

BETHPAGE UNION FREE SCHOOL DISTRICT

David Schneider
Superintendent of Schools

10 Cherry Avenue
Bethpage, New York 11714

Phone (516) 644-4000

Fax: (516) 644-4081

www.bethpagecommunity.com

TO: _____

FROM: _____

DATE: _____

RE: REGISTRATION PACKET

REGISTRATION PACKET - RESIDENCY DETERMINATION

These instructions are intended to provide you with an understanding of Bethpage Union Free School District's (the "District") registration and enrollment process. To demonstrate that you are entitled to a tuition-free education within the District, please submit the contents of this packet and adhere to the following instructions. If you have any questions, concerns, or complaints regarding the process, please contact the District's Central Registration Office at (516) 644-4060.

The District registers its students in accordance with New York State law and regulations. Accordingly, upon request, your child shall be enrolled and begin attendance on the next school day (unless a determination of non-residency is made on the date of the request). The contents of this packet must be compiled as soon as practical, but no later than three (3) business days after the child's enrollment. The District will provide you with its residency determination, within three (3) business days of your child's enrollment. However, if you submit the contents of this packet on the third (3rd) business day after your child's enrollment, the District will provide its residency determination on the fourth (4th) business day.

You will also be required to provide a certificate of a physical examination (that is no more than one year old) conducted by a New York State licensed physician within thirty (30) days of your child's enrollment and an up-to-date certification of immunization record for your child. If such immunization records are not available at the time of enrollment, you will have fourteen (14) days to provide the necessary immunizations. If your child is transferring from another state or country and you demonstrate a good faith effort to obtain immunizations, you will have up to thirty (30) days to provide the necessary documents. Your registration/enrollment will not be delayed in the absence of these documents, however, the documents must be produced in accordance with the time frames required by law, as set forth in this paragraph.

Children entering the District who have been identified under Section 504 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education (IDEA/IDEIA) must provide a copy of their current 504 Plan or Individualized Education Program (IEP), as applicable.

The District's registration procedures are intended to make enrollment easier for parents and guardians and to ensure that only Bethpage residents remain enrolled in our schools. In accordance with law and Board policy, only *bona fide* residents of the District are entitled to attend the District's schools on a tuition-free basis. Please be advised that these registration procedures apply to all students.

PLEASE READ INSTRUCTIONS CAREFULLY

- Please complete one Registration Packet per child to be registered.
- Please print clearly and please do not fold packets.

PLEASE CALL CENTRAL REGISTRATION IF YOU HAVE ANY QUESTIONS

****PLEASE CALL MS. RENEE KATZ AT (516) 644-4060 OR EMAIL centralreg@bethpage.ws**

TO ARRANGE AN APPOINTMENT TO COME IN AND REGISTER YOUR CHILD**

OFFICE HOURS: Monday-Friday ... 8:00 AM to 3:00 PM

REGISTRATION – PROOF OF RESIDENCY*

SCHOOL YEAR 2024-2025

[] NEW ENTRANT [] RE-ENTER [] TRANSFER FROM PRIVATE/PAROCHIAL

DOES YOUR CHILD CURRENTLY HAVE AN IEP OR 504 PLAN? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE DISTRICT WITH A COPY OF THE CURRENT INDIVIDUAL EDUCATION PROGRAM/504 PLAN.

PROOF OF RESIDENCY*

Please provide the following, as applicable.
(Examples of documents are not exhaustive)

1. Evidence of Physical Presence of Parent(s)/Person(s) in Parental Relation and the Child in the District.

If You **Own**:

- ☐ Deed **or** Mortgage Statement **or** Tax Receipt

If You **Rent**:

- ☐ Deed **or** Mortgage Statement **or** Tax Receipt **or** Lease **AND**

- ☐ Third Party Statement:

- ☐ Form 1 (Owner/Landlord Affidavit) *and*
☐ Form 2 (Renter/Non Owner Affidavit)

AND

- ☐ Two other Forms of Documentation Evidencing Residency
- ☐ Motor Vehicle registration indicating address
 - ☐ Utility bill (gas, electric, water, cable)
 - ☐ Non-cellular phone bill
 - ☐ Voter's registration documents
 - ☐ Insurance bill (Homeowner's/Renter's/Auto, etc.)
 - ☐ Bank statements or check with address
 - ☐ Valid Personal Income Tax Returns
 - ☐ Employment Pay Stub
 - ☐ State, Federal, Local or other Governmental issued ID
 - ☐ Other acceptable forms of proof _____

AND

2. Proof of Parental Relation or Proof that the Child Resides with the Parent or Person in Parental Relation.

- ☐ Birth Certificate
- ☐ Proof of Emancipation
- ☐ Foster Care Documentation (DSS 2999)
- ☐ Proof that Child Resides with a Sponsor with Whom the Child has been placed by a Federal Agency

AND

- ☐ Form 3 (Parent Affidavit if Child Living with Biological/Adoptive Parent)
**If Not Living with Biological/Adoptive Parent, Request Forms 4 and 5

SCHOOL

GRADE

DOB

LAST NAME

FIRST NAME

AND

- ☐ Proof of Your Identity
 - ☐ Driver's License
 - ☐ Non-Driver's Photo ID
 - ☐ Passport

AND

3. Proof of Student's Age

- A. ☐ Certified Transcript of a Birth Certificate

OR

IF A is NOT AVAILABLE then:

- B. ☐ Record of Baptism including Date of Birth
- C. ☐ Passport (Including foreign Passport)
- D. ☐ Other Documentary or Recorded Evidence in Existence two (2) years or more (Except an Affidavit of Age)
 - ☐ Official Driver's License
 - ☐ State or Other Government Issued Identification
 - ☐ School Photo Identification with Date of Birth
 - ☐ Consulate Identification Card
 - ☐ Military Dependent Identification Card
 - ☐ Documents issued by Federal, State, or local agencies (e.g., local social service agency, Federal Office of Refugee Resettlement)
 - ☐ Court orders or other court-issued documents
 - ☐ Native American Tribal Document
 - ☐ Records From Non-Profit International Aid Agencies and Voluntary Agencies
 - ☐ Other acceptable forms of proof _____

*All forms of documentation should be as current as possible. The District reserves the right to differentiate the weight given to each piece of documentation as it determines is necessary. Please submit documentation that is most supportive of your assertion of residency in the District. The District will view all documentation produced as a whole.

PARENT NOTIFIED ON _____ **PARENT SIGNATURE** _____

BETHPAGE UNION FREE SCHOOL DISTRICT
Bethpage, New York 11714

STUDENT INFORMATION

(PRINT LEGIBLY OR TYPE)

STUDENT INFORMATION		GENDER (M/F) _____	DOB _____	
LAST NAME	FIRST NAME	MIDDLE	SUFFIX (Jr., Sr., I, II, III, IV)	Nickname

PERSON IN PARENTAL/GUARDIAN RELATIONSHIP IN HOUSEHOLD			
RELATIONSHIP _____		GENDER (M/F) _____	
LAST NAME	FIRST NAME	MIDDLE	
CELL PHONE	WORK PHONE	E-MAIL	PREFERRED LANGUAGE

PERSON IN PARENTAL/GUARDIAN RELATIONSHIP IN HOUSEHOLD			
RELATIONSHIP _____		GENDER (M/F) _____	
LAST NAME	FIRST NAME	MIDDLE	
CELL PHONE	WORK PHONE	E-MAIL	PREFERRED LANGUAGE

HOUSEHOLD INFORMATION (RESIDENCE):		
HOME PHONE	HOUSE # / STREET	TOWN/ZIP

PREVIOUS ADDRESS (RESIDENCE):	
HOUSE # / STREET	TOWN/ZIP

OTHER CHILDREN AT SAME ADDRESS (UNDER 21 YEARS OF AGE)						
LAST NAME	FIRST NAME	DOB	GENDER	SCHOOL	GRADE	RELATIONSHIP

ALL OTHER PERSONS AT THIS RESIDENCE INCLUDING NON-FAMILY RESIDENTS:				
LAST NAME	FIRST NAME	AGE	RELATIONSHIP	SCHOOL/PLACE OF EMPLOYMENT



Lissette Colón-Collins, Assistant Commissioner

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
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HOME LANGUAGE CODE

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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?	☐ Parent 1	☐ Parent 2	_____
		specify	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	
10 a. Has your child ever been <u>referred</u> for a special education evaluation in the past? ☐ No ☐ Yes* *Please complete 10b below	
10. b. <u>*If referred for an evaluation</u> , has your child ever <u>received</u> 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)	
10. c. 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

Relationship to student: ☐ Mother ☐ Father ☐ Other: _____

Month: _____ Day: _____ Year: _____
Date

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: _____ _____ _____	

ENROLLMENT FORM – RESIDENCY QUESTIONNAIRE

Name of LEA: BETHPAGE UNION FREE SCHOOL DISTRICT

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth ____/____/____ Grade: ____ ID #: ____
Month Day Year

Address: _____ Phone: _____

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 a shelter
- ☐ With another family or other person because of loss of housing or 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

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, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled. After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

****If you have any questions, concerns or comments please contact the District's Homeless Liaison,
Thomas Kenny at 516-644-4120**

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David Schneider
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Bethpage, New York 11714

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FORM 1

OWNER/LANDLORD AFFIDAVIT

*** NOTE: The District may place greater weight on sworn statements regarding your residency within the District. However, you are not required to submit a sworn statement. If you do not wish to submit a sworn statement, please complete the subsequent form entitled Owner/Landlord Statement. If this form is not applicable to you, please write "N/A" and put a line through it.**

1. I/we _____, being duly sworn, deposes and says under the penalty of
Name(s)
perjury that I/We am/are the Legal owner(s) of the following premises: (Please attach proof of ownership)

Full Address

Section # _____ Lot # _____ Block #

2. To the best of my knowledge, the above mentioned property is the sole and only residence with a starting date of _____

Name of Parent/Guardian

Name of Child(ren)

3. The following names include ALL other persons living at this address and their relationship to child(ren):

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

4. I understand that this statement is being made UNDER THE PENALTIES OF PERJURY, in order that _____ may be admitted to the schools of the Bethpage Union Free School District as a District Resident(s). I understand that the Bethpage Union Free School District will rely on the representations herein and I further understand that if the aforementioned child(ren) is/are found not to be a legitimate resident(s) of the Bethpage Union Free School District, that the child(ren) will be discharged and I agree to bear legal responsibility for any and all costs including but not limited to the cost of the school district's tuition, costs associated with transportation, investigating and excluding non-residents, and reasonable attorney fees, retroactive to the first day of admission. I further understand that the filing of a false instrument and the theft of services from a governmental agency such as a school district are crimes punishable under New York State Law. I further acknowledge that making false statements in this affidavit may subject me to criminal prosecution. Any person or persons, in addition to the parents or guardians, who provide false evidence of residence, will also be prosecuted and will bear the legal responsibility for any and all costs associated with the false production of evidence.

(Initial Here)

5. I have been informed that the school district may conduct an investigation for purposes of residency verification, which may include home visits.

Date _____ Signature of Owner(s)/Landlord(s) _____

Print Name _____

Sworn to me before this
_____ day of _____, 20 _____

Notary Public _____

Lease Presented: [] Yes [] No

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FORM 2

RENTER/NON OWNER AFFIDAVIT*

*** NOTE: The District may place greater weight on sworn statements regarding your residency within the District. However, you are not required to submit a sworn statement. If you do not wish to submit a sworn statement, please complete the subsequent form entitled Renter/Non Owner Statement. If this form is not applicable to you, please write "N/A" and put a line through it.**

1. I/we _____, being duly sworn, deposes and says under the penalty of
Name(s)
perjury that I/We am/are the Renter(s) of the following premises (state address, and specify the exact nature of the space, i.e., basement apartment, second floor apartment, number of rooms).

Full Address

2. I/we, _____
Name(s) of Parent/Person in Parental Relation
And my/our child/ward _____
(Name of student)
reside at the above address, which is my/our actual and only permanent residence. My/our child/ward lives with me/us at said address as his/her actual and only permanent residence.

3. The following names include ALL other persons living at this address and their relationship to child(ren):

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 1. _____ |
| 3. _____ | 2. _____ |
| 4. _____ | 3. _____ |

4. I understand that this statement is being made UNDER THE PENALTIES OF PERJURY, in order that _____ may be admitted to the schools of the Bethpage Union Free School District as a District Resident(s). I understand that the Bethpage Union Free School District will rely on the representations herein and I further understand that if the aforementioned child(ren) is/are found not to be a legitimate resident(s) of the Bethpage Union Free School District, that the child(ren) will be discharged and I agree to bear legal responsibility for any and all costs including but not limited to the cost of the school district's tuition, costs associated with transportation, investigating and excluding non-residents, and reasonable attorney fees, retroactive to the first day of admission. I further understand that the filing of a false instrument and the theft of services from a governmental agency such as a school district are crimes punishable under New York State Law. I further acknowledge that making false statements in this affidavit may subject me to criminal prosecution. Any person or persons, in addition to the parents or guardians, who provide false evidence of residence, will also be prosecuted and will bear the legal responsibility for any and all costs associated with the false production of evidence.

(Initial Here)

5. I have been informed that the school district may conduct an investigation for purposes of residency verification, which may include home visits.

Date _____ Signature of Renter(s) _____

Print Name _____

Sworn to me before this
_____ day of _____, 20 _____

Notary Public _____

Lease Presented: [] Yes [] No

BETHPAGE UNION FREE SCHOOL DISTRICT

David Schneider
Superintendent of Schools

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Bethpage, New York 11714

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FORM 3

PARENT AFFIDAVIT*

(TO BE USED WHEN CHILD IS LIVING WITH A BIOLOGICAL/ADOPTIVE PARENT AND OTHER ACCEPTABLE PROOF IS NOT PROVIDED)

* This affidavit is not required but is one means that may be used to document that you are the child(ren)'s biological or adoptive parent. If this form is not applicable to you, please write "N/A" and put a line through it.

STATE OF NEW YORK)
) ss:
COUNTY OF _____)

_____, being duly sworn, deposes and says:

1. I live at _____.
(Full Address of Biological/Adoptive Parent)

2. I am the biological/adoptive parent of:

_____ (Full Name of Child)	_____ (Date of Birth)	_____ (M/F)
_____ (Full Name of Child)	_____ (Date of Birth)	_____ (M/F)
_____ (Full Name of Child)	_____ (Date of Birth)	_____ (M/F)

3. I understand that this statement is being made UNDER THE PENALTIES OF PERJURY, in order that _____ may be admitted to the schools of the Bethpage Union Free School District as a District Resident(s). I understand that the Bethpage Union Free School District will rely on the representations herein and I further understand that if the aforementioned child(ren) is/are found not to be a legitimate resident(s) of the Bethpage Union Free School District, that the child(ren) will be discharged and I agree to bear legal responsibility for any and all costs, including but not limited to the cost of the school district's tuition, costs associated with transportation, investigating and excluding non-residents, and reasonable attorney fees, retroactive to the first day of admission. I further understand that the filing of a false instrument and the theft of services from a governmental agency such as a school district are crimes punishable under New York State Law. I further acknowledge that making false statements in this affidavit may subject me to criminal prosecution. Any person or persons, in addition to the parents or guardians, who provide false evidence of residence, will also be prosecuted and will bear the legal responsibility for any and all costs associated with the false production of evidence.

(Initial Here)

(SIGNATURE(S) OF PARENT(S))

Sworn to me before this
_____ day of _____, 20 _____

Notary Public _____

DECLARATION OF INFORMATION
(PRINT LEGIBLY OR TYPE)

CHILD'S NAME (Last, First)

GRADE

ADDRESS

PHONE #

I CERTIFY THAT THE INFORMATION WHICH I HAVE SUPPLIED IN THIS PACKET IS TRUE TO MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT FILING A FALSE INSTRUMENT AND THE THEFT OF SERVICES FROM A GOVERNMENTAL AGENCY SUCH AS A SCHOOL DISTRICT IS A PUNISHABLE OFFENSE UNDER THE LAW AND MAY SUBJECT ME TO CRIMINAL PROSECUTION. I UNDERSTAND THAT THE DISTRICT MAY CONDUCT AN INVESTIGATION FOR THE PURPOSE OF CONFIRMING RESIDENCY WHICH MAY INCLUDE WITHOUT LIMITATION HOME VISITS. I UNDERSTAND THAT MY REGISTRATION OF A CHILD WHO IS NOT A BONA FIDE RESIDENT OF THE BETHPAGE UNION FREE SCHOOL DISTRICT WILL RESULT IN THE CHILD'S EXCLUSION FROM THE DISTRICT'S SCHOOLS AND I AGREE TO BEAR LEGAL RESPONSIBILITY FOR ANY AND ALL COSTS, INCLUDING BUT NOT LIMITED TO TUITION EXPENSES, TRANSPORTATION EXPENSES, INVESTIGATION AND EXCLUSION COSTS AND ATTORNEY'S FEES, RETROACTIVE TO THE FIRST DAY OF ENROLLMENT. ANY PERSON OR PERSONS, IN ADDITION TO THE PARENTS OR GUARDIANS, WHO PROVIDED FALSE EVIDENCE OF RESIDENCE, WILL ALSO BE PROSECUTED AND WILL BEAR THE LEGAL RESPONSIBILITY FOR ANY AND ALL COSTS ASSOCIATED WITH THE FALSE PRODUCTION OF EVIDENCE. I FURTHER AGREE TO PROMPTLY NOTIFY THE SCHOOL REGARDING ALL CHANGES IN THE RESIDENCY OR THE CUSTODY OF THIS CHILD.

SIGNED _____

DATE _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY 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 ☐ Type 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	Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB-PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre-K & K			Date	
☐ Test Done ☐ Lead Elevated ≥ 5 $\mu\text{g/dL}$				
☐ 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	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 Required for boys 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 <u>ONLY</u> 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, prosthetic, 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 NYSIS				
HEALTH CARE PROVIDER				
Medical Provider Signature:				
Provider Name: <i>(please print)</i>				
Provider Address:				
Phone:		Fax:		
Please Return This Form To Your Child's School When Entirely Completed.				

BETHPAGE UNION FREE SCHOOL DISTRICT

Bethpage, New York 11714

IMMUNIZATION RECORD

****YOU ARE REQUIRED TO SUBMIT AN UP-TO-DATE CERTIFICATE OF IMMUNIZATION RECORD FOR YOUR CHILD. IF SUCH IMMUNIZATION RECORDS ARE UNAVAILABLE AT THE TIME OF YOUR CHILD'S ENROLLMENT, YOU WILL HAVE FOURTEEN (14) DAYS TO PROVIDE THE NECESSARY IMMUNIZATIONS. IF YOUR CHILD IS TRANSFERRING FROM ANOTHER STATE OR COUNTRY AND YOU DEMONSTRATE A GOOD FAITH EFFORT TO OBTAIN IMMUNIZATIONS, YOU WILL HAVE UP TO THIRTY (30) DAYS TO PROVIDE THE NECESSARY DOCUMENTS.**

Student Name _____ Date of Birth: _____

IMMUNIZATIONS: (Give full dates)

Measles: _____ (History of disease : _____) (Presence of antibody: _____)

Rubella: _____ (History of disease : _____) (Presence of antibody: _____)

Mumps: _____ (History of disease : _____) (Presence of antibody: _____)

MMR: _____

DPT: _____

DTaP: _____

DT/Td: _____

Tdap: _____

Polio:

OPV _____

IPV _____

Hib: _____

Hep B: _____

Varicella: _____ (History of disease : _____) (Presence of antibody: _____)

Hepatitis A _____

Meningitis Vaccine _____

Other (Specify): _____

**Issuing Officials Signature: _____

Name Printed: (use stamp) _____

Title: _____

Date: _____

**NYS recognized providers: MD, DO, NP, PA

Dental Health Certificate - Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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, as 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 Person in Parental Relation (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. <table border="0" style="width: 100%;"><tr><td style="width: 50%; text-align: center;">Dentist's/Dental Hygienist's name address (please print or stamp)</td><td style="width: 50%; text-align: center;">Dentist's/Dental Hygienist's Signature</td></tr><tr><td style="height: 40px;"></td><td></td></tr></table>		Dentist's/Dental Hygienist's name address (please print or stamp)	Dentist's/Dental Hygienist's Signature			
Dentist's/Dental Hygienist's name 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): _____						
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.						

Name: _____

DOB: _____

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 auto-injector, 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: _____

BETHPAGE UNION FREE SCHOOL DISTRICT
Bethpage, New York 11714

PARENT HEALTH QUESTIONNAIRE

***Please complete this questionnaire in order to inform the District of your child's medical needs.**

Child's Name: _____ Birth Date: ____/____/____ Sex: M or F (circle one)

Mother's Name: _____ Father's Name: _____

Who is the Legal Guardian? _____

ALLERGIES AND ASTHMA

Please list and describe allergies or reactions to:

Medicines/Drugs: _____

Foods/Plants/Others: _____

Insect bites or stings (i.e. Bee, Wasp): _____

Does your child require any specific treatment in the event of an allergic reaction (i.e. Allergy Shots)? _____

Please explain any other recommended treatment in the event of an allergic reaction. _____

Has your child been diagnosed with asthma? _____ Yes _____ No

If yes, what specific treatment or medicine has been prescribed? _____

MEDICATIONS

Is your child currently prescribed daily medication? _____

If yes, please list all prescribed daily medication. _____

What medications are given frequently, but not daily? _____

INJURIES, ILLNESSES, SURGERIES

Please list any severe injuries, illnesses, or surgeries:

<u>Injuries, Illnesses, Surgeries</u>	<u>Age of Child</u>	<u>If Hospitalized (check here)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMERGENCY CONTACT INFORMATION

PLEASE LIST PEOPLE TO CONTACT IF THE SCHOOL IS UNABLE TO REACH A PARENT

EMERGENCY CONTACT:				
LAST NAME / FIRST NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE

EMERGENCY CONTACT:				
LAST NAME / FIRST NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE

EMERGENCY CONTACT:				
LAST NAME / FIRST NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE

ADDITIONAL INFORMATION

How physically active would you consider your child? _____

Please provide any additional comments or concerns regarding your child that you would like the District to be aware of.
(i.e. Your child's health, wellbeing, development, behavior, family or personal life)

Completed by: _____ Date: ____/____/____

Relationship to Child: _____

I would like a conference with the school nurse: ____ YES ____ NO