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# Mohonasen<sup>®</sup> CENTRAL SCHOOL DISTRICT

***Bradt Primary School***

2719 Hamburg Street

Schenectady, NY 12303

Tel: 518/356.8400 February 9, 2024

Fax: 518/356.8404

Dear Parent/Guardian:

Our records indicate that you have a child who is eligible to enter Kindergarten in September 2024. A child is eligible if he or she will be five (5) years old on or before December 1, 2024. Registering your child for kindergarten is not only an exciting benchmark for you and your child, it is also an important step to ensure that your child is able to begin kindergarten. We would like to make this process as smooth and flexible as possible for your family.

We are enclosing a registration packet that needs to be completed and submitted to Bradt Primary School in order to begin the registration process. Please read through the instructions and fill out all required forms, paying special attention to the need for a copy of your *child's birth certificate*. There is also detailed information about the other documents you will need to verify residency in the district. These documents are required even if you already have a child attending school in our district. If you have any questions regarding residency documentation please contact Susanne Candee, our Central Registrar, at 356-8222. Once you have completed the registration paperwork, you have three options in order to submit all of the information to us:

1. **Daytime registration at Bradt School on April 16th (9:00 AM-11:00 AM, and 12PM-2 PM) and April 17th (12:00 -2:00 PM).** Please bring all registration materials and necessary documentation.
2. **Evening registration is April 17th, from 5:30 PM - 7:00 PM.** Please bring all registration materials and necessary documentation.
3. **Mail In or Drop-off Registration Information** (prior to May 5th deadline) All completed paperwork should be returned to Bradt Primary School at 2719 Hamburg Street, Schenectady, NY 12303. **After the May 17th deadline**, send information to the District Office: 2072 Curry Road, Schenectady, NY 12303.

The deadline to register your child for the 2024-2025 school year is **May 17th**. Parents who choose to not send their child to school for the 2024-25 school year, or who are planning on enrolling their child in a non-public school, are asked to notify us in writing or by calling Bradt School at 356-8401 by **May 17, 2024**.



Once all of your paperwork has been submitted, the next step is for your child to be scheduled for kindergarten screening, which is an opportunity for us to meet your child and learn more about their developmental readiness for school. The dates of the screening will be May 14th-21st. You can sign up for a screening appointment at the evening or day registration times once all of the paperwork is received.

We are also hosting a Kindergarten Parent Orientation evening for parents of incoming kindergarteners on Wednesday, April 24th, 6:00 PM, starting in the cafeteria. You will have the opportunity to meet faculty members and learn more about the screening process and kindergarten expectations. Please mark your calendars for this night as well as the dates for in person registration and kindergarten screening.

*Just to summarize the important dates:*

**Feb 9**                      *Registration packets mailed (either mailed back or select an option below)*

**April 24**                  *Kindergarten Parent Orientation Night 6 PM*

**April 16 and 17** *Daytime registration option*

**April 17**                  *Evening registration option*

**May 17**                  *Date for notification that child is not starting kindergarten in the 2024-25.  
school year or will be attending a different school*

**May 17**                  *Registration deadline*

**May 14-21**              *Kindergarten Screening (appointments scheduled after registration  
packets are completed and received)*

Please feel free to call Bradt School at 356-8400 if you have any questions regarding the registration process. We also have information for Kindergarten posted on our district website, [mohonasen.org](http://mohonasen.org) under the Kindergarten Tab located on the Bradt School page. We are truly excited to meet you and your child and begin this important relationship!

In Partnership,



Mrs. Leslie A. Smith

Principal

# Mohonasen Central School District

2072 Curry Road, Schenectady, New York 12303

518-356-8222 Phone 518-356-8247 Fax scandee@mohonasen.org

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## ***To Families Registering Kindergarten Students***

***Refer to the following information regarding proof of residency and documents required to register a kindergarten student. Current proof of residency is REQUIRED even if you have another child in the district. Incomplete packets cannot be processed.***

### **Proof of Residency**

**One of the following items with your name and address, dated within the last 30 days:**

- 1) If you are a renter, **provide a current lease** which includes the landlord's name, address and contact number.
- 2) If you are a renter **without a current lease**, provide a current rent receipt with the landlord's name, address and phone number as we will need to call and speak with them.
- 3) If you are a homeowner, provide a current tax bill, deed or mortgage statement.
- 4) If you have just had your closing, closing documents and realtor information
- 5) **If you are moving in with someone else and you do NOT own the home**, that individual must provide one of the documents listed above and sign a notarized statement regarding residency. **The homeowner and parent must sign separate documents and have them notarized** and you must provide the items listed below.

**License and vehicle registration with your current address.**

**Two of the following items with your name and current address dated within the last 30 days. *THESE ITEMS ARE REQUIRED EVEN IF YOU RECENTLY MOVED:***

- 1) National Grid or Spectrum bill
- 2) Current pay stub
- 3) Bank and/or credit union statement
- 4) Income tax forms
- 5) Homeowners or renters insurance
- 6) Documents issued by federal, state or local agencies
- 7) Completed change of address document from the post office

**Continued on next page**

## **Proof of age**

### **Provide one of the following documents to show proof of age:**

- 1) Child's birth certificate
- 2) Passport
- 3) Baptism certificate

### **Alternate Forms of proof of age if one of the above cannot be provided:**

- 1) Student license or permit
- 2) State or other government issued identification
- 3) Hospital or health records
- 4) Military dependent identification card
- 5) Documents issued by federal, state or local agencies
- 6) Court ordered documents
- 7) Native American tribal documents

## **OTHER MANDATORY STUDENT INFORMATION**

- 1) Immunization records and current physical. The registration packet may not be processed without this!
- 2) Custody paperwork if applicable. If the student is not your biological child, an official court generated document that proves a permanent and total transfer of custody and control of the student to you must be provided.
- 3) Child's IEP(Individual Education Plan), if applicable
- 4) Child's 504 plan, if applicable
- 5) Last report card or transcript
- 6) Foster children, DSS-2999 form must be provided

**Please complete all forms PRIOR to registering**  
**(If you have questions regarding the forms feel free to call prior to the**  
**appointment)**

**All documents must be provided at the time of registration, or the registration**  
**cannot be processed.**

**Thank you for your cooperation,**  
**Mrs. Candee , District Registrar**

**Residency and Registration Verification Checklist**

**Parents please check off which items you have provided and return  
this checklist with your completed packet.**

Date: \_\_\_\_\_  
Student name(s): \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_  
Address: \_\_\_\_\_

**All proofs must be within the past 30 days and have name and current  
address listed. Proof is required even if you have another student  
already in the district !**

**Both required**      License and registration      \_\_\_\_\_

Choose **ONE** below regarding your living situation.

(You are either a homeowner, renter or living with someone else)

**Homeowners (1 proof required):**

School taxes      \_\_\_\_\_

Closing papers      \_\_\_\_\_

Mortgage statement      \_\_\_\_\_

**Renters:**

Lease      \_\_\_\_\_

Name & phone number for Landlord: \_\_\_\_\_

(OVER)

**If staying/living with someone else:**

**(both forms required)**

Notarized form--homeowner \_\_\_\_\_ AND 1 proof from homeowner  
\_\_\_\_\_

Notarized form--parent \_\_\_\_\_ AND 1 proof from parent \_\_\_\_\_

**Additional proof required(1)**

Parent(check off)

National grid bill \_\_\_\_\_

Cable/Internet bill \_\_\_\_\_

Insurance bill \_\_\_\_\_

Post Office change \_\_\_\_\_

of address

Bank Statement \_\_\_\_\_

Paycheck \_\_\_\_\_

Other: \_\_\_\_\_

**Student Information(all required)**

Birth Certificate \_\_\_\_\_

Immunizations \_\_\_\_\_

Custody paperwork \_\_\_\_\_

(if applicable)

**Notes:**

**Mohonasen Central School District New Student Registration Form**

\*Please print clearly, all information is entered into the students School Tool account from this paperwork.

School Year: \_\_\_\_\_

**Student Data:**

Student Name as listed on birth certificate: \_\_\_\_\_

Alternate Student Name or Nickname: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_ Circle one: Male Female Non-Binary

Address: \_\_\_\_\_

Is this for a pre-school evaluation? YES \_\_\_ NO \_\_\_

Grade at Entry: \_\_\_\_\_ School(Circle one): Bradt(K-2) Pinewood(3-5) Draper(6-8) High School(9-12) Private/ Parochial---Name of school: \_\_\_\_\_

Is the student a: Foreign Exchange Student, Refugee or Immigrant: Yes/No Country: \_\_\_\_\_

**Student lives with(check all that apply):**

- Mother  Father  Guardian  Step-Mother  Step-Father
- Siblings  Grandmother  Grandfather  Foster Parent (attach DSS 2999 form)
- Other \_\_\_\_\_

**Please list all children living in the home:**

- Name: \_\_\_\_\_ DOB/sex: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_
- Name: \_\_\_\_\_ DOB/sex: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_
- Name: \_\_\_\_\_ DOB/sex: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_
- Name: \_\_\_\_\_ DOB/sex: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_
- Name: \_\_\_\_\_ DOB/sex: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

**Family Data:**

- |   |                              |
|---|------------------------------|
| Parent/Guardian: _____                            | Spouse/Other: _____          |
| Relationship to Child: _____                      | Relationship to Child: _____ |
| Address: _____                                    | Address: _____               |
| Cell Phone: _____                                 | Cell Phone: _____            |
| Home Phone: (If there is one, if not leave blank) | Home Phone: _____            |
| Work phone#: _____                                | Work Phone: _____            |
| Email Address: _____                              | Email Address: _____         |
| Occupation: _____                                 | Occupation: _____            |

New Student Registration form continued

**Special Needs of the Child:**

Is your child identified by the Committee on Special Education? YES \_\_\_\_\_ NO \_\_\_\_\_

Does your child have a 504 plan or an IEP? YES \_\_\_\_\_ Circle one: IEP/504 NO \_\_\_\_\_

Are there any legal or custodial restrictions? YES \_\_\_\_\_ NO \_\_\_\_\_

\*If yes, a court document is required and must be attached.

Is there any other relevant information? YES \_\_\_\_\_ NO \_\_\_\_\_

\*If yes, please explain: \_\_\_\_\_

**Previous information that is required:**

Previous address: \_\_\_\_\_

Previous school attended with name, address and phone number for the school:

Other schools attended if prior school is less than 3 years: \_\_\_\_\_

Has the student repeated a grade: YES \_\_\_\_\_ NO \_\_\_\_\_ If YES, which grade? \_\_\_\_\_

**Parent Statement: I certify that the above information is true and correct. Any misinformation regarding residency could result in being billed the tuition and exclusion from attending Mohonasen Central Schools.**

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Office use only: Proof of Residency:**

**One of the following:**

School Taxes/Deed/Mortgage Statement \_\_\_\_\_ Lease Agreement \_\_\_\_\_

Notarized Statement from Homeowner \_\_\_\_\_ w/ 1 proof \_\_\_\_\_

Notarized Statement from Parent \_\_\_\_\_

**And at least two of the following documents:**

Utility Bill \_\_\_\_\_ Insurance Bill \_\_\_\_\_ Paycheck \_\_\_\_\_ Bank Statement \_\_\_\_\_

Change of Address \_\_\_\_\_ Other \_\_\_\_\_ Other \_\_\_\_\_

**AND**

Vehicle Registration \_\_\_\_\_ License \_\_\_\_\_ Current Address? Yes/No

Registered by: \_\_\_\_\_ Date: \_\_\_\_\_ Expected Start Date: \_\_\_\_\_

Notes/Comment section:





Elisa Alvarez, Associate Commissioner Office of  
Bilingual Education and World Languages

55 Hanson Place, Room 594  
Brooklyn, New York 11217  
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB  
Albany, New York 12234  
(518) 474-8775 / Fax: (518) 474-7948

## Home Language Questionnaire (HLQ)

Dear Parent or Person in Parental Relation:  
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.

<b>STUDENT NAME:</b>		
First	Middle	Last
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
Month	Day	Year
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
Last Name	First Name	Relation to

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 1	<input type="checkbox"/> Parent 2	_____
	<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	_____ <input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not write
			<i>specify</i>

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

SCHOOL DISTRICT INFORMATION:

Mohonasen Central School District  
2072 Curry Road  
Schenectady, NY 12303

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

## 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:     Parent     Other: \_\_\_\_\_

#### 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:

**Mohonasen Central School District**  
**Student Racial and Ethnic Identification Form**

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Grade:     K    

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South America, or other Spanish Culture of origin regardless of race.

YES, Hispanic

NO, not Hispanic

2. Select one or more of the races from the following 5 racial groups. Check all groups that apply, but you must check at least one.

**American Indian or Alaskan 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

**Asian** – a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam

**Native Hawaiian or other Pacific Islander** - a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

**Black or African American** – a person having origins in any of the Black racial groups of Africa

**White** - a person having origins in any of the original peoples of Europe, North Africa or the Middle East

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Relationship to Student (please mark one below)

Mother       Father       Guardian       Other: \_\_\_\_\_

## Mohonasen CSD Student Housing Questionnaire

The answers to the following questions can help determine the services this student may be eligible to receive under the McKinney-Vento Act (provides services and supports students experiencing homelessness).

**If you own your home or have a rental agreement or a lease, you do not need to complete this form.**

If you do **NOT** own your home or you do **NOT** have a rental agreement or lease, **check all that apply below**. Where is the student currently living?

- In someone else's house or apartment with another family (due to loss of housing, economic hardship or similar reason)
- In a shelter or a motel (circle which one)
- Moving from place to place/couch surfing
- In a car, park, campsite or similar location
- Transitional housing
- In a residence with inadequate facilities (no water, heat, electricity)
- Other (explain, use back if necessary): \_\_\_\_\_

Student's name: \_\_\_\_\_

Student's grade and date of birth: \_\_\_\_\_

Circle one: Bradt(k-2) Pinewood(3-5) Draper(6-8) Mohonasen High School

- Student is unaccompanied (not living with a parent or guardian)
- Student is living with a parent or guardian

Parent/Legal Guardian name: \_\_\_\_\_

Phone number and address: \_\_\_\_\_

\*Parent/Guardian signature and date:

\_\_\_\_\_  
\*I declare under penalty of perjury under the laws of New York State that the information provided is here and true and correct.

\*\*\*\*\*

**School personnel only**, for data collection purposes and student information coding. Not homeless shelters doubled up hotels/motel other



**BRADT SCHOOL**  
Mohonasen CSD



# Kindergarten

Call us for more info  
**+1518-356-8401**

## Important Dates:

- 2/16 Incoming Kindergarten Registration Packets Mailed
- 4/16 Incoming Kindergarten Daytime Registration 9-11 AM, 12-2 PM
- 4/17 Incoming Kindergarten Daytime/Evening Registration 12-2 PM, 5:30-7 PM
- 4/24 Incoming Kindergarten Parent Orientation, Bradt Cafeteria 6 PM
- 7/8-8/1 Summer Stars Program (Registration Required)

2719 Hambug Street

[mohonasen.org](http://mohonasen.org)

[lesmith@mohonasen.org](mailto:lesmith@mohonasen.org)

\*\*\*\*\*ATTENTION\*\*\*\*\*  
 If your answer is NO,  
 put an X on this line \_\_\_\_\_  
 AND sign by parent/guardian.



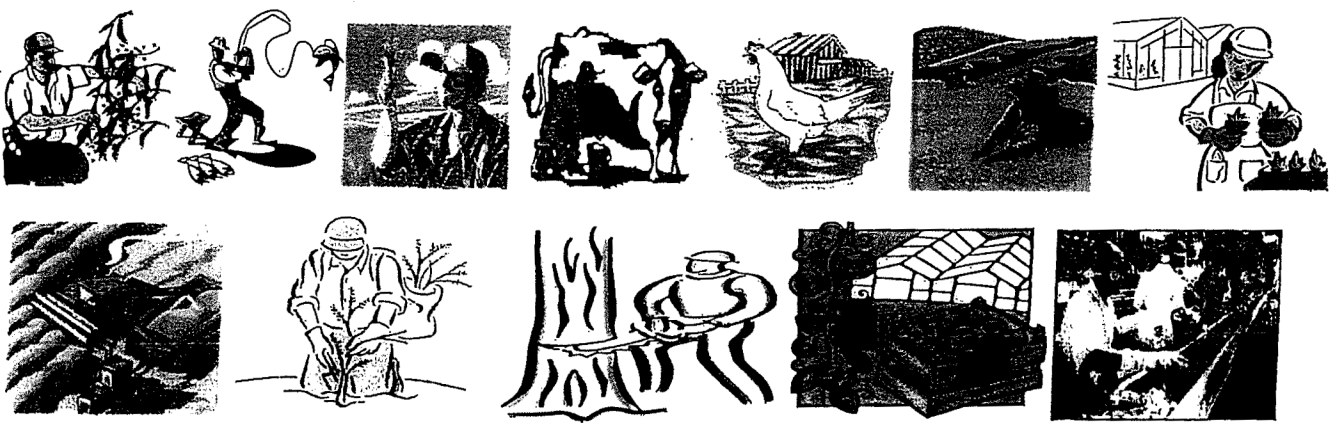
IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, regardless of their nationality or legal status. This program is free of charge to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

*Please take few minutes to complete this questionnaire.*

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

- Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- Work related to logging, harvesting, or initial processing of trees.
- Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



*If you answered YES, please provide your contact information below:*

\* Parent/Guardian Name: \_\_\_\_\_

Home address: \_\_\_\_\_

Telephone number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Best time to be reached: \_\_\_\_\_ AM/PM

Previous Address: \_\_\_\_\_

Student name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Student name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

**To submit this referral please fax to 607-436-3606, or by mail to NYS Migrant Education Program- Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.**

## Health Requirements for Students in Kindergarten

Dear Parent/Guardian,

New York State Law Section 2164 requires children to have the following immunizations (shots) to enter and attend school. **PROOF OF IMMUNIZATIONS MUST BE BROUGHT TO THE SCHOOL NURSE WHEN YOU REGISTER YOUR CHILD FOR SCHOOL.** Be sure to check with your health care provider as soon as possible to make sure that your child has all the needed immunizations. They are listed below.

### Required Immunizations for Kindergarten & Grade 1

Immunization	Number of Doses
Polio	4 doses or 3 if the 3rd dose at 4 years of age or older
Hepatitis B	3
Diphtheria/Tetanus/Pertussis	5 doses or 4 if the 4th dose given at 4 years of age or older
Measles/Mumps/Rubella	2
Varicella (Chickenpox)	2

**Proof of immunization must be any 1 of the 3 items listed below:**

- An immunization certificate signed by your health care provider. They may use the attached form.
- Immunization Registry report (NYSIIS or CIR from NYC) from your health care provider or your county health department
- A blood test (titer) lab report that proves your child is immune to the diseases. For varicella (chickenpox), a note from your health care provider (MD, NP, PA) which says your child had the disease is also acceptable.

**Prior to entering school**, all students are required to have a Physical with BMI Screening and an exam by their dentist. Any physical/dental exam done after 09/01/2024 will be accepted for school entry.

If you do not have a health care provider please make an appointment at any of the providers below.

Ellis Pediatrics

McClellan Street Campus

Phone: 347-5113

Hometown Health

1044 State Street

Phone: 370-1441

Please bring the completed medical forms when you register your child for school. If you have any questions regarding the above requirements, please contact your child's health care provider or the school nurse at 356-8410. Thank you for your cooperation in these important health matters.

Sincerely,

Lynn Boivin, RN

# Mohonasen Central School District

## Immunization Record

New York State Public Health Law 2164; Section 66.3

Requirement for school admission: A certificate of immunization signed by a licensed physician, or a certificate of religious or medical exemption. Please be advised that your child may be excluded from school if your child has not completed the immunizations or shown satisfactory progress toward completion.

Gr. K-1: 5- DTaP/DTP/Tdap, 4-Polio, 2-Measles, Mumps, Rubella, 3-Hepatitis B vaccine, 2-Varicella vaccine

Gr. 2-5: 5- DTaP/DTP/Tdap, 3-Polio, 2-Measles, Mumps, Rubella, 3-Hepatitis B vaccine, 1-Varicella vaccine

Gr. 6-7: 3-DTaP/DTP/Tdap, 1-booster Tdap, 4-Polio, 2-Measles, Mumps, Rubella, 3-Hepatitis B vaccine, 2-Varicella vaccine, 1-Meningococcal vaccine

Gr. 8-12: 3-DTap/DTP/Tdap, 1-booster Tdap, 3-Polio, 2-Measles, Mumps, Rubella, 3-Hepatitis B vaccine, 1-Varicella vaccine, 1-Meningococcal vaccine

Student Name \_\_\_\_\_ GR \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please indicate the full dates for the following immunizations:

Polio \_\_\_\_\_ DPT or DTaP \_\_\_\_\_

Hepatitis B (3 series) \_\_\_\_\_ or (2 dose adult series) \_\_\_\_\_

MMR \* \_\_\_\_\_ Measles \* \_\_\_\_\_

Mumps\* \_\_\_\_\_

Rubella\* \_\_\_\_\_

Varivax/Varicella Vaccine\* \_\_\_\_\_ Titer \_\_\_\_\_ Disease \_\_\_\_\_

Tdap booster \_\_\_\_\_ Meningococcal \_\_\_\_\_  
\* {1<sup>st</sup> dose must be given after 1 year of age}

### Additional Immunizations {not required for K-12 school attendance}

Hib \_\_\_\_\_ Pneumococcal \_\_\_\_\_

Lead Screening \_\_\_\_\_ Hepatitis A \_\_\_\_\_

HPV \_\_\_\_\_ Influenza (Flu) \_\_\_\_\_

H1N1 \_\_\_\_\_ TB Test: Date \_\_\_\_\_ Pos \_\_\_\_\_ Neg \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

PRINT: Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

(Physician's Stamp)



**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**  
**TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**  
**IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

**Note:** NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

**STUDENT INFORMATION**

Name	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

**HEALTH HISTORY**

<b>Allergies</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<b>Asthma</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<b>Seizures</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached Date of last seizure:
<b>Diabetes</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <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/m<sup>2</sup>

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

**Hyperlipidemia:**  No  Yes  Not Done      **Hypertension:**  No  Yes  Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **BP:** \_\_\_\_\_ **Pulse:** \_\_\_\_\_ **Respirations:** \_\_\_\_\_

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Lead Level Required Grades Pre- K &amp; K</b>			<b>Date</b>	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 µg/dL				

**System Review and Abnormal Findings Listed Below**

<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

**Assessment/Abnormalities Noted/Recommendations:** \_\_\_\_\_ **Diagnoses/Problems (list)** \_\_\_\_\_ **ICD-10 Code\*** \_\_\_\_\_

**Additional Information Attached** \_\_\_\_\_ **\*Required only for students with an IEP receiving Medicaid**

Name:				DOB:	
<b>SCREENINGS</b>					
Vision (w/correction if prescribed)		Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening		<input type="checkbox"/> Pass <input type="checkbox"/> Fail			<input type="checkbox"/>
Notes					
Hearing 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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Notes					
Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>					
<input type="checkbox"/> Student may participate in all activities without restrictions. <input type="checkbox"/> Student is restricted from participation in: <ul style="list-style-type: none"> <li><input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.</li> <li><input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.</li> <li><input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track &amp; Field.</li> <li><input type="checkbox"/> Other Restrictions:</li> </ul>					
Developmental Stage for Athletic Placement Process <u>ONLY</u> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V      Age of First Menses (if applicable) : _____					
<input type="checkbox"/> Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.					
<b>MEDICATIONS</b>					
<input type="checkbox"/> Order Form for Medication(s) Needed at School Attached					
<b>IMMUNIZATIONS</b>					
<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIIS			
<b>HEALTH CARE PROVIDER</b>					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form To Your Child's School When Completed.</b>					

## Mohonasen Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. 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 dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist 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 visit to a dentist?  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

I. The Dental Health condition of \_\_\_\_\_ on \_\_\_\_\_ (date of exam) The date of the exam 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 name and address (please print or stamp) Dentist'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): \_\_\_\_\_

#### III. 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.