Menands Union Free School District - Student Information Sheet
2017-2018 School Year

Student ID | Teacher | Grade | Gender

Student Name | Birthday

Physical Address: ______________________ Home Phone

Hispanic: Y N
Country of Birth: ______________________
Home Language ______________________
Years in US Schools: ______________________
Date of Entry into the US: ______________________

Race: B ______________
— American Indian
— Asian
— Black
— Native Hawaiian
— White

Bus Information:
AM Bus Number: PM Bus Number:

Mother

Name: | Employer: | Has Custody: Y N

Home Phone: | Day Phone: | Cell Phone:

Father

Name: | Employer: | Has Custody: Y N

Home Phone: | Day Phone: | Cell Phone:

2nd Parent Mailing Information

Parent Name: ______________________

Address:

Parent or Guardian Emails (List as many as are appropriate)

E-Mail:

Emergency Contacts: Please list 2 adults **other than parents** who could be contacted in case of a medical emergency.

Name: | Relationship: | Phone:

Name: | Relationship: | Phone:

Physicial Information

Dr. Name: | Dr. Phone:

Preferred Hospital: | Dentist Name: | Dentist Phone:

Medical Alert: Please list all pertinent information, ie. food allergies, bee sting, asthma, diabetes, etc.

Other Information

Adults Authorized to pick up my child (other than parent):

Siblings:

Other Adults living with Student:

PARENT/GUARDIAN SIGNATURE: ______________________ **DATE:** ____________

Registration Questionnaire Date:________________

Student's Name ______________________________ **Grade** _________ **Gender** _______

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

Where is the student currently living: (Please check <u>one</u>)

_____ In a shelter

_____ with another family or person because of loss of housing as a result of economic hardship (sometimes referred to as "doubled-up")

_____ In a hotel/motel

_____ In a car, park, bus, train, or campsite

_____ Other temporary living situation (Please describe): ____________________________

_____ In permanent housing (house or apartment)

Custody Papers

(If applicable: Most recent court order. It must clearly state who has physical/legal custody of the child and must have judge's signature)

Custody Issues ____

____

Second Parent Mailing: Yes ____ No ____

Name of last school attended/length of time at last school/dates/reason for leaving.

____

____

_____ Did your child attend pre-K

_____ Length of time in pre-K

_____ IEP (Individualied Education Plan) from previous school district

_____ ESL

_____ Other support services ____

_____Medical Needs ____

AFFIDAVIT OF RESIDENCY - MENANDS UNION FREE SCHOOL DISTRICT

STATE OF NEW YORK COUNTY OF ______________________

______________________________________being duly sworn, deposes and says:

(Name of Owner/Renter/Parent/guardian –Circle appropriate titles)

1. I reside at (legal residence) ____

Telephone number: _________________

2. Names of all residents at above address: Relationship to owner/renter

______________________________ ____________________________

______________________________ ____________________________

______________________________ ____________________________

______________________________ ____________________________

3. I make this affidavit for the purpose of establishing residency within the Menands Union Free School District. The student(s) belongings are kept at this address, they sleep at this address, and for all intents and purposes live at this address.

4. If the child's/children's other parent does not reside at the same location, then provide the following information:

________________________ ___________________________ ___________________

(Other Parent's Name) (Address) (Telephone Number)

COMPLETE EITHER 5A OR 5B

5A. In support of the above, as a home owner, I have attached a mortgage document and two of the following proofs of my residency.

____ Property tax bill ____ Water tax bill ____ Driver's license/photo ID ____ Electric bill ____ Bank statement

5B. In support of the above as a renter, I have attached the most recent copy of my lease listing all the residents in the apartment/home and two of the following proofs of my residency. Place a check in front of each item attached.

_____ Rent Receipt _____ Driver's license/photo ID ____ Electric bill ____ Bank statement

If you are a renter, complete the following:

Landlord's name_____________________ Landlord's phone number______________

By signing this affidavit, I am stating that the information that I provided above is accurate and truthful. If the information provided above changes, Menands School must be notified immediately. Should the District discover that this student is not living at this address, he or she will immediately be withdrawn as a student of the Menands School District and that I may be responsible for tuition payment, transportation costs, and other fees.

Sworn to me this __________

day of ______________, 2017.

________________________ ______________________________

(Notary Public) (Signature of Owner/Renter/Guardian

Menands Union Free School District
19 Wards Lane, Menands, N.Y. 12204
Ph: 518-465-4561 x 109 Fax: 518-465-4572
School Nurse: Carin D'Ambro R.N.

STUDENT HEALTH HISTORY

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian:	Home Phone: Cell Phone:	Date:

Check all that applies:	YES	NO	If Yes, please explain and include date:
Ongoing medical condition	☐	☐	
Followed by medical specialist	☐	☐	
Allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other (Explain)
Hospitalization	☐	☐	
Surgery	☐	☐	
Injury that required an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Bone/muscle injury	☐	☐	
Loss of consciousness, concussion or serious head injury. Please indicate approximate date.	☐	☐	
Convulsion/seizure	☐	☐	
Vision impairment or condition	☐	☐	☐ glasses ☐ contacts ☐ Prosthesis
Hearing impairment or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Dental injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition (Depression, ODD, OCD, anxiety, ect.)
- ☐ Scoliosis
- ☐ Single Organ (☐kidney, ☐testicle)
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Urinary Condition

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?
☐No ☐Yes: ____________________

Please list any additional concerns: (use back of sheet if necessary) ____________________

Parent/Guardian Signature:____________________ 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.

Menands Union Free School District

19 Wards Lane, Menands, N.Y. 12204
Ph: 518-465-4561 x. 109   Fax: 518-465-4572

School Nurse: Carin D'Ambro R.N.

Health and Dental Examination Requirements

Dear Parents/Guardians,

New York State law requires a health examination for all students **entering the school district for the first time and when entering Pre-K or K, 2nd, 4th, 7th, and 10th grade**. The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts K , 2nd ,4th ,7th , & 10th grades.

- If your child has an appointment for an exam during this school year that is after the first 30 days of school, you will need to forward a copy of the appointment card to the Health Office.

  Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the time of your child's appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office. Forms may also be faxed to the number above.

Sincerely,

Carin D'Ambro R.N.

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

Lissette Colón-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:		**GENDER:**
Month	*Day* *Year*	☐ 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* ☐ Guardian(s) ________ *specify*	☐ Father ________ *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 ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: