Mohonasen CENTRAL SCHOOL DISTRICT

Bradt Primary School
2719 Hamburg Street
Schenectady, NY 12303
Tel: 518/356.8400
Fax: 518/356.8404

February 14, 2025

Dear Parent/Guardian:

Our records indicate that you have a child who is eligible to enter Kindergarten in September 2025. A child is eligible if he or she will be five (5) years old on or before December 1, 2025. Registering your child for kindergarten is not only an exciting benchmark for you and your child, it is also an important step to ensure that your child is able to begin kindergarten. We would like to make this process as smooth and flexible as possible for your family.

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

1. **Daytime registration at Bradt School will be on April 22nd, (Last Name A-L), (9:00 AM-12:00) and April 29th, (Last Name M-Z), (9:00-12:00)**
2. **Evening registration will be on April 23rd, (Last Name A-L) (5:30 -7:30 PM), and April 30th, (Last Name M-Z) , (5:30-7:30 PM).** Please bring all registration materials and necessary documentation.
3. All registration packets and other documentation must be handed in during Kindergarten registration, or by an appointment with the Registrar located in the District Office. To make an appointment with the registrar, either send an email to scandee@mohonasen.org or call 518-356- 8222. Please make every effort to get registration packets completed by May 16, 2025.
4. All missing items from registration must be received by August 15th in order for your child to start school in September.

Parents who choose to not send their child to school for the 2025-26 school year, or who are planning on enrolling their child in a non-public school, are asked to notify us in writing or by calling Bradt School at 356-8401.

Once all of your paperwork has been submitted, the next step is for your child to be scheduled for kindergarten screening, which is an opportunity for us to meet your child and learn more about their developmental readiness for school. The dates of the screening will be May 14th-16th, May 19th-20th. You can sign up for a screening appointment at the evening or day registration times once all of the paperwork is received.

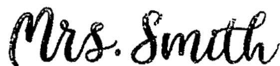
We are also hosting a Kindergarten Parent Orientation evening for parents of incoming kindergarteners on Wednesday, April 22nd, at 6:00 PM, starting in the cafeteria. You will have the opportunity to meet faculty members and learn more about the screening process and kindergarten expectations. Please mark your calendars for this night as well as the dates for in person registration and kindergarten screening.

Just to summarize the important dates:

Feb 14	*Registration packets mailed*
April 22	*Kindergarten Parent Orientation Night 6:00 PM*
April 22	*Daytime registration option (Last Name A-L) (9:00-12:00)*
April 29	*Daytime Registration option (Last Name M-Z) (9:00-12:00)*
April 23	*Evening registration option (Last Name A-L) (5:30-7:30)*
April 30	*Evening registration option (Last Name M-Z) (5:30-7:30)*
May 14-20	*Kindergarten Screening (appointments scheduled after registration packets are completed and received)*

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

In Partnership,



Mrs. Leslie A. Smith

Principal

Bradt Read Across America Month: PreK Story Time

For the month of March, Bradt Primary is opening its doors to registered incoming kindergarten students and their families for a classroom/library visit. During the visit, children and their families will join a teacher or the Principal, Mrs. Smith for a book read-aloud in a classroom or library. This is a great opportunity for your child to become familiar with the building and staff members.

Visits will take place throughout March during the school day. Spots are first come first serve and limited to 5 families in the classroom and 15 in the library. Click on the QR code below to register.

Please select an open time and put your name, email address and phone number.

If you have any additional questions contact the main office at 518.356.8400. If you have trouble accessing the sign up sheet please contact communications at communications@mohonasen.org.

Other important information:

7/8-8/1 Summer Stars Program (Registration Required)

Mohonasen Central School District
2072 Curry Road, Schenectady, New York 12303
518-356-8222 Phone 518-356-8247 Fax

To Families Registering Kindergarten Students

Refer to the following information regarding proof of residency and documents required to register. Current proof of residency if required even <u>if you have another child in the district or have registered for a preschool evaluation.</u> Incomplete packets cannot be processed. Thank you for your cooperation.

<u>Proof of Residency</u>

<u>One of the following items with your name and address, dated within the last 30 days:</u>

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

<u>License and vehicle registration with your current address.</u>

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

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

Students proof of age

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

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

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

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

OTHER MANDATORY STUDENT INFORMATION

1) **Immunization records.** ***The registration packet may not be processed without this!***
2) Physical paperwork must be submitted by September1st.
3) Custody paperwork if applicable. *If the student is not your biological child, an official court generated document that proves a permanent and total transfer of custody and control of the student to you must be provided.*
4) Child's IEP(Individual Education Plan), if applicable
5) Child's 504 plan, if applicable
6) Last report card or transcript (not applicable for Kindergarten registration)
7) Foster children, DSS-2999 form must be provided

Please complete all forms PRIOR to your appointment.
If you have any questions regarding the forms feel free to call

Incomplete packets cannot be processed

Thank you for your cooperation
Mrs. Candee, District Registrar

Residency and Registration Verification Checklist

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

Date: ________________

Student name(s): ______________________________

Parent/Guardian: ______________________________

Address: ______________________________

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

Both required License and registration ____ ____

Choose *ONE* below regarding your living situation.

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

Homeowners (1 proof required):

School taxes ____

Closing papers ____

Mortgage statement ____

Renters:

Lease ___

Name & phone number for Landlord: ________________________

If staying/living with someone else:

(both forms required)

Notarized form--homeowner ____ AND 1 proof from homeowner ____

Notarized form--parent ____ AND 1 proof from parent ____

Additional proof required(1) Parent(check off)

National grid bill ____

Cable/Internet bill ____

Insurance bill ____

Post Office change of address ____

Bank Statement ____

Paycheck ____

Other: ____

Student Information(all required)

Birth Certificate ____

Immunizations ____

Custody paperwork (if applicable) ____

Notes:

Mohonasen Central School District New Student Registration Form

*Please print ***clearly***, all linformation Is entered into the students School Tool account from this paperwork. School Year: ________________

Student Data:

Student Name as listed on birth certificate: ____________________________________

Alternate Student Name or Nickname: ____

Date of Birth: ____/____/________ Circle one: Male Female Non-Binary

Address: ____

Is this for a pre-school evaluation? YES ____ NO ____

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

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

Student lives with(check all that apply):

___Mother ___Father ___Guardian ___Step-Mother ___Step-Father

___Siblings ___Grandmother ___Grandfather ___Foster Parent (attach DSS 2999 form)

___Other ____________________

Please list all children living in the home:

Name: ________________ DOB/sex: __________ Grade: ____ School: __________

Name: ________________ DOB/sex: __________ Grade: ____ School: __________

Name: ________________ DOB/sex: __________ Grade: ____ School: __________

Name: ________________ DOB/sex: __________ Grade: ____ School: __________

Name: ________________ DOB/sex: __________ Grade: ____ School: __________

Family Data:

Parent/Guardian: ________________________ Spouse/Other: ___________________

Relationship to Child: ___________________ Relationship to Child: ______________

Address: ______________________________ Address: ________________________

_______________________________ ________________________

Cell Phone: ____________________________ Cell Phone: ______________________

Home Phone: (If there is one, if not leave blank) Home Phone: ____________________

_______________ Work phone#: __________ Work Phone: _____________________

Email Address: __________________________ Email Address: ___________________

Occupation: ____________________________ Occupation: _____________________

New Student Registration form continued

Special Needs of the Child:

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

Does your child have a 504 plan or an IEP? YES____ Circle one: IEP/504 NO____

Are there any legal or custodial restrictions? YES _____ NO _____

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

Is there any other relevant information? YES ___ NO____

*If yes, please explain: ____

____.

Previous Information that is required:

Previous address: ____

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

____

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

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

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

Parent signature: __________________________ **Date:** __________________

Office use only: Proof of Residency:

One of the following:

School Taxes/Deed/Mortgage Statement _______ Lease Agreement ______

Notarized Statement from Homeowner ______ w/ 1 proof ______

Notarized Statement from Parent _______

And at least two of the following documents:

Utility Bill ______ ______ Insurance Bill _____ Paycheck _____ Bank Statement ____

Change of Address _____ Other ___________________ Other ___________________

AND

Vehicle Registration _____ License ____ Current Address? Yes/No

Registered by: ______________ **Date:** __________ **Expected Start Date:** __________

Notes/Comment section:

Mohonasen CSD Student Housing Questionnaire

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

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

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

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

Student's name:____

Student's grade and date of birth: ______________________________

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

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

Parent/Legal Guardian name: ___________________________________

Phone number and address: ______________________________________

*Parent/Guardian signature and date:

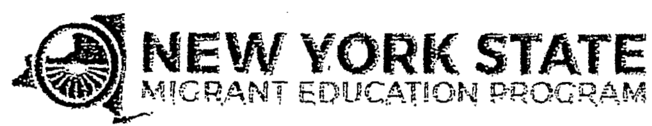
____

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

****

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

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



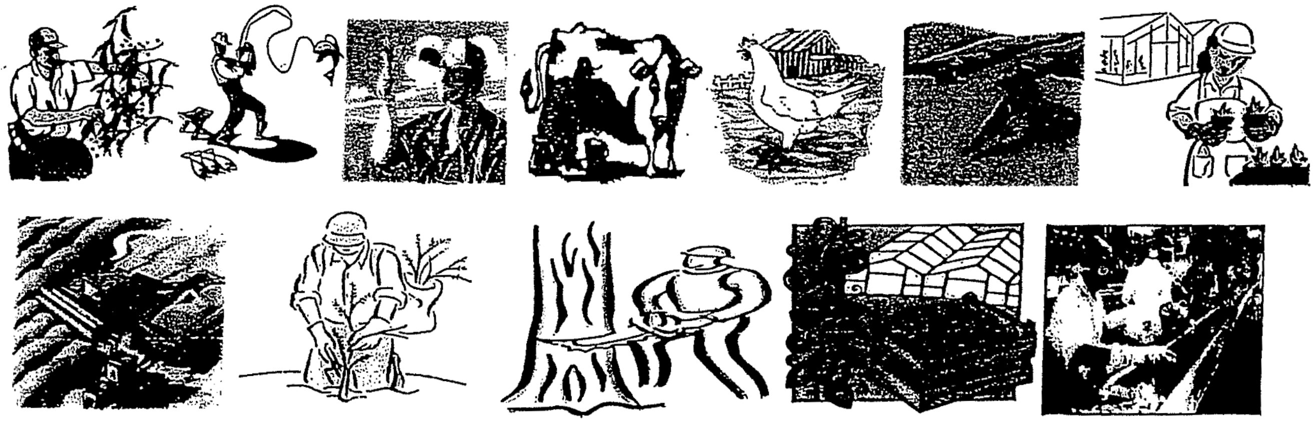
IDENTIFICATION & RECRUITMENT PARENT SURVEY

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

Please take few minutes to complete this questionnaire.

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

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



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

* Parent/Guardian Name: ________________________________

Home address: ________________________________

Telephone number: (____)-______-_______ Best time to be reached: ______ AM/PM

Previous Address: ________________________________

Student name: ______________________ Age __________ Grade________

Student name: ______________________ Age __________ Grade________

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

Mohonasen Central School District
Student Racial and Ethnic Identification Form

Student Name: ____

Date of Birth: ____________________ Grade: ____________________

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

- ☐ YES, Hispanic
- ☐ NO, not Hispanic

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

- ☐ **American Indian or Alaskan Native** – a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment
- ☐ **Asian** – a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam
- ☐ **Native Hawaiian or other Pacific Islander -** a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- ☐ **Black or African American –** a person having origins in any of the Black racial groups of Africa
- ☐ **White -** a person having origins in any of the original peoples of Europe, North Africa or the Middle East

______________________________________ ____________________

Signature of Parent/Guardian Date

Relationship to Student (please mark one below)

___ Mother ____ Father ____ Guardian ____ Other: ____________________

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:

Bradt Primary School
2719 Hamburg Street
Schenectady, NY 12303

District Name (Number) & School

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? ____________________

____________________ *Signature of Parent or of Person in Parental Relation*

Month: Day: Year: *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:

Rotterdam-Mohonasen Central School District

RESIDENCY QUESTIONNAIRE

Name of LEA: Rotterdam-Mohonasen CSD

Name of School: Bradt Elementary

Name of Student: ______________________________

Last First Middle

Gender: ☐ Male ☐ Female

Date of Birth: ____/____/____ (*Month Day Year*)

Grade: K (*preschool-12*)

ID#: ________ (*optional*)

Current Address: ______________________ Phone: ______________

Previous Address: ______________________

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 one box.*)

☐ In permanent housing (this includes apartments with a rental agreement)

☐ In a shelter

☐ With another family or other person (sometimes referred to as "doubled-up") due to a loss of housing, economic hardship, or similar reason

☐ In a hotel/motel

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

☐ Other temporary living situation (Please describe): ______________________

____

Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

____

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

____

Date

If the student is NOT living in permanent housing, please ensure that a Designation Form is completed.

Health Requirements for Students in Kindergarten

Dear Parent/Guardian,

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

Required Immunizations for Kindergarten & Grade 1

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

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

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

The best place for you to get your vaccines is your Primary care Provider. Simply Call and Schedule your appointment today. You can also call the immunization program at the Schenectady County Department of Health at 518 386-2824 ext. 1152.

Prior to entering school, all students are required to have a Physical with BMI Screening and an exam by their dentist. Any physical/dental exam done after 09/01/2025 will be accepted for school entry.

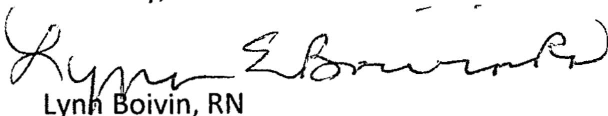
If you do not have a health care provider please make an appointment at any of the providers below.

Ellis Pediatrics
McClellan Street Campus
Phone: 347-5113

Hometown Health
1044 State Street
Phone: 370-1441

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

Sincerely,



Lynn Boivin, RN

Mohonasen Central School District
Health History for Elementary Students

Student Name ______________________ **Birthdate** _______ **Sex** ___ **Gr.**___

Please date and explain any of the following illness/conditions which have affected your child.
Please write NO if it does not apply:

Birth history: Full Term __ Preemie __ Birth weight _____ Condition at birth___________
Asthma_____ Triggers ______________________ Controlled with____________
Allergies_____ To what___________________ Controlled with____________
Insect bite sensitivity to____________________ Treatment ______________
Any known or suspected disability_________________________________
Diabetes_____ Controlled with___________________ Self administered?__________
Heart defect or condition_____________ Treatment ___________________
Seizures [date of last one and type]______________Controlled with ____________
Kidney/Bowel problems ____________________ Toileting issues___________
Neurologic Condition__________________ Autism _________Cerebral Palsy_________
Has your child been diagnosed with ADD or ADHD?___ Date_____ Doctor___________
Medication ___________________ Dose______ Frequency______________
Behavior or Emotional Problems __________________ Learning Disabilities ________
Ear Infection ~ Frequency__________ Tubes/date_____ Hearing Loss _____H.Aids ____
Speech Issues ________________________________ Therapy______________
Vision: Normal_____ Wears Glasses_______ For__________ When____________
Orthopedic condition______________________ Correction_______________
Uses: Braces____ Crutches ____ Cane _____ Walker ____ Wheelchair _____Other________
Occupational Therapy___ for_____________ Physical Therapy ___ for______________
Surgery__________________ Type and Date______________________________
Whooping Cough_____ Rheumatic Fever_____ Scarlet Fever_____ Tuberculosis_____
Mononucleosis___Pneumonia___Chicken Pox___Fifths Disease___ Hepatitis___Measles ___
Strep Throat {last occurence}________ Frequency____________
Dental condition/appliances ____
Last school attended ___________________________ Phone ______________

Medications student is currently on________________________ for____________
Is there a need to take the medication in school? Yes____ No ____

Please state below anything else the school nurse should be made aware of:

____
____
____

Pediatrician ____________________________ **Phone** _____________
Dentist ____________________________ **Phone** _____________

Parent/Guardian signature______________________________ Date __________

Mohonasen Central School District

Immunization Record

New York State Public Health Law 2164; Section 66.3

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

Gr. K-1: 5- DTaP/DTP/Tdap, 4-Polio, 2-Measles, Mumps, Rubella, 3-Hepatitis B vaccine, 2-Varicella vaccine
Gr. 2-5: 5- DTaP/DTP/Tdap, 3-Polio, 2-Measles, Mumps, Rubella, 3-Hepatitis B vaccine, 1-Varicella vaccine
Gr. 6-7: 3-DTaP/DPT/Tdap, 1-booster Tdap, 4-Polio, 2-Measles, Mumps, Rubella, 3-Hepatitis B vaccine, 2-Varicella vaccine, 1-Meningococcal vaccine
Gr. 8-12: 3-DTap/DTP/Tdap, 1-booster Tdap, 3-Polio, 2-Measles, Mumps, Rubella, 3-Hepatitis B vaccine, 1-Varicella vaccine, 1-Meningococcal vaccine

Student Name ______________________________ **GR** _____ **Date of Birth** ____________

Please indicate the **full dates** for the following immunizations:

Polio ______ ______ ______ ______ **DPT or DTaP** ______ ______ ______ ______ ______

Hepatitis B (3 series) ______ ______ ______ **or (2 dose adult series)** ______ ______

MMR * ______ ______ **Measles** *______ ______

Mumps*______ ______

Rubella*______ ______

Varivax/Varicella Vaccine* ________ ________ Titer__________ Disease______

Tdap booster________ **Meningococcal** ______ ______

*** {1st dose must be given after 1 year of age}**

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

Hib ________ ________ ________ ________ **Pneumococcal** ______ ______ ______ ______

Lead Screening _____ _____ **Hepatitis A** _____ _____

HPV _____ _____ **Influenza** (Flu) ______ ______ ______

H1N1 _____ _____ **TB Test:** Date________ Pos _____ Neg _____

Physician's Signature ______________________________ **Date** ____________

PRINT: Physician's Name____________________ **Phone** ______________ **Fax** ____________

(Physician's Stamp)

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

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

STUDENT INFORMATION

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

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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

BMI________kg/m2

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

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

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥5 μg/dL			

List Other Pertinent Medical Concerns
(e.g. concussion, mental health, one functioning organ)

☐ **System Review and Abnormal Findings Listed Below**

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

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list) ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process __**ONLY**__ **required** for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : ____________

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

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

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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

Mohonasen Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year	Sex: ☐ Male ☐ Female	Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name	Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_______________________________________ Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of ______________________ on ______________ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_______________________________________

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.