCC Children's Center	_____	Wrap around available*
Lederman Children's Center	_____	Wrap around available*

*Wrap around-Parent pays for before and after care.

The Half-Day program will only be held at the Brookside School.

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 12:00 p.m., May 3, 2019.

1) Kerhonkson Full Day lottery is May 7, 2019 at 5:00 p.m. in the **District Office.**
2) 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.**
3) Half-Day Universal Pre-Kindergarten (UPK) lottery will take place on May 16, 2019 at 5:00 p.m. in the **District Office.**

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT
UPK REGISTRATION FORM-KERHONKSON

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): 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			
(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				

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT
TRANSPORTATION FORM
FOR KERHONKSON UPK FULL DAY ONLY

Student ID# _____ (For office use) Family ID# _____ (For office use)

Student's Name _____ Sex: M _____ F _____

Grade: _____ Date of Birth _____

Please circle one:
Student Lives with: Both Parents Father Mother Guardian Relative

Parent's Name _____

_____

Guardian / Relative Name _____

_____

Physical address: _____

_____
City State Zip Code

Mailing address (if different from physical address)_____

_____
City State Zip Code

	Father	Mother	Guardian / Relative
Home Phone Number:	_____	_____	_____
Work Phone Number:	_____	_____	_____
Cell Phone Number:	_____	_____	_____

Phone number to be contacted in case of emergency:

Name: _____

Relationship to student: _____ Phone number: _____

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT
HEALTH SERVICES HEALTH/ EMERGENCY INFORMATION

Bus Route No.:_____//_____ ID#: _____ Grade in Sept.: _____ Year: **19/20** Homeroom _____Teacher_____

Student Name: _____ **Date Of Birth:** _____ **M F**
(Last) (First) (Middle)

Residence Address: _____ Is this address new? Y N
(Location of Home: Street/Road/Fire No.)

Mailing Address: _____ is this address new? Y N
(PO Box or No. of Street or Road)

Student resides with (circle one): Both Parents at same address Both Parents at separate addresses Mother Father Mother/Stepfather* Father/Stepmother* Guardian* Foster Parents* Grandparents*

Parent/Guardian Name: _____

Relationship to Child: _____

Residence Address: _____

Mailing Address: _____

_____

Home Phone: _____

Business Phone: _____

Cell Phone: _____

e-mail address: _____

Parent/Guardian Name: _____

Relationship to child: _____

Residence Address: _____

Mailing Address: _____

_____

Home Phone: _____

Business Phone: _____

Cell Phone: _____

e-mail address: _____

Are there any custody issues with court papers given to school office? YES or NO (circle if applicable)
***Name of natural Parent/Guardian not living in the home (include address & phone if available). Contact in emergency? YES or NO**

_____

*** Name & Mailing Address of Guardian, Grandparent, Step Parent or Foster Parent if not included above** (include residence address if different)**:**

_____

***Home Phone, Business, or Cell of Guardian, Grandparent, Step Parent, or Foster Parent:**

_____

List two local relatives or neighbors to contact if you are not available:
(I give permission for these people to pick up my child and assume temporary care if necessary and I cannot be reached)

1)_____
(Name) (Address) (Phone)

2)_____
(Name) (Address) (Phone)

List other brothers/sisters currently attending Rondout Valley Central Schools:

(Name)	(DOB)	(School building name)	(Grade in Sept.)	(List address if different than above)
(Name)	(DOB)	(School building name)	(Grade in Sept.)	(List address if different than above)
(Name)	(DOB)	(School building name)	(Grade in Sept.)	(List address if different than above)
(Name)	(DOB)	(School building name)	(Grade in Sept.)	(List address if different than above)

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT HEALTH OFFICE EMERGENCY FORM

Hospital Choice: _____

Doctor: 1st Choice _____ **Phone:** _____

2nd Choice _____ **Phone:** _____

_____ _____ _____

Hospitalization coverage name of insurance company contract policy #

In the event that neither parent/guardian can be contacted in a serious emergency requiring medical attention, you have my permission to take my child _____ to the Emergency Room and this note will serve as authorization for the Emergency Room Staff to take whatever steps they think necessary for the welfare of my child.

_____ _____

Signature of Parent/Guardian Date

Dear Parent/Guardian:

Every year it is necessary to update the health information on your child. Please indicate below any pertinent information regarding your child's health that we should be aware of during the time she/he is in school. Also, indicate the course of action you would like followed if a problem occurs.

It is your right to approve or disapprove the sharing of this information with the appropriate staff. Though we feel that it is important for the appropriate staff to have this information in order to better understand any problems that may arise during the school day, it will only be shared with them if you approve.

Sincerely,

School Nurse

HEALTH INFORMATION AND INSTRUCTIONS:

_____

_____

_____

_____

_____

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT
PO BOX 9
ACCORD, NY 12404
STUDENT ADMISSION HEALTH HISTORY

Student's Name: _____ Sex: M____ F____

Date of Birth: _____ Place of Birth: _____

Address: _____ Phone Number:_____

Previous School Name and Address:_____

Previous Grade and Teacher: _____

Entry Date: _____ Individual providing health history: _____

Parent: _____Address_____Phone: _____

Parent: _____Address_____Phone: _____

Guardian: _____Address_____Phone: _____

Health History:

Were there any issues during pregnancy, labor and/or delivery for this child? ❑ Yes ❑ No Birth Weight _____
If yes, please describe: _____

Does this child have an ongoing health concern? (asthma, diabetes, etc.) ❑ Yes ❑ No
If "yes", please describe: _____

Does this child have any allergies? ❑ Yes ❑ No
If "yes", please list: _____
Has the allergy required emergency treatment? ❑ Yes ❑ No
If "yes", please explain: _____

Is there a history of any hospitalizations, accidents, significant injuries or surgery? ❑ Yes ❑ No
If "yes", please describe: _____

Are there any current medical concerns/injuries? ❑ Yes ❑ No
❑ Head _____ ❑ Eyes _____ ❑ Nose _____
❑ Ears _____ ❑ Throat _____ ❑ Neck _____
❑ Chest _____ ❑ Respiratory _____
❑ Cardiovascular _____ ❑ Gastrointestinal _____
❑ Genitourinary _____ ❑ Neurological _____
❑ Musculoskeletal (include any past fractures, etc.) _____

Does this child take any medication regularly at home? ❑ Yes ❑ No
Require medication at school? ❑ Yes ❑ No
If "yes", please describe: _____

Has this child been examined by any of the following (please give date):
❑ Pediatrician _____ ❑ Psychiatrist _____
❑ Ophthalmologist _____ ❑ Psychologist _____
❑ Optometrist_____ ❑ Speech Clinic _____
❑ Neurologist_____ ❑ Physical/Occupational Therapist _____
❑ Other _____

Describe your child's nutrition pattern and dietary intake:

_____

Developmental milestones:

At what age did your child:

Sit alone: _____ Crawl: _____ Walk alone: _____

Talk (two words together): _____ Achieve daytime toilet training: _____

Is bedwetting a problem: ❑ Yes ❑ No If so, please explain: _____

Family Health History:

List any significant medical concerns in family:

❑ Parent _____ ❑Parent_____

❑ Siblings _____ ❑ Grandparents _____

❑ Other _____

Family and Social History:

Parents (Please list names and birth year):

1._____

2._____

Siblings:

1._____

2._____

3._____

4._____

5._____

6._____

Have there been any difficult times in the child's life that you think may help us understand him/her?

_____

_____

Tell us about your child's personality:

_____

_____

Who lives with the child in his/her primary household? _____

Does child spend a significant amount of time in another household? ❑ Yes ❑ No

If "yes", please describe: _____

Who has legal custody of this child? _____

Describe any custody arrangements: _____

Please list any additional concerns or information: _____

_____

_____

_____

Signature of Parent/Guardian: _____ Date: _____

RONDOUT VALLEY CENTRAL SCHOOL
PO Box 9
Accord, NY 12404
845-687-2400
845-687-0945 Fax

RESIDENCE VERIFICATION

This is not a proof of Residency.

I hereby certify that:

_____ resides with me at
(Students Name)

_____
(Street Address & Town)

_____ is a **bonafide** resident of
(Students Name)

the Rondout Valley Central School District as evidenced by the fact he/she lives at the residence on a permanent basis.

_____ has no other residence
(Student Name)

or domicile** and my relationship to _____
(Student Name)

is _____
(Relationship to Student)

_____ _____
(Signature) (Date)

* A permanent basis means that this child sleeps at your residence during the week and on weekends, and spends vacations and holidays at your residence. This takes into consideration that there are times a child can be away from home for vacations, to visit relatives, or to sleep over at a friend's house.

**A domicile is a place, which an individual considers his permanent home

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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,
Dr. Joseph Morgan, Superintendent

upk kes

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

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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 UPK placement ONLY.
You must return this application by May 3, 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:______________________

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 May 3rd

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 3, 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- 4 doses (See footnote 4a-c)
Measles, Mumps and Rubella(MMR)	1 dose (See footnote 5a-d)	2 dose
Hepatitis B	3 doses (See footnote 6a)	2-3 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.

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.