



Rhinebeck Central School District

POST OFFICE BOX 351
RHINEBECK, NEW YORK 12572
(845) 871-5500 x-6560
(845) 876-4963 (fax)

RESIDENCY QUESTIONNAIRE

Name of LEA: Rhinebeck Central School District

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



Rhinebeck Central School District

POST OFFICE BOX 351
RHINEBECK, NEW YORK 12572
(845) 871-5500 x-6560
(845) 876-4963 (fax)

CUESTIONARIO DE RESIDENCIA

Nombre del Distrito Escolar: Rhinebeck Central School District

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

POST OFFICE BOX 351
RHINEBECK, NEW YORK 12572
(845) 871-5500 x-6560
(845) 876-4963 (fax)

Date: _____

Welcome to the Rhinebeck Central School District.

Parents/guardians should begin the registration process by calling (845) 871-5570 x5560. The District will mail the registration packet to you in advance to minimize your appointment time or you may visit the District's website at www.rhinebeckcsd.org (under the Departments tab) to obtain the required forms.

The school district is required by NYS Education Law to verify the prospective student's eligibility for enrollment based on age and residency within the district's boundaries.

In order to verify your child's eligibility to attend the schools of our district, you must submit the following documents, records, or information to my office **immediately**, if available, but not later than the close of the next regular business day.

- A residential lease, mortgage, or deed
- A statement from a landlord concerning your tenancy (see attached statement)
- An affidavit from a third party that establishes your presence in the Rhinebeck Central School District (see attached affidavit)

You may also submit any other relevant evidence you wish to, including but not limited to the following types of documentation:

- a) pay stub;
- b) income tax form;
- c) utility or other bills;
- d) membership documents (e.g., library cards) based upon residency;
- e) voter registration document(s);
- f) official driver's license, learner's permit or non-driver identification;
- g) state or other government issued identification;
- h) documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement); or
- i) evidence of custody of the child in question, including but not limited to judicial custody or order or guardianship documentation.

Finally, if available, you must submit the following: an original or certified transcription of your child's birth certificate, or an original or certified transcription of your child's certificate of baptism, if available. If you are unable to provide the District with either of these types of documents, please provide your child's passport, regardless of the issuing nation. In the absence of any of the aforementioned, you may provide any other documentation that has been in existence for over two years that could be used to establish your child's age.

For example:

- a) official driver's license;
- b) state or other government issued identification;
- c) school photo identification with date of birth;
- d) consulate identification cards;
- e) hospital or health records;
- f) documents issued by federal, state or local agencies (e.g., local service agency, federal Office of Refugee Resettlement);
- g) court orders or other court-issued documents;
- h) Native American tribal document; or
- i) records from non-profit international aid agencies and voluntary agencies.

In order to make a timely decision regarding a student's right to continued enrollment in the District, the aforementioned information and documentation should be delivered to the Office of Registration located at 48 Knollwood Road, Rhinebeck, NY **by tomorrow** (or the next regular business day if tomorrow is a weekend or holiday). If you have any questions, please contact the Office of Registration at (845) 871-5500 x6560.

Thank you,

Joseph Phelan
Superintendent of Schools
Residency Officer

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.



Rhinebeck Central School District

POST OFFICE BOX 351
RHINEBECK, NEW YORK 12572
(845) 871-5500 x-6560
(845) 876-4963 (fax)

STUDENT REGISTRATION FORM

STUDENT INFORMATION

Name: _____ Gender: _____ Age: _____
(Last) (First) (Middle)

Address: _____

Phone number (____) _____ Unlisted: Yes No Date of Birth: ____/____/____

Entering Grade: _____ Date of entry in Grade 9: ____/____/____

Note: Official grade level to be determined by Principal of assigned school.

Has the student attended Rhinebeck Schools before? Yes No If Yes, when? ____/____/____ Grade(s): _____

Academic Needs: Reading Assistance Yes No Prior enrollment in any Special Programs? Yes No

If Yes, list: _____

Are there any special concerns that the teacher/nurse/counselor should be aware of? Yes No

If Yes, list: _____

Immunization date of first Polio vaccination: ____/____/____

Health: Glasses, allergies, etc.: _____

ACADEMIC HISTORY

Name of last school attended: _____ Phone: (____) _____

Address: _____

Reason for leaving school: _____ Counselor Name: _____

Enrollment dates: _____

Names of any prior schools/academic programs attended:

1. _____

2. _____

FAMILY HISTORY

<u>PARENT/GUARDIAN:</u> Name:	<u>PARENT/GUARDIAN:</u> Name:
Address: <i>(include street address if PO Box)</i>	Address: <i>(include street address if PO Box)</i>
Phone:	Phone:
Employer/job title:	Employer/job title:
Business Phone:	Business Phone:
Email:	Email:

OTHER CHILDREN IN THE FAMILY

Name	Date of Birth	Address (other than home)	School	Grade

SINGLE / SEPARATED / DIVORCED / FOSTER PARENT, OR GUARDIAN

• If you are a single parent, please complete the following and submit any legal documents:

Custody is with: _____

Official Document on file: _____

Are there any court orders of protection or restricted visitation papers? Yes No

If Yes, legal documentation must be submitted to the Office of Registration within three (3) days from enrollment.

• If you are the Legal Guardian, and not the Parent, please complete the following and submit any legal documents:

Legal documentation must be submitted to the Office of Registration within three (3) days from enrollment.

Name: _____

Relationship to child: _____

• If you are a Foster parent, please complete the following:

Name of Foster Parent(s): _____

Name of Agency: _____

Social Worker name and phone number: _____



Rhinebeck Central School District

POST OFFICE BOX 351
RHINEBECK, NEW YORK 12572
(845) 871-5500 x-6560

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

Please provide 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.



Rhinebeck Central School District

POST OFFICE BOX 351
 RHINEBECK, NEW YORK 12572
 (845) 871-5500 x-6560
 (845) 876-4963 (fax)

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?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent _____ <i>specify</i>	<input type="checkbox"/> Parent _____ <i>specify</i>
	<input type="checkbox"/> Guardian(s) _____ <i>specify</i>	
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> 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* <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/> *If yes, please explain: _____ How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____ Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <small>MO. DAY YR.</small>	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <small>MO. DAY YR.</small>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:	



Rhinebeck Central School District

POST OFFICE BOX 351
 RHINEBECK, NEW YORK 12572
 (845) 871-5500 x-6560
 (845) 876-4963 (fax)

STUDENT INFORMATION

1. INFORMATION

Child's Name	
Custodial Parent/Guardian	

Information collected below is required by the NYS Education Department for data collection purposes only. This information shall not be used to deny resident students enrollment in the school district.

2. CITIZENSHIP

Immigrant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>(If answer is No, skip rest of question 2)</i>
Country of Origin		Date Entered US Schools	

3. ETHNICITY/RACE*

Ethnicity*	Is the Student Hispanic, Latino, or of Spanish origin? <input type="checkbox"/> Yes <input type="checkbox"/> No
Race* (Please circle all that apply)	I B A W P
Ethnicity*	
Hispanic, Latino, or of Spanish origin: Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.	
Race*	
I - American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.	
B - Black or African-American: A person having origins in any of the Black racial groups of Africa	
A - Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.	
W - White: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.	
P - Native Hawaiian Or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	

4. STUDENT SCREENING

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



Rhinebeck Central School District

POST OFFICE BOX 351
RHINEBECK, NEW YORK 12572
(845) 871-5500 x-6560
(845) 876-4963 (fax)

Dear Parent or Guardian:

The New York State Education Law requires that every child in **grades Pre K or K, 1, 3, 5, 7, 9, 11, and any new entrants** to the school district, must have a health examination given by either their family physician or the school doctor. Your family physician has a more complete understanding of your child, can interpret his findings directly to you, and assist you, in carrying out any recommendations which may be indicated.

We respectfully urge, therefore, that you take your child to your family physician and have the **ANNUAL HEALTH APPRAISAL FORM** on the other side of this sheet filled out and returned when the child enters school. This exam should be done **within twelve months** of your child's current school year in order to be accepted.

We are asking that all statements from the private physician be turned in to the Health Office (**NO LATER THAN OCTOBER 1st**). If, by that time, we do not have the record of examination, (or a known appointment date), it will be necessary to have the examination done by the school physician, in order to have the record of the child's physical condition on hand for reference.

The New York State Department of Health has revised the regulations regarding immunization requirements for school attendance **EFFECTIVE July 1, 2018**. The new dosing requirements are based on the Advisory Committee on Immunization Practice (ACIP).

THE FOLLOWING VACCINATIONS ARE REQUIRED AND MANDATORY before a child enters or transfers to our school:

Vaccines	Grades K-4	Grades 5	Grade 6-7	Grades 8 - 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (<i>DTaP/DTP/Tdap</i>)	5 doses	5 doses	3 doses	3 doses
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (<i>Tdap</i>) <i>(Required only for students enrolling in grades 6-12 who have not previously received a Tdap at 7 years of age or older)</i>	Not applicable	Not applicable	1 dose	1 dose
Polio vaccine (<i>IPV/OPV</i>)	4 doses	3 doses	3-4 doses	3-4 doses
Measles, Mumps, and Rubella vaccine (<i>MMR</i>)	2 doses	2 doses	2 doses	2 doses
Hepatitis B vaccine	3 doses	3 doses	3 doses	3 doses
Varicella (chicken pox) vaccine	2 doses	1 dose	2 doses-grades 6-10	1 dose-grades 11, 12

Meningococcal Vaccine -1 dose-REQUIRED for grades 7, 8, 9 and 2 doses for grade12 unless the 1st dose was given at age 16 or older

Sincerely,
Mary Skeen, RN
Teresa Costakis, RN
School Nurses

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:	Gender:	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

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

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

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

Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____ Date Drawn: _____	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
--	---	---

Risk Factors for Diabetes or Pre-Diabetes:

Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI _____ kg/m2 **Percentile (Weight Status Category):** <5th 5th-49th 50th-84th 85th-94th 95th-98th 99th and >

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

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
----------------	----------------	------------	---------------	----------------------

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

System Review and Exam Entirely Normal

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

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

Additional Information Attached

Name:			DOB:	
SCREENINGS				
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis Required for boys grade 9 And girls grades 5 & 7	Negative	Positive	Referral	
	<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"/> Full Activity without restrictions including Physical Education and Athletics.				
<input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications				
<input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling				
<input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field				
<input type="checkbox"/> Other Restrictions:				
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> Accommodations: Use additional space below to explain				
<input type="checkbox"/> Brace*/Orthotic				
<input type="checkbox"/> Colostomy Appliance*				
<input type="checkbox"/> Hearing Aids				
<input type="checkbox"/> Insulin Pump/Insulin Sensor*				
<input type="checkbox"/> Medical/Prosthetic Device*				
<input type="checkbox"/> Pacemaker/Defibrillator*				
<input type="checkbox"/> Protective Equipment				
<input type="checkbox"/> Sport Safety Goggles				
<input type="checkbox"/> Other:				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
MEDICATIONS				
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached				
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:				
Please Return This Form To Your Child's School When Entirely Completed.				

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 _____	Scarlet Fever _____	Ear Conditions _____
Diphtheria _____	Whooping Cough _____	Frequent Colds _____
German Measles _____	Diabetes _____	Sore Throats _____
Measles _____	Epilepsy _____	Operations _____
Mumps _____	Heart Disease _____	_____
Pneumonia _____	Tuberculosis _____	_____
Poliomyelitis _____	Contact w/TB _____	_____
Rheumatic Fever _____	Asthma or Allergies _____	_____
Serious Injuries _____	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: _____

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: / /	Gender:	Will this be your child's first oral health assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Month	Day	Year			
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.

**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

[Optional]

Sworn to before me this _____
day of _____, 20__

Notary Public

**RHINEBECK CENTRAL SCHOOL DISTRICT
THIRD PARTY AFFIDAVIT REGARDING RESIDENCY**

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

I, _____, being duly sworn, say:

1. I reside at: _____
_____.

2. I know _____ and
 Name[s] of Parent[s] or Guardian[s]

understand that he/she/they wish[es] to enroll the following child[ren] in the Rhinebeck Central School District:

3. I know _____ and the above-
 Name[s] of Parent[s] or Guardian[s]

named children to reside at _____
_____, an address within

the Rhinebeck Central Schools. I do _____ do not _____ reside at this address.
 (check one)

4. The basis of my knowledge is:

I affirm that the information provided on this form is true and correct and that the statements made in this document are being made under the penalties of perjury. I understand that the District may investigate any allegation contained in this document and may ask for written proof of any statement.

I further understand that in the event the information contained in this affidavit is determined to be inaccurate or false, in whole or in part, the District may commence legal proceedings against me.

Signature of Third Party Resident

Subscribed and sworn to before me
this ___ day of _____, 20___

NOTARY PUBLIC