Menands Union Free School District
19 Wards Lane, Menands, NY 12204-2197
Phone (518)465-4561
*Fax (518)434-2840 (Main Office)
*Fax (518)465-4572 (Health Office)
www.menands.org

RELEASE OF RECORDS

NAME AND ADDRESS OF SCHOOL LAST ATTENDED

_____

_____

_____

Does your child have an IEP (Individualized Education Program)? YES___ NO___

I hereby grant permission for copies of my child's school records, including academic, health and psychological materials to be sent by mail to:

Menands Union Free School District
19 Wards Lane
Menands, NY 12204

By Fax: 518-434-2840 or Email to anicoll@menands.org

Student's Name:_____

Parent/Guardian Signature:_____ Date:_____

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

School Phone _____
School Fax _____
Sent _____

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: _____

— American Indian
— Asian
— Black
— Native Hawaiian
— White

Bus Information:

AM Bus Number: PM Bus Number:

Mother

Name: | Employer: | Active Military Y N | Has Custody: Y N

Home Phone: | Day Phone: | Cell Phone:

Father

Name: | Employer: | Active Military Y N | 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

Preferred Hospital: | Dr. Name: | Dr. Phone:

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 McKiney-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 one)

_____ 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:

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:

District Name (Number) & School | Address

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

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

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

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

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

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

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

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

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

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

Relationship to student: ☐ 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:

Menands School, 19 Wards Lane, Menands, NY 12204 Phone 518-465-4561 Fax 518-465-4572

STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)

Note: NYSED requires a physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers.

Name: _____ DOB: _____ Gender: ☐M ☐F

School: Grade: ☐No Grade Exam Date:

IMMUNIZATIONS

☐ Immunization record attached

☐ Immunizations reported on NYSIIS

☐ No immunizations received today

☐Immunizations received today:

☐Will return on: to receive:

HEALTH HISTORY

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

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

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

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

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

Allergen(s):

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

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

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

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

PHYSICAL EXAMINATION

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

Scoliosis: ☐Negative ☐Positive

Degree of deviation: _____

Angle of trunk rotation via scoliometer:

Weight Status Category (BMI Percentile):

☐ <5th ☐ 85th - 94th

☐ 5th - 49th ☐ 95th - 98th

☐ 50th - 84th ☐ 99th & higher

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

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

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ Additional information attached

Specify any abnormalities:

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

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

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

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

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

MEDICATION HISTORY (optional)

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

_____ _____

_____ _____

_____

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

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

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

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

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

Parent/Guardian Signature:

HEALTH CARE PROVIDER

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

Medical Provider Signature: _____ Date: _____

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

Provider Address: _____ Fax #: ( )

Return to:

School Nurse: _____ School: _____

Phone #: ( ) Fax: ( ) Date: