2017-2018
Universal Pre-Kindergarten Registration

IMPORTANT INFORMATION: **(Please register your child for the UPK Program at your *"home building"* which is the school your child will attend at the time of Kindergarten. If you are unsure of your Elementary School Building, please contact the Transportation Dept. at (914) 528-4445 and provide them with your home address).**

FEBRUARY 6 – 8, 2017 (9:00 AM – 12 NOON)

&

FEBRUARY 9, 2017 (5:30 PM – 8:30 PM)

AT INDIVIDUAL ELEMENTARY SCHOOLS

Benjamin Franklin
Elementary School
3477 Kamhi Drive
Yorktown Heights, NY 10598

George Washington
Elementary School
3634 Lexington Avenue
Mohegan Lake, NY 10547

Lincoln Titus
Elementary School
10 Lincoln Avenue
Crompond, NY 10517

Thomas Jefferson
Elementary School
3636 Gomer Street
Yorktown Heights, NY 10598

Van Cortlandtville
Elementary School
3100 E. Main Street, Route 6
Mohegan Lake, NY 10547

FORMS AND PACKETS MAY BE FOUND ONLINE AT: WWW.LAKELANDSCHOOLS.ORG

LAKELAND CENTRAL SCHOOL DISTRICT
Educating Today for a Better Tomorrow

CENTRAL ADMINISTRATION

Dr. George E. Stone
Superintendent

Jean Miccio
Assistant Superintendent for Instruction

Dr. Tammy Cosgrove
Assistant Superintendent for Human Resources

MaryEllen Herzog
Assistant Superintendent for Pupil Personnel Services

Binoy Alunkal
Business Manager

Jim Van Develde
Director of Communications

January 2017

Dear Parent/Guardian:

Thank you for your interest in our Universal Pre-Kindergarten (UPK) program. Our program serves students of the Lakeland Central School District who will be 4 years of age by December 1, 2017. The program is developmentally appropriate and is designed to meet universal standards for Pre-K students in areas of pre-reading skills, early numeracy skills, fine and gross motor skills, and social skills necessary for transition to school age programs. This opportunity comes to us from a grant from the State Education Department, and is free to our students.

Our UPK classroom is located at Lincoln Titus Elementary School. Each pre-k class, of no more than 18 students, is supported by a full-time preschool certified teacher and a full time teachers' aide. Sessions run from 8:30 AM to 11:00 AM and 12:00 PM to 2:30 PM daily. You will be asked to select your preferences for your first and second choice for time. This will assist us in assigning placements, which is done at Central Office. We will do the best we can to accommodate your child. Please be advised that it is the responsibility of the Parent/Guardian to provide transportation. There will be a lottery process for selection of students, and a waiting list will be established.

If your child is not selected as a result of the lottery, and depending on the number of spots available, you will have an opportunity on a first come first serve basis to take part in our Pre-K programs located at Lakeland High School and Walter Panas High School. Again, it is a program that is developmentally appropriate for four year old students, and is supported by our high school program for Early Childhood development, where high school students work with our preschool students under the supervision of a certified teacher, three days a week from 8:30 AM to 10:30 AM. The cost to take part in this program is $200.00 for the school year to cover the cost of materials.

Please be sure that you complete all necessary forms so as not to delay your child's placement opportunities. Incomplete submission of the packet could result in not securing an opening.

We are excited about the success of our preschool programs thus far and look forward to continuing to work with our young learners. Again, thank you for your interest in our programs.

Sincerely,

Jean Miccio

Jean Miccio
Assistant Superintendent for Instruction

1086 East Main Street • Shrub Oak, New York 10588
Tel: 914-245-1700 • Fax: 914-245-4391 • www.lakelandschools.org

PUPIL PERSONNEL SERVICES

Mary Ellen Herzog
Assistant Superintendent for Pupil Personnel

Thomas Murphy
Supervisor

Joseph Spatola
Supervisor

Jessica Giangrande
Supervisor

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REGISTRATION CHECKLIST FOR PRE-SCHOOL PARENTS

- ☐ Residency Questionnaire (**to determine homelessness**)
- ☐ Student Registration Data Sheets
- ☐ ***Original*** Birth Certificate
- ☐ Photo ID of Parent/Legal Guardian
- ☐ Passport (***if available***)
- ☐ Residency information (lease, mortgage, affidavit of landlord)
- ☐ Utility bills
- ☐ Immunizations
- ☐ Physical/Entering Health Forms
- ☐ Home Language Questionnaire
- ☐ KI Release
- ☐ Media Permission Form
- ☐ Automated Phone Messaging

If you have concerns that your child may require special education services please refer to the New York State Education website at:
http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm

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PRE-SCHOOL REGISTRATION DATA SHEET

STUDENT NAME: _____ **DATE** _____

STUDENT ID #:_____ **GRADE:** _____ **HOMEROOM** _____

This section to be filled out by parent/guardian

YOU MUST COMPLETE ALL INFORMATION ON THIS FORM AND PROVIDE ALL DOCUMENTS FOR YOUR CHILD'S REGISTRATION TO BE PROCESSED. IF YOU SHOULD HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO ASK.
FAILURE TO COMPLETE THE FORM OR PROVIDE INFORMATION WILL DELAY THE REGISTRATION OF YOUR CHILD.

Student's Name: First _____ **Middle** _____ **Last** _____

Address: House Number and Street _____

City/Town/State/Zip Code _____

Telephone Number _____

Information about Student:

Date of Birth _____**Place of Birth (City, State, Country)** _____

If Birthplace is outside of US, enter date student entered the US _____

Gender ____

Both sections A and B must be completed:

A. Is this student Hispanic or Latino? *(Choose only one)*

- ☐ **No, not Hispanic or Latino**
- ☐ **Yes, Hispanic or Latino**

B. Is this student: (*Choose one or more. You must select at least one.*)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Dominant Language _____

Student is living with:

___ Natural Parent(s)	(If separated or divorced, provide a Certified Copy of any Separation Agreement, Divorce Decree or Custody Order)
___ Custodial Parent	(Parent Student resides with)
___ Legal Guardian	(Guardianship Papers are Required)
___ Foster Family	(Foster Child Data Sheet is Required)
___ Emancipated	(Order of Emancipation or Affidavit of Emancipation is Required)
___ Other	(Must submit Completed and Notarized Affidavits of Responsibility)

Father's Name: First _____ Last _____

Father's Address: _____

Father's Telephone No. (Day)_____ (Night) _____

Cell Phone _____

Mother's Name: First _____ Last _____

Mother's Address: (If different from above) _____

Mother's Telephone No. (Day)_____ (Night) _____

Cell Phone _____

If Student lives with someone other than a Parent:

Guardian's Name: First _____ Last _____

Guardian's Address: _____

Guardian's Telephone No. (Day)_____ (Night) _____

Cell Phone _____

Emergency Contact Name _____ Telephone No. _____

Physician Name: _____ **Telephone No.** _____

Previous School(s) Attend: Please provide Names of Schools, Addresses and Telephone Numbers

_____

_____

Other Children in the Household:

Name	Birth date	Relationship	School of Attendance	Grade
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

NOTE: REGISTRATION GENERALLY TAKES UP TO FIVE (5) SCHOOL DAYS DEPENDING UPON THE REGISTRATION MATERIALS PROVIDED.

Parent/Guardian
Initial after reading

_____ **1. I understand the submission of this document does not guarantee registration of my child in the Lakeland Central School District.**

_____ **2. I understand that the District may verify all of the information provided, including telephone calls and site visits.**

_____ **3. I understand that if I change my place of residence or any information provided above, i.e., telephone numbers, I must notify school personnel immediately and fill out appropriate form.**

_____ **4. I affirm that the information given is complete and accurate. I understand that if I have provided false information or misrepresentation of information regarding residence, it may be grounds for exclusion of the student. In addition, I may be liable for the costs of educating my child and may be subject to civil or criminal prosecution.**

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

If you have concerns that your child may require special education services please refer to the New York State Education website at: http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm

*Student Name:*_____ *DOB:*_____ *ID#*_____

FOR SCHOOL OFFICE USE ONLY:

Start Date: _____

First Time Registrant _____
Re-Registrant _____

SCHOOL

RESIDENCY INFORMATION (All Information must be Current - within the last 30 days)

HOMEOWNER

RENTER

EXCEPTION CODE (If Applicable)

ELL SE FOSTER TUITION OUT OF DISTRICT PLACEMENT

HOMELESS SSI MEDICAID SOCIAL SECURITY EMPLOYEE TUITION

MEDICAL INFORMATION: Current Immunization and Medical Examination Information must be received and verified by the School Nurse prior to request for Student Identification Number. The School Nurse must sign below to confirm verification.

_____ _____
School Nurse **Date**

SCHOOL OFFICE PERSONNEL MUST SIGN BELOW TO VERIFY THAT THEY HAVE CONFIRMED ALL INFORMATION GIVEN BY THE PARENT/GUARDIAN REGARDING THE STUDENT AND RESIDENCY

_____ _____
School Office **Date**

_____ _____
School Counselor **Date**

_____ _____
School Principal **Date**

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Supervisor
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Jessica Giangrande
Supervisor

PRE-KINDERGARTEN REGISTRATION ONLY

PARENTS FILL OUT BELOW IN ADDITION TO PREVIOUS PAGES

Universal pre-kindergarten is funded by the New York State Education Department. The following information is required to document eligibility.

Please rank in order of preference – First (1), Second (2):
LINCOLN TITUS ELEMENTARY SCHOOL – Universal Pre-Kindergarten Program

_____ (AM Session/ 8:30 AM – 11:00 AM) _____ (PM Session/12:00 PM – 2:30 PM)

Does your child currently attend any early childhood program? If yes, where? _____
_____

If not, did he/she attend any other program in the past? If yes, when? _____
_____

Are there any other children not living at home? (Please explain) _____
_____

If your child goes to a sitter or child care, and will be coming from or going to sitter's home or child care agency, please complete the following:

Sitter/Child Care Provider: _____

Address: _____

Phone: _____

Parents are expected to provide transportation. If you will not be transporting your child please indicate who will be: _____
_____

Please state why you believe the Pre-kindergarten program would be a good program for your child, and for you as a parent: _____
_____
_____
_____

The Pre-kindergarten program requires active parent involvement in monthly activities. Will you be able to commit to participating in activities each month? ☐ YES ☐ NO

Your child will be placed in either an AM or PM class. If there is a valid reason why your child must attend a specific session, please state below. If you have preference for a specific program provider, please state. We will try to schedule your child for that session or provider; however, we are not able to make any guarantees.

_____

_____

_____

_____

LAKELAND CENTRAL SCHOOL DISTRICT

Educating Today for a Better Tomorrow

VERIFICATION OF RESIDENCY REQUIREMENTS

The Lakeland Central School District requires proof of residency and may make reasonable inquiry to verify residency and eligibility for admission to its schools.

To verify residency at the time of registration the following are required:

A. For Homeowners - You must present three (3) documents, as follows:

Real property tax receipt or signed closing statement from Attorney and deed (including Westchester County or Putnam County Recording Cover Sheet)

AND

Two (2) of the following current documents in the Homeowner's name:

Mortgage Statement	Property Insurance Certificate
Utility bill	Voter Registration Card
Fuel Oil bill	Recent W2 Form
Cable TV bill	Library Card

Driver's License, Learner's Permit, Non-Driver ID

Note: Documents with only a P.O. Box address will not be accepted.

B. For Renters - You must present four (4) documents, as follows:

A valid and fully executed lease for the rental unit and a rent receipt signed by the landlord, including the landlord's address and telephone number and property address (within the past 30 days).

AND

A Completed, Signed and Notarized Affidavit of Property Owner/Landlord (LCSD Form)

AND

Two (2) of the following current documents in the Renter's name:

Utility bill	Property Insurance Certificate
Fuel Oil bill	Voter Registration Card
Cable TV bill	Recent W2 Form
DSS Budget Sheet	Letters from Agencies or caseworkers
Library Card	Section 8 or Municipal Housing Statement

Driver's License, Learner's Permit, Non-Driver ID

Administration Building, 1086 East Main Street • Shrub Oak, New York 10588
Tel: 914-245-1700 • Fax: 914-245-2381 • www.lakelandschools.org

Note: Documents with only a P.O. Box address will not be accepted.

C. ***For parents/students who reside with a family member/friend, you must present five (5) documents, as follows:***
A Completed, Signed and Notarized Affidavit of Property Owner/Landlord (LCSD Form)

AND

Two (2) documents verifying the residency of the family member/friend (see above for Homeowners and Renters).

AND

Two (2) of the following documents in the Parents' name:

Utility bill	Property Insurance Certificate
Fuel Oil bill	Voter Registration Card
Cable TV bill	W2 Form
Section 8 or Municipal Housing Statement	
DSS Budget Sheet	Letters from Agencies or caseworkers
Library Card	
Driver's License, Learner's Permit, Non-Driver ID	
Government Agency Documents (food stamps, medical cards, DMV change of address)	

Note: Documents with only a P.O. Box address will not be accepted.

We do not accept the following for proof of residency: checkbook, bank statement, credit card statement, car insurance statement/card, cellular phone or telephone bills, car loan statements.

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AFFIDAVIT OF PROPERTY OWNER/LANDLORD IN SUPPORT OF ADMISSION TO LAKELAND CENTRAL SCHOOL DISTRICT

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

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

or manager/agent of the dwelling located at _____
(Street #, Address, City, State, Zip)

_____, in the Town/Village of _____

hereby certify that I am renting space in this dwelling on a _____ to _____ basis
(Week/Month/Year)

beginning on _____.
(Date)

The following persons are identified as tenants having the right to be occupants in the dwelling:

- Maternal Parent/Guardian: _____
- Paternal Parent/Guardian: _____

Name of Child(ren) in Application for Admission:

Last: _____ First: _____ MI: _____ and

Last: _____ First: _____ MI: _____

List all other persons residing in the dwelling:

Last Name	First Name
_____	_____
_____	_____
_____	_____

Is this a multiple dwelling? Yes _____ No _____

Is the payment of Electric Utility Bill included in rent: Yes _____ No _____
If Yes, a copy of the "mutually acceptable written agreement" for shared meter usage must be submitted in accordance with Public Service Law §52, Part 2(b)(i).

NOTE: THE DISTRICT RESERVES THE RIGHT TO CONTACT THE APPROPRIATE MUNICIPALITY TO VERIFY THAT THE USE OF THE PREMISES IS IN COMPLIANCE WITH LOCAL LAWS AND CODES.

As property owner/landlord, I CERTIFY that I will notify the Lakeland Central School District Superintendent's Office, 1086 East Main Street, Shrub Oak, New York 10588, within 30 days of termination of this tenancy.

I CERTIFY that the information provided on this form is true and correct and that the statements made herein are being made under the penalties of perjury, knowing that the Lakeland Central School District will rely upon them in determining whether the above-named child(ren) will be admitted to its school system. I 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 personally to collect the costs of educating such child(ren) and/or seek criminal action against me for falsifying business records and/or filing a false instrument.[1]

_____ _____
(Signature of Property Owner/Landlord) (Print Name & Title)

Sworn to before me this _____
day of _____, 20___ _____ Notary Public

[1] Penal Law §175.05 (Falsifying Business Records in the Second Degree - Class A Misdemeanor.
Penal Law §175.20 (Tampering with Public Records in the Second Degree - Class A. Misdemeanor.
Penal Law §175.25 (Tampering with Public Records in the First Degree - Class D Felony.
Penal Law §175.30 (Offering a False Instrument for Filing in the Second Degree) - Class A Misdemeanor.
Penal Law §175.35 (Offering a False Instrument for Filing in the First Degree) - Class E Felony.

PUPIL PERSONNEL SERVICES

Mary Ellen Herzog
Assistant Superintendent for Pupil Personnel
Thomas Murphy
Supervisor
Joseph Spatola
Supervisor
Jessica Giangrande
Supervisor

To: Parent of New Entrants

From: Office of Pupil Personnel Services

Re: New York State Law and District Policy Regarding Immunizations and Physical Examinations for New Entrants to the Lakeland School District

New York State Education Law and New York State Public Health Law require that all new entering students, UPK, Grade K-12, be properly and completely immunized in accordance with the law at the time of admission to school. http://www.health.ny.gov/publications/2370.pdf

Proof of the child having received all of the required immunizations is to be submitted to the school upon admission. Said statement of proof must include dates of the immunizations and must be signed and stamped by the student's medical provider.

Please note that a child should be considered in compliance with school immunization requirements and should remain in school, if he or she has received at least one dose of each of the required vaccines and has appointments to return to his health care provider for the remainder of the required immunizations.

New York State Public Health Law provides that no school shall allow a child to attend for more than 14 days without a proper certificate of immunization. However, when a student is transferring from another country, public health law states that a principal or other designee may allow that child to attend school for up to 30 days if there is evidence of a good faith effort to obtain immunizations or proof of past immunization via serologic testing.

The law also states that each child enrolled in the public school must have a satisfactory physical examination upon the child's entrance into such school. Written evidence of the child having the required physical examination by a licensed medical provider must be submitted within thirty (30) days of the date of entrance. A completed physical examination form signed and dated by a licensed physician within one year prior to the child's entrance date into school will be accepted and will satisfy this requirement. Students who do not return evidence of a physical examination will have an exam scheduled with our school doctor.

Lakeland Board of Education Policy #5141.3 calls for the adherence to, and the enforcement of, the Education Law and Public Health Law on the matter of required immunizations and required physical examinations.

Should there be any questions or assistance needed, please contact the Registered Nurse in your child's school or this office.

R-2

2016-17 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades Pre-k through 8, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: intervals between doses of polio vaccine need to be reviewed only for grades prekindergarten, kindergarten, 1, 2, 6, 7 and 8.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 9 through 12. See footnotes for specific information for **each** vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule.

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1 and 2	Grades 3, 4 and 5	Grades 6, 7 and 8	Grades 9, 10, 11 and 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years of age or older or **3 doses** if aged 7 years or older and the series was started at 1 year of age or older		**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)[3]	**Not applicable**			**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years of age or older	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years of age or older	**3 doses**
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**			
Hepatitis B vaccine[6]	**3 doses**	**3 doses or 2 doses** of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years of age			
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**	**1 dose**	**2 doses**	**1 dose**
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**			**By Grade 7 1 dose**	**Grade 12: 2 doses or 1 dose** if the dose was received at 16 years of age or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**			
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**			

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at ages 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years of age or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday.
   b. If the fourth dose of DTaP was administered at age 4 years or older, the fifth (booster) dose of DTaP vaccine is not required.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children ages 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. A Tdap vaccine (or incorrectly administered DTaP vaccine) received at 7 years or age or older will meet the 6th grade Tdap requirement.
   e. For children 7 years of age or older who received the first dose on or after their first birthday, the immunization requirement is 3 doses. If the first dose was received before their first birthday, then 4 doses are required.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
   a. Students 11 years of age or older entering grades 6 through 12 are required to have one dose of Tdap. A dose received at 7 years of age or older will meet this requirement.
   b. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years of age.

4. Poliovirus vaccine (IPV/OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at ages 2 months, 4 months and at 6 through 18 months, and 4 years of age or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at age 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten and grades 9 through 12. Two doses are required for grades kindergarten through 8.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than 24 weeks of age.
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children aged less than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons aged 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate vaccine (MenACWY). (Minimum age: 6 weeks)
   a. One dose of meningococcal conjugate vaccine (Menactra or Menevo) is required for students entering grade 7.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at age 16 years or older, the second (booster) dose is not required.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months of age.
   b. If 2 doses of vaccine were received before 12 months of age, only 3 doses are required with dose 3 at 12 through 15 months of age and at least 8 weeks after dose 2.
   c. If dose 1 was received at ages 12 through 14 months of age, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months of age or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years of age or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months of age.
   b. Unvaccinated children 7 through 11 months of age are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at age 12 through 15 months.
   c. Unvaccinated children 12 through 23 months of age are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months of age or older, no further doses are required.
   e. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

Minimum Pneumococcal Vaccine (PCV) Requirements for Children Attending Child Care and Pre-Kindergarten Programs in New York State

Instructions for reading this chart (which follows on page 2): When a child presents to a child-care center, group family day care, or pre-kindergarten program, the individual reviewing the immunization record for that child should determine: 1) the current age of the child; 2) the age of the child when previous doses were administered; and 3) the number of doses of PCV vaccine that the child is required to have to attend. The age of the child when the first dose was administered affects the total number of doses the child is required to have.

If a child presents to the facility or program at less than 12 months of age, then the facility or program must follow up with the child's parent or guardian to ensure that the child completes the vaccine series by age 15 months.

Children missing any required doses must receive the missing doses following the minimum ages and intervals noted below.

1. The recommended vaccine schedule for children starting the series at age 2 months is 2 months, 4 months, 6 months, and 12 – 15 months.

2. The minimum age for the first dose is 6 weeks.

3. The minimum age for the final dose is 12 months.

4. The minimum interval between doses is 4 weeks; the final dose must be administered a minimum of 8 weeks after the previous dose.

Public Health Law Section 2164 requires that children who have not met the immunization requirements be excluded from day care or pre-kindergarten if they do not have medical or religious exemption to PCV vaccine. A child may be considered in process and able to attend day care or pre-kindergarten if she or he has received the first dose of PCV and has appointments for the remaining doses, if further doses are required.

Minimum Pneumococcal Vaccine (PCV) Requirements for Children Attending Child Care and Pre-Kindergarten Programs in New York State

Current Age	Doses Required By Now	Doses Required in the Future
Less than 2 months	**None**	**4 total** at ages 2 months, 4 months, 6 months, and 12 – 15 months
2 – 3 months	**1 dose**	**3 more (for a total of 4)** at ages 4 months, 6 months, and 12 – 15 months
4 – 5 months	**2 doses**	**2 more (for a total of 4)** at ages 6 months and 12 – 15 months
6 – 11 months	**3 doses** OR **2 doses** if the child received the first dose at 7 – 11 months of age	**1 more (for a total of 4)** at age 12 – 15 months OR **1 more (for a total of 3)** at age 12 – 15 months
12 – 23 months	**4 doses** with the final dose on or after age 12 months OR **3 doses** if the child received only 1 or 2 doses prior to age 12 months OR **2 doses** if the child is unvaccinated or received the first dose on or after age 12 months	**None**
24 – 59 months	**4 doses** with the final dose on or after age 12 months OR **3 doses** if the child received 2 or 3 doses prior to age 24 months of which 1 or 2 were received before age 12 months OR **2 doses** if the child received the first dose at age 12 – 23 months or received only 1 dose prior to age 24 months OR **1 dose** if the child is unvaccinated or received 1 dose on or after age 24 months	**None**
60 months (5 years) or older	Not required for children 60 months (5 years) of age or older	

ENTERING HEALTH HISTORY
CONFIDENTIAL INFORMATION

LAKELAND CENTRAL SCHOOL DISTRICT
SHRUB OAK, NEW YORK

ENTERING GRADE _____
TO BE COMPLETED BY PARENT/GUARDIAN

NAME_____SEX M_____ F_____BIRTHDATE_____BIRTHPLACE_____

ADDRESS_____ HOME PHONE ( )_____

FATHER'S NAME_____HOME ( )_____ WORK ( )_____CELL ( )_____

MOTHER'S NAME_____HOME ( )_____ WORK ( )_____CELL ( )_____

Child resides with: _____

EMERGENCY – PERSON TO CONTACT if parent is not available.

(1) NAME_____HOME ( )_____ WORK ( )_____ CELL ( )_____

Is child covered by health insurance? _____ Yes _____ No

Physician_____Phone ( )_____Dentist _____Phone ( )_____

New York State Education Law and New York State Public Health Law requires for all students will be properly & completely immunized in accordance with the law at the time of admission. A signed and stamped copy of immunization by your Health care provider must be presented to the school before entering http://www.health.ny.gov/publications/2370.pdf

Has your child resided outside the UNITED STATES for more than TWO (2) months? YES_____ NO_____

If yes where? _____

TO BE COMPLETED BY PARENT/GUARDIAN **Assessment of Student's Health History**

To the best of your knowledge, has your child had any problem with the following? Please check **Yes** or **No.**

Condition	Yes	No	Comment if "Yes"
Allergy __ food __ Insect __Latex __ ____ medication ____ seasonal ____ other			Specify allergen(s): _____ Specify previous symptoms: _____
Has the allergy required emergency treatment?			Treatment Prescribed: _____
History of anaphylaxis			History of anaphylaxis: last occurrence _____
Asthma or breathing problems ___ Intermittent or _____Persistent			Quick relief inhaler ____ Yes NO _____ Asthma Action Plan _____ Yes NO
Attention-Deficit/Hyperactivity Disorder			
Behavioral problems			
Developmental problems			
Bladder and/or bowel problems			
Bleeding problems			
Cerebral Palsy			
Cystic Fibrosis			
Dental Problems			* Date of last dental visit *
Diabetes			
Head or spinal injury			
Hearing problems or deafness			
Heart problems			
Hospitalizations / Surgery (reason/ date)			
Lead poisoning			
Lyme disease			
Musculoskeletal problems			(include any past fractures, etc)
Seizures / Seizure Action Plan			Date of last seizure _____
Sickle Cell Disease (not trait)			
Speech Problems			
Stomach /Nutritional issues			
Vision problems/ eye glasses			

List all prescription and over-the-counter medications your child takes regularly: _____

TO BE COMPLETED BY PARENT/GUARDIAN

Describe any other important health-related information or concerns about your child (i.e., feeding tube, oxygen support, hearing aid, etc.):

_____

DEVELOPMENTAL HISTORY: Delivery: _____ Term: _____ Birth Weight _____/ Length: _____

Condition at birth: _____ Cyanosis: _____ Jaundice: _____ Feeding Habits: _____ Bladder _____ Bowel _____

Indicate approximate age for the following: SAT UP_____ STOOD_____ WALKED_____ SENTENCES_____ TEETH_____

Name of Nursery School or Previous School _____

Signature of Parent or Legal Guardian: _____ **Date:** _____

Please note: A physical exam must be provided within 30 days of entrance. Students who do not return evidence of a physical exam will have a HEALTH APPRAISAL scheduled with our Medical Director.

Lakeland Central School District
1086 East Main Street, Shrub Oak, NY 10588

STUDENT HEALTH EXAMINATION FORM (To be completed 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, 2, 4, 7 & 10, interscholastic sports and working papers.

Name: _____ DOB: _____ Gender: ☐M ☐F

School: Grade: ☐No Grade Exam Date:

IMMUNIZATIONS

☐ Immunization record attached

☐ Immunizations reported on NYSIIS

☐ No immunizations received today

☐Immunizations received today:

☐Will return on: to receive:

HEALTH HISTORY

☐**Asthma:** ☐Intermittent ☐Persistent ☐Asthma Action Plan Attached

☐**Diabetes:** ☐Type I ☐ Type 2 ☐Hyperlipidemia ☐Hypertension ☐Diabetes Medical Mgmt Plan Attached

☐**Seizures** Type: _____ Last Occurrence: _____ ☐Emergency Care Plan Attached

☐**Allergies:** ☐Non Life-Threatening ☐Life-Threatening ☐Emergency Care Plan Attached

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Allergen(s): _____

☐Hx of Anaphylaxis: Last occurrence: _____ Previous symptoms: _____

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

Significant Medical/Surgical Information:	**Diagnostic Tests**	**Positive**	**Negative**	**Not Done**	**Date**
	Sickle Cell Screen	☐	☐	☐	
	PPD	☐	☐	☐	
	Elevated Lead:	☐	☐	☐	

☐Vision one eye only ☐One functioning kidney ☐One testicle ☐Concussion - Last occurrence:

PHYSICAL EXAMINATION

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

Scoliosis: ☐Negative ☐Positive

Degree of deviation: _____

Angle of trunk rotation via scoliometer:

Weight Status Category (BMI Percentile):

☐ <5th ☐ 85th - 94th

☐ 5th - 49th ☐ 95th - 98th

☐ 50th - 84th ☐ 99th & higher

Vision	**Right**	**Left**	***Referral***
Distance acuity			☐Yes ☐No
Distance acuity with lenses			☐Yes ☐No
Vision - near vision			☐Yes ☐No
Vision - color perception	☐ Pass	☐ Fail	☐Yes ☐No
Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes ☐No

Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders): **Tanner:** ☐I ☐II ☐III ☐IV ☐V

☐ SYSTEM REVIEW AND EXAM **ENTIRELY NORMAL** ☐ Additional information attached

Specify any abnormalities:

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations.** Please base restrictions/modifications on the following Interscholastic Sports Categories.

- ☐ **No Contact Sports** includes: basketball, baseball, field hockey, ice hockey, lacrosse, soccer, football, softball, volleyball, competitive cheerleading and wrestling
- ☐ **No Non-Contact Sports** includes: archery, bowling, cross-country, golf, gymnastics, rifle, swimming and diving, skiing, tennis, track & field, fencing, badminton
- ☐ **Other Specific Restrictions:**

Accommodations / Protective Equipment:	☐Athletic Cup	☐Insulin Pump/Insulin Sensor	☐Pacemaker
	☐Brace/Orthotic	☐Medical /Prosthetic Device	☐Sports Safety Goggles
	☐Hearing Aides	☐Other:	

MEDICATION HISTORY (optional)

Please list names of prescribed or OTC medications used on a routine basis at home

_____ _____

_____ _____

_____

PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS - VALID 1 YEAR

Independent Carry and Use Option: NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine autoinjector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option in schools.

☐ **Required Independent Carry and Use Attestation documentation is attached.**

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

Parent/Guardian Permission: I request the school nurse give the medications listed on this plan; or after the nurse determines my child can take their own medications, trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff caring for my child

Parent/Guardian Signature:

HEALTH CARE PROVIDER

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: _____ Date: _____

Provider Name: (please print) _____ Phone #: ( )

Provider Address: _____ Fax #: ( )

Return to:

School Nurse: _____ School: _____

Phone #: ( ) Fax: ( ) Date:

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment 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 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.

Lakeland Central School District

Authorization for Medication Administration

Medication of any kind (prescription &/or over the counter) cannot legally be dispensed to any child in school without a health care provider's order and written parental/guardian consent. Medication must be in original pharmacy labeled container with specific orders & brought in by an adult. Medications that can be taken at home before or after school should be arranged in this manner.

Request Form for Administration of Medication to Student in School

Student Name____ Date of Birth____/____/____

I request that my child, ______________________________, grade ________ receive the medication prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. The school nurse may contact the prescriber as needed.

Parent /Guardian Signature ______________________________ Date_______________

Print Parent/Guardian Name ____________________ Telephone Number: _______________

***************************TO BE COMPLETED BY A HEALTH CARE PROVIDER***************************************

Diagnosis____

Name of Medication________________________ Amount of Dosage __________________

Time medication is to be administered __________________ Route __________________

Duration of Treatment ________________________ Expiration Date of Treatment _______________

Possible adverse reaction or side effects ____

____

Physician's Signature ____________________________________ Date ____/____/____

Physician's Stamp and/or Name:____

Address: ____

____

Phone: ______________________________ Fax: ____________________

Provider and Parent Permissions Required for Independent Medication Carry and Use.

(formerly self-administer and/or self-carry) **Please Complete the Section below & sign if applicable.**

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- ☐ Allergy and requires Epinephrine Auto-Injector
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ☐ __________________ which requires rapid administration of __________________________
  (State Diagnosis) (Medication Name)

Signature: ________________________ Date: ____________

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: ________________________ Date: __________________

This medication order is valid for the school year. Medication must be picked up at the end of the school year or be discarded.

MEDICATION ORDER(S) MAY BE FAXED TO: Fax # 914 __________ Attention: School Nurse

LAKELAND CENTRAL SCHOOL DISTRICT
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 English. Your assistance in answering these questions is greatly appreciated.

Thank you.

TO BE COMPLETED BY SCHOOL PERSONNEL
Please print or type clearly

DISTRICT

SCHOOL GRADE

STUDENT NAME

DATE OF BIRTH
Month: Day: Year:

STUDENT IDENTIFICATION NUMBER

COUNTRY OF BIRTH/ANCESTRY

NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.

NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION

DETERMINATION: ☐ Possible LEP

☐ English Proficient

(✓ boxes that apply)

1. What language(s) is spoken in the student's home or residence? ☐ English ☐ Other_____ *specify*

2. What language(s) are spoken most of the time to the student, in the home or residence: ☐ English ☐ Other_____ *specify*

3. What language(s) does the student understand? ☐ English ☐ Other_____ *specify*

4. What language(s) does the student speak? ☐ English ☐ Other_____ *specify*

5. What language(s) does the student read? ☐ English ☐ Other_____ *specify* ☐ Does Not Read

6. What language(s) does the student write? ☐ English ☐ Other_____ *specify* ☐ Does Not Write

7. In your opinion, how well does the student understand, speak, read and write English?

	Very well	*Only a little*	*Not at all*
Understands English	☐	☐	☐
Speaks English	☐	☐	☐
Reads English	☐	☐	☐
Writes English	☐	☐	☐

Signature of Parent/Guardian/Other

Month: Day: Year:
Date:

06/03

LAKELAND CENTRAL SCHOOL DISTRICT
Educating Today
for a Better Tomorrow

PUPIL PERSONNEL SERVICES

Mary Ellen Herzog
Assistant Superintendent for Pupil Personnel

Thomas Murphy
Supervisor
Joseph Spatola
Supervisor
Jessica Giangrande
Supervisor

To the Parent/Guardian of:

This is to inform you that the recommended dosage of Potassium Iodide (KI) has been changed. Please refer to the chart below:

Recommended Doses of KI for Different Age Groups

Age Group	KI Dosage	Number of ml liquid (65 mg/ml)	Number of 65-mg tablets	Number of 130-mg tablets
Adults over 18 years	130 mg	2	2	1
Over 12-18 years and over 150 pounds	130 mg	2	2	1
Over 12 – 18 years and less than 150 pounds	65 mg	1	1	½
Over 3 – 12 years	65 mg	1	1	½
Over 1 month to 3 years	32 mg	0.5	½	¼
Birth – 1 month	16 mg	0.25	¼	1/8

It will not be necessary for you to fill out another permission form. Since weight is a changing factor we have determined that it would be safest to continue to keep the middle school and the high school students at the 130 mgm. dose. This dose is considered to be safe. The elementary students who weigh less than 150 pounds will receive the 65 mgm. doses.

If you have any questions please call your school nurse.

Sincerely,

MaryEllen Herzog
Assistant Superintendent for Pupil Personnel Services

MEH:ct

LAKELAND CENTRAL SCHOOL DISTRICT
Educating Today for a Better Tomorrow

CENTRAL ADMINISTRATION

Dr. George E. Stone
Superintendent

Jean Miccio
Assistant Superintendent for Instruction

Dr. Tammy Cosgrove
Assistant Superintendent for Human Resources

MaryEllen Herzog
Assistant Superintendent for Pupil Personnel Services

Binoy Alunkal
Business Manager

Jim Van Develde
Director of Communications

Dear Parents/Guardians/Caregivers:

The Lakeland Central School District, in compliance with the State Education Department and Westchester County Department of Emergency Services, will administer potassium iodide (KI) to all students whose parents provide written consent in the event of a radiological emergency. Potassium iodide (KI) is an over-the-counter drug that protects the thyroid from exposure to radioactive iodine. It only protects the thyroid gland against one radioactive substance. Potassium iodide (KI) is most effective when taken within hours of exposure. The protective effect lasts for approximately 24 hours. It is available only in a pill form. It is not an alternative to evacuation or sheltering. Sheltering remains New York's primary public protective action in the event of an emergency at any nuclear power site.

The school district will only administer potassium iodide (KI) pills to children whose parents have opted-in by filing their consent to administer with the school district. People with known iodine sensitivity, shellfish allergies or thyroid disorders should consult their physician for guidance. If you have any questions regarding the administration of potassium iodide (KI) to your child, please contact your physician or the Westchester County Department of Health at (914) 813-5000. Information is also available at the following website: www.westchestergov.com/health.

In order for your child to receive one 130mg dose of Potassium Iodide (KI) the attached form must be filled out and returned to your child's school as soon as possible. This form will remain in effect as long as your child attends Lakeland Schools.

Sincerely,

George E. Stone, Ed.D.
Superintendent of Schools

If you would like your child to receive one dose of Potassium Iodide (KI) in the event of a nuclear emergency, please fill out and return this form **to your child's school**.

In the event of a radiological emergency, I request that my child receive one 130mg dose of Potassium Iodide (KI).

Child's Name _____ Date of Birth _____

Current School _____ Grade _____

Parent/Guardian Name (Please Print) _____ Parent/Guardian Signature _____ Date _____

Return to your child's teacher: To be filed by nurse in student's health record. ***Please see attached chart**

1086 East Main Street • Shrub Oak, New York 10588
Tel: 914-245-1700 • Fax: 914-245-4391 • www.lakelandschools.org

PHOTO/VIDEO PERMISSION FORM

Throughout the school year, the Lakeland Central School District (LCSD) celebrates the accomplishments of its students. As a part of this, the Lakeland Central School District may use photographs and/or videotape recordings of your child, as well as the following types of information regarding your daughter/son, in articles about the School District in local newspapers, the District newsletter, the District website, the Yearbook, the district's Social Media sites (Facebook, etc.), and by both local television stations and the district cable television channel during the 2017-2018 school year.

- Name
- Participation in activities and sports
- Degrees, honors and awards received
- Photographs, digital images and/or videotapes of child's participation in school and school-related activities
- Interviews regarding school-related activities

This form provides you with the opportunity to let us know if you **DO NOT** wish your son/daughter to be included in such coverage – including photographs, videos, or samples of her/his work.

Please return this form only if you **DO NOT** wish your daughter/son to be included, as described, in any media coverage. It should be returned to the main office of your son's/daughter's school.

IF YOU DO NOT WISH TO HAVE THIS INFORMATION USED BY THE LAKELAND CENTRAL SCHOOL DISTRICT IN THE MANNER DESCRIBED ABOVE, PLEASE COMPLETE THIS SECTION:

I do not want the types of information described above regarding my child, _____ given
Name of Student
to local newspapers, used in District newsletters, the District website, District social media sites, the Yearbook or given to local television stations, and the district's cable channel during the 2017-2018 school year.

Date: _____ Signed: _____
Parent/Guardian

Print Name: _____
Parent/Guardian

Relationship to child: _____

PLEASE RETURN THIS FORM TO: _____ LAKELAND CENTRAL

SCHOOL DISTRICT AT: _____ AS SOON AS POSSIBLE.

LAKELAND CENTRAL SCHOOL DISTRICT
Educating Today
for a Better Tomorrow

PUPIL PERSONNEL SERVICES

Mary Ellen Herzog
Assistant Superintendent for Pupil Personnel
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Supervisor

AUTOMATED PHONE MESSAGE

In an effort to keep parents/guardians of children in the Lakeland Central School District informed, the district has implemented a "School to Home Messaging System." This automated system, "SchoolConnects", delivers approximately 1,000 thirty-second messages in ten minutes. SchoolConnects allows the district to call and/or email parents/guardians in the event of an emergency (delayed opening, early dismissal and full day closing) and any other event that requires timely school to parent/guardian communication. SchoolConnect allows for additional phone numbers, such as cell phone and direct business numbers, in the event you are not at home when the announcement is made. Any additional numbers must be direct-line numbers, numbers that don't have extensions and/or other people who normally answer the phone.

If you would like to provide additional contact numbers (direct lines) and an email address, please do so below. Return any additional contact information to your child's school building. This information will be added to the Student Information System and uploaded into the SchoolConnects system. If no response is received, SchoolConnects will only call the home phone number. In the future, if any of your contact information changes, please inform your child's school as soon as possible.

Additional Contact Numbers including area code:(1) _____

(2) _____

Email address: _____

Parent/Guardian signature: _____ Date: _____