Rhinebeck Central School District

POST OFFICE BOX 351
RHINEBECK, NEW YORK 12572
(845) 871-5570 x-5560
(845) 876-4963 (fax)

RESIDENCY QUESTIONNAIRE

Name of LEA: Rhinebeck Central School ______________________________

Name of School: ______________________________

Name of Student: ______________________________
Last First Middle

Gender: ________________ Date of Birth: ______/_____ /_______ Grade: _________
Month Day Year *(preschool-12)*

Address: ______________________________ Phone: ________________________

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or proof of age. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (*Please check* ***one*** *box.*)

- ❑ In a shelter
- ❑ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ❑ In a hotel/motel
- ❑ In a car, park, bus, train, or campsite
- ❑ Other temporary living situation (Please describe): ________________________________
____
- ❑ In permanent housing

____
Print name of Parent, Guardian, or
Student (for unaccompanied homeless youth)

____
Signature of Parent, Guardian, or
Student (for unaccompanied homeless youth)

____
Date

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CUESTIONARIO DE RESIDENCIA

Nombre del Distrito Escolar: Rhinebeck Central School

Nombre de la Escuela: ______________________________

Nombre del Estudiante: ______________________________
Apellido Primer Nombre Segundo Nombre

Género: ______________ Fecha de Nacimiento: _____ / _____ / ______ Grado: ______________
Mes *Día* *Año* *(jardín de infantes – 12)*

Dirección: ______________________________ Teléfono: ____________________

Su respuesta abajo permitirá al distrito escolar definir los servicios que puede aprovechar su hijo/hija según el Acto de McKinney-Vento. Los estudiantes elegibles tienen derecho a la inscripción inmediata en la escuela, aun si ellos no tienen los documentos necesarios tales como: prueba de residencia, documentos escolares, documentos de inmunización, o partida de nacimiento. Los estudiantes elegibles según el Acto de McKinney-Vento tienen además derecho al transporte gratuito y otros servicios que ofrece el distrito escolar.

¿Donde está el estudiante viviendo actualmente? (*Por favor marque* ***una*** *caja*.)

- ❑ En un refugio
- ❑ Con otra familia o otra persona debido a la pérdida del hogar o a dificultades económicas
- ❑ En un hotel/motel
- ❑ En un carro, parque, autobús, tren, o camping
- ❑ Otra vivienda temporal (Por favor describa): ______________________________
- ❑ En un hogar permanente

____
Nombre de Padre, Guardián, o
Estudiante (para jóvenes sin acompañamiento)

____
Firma de Padre, Guardián, o
Estudiante (para jóvenes sin acompañamiento)

____
Fecha

RHINEBECK CENTRAL SCHOOL DISTRICT
EMILY DAVISON
OFFICE OF SPECIAL PROGRAMS
P.O. BOX 351
RHINEBECK, NEW YORK 12572
(845) 871-5500 x6551

Parental Rights to Referral and Evaluation for Special Education Services or Programs

The Rhinebeck Central School District offers supports for students attending Chancellor Livingston Elementary School, Bulkeley Middle School or Rhinebeck High School in general education such as related services, curriculum and instructional modifications and Academic Intervention Services (AIS). The Response to Intervention (RtI) team in your child's school may make a referral to the Committee on Special Education (CSE) if interventions have not been successful. Contact your child's teacher for more information.

If you think your child has a disability which adversely affects his/her educational performance and may require special education, you may initiate a referral by writing to the Committee on Special Education ("CSE") in this school district or where the nonpublic school is located.

A referral is a written statement asking that the school district evaluate your child to determine if he or she needs special education services. This written statement should be addressed to:

Emily Davison
Director of Special Education
Rhinebeck Central School District
PO Box 351
Rhinebeck, NY 12572

Additional information is available in English and Spanish in a document called, *A Parent's Guide to Special Education* at www.nysed.gov.

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Rhinebeck Central School District
PO Box 351, Rhinebeck, New York 12572
(845) 871-5500 x-6560
(845) 876-4963 (fax)

REGISTRATION CHECKLIST

Student Name: ____ Date: ______________

Name of Person Registering Student: ____

Relationship to Student: ____________________________________Phone: ________________

Along with the completed registration packet, please provide the following:

Parent ✓	DOCUMENTS to be PROVIDED by PARENT/GUARDIAN to complete registration:	Staff initials
	Proof of Residency: **Homeowners**: The most recent school or property tax bill, **AND** 1 current, recurring bill with your name & address for services you receive at this address, such as your electric, cable or telephone bill. **Renting in an apartment complex**: Your current signed lease, **AND** 1 current recurring bill for services you receive at this address, with your name & address, such as your electric, cable, or telephone bill. **Renting from a private owner**: Your current lease, **AND** the owner's school or property tax bill, **AND** 1 current recurring bill with your name & address for services you receive at this address, such as your electric, cable, or telephone bill. **No formal lease**: Your landlord will need to complete the attached Owners' Affidavit (must be notarized), **AND** 1 current, recurring bill with your name & address for services you receive at this address, such as your electric, cable or telephone bill. If utilities are included in your lease, you will need to provide an additional form of proof of residency.	
	Proof of Birth: Birth Certificate, Passport (current) or NYS ID Card	
	Photo ID of parent/guardian: Driver's license, passport (current) or NYS ID Card	
	Proof of Immunizations	
	Physical Exam Report (must be from within 1 year of start date in school)	
	Current IEP or 504 plan, if applicable	
	Court Documents, such as Custody Order, Order of Protection, etc., if applicable	

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ESTA PÁGINA SE HA DEJADO EN BLANCO INTENCIONALMENTE

STUDENT REGISTRATION FORM

PLEASE PRINT ALL INFORMATION

Child's Name:			
	Last	*First*	*Middle*
Child's Street Address:			
City:		**State:**		**Zip Code:**	
Home Phone #:		**Grade:**	
Gender Identification:	☐ Male ☐ Female ☐ Non-Binary	**Grade 9 Entry Date:**	
Date of Birth:		**Place of Birth:**	
How many years has child attended school in the USA?			
Name and Town of previous school:			
Ethnic Origin *(check one)*:	☐ YES, Hispanic ☐ NO, not Hispanic		
Race *(check all that apply)*:			
☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black ☐ White			
Child's Legal Guardian:	☐ Mother ☐ Father ☐ Foster Parent ☐ Other:		
Child Lives with:	☐ Mother ☐ Father ☐ Foster Parent ☐ Other:		
Is there a custody order for this child?*	☐ Yes ☐ No	**Is there an Order of Protection?***	☐ Yes ☐ No

**Please provide court documents*

Parent/Guardian #1	**This will be the FIRST parent/guardian contacted**				
Name:		Relationship to student:			
Residential Address:					
Mailing Address:					
Home Phone:		Cell Phone:		Work Phone:	
Is this parent/guardian in **Active** Military Service:	☐ Yes ☐ No	Entry Date:		Exit Date:	
Email Address:					

Parent/Guardian #2 *	**This will be the SECOND parent/guardian contacted**				
Name:		Relationship to student:			
Residential Address:					
Mailing Address:					
Home Phone:		Cell Phone:		Work Phone:	
Is this parent/guardian in **Active** Military Service:	☐ Yes ☐ No	Entry Date:		Exit Date:	
Email Address:					

**To add additional parents/guardians (i.e. step-parents), please attach a separate sheet.*

Other children in the family:			
Name of Child	Date of birth	Grade	School

Does your child receive services and supports through an IEP or 504 Plan?		☐ Yes ☐ No ☐ None	
If IEP or 504 is checked, please complete the following:			
Name of School District Attended:		Phone #:	

Check all support services (including AIS) that you child currently receives:		
☐ Reading	☐ Math	☐ Speech
☐ Occupational Therapy	☐ Physical Therapy	☐ English as a New Language
☐ Writing	☐ Counseling	☐ Other

Student Screening	
Has your child ever attended a NYS public school? ☐ Yes ☐ No If so, where and when? ____________________	
All students new to entering the New York State public school system are mandated to be screened in the areas of cognitive, academic, language, and motor development for the possibility of being gifted, the possibility of having or the suspicion of having a disability, and the possibility of being limited English proficient. The results of the screening will be mailed home to parents/guardians and may be shared with the student's teacher(s) to better their educational instruction. Please sign below in acknowledgement of this.	
Parent/Guardian Signature	Date

I understand the requirements for enrollment and request that my child(ren) be admitted to schools in the Rhinebeck Central School District. This is my actual and only permanent address. I am the legal guardian of the above listed child(ren). This/these child(ren) reside with me at this address. I certify that the information provided on this form is true and correct and that the statements made herein are being made under penalty of perjury, knowing that the Rhinebeck Central School District will rely upon them in determining whether the above child(ren) will be admitted to its schools. I understand that in the event the information contained in this document is determined to be inaccurate or false, in whole or in part, the district may commence legal proceedings against me to collect the annual tuition rate, determined by the New York State Education Department, retroactive to the first date of admission for each child, and may seek criminal action against me for filing a false document. I understand that the district reserves the right to investigate any student's residency by any legal means available, including but not limited to, public records, site visits and any other lawful methods of investigation. I understand that any false statements made herein are punishable as a Class A misdemeanor pursuant to Section 210.45 of the penal law of the State of New York and may be referred to the office of the district attorney.	
Parent/Guardian Signature	Date

Rhinebeck Central School District
PO Box 351, Rhinebeck, New York 12572
(845) 871-5500 x-6560
(845) 876-4963 (fax)

REQUEST FOR RECORDS

Student Name: ____

Date of Birth: ____

Previous School Attended:

School Name: ____

Street Address: ____

City: ____

State: _________________________________Zip: ____________________________

Phone: ________________________________ Fax: ____________________________

Kindly fax or mail to:

☐ **Chancellor Livingston Elementary School**
PO Box 351, Knollwood Road
Rhinebeck, NY 12572
Attn: Main Office
(845) 871-5570 ext. 5571
(845) 876-4174 (fax)
rranalli@rhinebeckcsd.org

☐ **Bulkeley Middle School**
PO Box 351, North Road
Rhinebeck, NY 12572
Attn: Carmela Fountain, Guidance Office
(845) 871-5500 ext. 5552
(845) 871-5553 (fax)
cfountain@rhinebeckcsd.org
scawley@rhinebeckcsd.org

☐ **Rhinebeck High School**
PO Box 351, North Road
Rhinebeck, NY 12572
Attn: Guidance Office
(845) 871-5500 ext. 5505
(845) 871-5562 (fax)
smulkins@rhinebeckcsd.org

I, the parent/guardian of the above named child, hereby give my consent to the release of any and all records as follows:

1. Academic records including grades/transcripts, discipline, attendance, testing/assessments
2. Medical records including immunization records
3. Psychological, psychiatric and neurological evaluations
4. Individualized Education Plan or 504 Plan, if applicable.

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Rhinebeck Central School District

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Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:		
First	*Middle*	*Last*
DATE OF BIRTH:		
Month	*Day*	*Year*
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to Student*

HOME LANGUAGE CODE ____________

Language Background *(Please check all that apply.)*			
1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other ________ *specify*	
2. What was the first language your child learned?	❑ English	❑ Other ________ *specify*	
3. What is the Home Language of each parent/guardian?	❑ Parent ________ *specify* ❑ Guardian(s) ________ *specify*	❑ Parent ________ *specify*	
4. What language(s) does your child understand?	❑ English	❑ Other ________ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other ________ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other ________ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other ________ *specify*	❑ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:		STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
Rhinebeck Central School District, PO Box 351, Rhinebeck, NY 12572		
District Name (Number) & School	*Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school ____________

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** ❑ *No* ❑ *Not sure* ❑ ***If yes,** please explain: ____________________

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ **No** ❑ **Yes*** **Please complete 10b below*

10b. ****If referred for an evaluation,*** **has your child ever *received* any special education services in the past?**
❑ **No** ❑ **Yes – Type of services received:** ____________________

Age at which services received *(Please check all that apply):*
❑ **Birth to 3 years (Early Intervention)** ❑ **3 to 5 years (Special Education)** ❑ **6 years or older (Special Education)**

10c. Does your child have an Individualized Education Program (IEP)? ❑ **No** ❑ **Yes**

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

____

____

12. In what language(s) would you like to receive information from the school? ____________________

____________________ Month: Day: Year: ____________________

Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ____________________

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: ____________________ **POSITION:** ____________________

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

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

NAME: ____________________ **POSITION:** ____________________

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

****DATE OF INDIVIDUAL INTERVIEW:** ______ MO DAY YR.	**OUTCOME OF INDIVIDUAL INTERVIEW:**	❑ ADMINISTER NYSITELL ❑ ENGLISH PROFICIENT ❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: ____________________ **POSITION:** ____________________

DATE OF NYSITELL ADMINISTRATION: ______ MO. DAY YR.	**PROFICIENCY LEVEL ACHIEVED ON NYSITELL:**	❑ ENTERING	❑ EMERGING	❑ TRANSITIONING	❑ EXPANDING	❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Rhinebeck Central School District

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(845) 876-4963 (fax)

Cuestionario de Idioma del Hogar ("HLQ" por sus siglas en inglés)

Estimados padres o tutores:
Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura, escritura y comprensión en el inglés, así como conocer su educación previa e historial personal. Por favor, llene con su información las secciones "Conocimientos de idiomas" e "Historial educativo". Apreciamos mucho su colaboración respondiendo a estas preguntas.
Gracias.

Por favor escriba con claridad al completar esta sección.

NOMBRE DEL ESTUDIANTE:

Nombre *Segundo nombre* *Apellido*

FECHA DE NACIMIENTO:

Mes *Día* *Año*

GÉNERO:

❑ Masculino
❑ Femenino

INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL

Apellido *Primer Nombre* *Relación con el estudiante*

CÓDIGO DEL IDIOMA DEL HOGAR

Conocimientos de idiomas

(Por favor, marque todas las opciones que sean aplicables)

Pregunta			
1. ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante?	❑ Inglés	❑ Otro ________ *especifique*	
2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?	❑ Inglés	❑ Otro ________ *especifique*	
3. ¿Cuál es el idioma primario de cada padre / tutor?	❑ Madre ________ *especifique* ❑ Tutor(es) ________ *especifique*	❑ Padre ________ *especifique*	
4. ¿Qué idioma o idiomas entiende su hijo(a)?	❑ Inglés	❑ Otro ________ *especifique*	
5. ¿Qué idioma o idiomas habla su hijo(a)?	❑ Inglés	❑ Otro ________ *especifique*	❑ No sabe hablar
6. ¿Qué idioma o idiomas lee su hijo(a)?	❑ Inglés	❑ Otro ________ *especifique*	❑ No sabe leer
7. ¿Qué idioma o idiomas escribe su hijo(a)?	❑ Inglés	❑ Otro ________ *especifique*	❑ No sabe escribir

TO BE COMPLETED BY THE DISTRICT IN WHICH THE STUDENT IS REGISTERED

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School *Address*	

PARA LLENAR POR EL DISTRITO EN EL QUE EL ESTUDIANTE SE HA INSCRITO

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

8. Indique con un número el total de años que su hijo(a) lleva inscrito en una escuela: ____________

9. ¿Cree usted que su hijo(a) pueda tener dificultades, interferencias o problemas educacionales que le afecten su capacidad para entender, hablar, leer o escribir en inglés o en cualquier otro idioma? En caso afirmativo, por favor descríbalos.

*Sí** ❑ *No* ❑ *No se sabe* ❑ * En caso afirmativo, por favor explique :____

¿Qué gravedad considera usted que tienen estas dificultades educacionales? ❑ Poca gravedad ❑ Algo grave ❑ Muy grave

10a. ¿Alguna vez se ha recomendado a su hijo(a) a tener una evaluación de educación especial? ❑ No ❑ Sí* * *Por favor, llene 10b.*

10b. *__*Si se le ha recomendado alguna vez una evaluación,__* ¿ha __recibido__ su hijo(a) alguna vez alguna forma de educación especial?

❑ No ❑ Sí – Explique, que forma o formas de educación especial recibió:

____

Edad en la que recibió la intervención o forma de educación especial *(favor de marcar todas las opciones que sean aplicables):*

❑ De nacimiento a 3 años (Intervención Temprana) ❑ 3 a 5 años (Educación Especial) ❑ 6 años o mayor (Educación Especial)

10c. ¿Tiene su hijo(a) un Programa de Educación Individualizada ("IEP" por sus siglas en inglés)? ❑ No ❑ Sí

11. ¿Considera que hay alguna otra información importante que la escuela deba saber sobre su hijo(a)?
(*Por ejemplo, talentos especiales, problemas de salud, etc.)*

12. ¿En qué idioma(s) quiere usted recibir la información de la escuela? ____

____ Mes: Día: Año: ____________

Firma del padre/madre o de la persona en relación paternal *Date*

Relación con el estudiante: ❑ Madre ❑ Padre ❑ Otra:________________________

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: ____________________ POSITION: ____________________

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

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

NAME: ____________________ POSITION: ____________________

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

**DATE OF INDIVIDUAL INTERVIEW: ____________ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW: ❑ ADMINISTER NYSITELL ❑ ENGLISH PROFICIENT ❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: ____________________ POSITION: ____________________

DATE OF NYSITELL ADMINISTRATION: ____________ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Required School Health Examination Form
Effective January 1, 2021

Education law requires all New York State (NYS) public school students to have a health exam as a new entrant and in Pre-K or Kindergarten and grades 1, 3, 5, 7, 9, and 11.

Effective February 1, 2021, all health examinations performed for school must be documented on the NYS Required Health Examination Form – pursuant to Education Law. The form will be available on the NYSDOH Health Commerce System (HCS) in mid-February.

ONLY the approved form will be accepted by schools for health examinations conducted on or after January 31, 2021.

Students who present a physical exam that is not acceptable will be required to have the parent/guardian contact their healthcare provider to complete the correct form. Students who are unable to obtain the correct form will be required to have the health examination repeated at school. We ask that you comply with Education Law and document a health exam on the correct form.

Please note all components on the health exam form are required in NYS Law.

Thank you for your cooperation.

Sincerely,
Mary Skeen, RN
Teresa Costakis, RN
School Nurses
Rhinebeck Central School District

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Rhinebeck Central School

HEALTH RECORD

Child's Name ____ Gender: ____________

Address ____ Place of Birth ___________

Date of Birth ________________________________ Home Phone # _____________

Month Day Year

Parent/Guardian Name ______________________________ Bus. Phone # ______________

Parent/Guardian Name ______________________________ Bus. Phone # ______________

Local Physician _____________________________ Phone # ____________________

Siblings ___________________________________ Birth Date ___________________

___________________________________ Birth Date ___________________

Have you ever suspected that your child may have problems with his eyesight? If so, has he/she ever been seen by an optometrist or an eye specialist?

____

If so, what was the result of the examination and recommendations, if any?

____

Have you ever suspected that your child may have hearing problems?

____

If so, has your child been tested? Yes/No Date___________________

If so what was the result of the examination and recommendations, if any?

____

Has your child had any other screening or evaluations? Yes/No Date __________

If yes, what were the results? ____

____

Has your child been hospitalized since birth? Yes/No Date ____________________

If so, what was the reason? ____

____

Does your child take any medications at home? Yes/No

Please list:____

Any other serious illnesses or injuries? ____

Has your child seen a dentist? Yes/No Date ____________________

If so, for what reason? ____

Does your child have allergies? Yes/No

Please list: ____

Has your child ever had any of the following? If so, give dates below:

Chicken Pox________________
Diphtheria__________________
German Measles______________
Measles____________________
Mumps_____________________
Pneumonia__________________
Poliomyelitis________________

Scarlet Fever______________
Whopping Cough___________
Diabetes__________________
Epilepsy__________________
Heart Disease______________
Tuberculosis______________
Contact w/TB______________

Ear Conditions____________
Frequent Colds____________
Sore Throats______________
Operations_______________
____
____
____

Rheumatic Fever______________________
Serious Injuries_______________________

Asthma or Allergies_______________________
Other______________________________________

Health Record Consent

*This information will be kept confidential unless an emergency arises, or the nurse determines that the school team, or primary care provider have a need to know because of a specific health concern regarding your child.

I give consent to share this information with the school team, and primary care provider if an emergency occurs or if the nurse determines that there is a need to know to ensure the health, safety, and well-being of your child. I understand that it's my (parent's/guardian's) responsibility to inform teacher(s), and school staff, including extracurricular coaches and club advisors, of my child's health condition(s).

Parent/Guardian Signature:_____________________________ Date:_____________

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ 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: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

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

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / (Month Day Year)

Sex: ❑ Male ❑ Female

Will this be your child's first oral health assessment? ❑ Yes ❑ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ❑ Yes ❑ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature____ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of ______________________________ _______ on__________ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means, that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address (please print or stamp)	**Dentist's/Dental Hygienist's Signature**

Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).

❑ Yes ❑ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

❑ Yes ❑ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

❑ Yes ❑ No **Dental Sealants Present**

Other problems (Specify):____

II. Treatment Needs (check all that apply)

❑ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

❑ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

❑ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

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ESTA PÁGINA SE HA DEJADO EN BLANCO INTENCIONALMENTE

STATEMENT OF PROPERTY OWNER/LANDLORD
IN SUPPORT OF ADMISSION TO THE
RHINEBECK CENTRAL SCHOOL DISTRICT

STATE OF NEW YORK)
) SS.:
COUNTY OF ___________)

I, ____, a property owner or
Name of Property Owner/Landlord or Property Manager

manager/agent of the dwelling located at:

____

____

hereby state that I am renting space in this dwelling to the tenants identified below.

The term of the lease is from ______________________ to ______________________.

Please indicate if this is a month-to-month lease/tenancy? Yes _____ No _____.

I hereby state that the following persons are identified as tenants having the right to be occupants in the dwelling:

Parent/Guardian: ____

Parent/Guardian: ____

Name(s) of Child/Children Seeking to Enroll:

Last: ______________________ First: ______________________ MI: _______

Last: ______________________ First: ______________________ MI: _______

Last: ______________________ First: ______________________ MI: _______

The payment of Electric Utility Bill is included in rent: Yes _____ No _____

As property owner/landlord, I will notify the Rhinebeck Central School District, PO Box 351, Rhinebeck, New York 12572, within 30 days of termination of this tenancy.

The information provided on this form is true and correct and the statements made in this document are being made with knowledge that the Rhinebeck Central School District will rely upon them in determining whether the above-named child(ren) will be admitted to its School District.

_______________________________________ _______________________________

Signature of Property Owner/Landlord Print Name & Title

____

Telephone Number

Sworn to before me this _____
day of ________________, 20___

____

Notary Public