PUPIL PERSONNEL SERVICES

Mary Ellen Herzog
Assistant Superintendent for Pupil Personnel

Thomas Murphy
Supervisor

Joseph Spatola
Supervisor

Jessica Giangrande
Supervisor

YOUR CHILD MUST REACH AGE 5 ON OR BEFORE DEC.1ST

REGISTRATION CHECKLIST FOR 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
- ☐ Request for Records
- ☐ Student's last Report Card (*when available*)
- ☐ IEP/504 Accommodation Plan (*if applicable*)
- ☐ Care/Custody Control (*if applicable*)
- ☐ Foster Child Data Sheet with DS29-99 Form (Questions 2 and 5 ONLY to be answered by parents)
- ☐ KI Release
- ☐ Transportation Form (Transportation will not begin until registration at the building is complete)
- ☐ Food Services
- ☐ Media Use Form
- ☐ Computer/Internet Use Forms

LAKELAND CENTRAL SCHOOL DISTRICT

Educating Today
for a Better Tomorrow

YOUR CHILD MUST REACH AGE 5 ON OR BEFORE DEC.1ST

Student Name: _____	Student ID #: _____
Grade: _____	Homeroom: _____

Registration Process & Checklist

1. Secretary gives/mails registration packet to new registrant. _____
2. Secretary schedules an appointment, if appropriate. _____
3. Registrant completes and returns the packet to the secretary. _____
   a. Residency Questionnaire (to determine homelessness)
   b. Student Registration Data Sheet
   c. Home Language Questionnaire
   d. Student Emergency Contact Form
   e. **Original** Birth Certificate
   f. Photo ID of Parent/Legal Guardian
   g. Student's last Report Card (when available)
   h. Passport (if available)
4. Secretary reviews packet for:
   a. Completeness _____
   b. Proof of Residency _____
   c. Custody/Proof of Guardianship _____
   d. School Records _____
   e. Signed Releases: _____

      Medication Form (if appropriate) _____
      School District/Media Permission Form _____
      Home Language Questionnaire Form _____
5. Nurse reviews medical records and immunization form. _____

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

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, 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.

6. Registration materials given to the school principal and/or school counselors (at secondary level) to verify for accuracy and completeness. _____

7. Registration materials returned to the secretary for:

   a. Data entry into Student Information System _____

      1. After Student ID Number is generated by S.I.S., enter The Student ID # on registration form. _____

   b. Fax Transportation and Food Service data sheets to the Transportation and Food Service Departments with all student Demographic data completed. _____

      1. Transportation Department returns the data sheet with bus information by fax to the secretary. _____

   c. Secretary sends copies of verification of residency forms to Gisele Staino at District Office. _____

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

SECRETARY/COUNSELOR IS TO MAINTAIN ALL ORIGINAL FORMS IN THE INDIVIDUAL STUDENT FILES AT THE SCHOOL

Special Alerts: Any of the following:

a. Foster Placement (Attach DS-29-99 Form and return with foster child data sheet)*****
b. SSI, Medicaid, Social Security
c. Homelessness
d. Parents Separated/Divorced
e. Child residing with other than Parents
f. Emancipation
g. ELL

****Sections 2 and 5 ONLY to be completed by parent***

Please alert Gisele Staino at District Office if any of the above situations exist.

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Student Residency Questionnaire

Students who are homeless may, but are NOT REQUIRED to complete this form. These students are protected under the McKinney-Vento Act and are eligible for immediate or continued enrollment. If you think that you are homeless, or are living doubled-up, please call the district's liaison as soon as possible at 914-245-1700 x 236.

NAME OF SCHOOL: _____

NAME OF STUDENT: _____

DOB: _____ GRADE: _____

STUDENT ID: _____ SCHOOL ATTENDING: _____

DATE WHEN STUDENT BECAME HOMELESS: _____

DISTRICT ATTENDING WHEN MADE HOMELESS: _____

1. IS YOUR CURRENT LIVING ARRANGEMENT TEMPORARY ____ YES ____ NO
2. IS THIS TEMPORARY LIVING ARRANGEMENT DUE TO LOSS OF HOUSING OR ECONOMIC HARDSHIP?
___ YES ___ NO

IF YOU ANSWERED NO YOU MAY STOP HERE.

IF YOU ANSWERED **YES** TO BOTH QUESTIONS 1 AND 2, **COMPLETE THE REST OF THE FORM**.

LIVING ARRANGEMENTS (CHECK): __MOTEL __MOVING FROM PLACE TO PLACE

___IN SHELTER___WITH RELATIVE ___IN PLACE NOT DESIGNED FOR ORDINARY

SLEEPING ACCOMMODATIONS, SUCH AS A CAR, PARK, OR CAMPSITE.

OTHER (SPECIFY) _____

Name of Legal Guardian _____

Signature of Parent or Guardian: _____

Address: _____

Presenting a false record or falsifying information is an offense under Section 37.10, Penal Code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002(3)(d)

NCLB requirement/ Mc Kinney Vento Act 42 USC 11435

FAX copy to MaryEllen Herzog, Assistant Superintendent for Pupil Personnel Services at Central Office 914-245-2381

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	Fuel Oil bill
Recent W2 Form	Driver's License, Learner's Permit, Non-Driver ID
Cable TV bill	*(with new address)*

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

AND

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

AND

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

Utility bill	Property Insurance Certificate
Fuel Oil bill	Cable TV bill
Recent W2 Form	Letters from Agencies or caseworkers
DSS Budget Sheet	
Section 8 or Municipal Housing Statement	
Driver's License, Learner's Permit, Non-Driver ID *(with new address)*	

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	Cable TV bill
W2 Form	Section 8 or Municipal Housing Statement
DSS Budget Sheet	Letters from Agencies or caseworkers
Checkbook, bank statement	Credit card statement
Car insurance statement/card	Car loan statements
Cellular phone or telephone bills	

Driver's License, Learner's Permit, Non-Driver ID (*with new address*)

Government Agency Documents (food stamps, medical cards, DMV change of address)

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

STUDENT NAME: _____ **DATE** _____
STUDENT ID #:_____ **GRADE:** _____ **HOMEROOM** _____
SCHOOL: _____

LAKELAND

YOUR CHILD MUST REACH AGE 5 ON OR BEFORE DEC.1ST

STUDENT REGISTRATION DATA SHEET

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)**_____

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**

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Tel: 914-245-1700 • Fax: 914-245-2381 • www.lakelandschools.org

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 _____

Parent/Guardian's Dominant Language_____

Need for interpreter for school meetings _____ YES _____NO

Student is living with: ___ Natural Parent(s) (If separated or divorced, provide a Certified Copy of any Separation Agreement, Divorce Decree or Custody Order OR Complete LCSD Care, Custody and Control Form)

___ Custodial Parent (Parent Student resides with)
(If separated or divorced, provide a Certified Copy of any Separation Agreement, Divorce Decree or Custody Order OR Complete LCSD Care, Custody and Control Form)

___ 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

_____

_____

Has the Child Ever Attended the Lakeland Schools Before? _____ If Yes, When _____

Has the Child ever been classified as a student with a disability or has an Individualized Educational Program (IEP)? ❑ Yes ❑ No

Other Children in the Household:

Name	**Birthdate**	**Relationship**	**School of Attendance**	**Grade**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

NOTE: REGISTRATION GENERALLY TAKES UP TO THREE (3) 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

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

REVISED 2/18

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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)

_____
Property Owner/Landlord Address and Telephone #

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.

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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

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.

Tuberculosis screening

Per district policy all children who have resided outside of the United States for more than two (2) months just prior to entering or returning to the District, must submit medical documentation of current tuberculosis screening through either a PPD skin test or an Interferon Gold blood test in order to ascertain exposure to or active tuberculosis disease.

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

ENTERING HEALTH HISTORY **LAKELAND CENTRAL SCHOOL DISTRICT** **ENTERING GRADE** _____
CONFIDENTIAL INFORMATION **SHRUB OAK, NEW YORK** **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.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HgbA1c results: _____ Date Drawn: _____

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

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and<

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

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code
_____	_____
_____	_____
_____	_____
_____	_____

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

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

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

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

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

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

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

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

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 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 r 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

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):_____

I

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

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

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

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:

❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

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

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

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

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

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

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

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

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

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

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

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

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

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ **Mother** ❑ **Father** ❑ **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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colon-Collins, Assistant Commissioner
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(518) 474-8775 / Fax: (518) 474-7948

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

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

Por favor escriba con claridad al completar esta sección.

NOMBRE DEL ESTUDIANTE:		
Nombre	*Segundo nombre*	*Apellido*
FECHA DE NACIMIENTO:		GÉNERO:
Mes / *Día* / *Año*		❑ Masculino ❑ Femenino
INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL		
Apellido	*Primer Nombre*	*Relación con el estudiante*

CÓDIGO DEL IDIOMA DEL HOGAR

Conocimientos de idiomas

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

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

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

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

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

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

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

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

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

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

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

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

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

_____

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

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

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

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

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

_____ Mes: Día: Año:
Firma del padre/madre o de la persona en relación paternal *Date*
Relación con el estudiante: ❑ Madre ❑ Padre ❑ Otra:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

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

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

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

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

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

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

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

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

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

REQUEST FOR RECORDS

Student Name: _____DOB:_____

I give the Lakeland Central School District my permission to send or request copies of the school records regarding my child (which include but are not limited to academic, special education, evaluations, discipline, medical, observations) to the individual, school or agency indicated below:

School Name: _____

Contact Name: _____

Address: _____

_____

_____ _____

Parent/Guardian Signature Date

Please remit records to: Lakeland Central School District

School Name: _____

Contact Name: _____

Address: _____

_____

Fax Number: _____

NOTE: THE REQUEST FOR PERMISSION IS MERELY A COURTESY. THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT DOES NOT REQUIRE THE SPECIFIC PERMISSION OF THE PARENT/GUARDIAN TO REQUEST AND RECEIVE STUDENT RECORDS FOR A CHILD WHO SEEKS TO REGISTER IN A SCHOOL DISTRICT.

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

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

The Lakeland Central School District, in compliance with the State Education Department and Westchester County Department of Emergency Services, has plans in place for all students for administering Potassium Iodide (KI) 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. 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. Potassium Iodide (KI) is most effective when taken within hours of exposure. The protective effects last for approximately 24 hours. It is available only in a pill form. For children who are unable to swallow pills, it may be taken with food.

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 would like your child to receive age appropriate dose* of Potassium Iodide (KI) in the event of a nuclear emergency, please fill out the permission form below and return this form to your child's school. Without this form being filed, your child will not receive Potassium Iodide (KI) from school district personnel in the event of a nuclear emergency. This form will remain in effect as long as your child attends this school district. 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. If you have any questions regarding school procedures for the administration of Potassium Iodide (KI), please contact your school administrator.

Sincerely,

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

If you would like your child to receive an age appropriate 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 dose of Potassium Iodide (KI).

_____ _____
Child's Name Date of Birth

_____
Current School and Grade

_____
Parent's Name (Please Print)

_____ _____
Parent's Signature Date Signed

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

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

TRANSPORTATION START DATE:

DATE: _____

LAKELAND CENTRAL SCHOOL DISTRICT
1086 East Main Street
Shrub Oak, NY 10588
(914) 245-1700

TRANSPORTATION START DATE:

_____

TRANSPORTATION DATA SHEET FAX TO 528-1839

TO BE FILLED OUT BY SCHOOL ***TO BE FILLED OUT BY TRANSPORTATION***

SCHOOL _____ ***AM BUS # _____*** ***RT # _____***

STUDENT ID_____ ***PM BUS # _____*** ***RT # _____***

GRADE_____ ***PICKUP TIME_____***

PICKUP LOCATION_____

STUDENT'S NAME

FIRST _____ *LAST* _____

DATE OF BIRTH _____ *GENDER* ☐ MALE ☐ FEMALE

FATHER'S NAME

FIRST _____ *LAST* _____

HOME PHONE (_____)_____ *CELL* _____

MOTHER'S NAME

FIRST

_____ *LAST* _____

HOME PHONE (_____)_____ *CELL* _____

ADDRESS

HOUSE NUMBER/STREET _____

CITY _____

STATE _____ *ZIP* _____

MAILING ADDRESS (IF DIFFERENT)

HOUSE NUMBER/STREET/P.O. BOX _____

CITY _____

*STATE*_____ *ZIP* _____

EMERGENCY CONTACT INFORMATION

NAME _____ PHONE NUMBER _____

NAME _____ PHONE NUMBER_____

FOOD SERVICE
NEW STUDENT REGISTRATION

Please complete & fax immediately to 914-245-3214 as soon as registration is complete

Please print all information clearly:

Student Identification Number: _____ **Homeroom Number:** _____
For School Office Personnel Only — For School Office Personnel Only

School Name: _____ Grade:_____ Student Date of Birth:_____

Students
Name: (First) _____ (Middle)_____ (Last)_____

Address: Street _____

City/Town:_____ Zip Code:_____

Parent/Guardian Name: (First)_____ (Last)_____

Parent/Guardian Email Address: _____

Parent/Guardian Phone Number (best number to call):_____

Was student eligible for free or reduced meals in previous district? (Circle one): YES NO N/A

Student was transferred from (previous district name):_____

Administration Building, 1086 East Main Street • Shrub Oak, New York 10588
Tel: 914-245-1700, ext. 246 • Fax: 914 245-3214 • 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 my child, 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 2015-2016 school year.

- Name
- Participation in activities and sports
- Degrees, honors and awards received
- Photographs, digital images and/or videotapes of child 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 son/daughter 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, the Yearbook or given to local television stations and the district's cable channel during the 2015-2016 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.

TECHNOLOGY

Dwayne Hoffmann
Director of Information Technology

Linda Brandon
Director of Instructional Technology

Matt Weiner
Assistant Director of Information Technology

Dear Parent or Guardian:

The Lakeland School District will be offering students, grades 4- 12, district email accounts. A student's network/Internet and email account will not be activated unless there is consent from a parent or guardian. A parent or guardian will have the option to permit network/Internet access for their child while not allowing email access. Please note, student email access will be internal to the district only, these accounts will not be able to send or receive emails outside the district. Please read the attached Acceptable Use Policy packet carefully. All students are expected to comply with the procedures listed on these pages and any violations may result in loss of computer privileges. Students are required to sign the upper portion of the notice and parents/guardians are required to sign the lower portion. Every student needs to have a copy of this form on file at the school. Students who do not have a copy on file **will be prohibited from using the Network/Internet System**.

If you have any questions regarding the Acceptable Use Policy, please contact the Information Technology Facilitator in your school.

Thank you for your cooperation regarding this matter.

Sincerely,

Dwayne Hoffmann
Director, Information Technology

Administration Building, 1086 East Main Street • Shrub Oak, New York 10588
Tel: 914-245-1700, ext. 247 • Fax: 914 245-9467 • www.lakelandschools.org

Policy Information

Series 6000 - Instruction

Curriculum
Computer and Internet Use and, Internet Safety
Policy # 6154

The Board of Education encourages the use of the District's computer systems and the Internet (a global network made up of small contributing networks) and its services in order to support open research and education in the School District. The use of the District's computer systems and the Internet for other purposes, such as for-profit activity, financial gain, personal business or illegal activity is prohibited.

In order to assure the integrity of the computer systems in the School District, each user must agree to act responsibly and to comply with this policy and the regulations promulgated by the Superintendent of Schools regarding use of the systems and the Internet. Therefore, prior to using the District's systems and Internet access, each student and staff member must sign a user agreement. In the case of students, the student's parent or guardian must also sign the user agreement.

Notwithstanding the requirement for a signed user agreement, in the event that a state or local assessment must be administered using the District's technology resources, the student will be permitted to use the District's technology to take the assessment.

Internet access is provided with the understanding that the District cannot control the content available on the Internet. The vast majority of sites available provide a wealth of useful information to staff and students. The District cannot warrant the accuracy of all such sites. However, some sites may contain information that is offensive, defamatory or otherwise inappropriate for students. The District does not condone or permit the use of such materials in the school environment and makes good faith efforts to limit access by students to such inappropriate materials. Users who bring such material into the school environment may have their accounts suspended or terminated, may be subject to disciplinary action and may be referred to appropriate law enforcement officials where such activities are or are suspected of being illegal.

Internet Safety

The District, in accordance with the Children's Internet Protection Act, requires all District computers to be equipped with filtering or blocking technology that blocks or filters Internet access by:

- Adults to visual depictions that are obscene or child pornography; and
- Minor to visual depictions that are obscene, child pornography or harmful to minors. [1]

All newly acquired computers with Internet access will have this filtering or blocking technology installed onsuch computers prior to permitting their use by students. This shall be documented by the District in accordance with law. The District, however, does not guarantee that students will be prevented from accessing all inappropriate locations.

Parents, staff members and student must be aware that it is the responsibility of the user to monitor his/her own access to the internet and to use sound judgment. However, the District, through its staff members, technology and systems reviews, shall monitor online activities of

students while in school, including but not limited to use of e-mail, chat rooms and other forms of direct electronic communication, "hacking" and other unlawful activities by minors, and access to materials harmful to minors.

Any user who receives harassing, threatening or unwelcome communications shall immediately bring them to the attention of the teacher, the building principal or the superintendent, as appropriate.

The District prohibits the unauthorized disclosure, use and dissemination of personal information regarding minors by its officers, employees or agents.

The District shall provide age appropriate instruction to students regarding appropriate online behavior including interacting on social networks, websites and chat rooms, and cyberbullying awareness and response. Such instruction will be provided even if the District prohibits students from accessing social networking sites and chat rooms on District computers and resources.

Privacy

Computers and files stored on the District's system are the property of the District. Users acknowledge that school officials will periodically review online activities. Users further acknowledge that if there is reasonable suspicion of a user having violated this or any other Policy or Regulation, or any applicable law, the network administrator or appropriate school official may require access to his/her files, including correspondence and files, to review online activities. Any administrator reviewing such files in accordance with this Policy shall not be subject to any claims arising out of such review.

The use of the District's computer systems and access to the Internet, pursuant to this policy, is a privilege that may be revoked in the event of a breach of the policy and regulations by a user. Any user who is determined to have used the District's computer systems or the Internet inappropriately or who violates this policy and its regulations will have his/her use terminated, except under strict supervision. Further, a breach of the terms of this policy and regulations may be considered an act of insubordination which may result in discipline under the Student Code of Conduct for students and pursuant to law and applicable collectively negotiated agreement for staff members.

A breach of the terms of this Policy shall result in referral to appropriate law enforcement officials where the breach involves suspected illegal or criminal activities.

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[1] *The term "harmful to minors" means any picture, image, graphic image file, or other visual depiction that:*

(a) Taken as a whole and with respect to minors, appeals to a prurient interest in nudity, sex or excretion;

(b) Depicts, describes or represents, in a patently offensive way with respect to what is suitable for minors, an actual or simulated sexual act or sexual contact, actual or simulated normal or perverted sexual acts, or a lewd exhibition of the genitals; and

(c) Taken as a whole, lacks serious literary, artistic, political or scientific value as to minors.

LAKELAND CENTRAL SCHOOL DISTRICT
RULES AND CODE OF ETHICS AGREEMENT
FOR NETWORK, INTERNET AND EMAIL USERS

Section 1: To be signed by student

I understand that the Lakeland Central School District reserves the right to monitor all computer, Internet and Email use to ensure compliance with District policy, regulations, and law.
I understand that violations of the Acceptable Use policy will be considered as insubordination and will be dealt with seriously. Violators' risk:

- Losing computer privileges on a temporary or permanent basis; and/or
- Disciplinary action; and/or
- Academic sanctions for academic infractions (plagiarism); and/or
- Prosecution for violation of local, state and federal laws

I have read the Lakeland School District Acceptable Use Policy for Computer and Internet Use and agree to abide by its terms. I further understand that violation of the policy regulations may lead to my access privileges being revoked, school disciplinary action, academic sanctions, and/or appropriate legal action.

Student's Name
(Please Print) _____ **Grade**_____

Signature _____ **Date**_____

Section 2: To be signed by parent or guardian

As the parent or guardian of (please print your son/daughter's name_____)
I have read and discussed with my son/daughter the Acceptable Use Policy for the Lakeland Central School district Computer and Internet use. I recognize that it is impossible for the School district to restrict access to all controversial materials; and I will not hold the district, its officers, employees, or the Internet provider, responsible for materials acquired on the network.

I hereby give permission for my child to have user access to the following (please initial):

_____ Network/Internet _____ District Email

I realize that under the law, I may be held financially responsible for the willful, malicious, or unlawful damage of property by my minor child.

Parent's name (Please print) _____

Parent's Signature_____ **Date** _____

Copy to student's folder and Computer Facilitator.

PUPIL PERSONNEL SERVICES

Mary Ellen Herzog
Assistant Superintendent for Pupil Personnel

Thomas Murphy
Supervisor

Joseph Spatola
Supervisor

Jessica Giangrande
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: _____