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

REGISTRATION CHECKLIST FOR PARENTS

☐ Residency Questionnaire (to determine homelessness)
☐ Student Registration Data Sheets
☐ **Original** Birth Certificate
☐ Photo ID of Parent/Legal Guardian
☐ Passport *(if available)*
☐ Residency information (lease, mortgage, affidavit of landlord)
☐ Utility bills
☐ Immunizations
☐ Physical/Entering Health Forms
☐ Home Language Questionnaire
☐ Request for Records
☐ Student’s last Report Card *(when available)*
☐ IEP/504 Accommodation Plan *(if applicable)*
☐ Care/Custody Control *(if applicable)*
☐ Foster Child Data Sheet with DS29-99 Form *(Questions 2 and 5 ONLY to be answered by parents)*
☐ KI Release
☐ Transportation Form (Transportation will not begin until registration at the building is complete)
☐ Food Services
☐ Media Use Form
☐ Computer/Internet Use Forms
**YOUR CHILD MUST REACH AGE 5 ON OR BEFORE DEC. 1ST**

<table>
<thead>
<tr>
<th>Student Name: ____________________________</th>
<th>Student ID #: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade: ___________________________</td>
<td>Homeroom: ___________________________</td>
</tr>
</tbody>
</table>

### Registration Process & Checklist

1. Secretary gives/mails registration packet to new registrant.  
2. Secretary schedules an appointment, if appropriate.  
3. Registrant completes and returns the packet to the secretary.  
   a. Residency Questionnaire (to determine homelessness)  
   b. Student Registration Data Sheet  
   c. Home Language Questionnaire  
   d. Student Emergency Contact Form  
   e. **Original** Birth Certificate  
   f. Photo ID of Parent/Legal Guardian  
   g. Student’s last Report Card (when available)  
   h. Passport (if available)  
4. Secretary reviews packet for:  
   a. Completeness  
   b. Proof of Residency  
   c. Custody/Proof of Guardianship  
   d. School Records  
   e. Signed Releases:  
      - Medication Form (if appropriate)  
      - School District/Media Permission Form  
      - Home Language Questionnaire Form  
5. Nurse reviews medical records and immunization form.
Public Health Law provides that no school shall allow a child to attend for more than 14 days without a proper certificate of immunization. However, when a student is transferring from another country, a principal or other designee may allow that child to attend school for up to 30 days if there is evidence of a good faith effort to obtain immunizations or proof of past immunization via serologic testing.

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

7. Registration materials returned to the secretary for:
   a. Data entry into Student Information System
      1. After Student ID Number is generated by S.I.S., enter The Student ID # on registration form.
   b. Fax Transportation and Food Service data sheets to the Transportation and Food Service Departments with all student Demographic data completed.
      1. Transportation Department returns the data sheet with bus information by fax to the secretary.
   c. Secretary sends copies of verification of residency forms to Gisele Staino at District Office.

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

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

Special Alerts: Any of the following:

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

*Sections 2 and 5 ONLY to be completed by parent

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

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

NAME OF SCHOOL: ________________________________

NAME OF STUDENT: ____________________________________________

DOB: _______________       GRADE: ______________________

STUDENT ID: ______________________       SCHOOL ATTENDING: ______________

DATE WHEN STUDENT BECAME HOMELESS: __________________________

DISTRICT ATTENDING WHEN MADE HOMELESS: _______________________

1. IS YOUR CURRENT LIVING ARRANGEMENT TEMPORARY ____ YES ____ NO

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

IF YOU ANSWERED NO YOU MAY STOP HERE.

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

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

___IN SHELTER___WITH RELATIVE ___IN PLACE NOT DESIGNED FOR ORDINARY

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

OTHER (SPECIFY) ____________________________________________

Name of Legal Guardian _______________________________________________________________________

Signature of Parent or Guardian: _________________________________________________________________

Address: ___________________________________________________________________________________

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

NCLB requirement/ Mc Kinney Vento Act 42 USC 11435

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

The Lakeland Central School District requires proof of residency and may make reasonable inquiry to verify residency and eligibility for admission to its schools.

To verify residency at the time of registration the following are required:

A. For Homeowners - You must present three (3) documents, as follows:

Real property tax receipt or signed closing statement from Attorney and deed (including Westchester County or Putnam County Recording Cover Sheet)

AND

Two (2) of the following current documents in the Homeowner’s name:

- Mortgage Statement
- Utility bill
- Fuel Oil bill
- Cable TV bill
- Driver’s License, Learner’s Permit, Non-Driver ID

Property Insurance Certificate
Voter Registration Card
Recent W2 Form
Library Card

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

B. For Renters - You must present four (4) documents, as follows:

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

AND

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

AND

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

- Utility bill
- Fuel Oil bill
- Cable TV bill
- DSS Budget Sheet
- Library Card
- Driver’s License, Learner’s Permit, Non-Driver ID

- Property Insurance Certificate
- Voter Registration Card
- Recent W2 Form
- Letters from Agencies or caseworkers
- Section 8 or Municipal Housing Statement
Note: Documents with only a P.O. Box address will not be accepted.

C. For parents/students who reside with a family member/friend, you must present five (5) documents, as follows:
   A Completed, Signed and Notarized Affidavit of Property Owner/Landlord (LCSD Form)

   AND

   Two (2) documents verifying the residency of the family member/friend (see above for Homeowners and Renters).

   AND

   Two (2) of the following documents in the Parents’ name:

   Utility bill       Property Insurance Certificate
   Fuel Oil bill     Voter Registration Card
   Cable TV bill     W2 Form
   Section 8 or Municipal Housing Statement
   DSS Budget Sheet  Letters from Agencies or caseworkers
   Library Card
   Driver’s License, Learner’s Permit, Non-Driver ID
   Government Agency Documents (food stamps, medical cards, DMV change of address)

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

We do not accept the following for proof of residency: checkbook, bank statement, credit card statement, car insurance statement/card, cellular phone or telephone bills, car loan statements.
LAKELAND

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

STUDENT REGISTRATION DATA SHEET

This section to be filled out by parent/guardian

YOU MUST COMPLETE ALL INFORMATION ON THIS FORM AND PROVIDE ALL DOCUMENTS FOR YOUR CHILD’S REGISTRATION TO BE PROCESSED. IF YOU SHOULD HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO ASK. FAILURE TO COMPLETE THE FORM OR PROVIDE INFORMATION WILL DELAY THE REGISTRATION OF YOUR CHILD.

Student’s Name: First __________________ Middle ________________ Last ____________________

Address: House Number and Street ____________________________________________________________

City/Town/State/Zip Code _________________________________________________________

Telephone Number _________________________

Information about Student:

Date of Birth ____________________ Place of Birth (City, State, Country) _____________________

If Birthplace is outside of US, enter date student entered the US _____________________________

Gender _____

Both sections A and B must be completed:

A. Is this student Hispanic or Latino? (Choose only one)

☐ No, not Hispanic or Latino
☐ Yes, Hispanic or Latino

B. Is this student: (Choose one or more. You must select at least one.)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

Dominant Language _______________________

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

☐ Custodial Parent (Parent Student resides with)
☐ Legal Guardian (Guardianship Papers are Required)
☐ Foster Family (Foster Child Data Sheet is Required)
☐ Emancipated (Order of Emancipation or Affidavit of Emancipation is Required)
☐ Other (Must submit Completed and Notarized Affidavits of Responsibility)

Father’s Name: First ____________________________  Last ____________________________________
Father’s Address: _______________________________________________________________________
Father’s Telephone No. (Day)_____________________ (Night) _____________________________
Cell Phone _____________________

Mother’s Name: First ___________________________  Last _____________________________________
Mother’s Address: (If different from above) ___________________________________________________
Mother’s Telephone No. (Day)_____________________ (Night) _____________________________
Cell Phone _____________________

If Student lives with someone other than a Parent:

Guardian’s Name: First ________________________  Last _____________________________________
Guardian’s Address: _____________________________________________________________________
Guardian’s Telephone No. (Day) ____________________________  (Night) ____________________________  
Cell Phone __________________________

Emergency Contact Name ____________________________  Telephone No. ____________________________

Physician Name: ____________________________  Telephone No. ____________________________

Previous School(s) Attend: Please provide Names of Schools, Addresses and Telephone Numbers

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

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

Other Children in the Household:

<table>
<thead>
<tr>
<th>Name</th>
<th>Birthdate</th>
<th>Relationship</th>
<th>School of Attendance</th>
<th>Grade</th>
</tr>
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</table>

**NOTE: REGISTRATION GENERALLY TAKES UP TO THREE (3) SCHOOL DAYS DEPENDING UPON THE REGISTRATION MATERIALS PROVIDED.**

Parent/Guardian

Initial after reading
1. I understand the submission of this document does not guarantee registration of my child in the Lakeland Central School District.

2. I understand that the District may verify all of the information provided, including telephone calls and site visits.

3. I understand that if I change my place of residence or any information provided above, i.e., telephone numbers, I must notify school personnel immediately and fill out appropriate form.

4. I affirm that the information given is complete and accurate. I understand that if I have provided false information or misrepresentation of information regarding residence, it may be grounds for exclusion of the student. In addition, I may be liable for the costs of educating my child and may be subject to civil or criminal prosecution.

____________________  ________________
PARENT/GUARDIAN SIGNATURE           DATE
Student Name:_____________________________  DOB: ___________  ID# ____________

FOR SCHOOL OFFICE USE ONLY:

Start Date: __________________________      First Time Registrant  ______
Re-Registrant  ______

SCHOOL

RESIDENCY INFORMATION (All Information must be Current - within the last 30 days)

HOMEOWNER

RENTER

EXCEPTION CODE (If Applicable)

ELL  SE  FOSTER TUITION  OUT OF DISTRICT PLACEMENT

HOMELESS  SSI  MEDICAID  SOCIAL SECURITY  EMPLOYEE TUITION

MEDICAL INFORMATION: Current Immunization and Medical Examination Information must be received and verified by the School Nurse prior to request for Student Identification Number. The School Nurse must sign below to confirm verification.

________________________________________       _________________
School Nurse       Date

SCHOOL OFFICE PERSONNEL MUST SIGN BELOW TO VERIFY THAT THEY HAVE CONFIRMED ALL INFORMATION GIVEN BY THE PARENT/GUARDIAN REGARDING THE STUDENT AND RESIDENCY

________________________________________       _________________
School Office       Date

________________________________________       _________________
School Counselor       Date

________________________________________       _________________
School Principal       Date

REVISED 01/2015
AFFIDAVIT OF PROPERTY OWNER/LANDLORD  
IN SUPPORT OF ADMISSION TO  
LAKELAND CENTRAL SCHOOL DISTRICT

STATE OF NEW YORK  )
COUNTY OF  )

I, ______________________________________________________, a property owner (Name of Property Owner/Landlord or Property Manager or manager/agent of the dwelling located at ________________________________ (Street #, Address, City, State, Zip)
___________________________________________, in the Town/Village of ________________ hereby certify that I am renting space in this dwelling on a ____________ to _____________ basis (Week/Month/Year) beginning on ______________________. (Date)

The following persons are identified as tenants having the right to be occupants in the dwelling:

• Maternal Parent/Guardian: __________________________________________
• Paternal Parent/Guardian: __________________________________________

Name of Child(ren) in Application for Admission:

Last: ______________________ First: _______________________ MI: _______ and Last: ______________________ First: _______________________ MI: _______

List all other persons residing in the dwelling:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
Is this a multiple dwelling? Yes _____ No _____

Is the payment of Electric Utility Bill included in rent: Yes _____ No _____
If Yes, a copy of the “mutually acceptable written agreement” for shared meter usage must be submitted in accordance with Public Service Law §52, Part 2(b)(i).

NOTE: THE DISTRICT RESERVES THE RIGHT TO CONTACT THE APPROPRIATE MUNICIPALITY TO VERIFY THAT THE USE OF THE PREMISES IS IN COMPLIANCE WITH LOCAL LAWS AND CODES.

As property owner/landlord, I CERTIFY that I will notify the Lakeland Central School District Superintendent’s Office, 1086 East Main Street, Shrub Oak, New York 10588, within 30 days of termination of this tenancy.

I CERTIFY that the information provided on this form is true and correct and that the statements made herein are being made under the penalties of perjury, knowing that the Lakeland Central School District will rely upon them in determining whether the above-named child(ren) will be admitted to its school system. I understand that in the event the information contained in this affidavit is determined to be inaccurate or false, in whole or in part, the District may commence legal proceedings against me personally to collect the costs of educating such child(ren) and/or seek criminal action against me for falsifying business records and/or filing a false instrument.¹

____________________________________  ______________________________
(Signature of Property Owner/Landlord)    (Print Name & Title)

______________________________________________________________________________
Property Owner/Landlord Address and Telephone #

Sworn to before me this _____
__ day of ________________, 20___    _______________________________ Notary Public

¹ Penal Law §175.05 (Falsifying Business Records in the Second Degree - Class A Misdemeanor.
Penal Law §175.20 (Tampering with Public Records in the Second Degree - Class A. Misdemeanor.
Penal Law §175.25 (Tampering with Public Records in the First Degree - Class D Felony.
Penal Law §175.30 (Offering a False Instrument for Filing in the Second Degree) - Class A Misdemeanor.
Penal Law §175.35 (Offering a False Instrument for Filing in the First Degree) - Class E Felony.
To: Parent of New Entrants

From: Office of Pupil Personnel Services

Re: New York State Law and District Policy Regarding Immunizations and Physical Examinations for New Entrants to the Lakeland School District

New York State Education Law and New York State Public Health Law require that all new entering students, UPK, Grade K-12, be properly and completely immunized in accordance with the law at the time of admission to school.  


Proof of the child having received all of the required immunizations is to be submitted to the school upon admission. Said statement of proof must include dates of the immunizations and must be signed and stamped by the student’s medical provider.

Please note that a child should be considered in compliance with school immunization requirements and should remain in school, if he or she has received at least one dose of each of the required vaccines and has appointments to return to his health care provider for the remainder of the required immunizations.

New York State Public Health Law provides that no school shall allow a child to attend for more than 14 days without a proper certificate of immunization. However, when a student is transferring from another country, public health law states that a principal or other designee may allow that child to attend school for up to 30 days if there is evidence of a good faith effort to obtain immunizations or proof of past immunization via serologic testing.

The law also states that each child enrolled in the public school must have a satisfactory physical examination upon the child’s entrance into such school. Written evidence of the child having the required physical examination by a licensed medical provider must be submitted within thirty (30) days of the date of entrance. A completed physical examination form signed and dated by a licensed physician within one year prior to the child’s entrance date into school will be accepted and will satisfy this requirement. Students who do not return evidence of a physical examination will have an exam scheduled with our school doctor.

Lakeland Board of Education Policy #5141.3 calls for the adherence to, and the enforcement of, the Education Law and Public Health Law on the matter of required immunizations and required physical examinations.

Should there be any questions or assistance needed, please contact the Registered Nurse in your child’s school or this office.

R-2
The law also states that each child enrolled in the public school must have a satisfactory physical examination upon the child’s entrance into such school. Written evidence of the child having the required physical examination by a licensed medical provider must be submitted within thirty (30) days of the date of entrance. A completed physical examination form signed and dated by a licensed physician within one year prior to the child’s entrance date into school will be accepted and will satisfy this requirement. Students who do not return evidence of a physical examination will have an exam scheduled with our school doctor.

**Tuberculosis screening**

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

Lakeland Board of Education Policy #5141.3 calls for the adherence to, and the enforcement of, the Education Law and Public Health Law on the matter of required immunizations and required physical examinations.

Should there be any questions or assistance needed, please contact the Registered Nurse in your child’s school or this office.

R-2
### 2016-17 School Year

**New York State Immunization Requirements for School Entrance/Attendance**

**NOTES:**
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades Pre-k through 8, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: intervals between doses of polio vaccine need to be reviewed only for grades prekindergarten, kindergarten, 1, 2, 6, 7 and 8.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 9 through 12. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

**Dose requirements MUST be read with the footnotes of this schedule.**

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Prekindergarten (Day Care, Head Start, Nursery or Pre-k)</th>
<th>Kindergarten and Grades 1 and 2</th>
<th>Grades 3, 4 and 5</th>
<th>Grades 6, 7 and 8</th>
<th>Grades 9, 10, 11 and 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap)²</td>
<td>4 doses</td>
<td>5 doses or 4 doses if the 4th dose was received at 4 years of age or older or 3 doses if aged 7 years or older and the series was started at 1 year of age or older</td>
<td>3 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)²</td>
<td>Not applicable</td>
<td></td>
<td></td>
<td>1 dose</td>
<td></td>
</tr>
<tr>
<td>Polio vaccine (IPV/OPV)⁴</td>
<td>3 doses</td>
<td>4 doses or 3 doses if the 3rd dose was received at 4 years of age or older</td>
<td>3 doses</td>
<td>4 doses or 3 doses if the 3rd dose was received at 4 years of age or older</td>
<td>3 doses</td>
</tr>
<tr>
<td>Measles, Mumps and Rubella vaccine (MMR)⁵</td>
<td>1 dose</td>
<td></td>
<td></td>
<td>2 doses</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B vaccine⁸</td>
<td>3 doses</td>
<td></td>
<td></td>
<td>3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years of age</td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox) vaccine⁷</td>
<td>1 dose</td>
<td>2 doses</td>
<td>1 dose</td>
<td>2 doses</td>
<td>1 dose</td>
</tr>
<tr>
<td>Meningococcal conjugate vaccine (MenACWY)⁹</td>
<td>Not applicable</td>
<td></td>
<td></td>
<td>By Grade 7: 1 dose</td>
<td>Grade 12: 2 doses or 1 dose if the dose was received at 16 years of age or older</td>
</tr>
<tr>
<td>Haemophilus influenzae type b conjugate vaccine (Hib)⁸</td>
<td>1 to 4 doses</td>
<td></td>
<td></td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate vaccine (PCV)⁰</td>
<td>1 to 4 doses</td>
<td></td>
<td></td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>
1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at ages 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years of age or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday.
   b. If the fourth dose of DTaP was administered at age 4 years or older, the fifth (booster) dose of DTaP vaccine is not required.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children ages 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. A Tdap vaccine (or incorrectly administered DTaP vaccine) received at 7 years or age or older will meet the 6th grade Tdap requirement.
   e. For children 7 years of age or older who received the first dose on or after their first birthday, the immunization requirement is 3 doses. If the first dose was received before their first birthday, then 4 doses are required.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
   a. Students 11 years of age or older entering grades 6 through 12 are required to have one dose of Tdap. A dose received at 7 years of age or older will meet this requirement.
   b. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years of age.

4. Poliovirus vaccine (IPV/OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at ages 2 months, 4 months and at 6 through 18 months, and 4 years of age or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at age 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten and grades 9 through 12. Two doses are required for grades kindergarten through 8.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 and no earlier than 24 weeks of age.
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children aged less than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons aged 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate vaccine (MenACWY). (Minimum age: 6 weeks)
   a. One dose of meningococcal conjugate vaccine (Menactra or Menevo) is required for students entering grade 7.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at age 16 years or older, the second (booster) dose is not required.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months of age.
   b. If 2 doses of vaccine were received before 12 months of age, only 3 doses are required with dose 3 at 12 through 15 months of age and at least 8 weeks after dose 2.
   c. If dose 1 was received at ages 12 through 14 months of age, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months of age or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years of age or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
    a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months of age.
    b. Unvaccinated children 7 through 11 months of age are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at age 12 through 15 months.
    c. Unvaccinated children 12 through 23 months of age are required to receive 2 doses of vaccine at least 8 weeks apart.
    d. If one dose of vaccine was received at 24 months of age or older, no further doses are required.
    e. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information contact:
New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

New York State Department of Health/Bureau of Immunization
health.ny.gov/immunization

10/16
**Entering Health History**

**Lakeland Central School District**

**Shrub Oak, New York**

**To Be Completed By Parent/Guardian**

<table>
<thead>
<tr>
<th>NAME</th>
<th>SEX</th>
<th>BIRTHDATE</th>
<th>BIRTHPLACE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDRESS</th>
<th>HOME PHONE</th>
<th>WORK PHONE</th>
<th>CELL PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Father’s Name**

<table>
<thead>
<tr>
<th>HOME PHONE</th>
<th>WORK PHONE</th>
<th>CELL PHONE</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

**Mother’s Name**

<table>
<thead>
<tr>
<th>HOME PHONE</th>
<th>WORK PHONE</th>
<th>CELL PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Child Resides With:**

_____________________________________________________________________________________________________

**Emergency Person To Contact**

<table>
<thead>
<tr>
<th>NAME</th>
<th>HOME PHONE</th>
<th>WORK PHONE</th>
<th>CELL PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Is Child Covered By Health Insurance?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Physician**

<table>
<thead>
<tr>
<th>Phone</th>
<th>Dentist</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Physician**

<table>
<thead>
<tr>
<th>Phone</th>
<th>Dentist</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

New York State Education Law and New York State Public Health Law requires for all students will be properly & completely immunized in accordance with the law at the time of admission. A signed and stamped copy of immunization by your Health care provider must be presented to the school before entering http://www.health.ny.gov/publications/2370.pdf

Has your child resided outside the UNITED STATES for more than TWO (2) months? **YES** __________ **NO** __________

If yes where? ___________________

**Assessment of Student’s Health History**

To the best of your knowledge, has your child had any problem with the following? Please check Yes or No.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

- Allergy ___ Food ___ Insect ___ Latex ___ Medication ___ Seasonal ___ Other

Specify allergen(s): ____________________________

Specify previous symptoms: __________________________

Has the allergy required emergency treatment? __________________________

History of anaphylaxis: __________________________

History of anaphylaxis: last occurrence__________.

Asthma or Breathing problems

___ Intermittent or ___ Persistent

Quick relief inhaler ___ Yes ___ NO ___

Asthma Action Plan ___ Yes ___ NO ___

Attention-Deficit/Hyperactivity Disorder

Behavioral problems

Developmental problems

Bladder and/or bowel problems

Bleeding problems

Cerebral Palsy

Cystic Fibrosis

Dental Problems

* Date of last dental visit *

Diabetes

Head or Spinal injury

Hearing problems or deafness

Heart problems

Hospitalizations / Surgery (reason/ date)

Lead poisoning

Lyme disease

Musculoskeletal problems (include any past fractures, etc)

Seizures / Seizure Action Plan

Date of last seizure ______

Sickle Cell Disease (not trait)

Speech Problems

Stomach / Nutritional issues

Vision problems/ eye glasses

List all prescription and over-the-counter medications your child takes regularly: __________________________________________

**Describe any other important health-related information or concerns about your child (i.e., feeding tube, oxygen support, hearing aid, etc.):**

__________________________________________________________________________________________________________________________________________

**Developmental History:**

Delivery: __________________________

Term: __________________________

Birth Weight ______ / Length: __________

Condition at birth: __________________________


Indicate approximate age for the following: SAT UP __________ STOOD __________ WALKED __________ SENTENCES __________ TEETH __________

Name of Nursery School or Previous School __________________________

Signature of Parent or Legal Guardian: __________________________

Date: __________________________

Please note: A physical exam must be provided within 30 days of entrance. Students who do not return evidence of a physical exam will have a HEALTH APPRAISAL scheduled with our Medical Director.
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

- Will return on: to receive:

### HEALTH HISTORY

**Asthma:** □ Intermittent    □ Persistent

**Diabetes:** □ Type I    □ Type 2    □ Hyperlipidemia    □ Hypertension

**Seizures**

- Type: ______________________
- Last Occurrence: _________

**Allergies:**

- 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:

<table>
<thead>
<tr>
<th>Diagnostic Tests</th>
<th>Positive</th>
<th>Negative</th>
<th>Not Done</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickle Cell Screen</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>PPD</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Elevated Lead:</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
</tbody>
</table>

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

### PHYSICAL EXAMINATION

**Height:**

**Weight:**

**BP:**

<table>
<thead>
<tr>
<th>Pulse:</th>
<th>Respirations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>Right</td>
</tr>
<tr>
<td></td>
<td>Distance acuity</td>
</tr>
<tr>
<td></td>
<td>Distance acuity with lenses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weight Status Category (BMI Percentile):</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ &lt;5th</td>
</tr>
<tr>
<td>□ 5th - 49th</td>
</tr>
<tr>
<td>□ 50th - 84th</td>
</tr>
<tr>
<td>□ 85th - 94th</td>
</tr>
<tr>
<td>□ 95th - 98th</td>
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<tr>
<td>□ 99th &amp; higher</td>
</tr>
</tbody>
</table>

- Vision - near vision
- Vision - color perception
- Hearing
- 20 db sweep screen both ears or

### Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders): \( Tanner: □ \text{I} □ \text{II} □ \text{III} □ \text{IV} □ \text{V} \)

- Additional information attached

Specify any abnormalities:
**MEDICATION HISTORY (optional)**

<table>
<thead>
<tr>
<th>Accommodations / Protective Equipment:</th>
<th>Athletic Cup</th>
<th>Insulin Pump/Insulin Sensor</th>
<th>Pacemaker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Brace/Orthotic</td>
<td>Medical /Prosthetic Device</td>
<td>Sports Safety Goggles</td>
</tr>
<tr>
<td></td>
<td>Hearing Aides</td>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD Code</th>
<th>Medication Name</th>
<th>Dose</th>
<th>Route</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

**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.

**REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL**

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

Parent/Guardian Signature:

**HEALTH CARE PROVIDER**

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

Medical Provider Signature: ___________________________ Date: __________

Provider Name: (please print) ___________________________ Phone #: (______)

Provider Address: ___________________________ Fax #: (______)

return to:

School Nurse: ___________________________ School: ___________________________

Phone #: (______) Fax: (______) Date: __________
Dental Health Certificate- Optional

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

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

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Month</td>
<td>Day</td>
<td>Year</td>
<td></td>
</tr>
<tr>
<td>Sex:</td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>Will this be your child’s first visit to a dentist?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>School:</td>
<td>Name</td>
<td>Grade</td>
<td></td>
</tr>
<tr>
<td>Have you noticed any problem in the mouth that interferes with your child’s ability to chew, speak or focus on school activities?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Parent’s Signature</td>
<td>Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 ¼ 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):______________________________________
Authorization for Medication Administration

Medication of any kind (prescription &/or over the counter) cannot legally be dispensed to any child in school without a health care provider’s order and written parental/guardian consent. Medication must be in original pharmacy labeled container with specific orders & brought in by an adult. Medications that can be taken at home before or after school should be arranged in this manner.

Request Form for Administration of Medication to Student in School

Student Name_________________________________________________ Date of Birth_______/______/______

I request that my child, ____________________________________________________, grade _____________ receive the medication prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. The school nurse may contact the prescriber as needed.

Parent /Guardian Signature _____________________________________ Date__________________________

Print Parent/Guardian Name ___________________________________ Telephone Number: _____________________________________

*************************TO BE COMPLETED BY A HEALTH CARE PROVIDER****************************************

Diagnosis_______________________________________________________________________________________________________________

Name of Medication__________________________________________________ Amount of Dosage ____________________________________

Time medication is to be administered ___________________________________ Route ______________________________________________

Duration of Treatment ________________________________________________ Expiration Date of Treatment ___________________________

Possible adverse reaction or side effects _____________________________________________________________________________________

______________________________________________________________________________________________________________________

Physician’s Signature _____________________________________________ Date ______/______/______

Physician’s Stamp and/or Name: __________________________________________________________________________________________

Address: _______________________________________________________________________________________________________________

Phone: __________________________________________ Fax: _________________________________________

Provider and Parent Permissions Required for Independent Medication Carry and Use.

(formerly self-administer and/or self-carry) Please Complete the Section below & sign if applicable.

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

☐ Allergy and requires Epinephrine Auto-injector
☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
☐ __________________________which requires rapid administration of __________________________

(State Diagnosis) (Medication Name)

Signature: __________________________________________ Date: __________________

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: __________________________________ Date: __________________

This medication order is valid for the school year. Medication must be picked up at the end of the school year or be discarded.

MEDICATION ORDER(S) MAY BE FAXED TO: Fax # 914 _______________ Attention: School Nurse
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/PERSOIN 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

- Father

- 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

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: ___

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:**  
**Month:** __  
**Day:** __  
**Year:** __

**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:**  
**Month:** __  
**Day:** __  
**Year:** __

**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:**

---

ENGLISH
Cuestionario de Idioma del Hogar (“HLQ” por sus siglas en inglés)

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

Por favor escriba con claridad al completar esta sección.

NOMBRE DEL ESTUDIANTE:

Nombre    Segundo nombre    Apellido

FECHA DE NACIMIENTO:

Mes    Día    Año

GÉNERO:

☑ Masculino
☑ Femenino

INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL

Apellido    Primer Nombre    Relación con el estudiante

CÓDIGO DEL IDIOMA DEL HOGAR

Conocimientos de idiomas

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

1. ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante?

☑ Inglés       ☐ Otro    especifique

2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?

☑ Inglés       ☐ Otro    especifique

3. ¿Cuál es el idioma primario de cada padre / tutor?

☐ Madre     especifique
☐ Padre     especifique
☐ Tutor(es)     especifique

4. ¿Qué idioma o idiomas entiende su hijo(a)?

☑ Inglés    ☐ Otro    especifique

5. ¿Qué idioma o idiomas habla su hijo(a)?

☑ Inglés    ☐ Otro    especifique
☐ No sabe hablar

6. ¿Qué idioma o idiomas lee su hijo(a)?

☑ Inglés    ☐ Otro    especifique
☐ No sabe leer

7. ¿Qué idioma o idiomas escribe su hijo(a)?

☑ Inglés    ☐ Otro    especifique
☐ No sabe escribir

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

SCHOOL DISTRICT INFORMATION:

Student ID Number in NYS Student Information System:

District Name (Number) & School Address

PARA LLENAR POR EL DISTRITO EN EL QUE EL ESTUDIANTE SE HA INSCRITO
Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

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

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

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

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

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

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

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

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

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

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

11. ¿Considera que hay alguna otra información importante que la escuela deba saber sobre su hijo(a)?

(Por ejemplo, talentos especiales, problemas de salud, etc.)

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

___________________________  Mes:  Día:  Año:  

Firma del padre/madre o de la persona en relación paternal  

Relación con el estudiante:  ☐ Madre  ☐ Padre  ☐ Otra: ______________________

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: ___________________________  POSITION: ___________________________

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

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

NAME: ___________________________  POSITION: ___________________________

ORAL INTERVIEW NECESSARY: ☐ No  ☐ Yes

**DATE OF INDIVIDUAL INTERVIEW:

NO  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:

NO  DAY  YR.

PROFICIENCY LEVEL ACHIEVED ON NYSITELL:

☐ ENTERING  ☐ EMERGING  ☐ TRANSITIONING  ☐ EXPANDING  ☐ COMMANDING

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

Student Name: _____________________________________________ DOB: __________________________

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

School Name: ____________________________________________
Contact Name: ____________________________________________
Address: ____________________________________________
____________________________________________  ___________________________
Parent/Guardian Signature     Date

Please remit records to: Lakeland Central School District

School Name: ____________________________________________
Contact Name: ____________________________________________
Address: ____________________________________________
____________________________________________________
Fax Number: ____________________________________________

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

If you have concerns that your child may require special education services please refer to the New York State Education website at: http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm
The Lakeland Central School District, in compliance with the State Education Department and Westchester County Department of Emergency Services, has plans in place for all students for administering Potassium Iodide (KI) in the event of a radiological emergency. Potassium Iodide (KI) is an over-the-counter drug that protects the thyroid from exposure to radioactive iodine. It only protects the thyroid gland against one radioactive substance. It is not an alternative to evacuation or sheltering. Sheltering remains New York’s primary public protective action in the event of an emergency at any nuclear power site. Potassium Iodide (KI) is most effective when taken within hours of exposure. The protective effects last for approximately 24 hours. It is available only in a pill form. For children who are unable to swallow pills, it may be taken with food.

The school district will only administer Potassium Iodide (KI) pills to children whose parents have opted-in by filing their consent to administer with the school district. People with known iodine sensitivity, shellfish allergies or thyroid disorders should consult their physician for guidance.

If you would like your child to receive an age appropriate dose* of Potassium Iodide (KI) in the event of a nuclear emergency, please fill out the permission form below and return this form to your child’s school. Without this form being filed, your child will not receive Potassium Iodide (KI) from school district personnel in the event of a nuclear emergency. This form will remain in effect as long as your child attends this school district. If you have any questions regarding the administration of Potassium Iodide (KI) to your child, please contact your physician or the Westchester County Department of Health at (914) 813-5000. Information is also available at the following website: www.westchestergov.com/health. If you have any questions regarding school procedures for the administration of Potassium Iodide (KI), please contact your school administrator.

Sincerely,

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

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If you would like your child to receive an age appropriate dose* of Potassium Iodide (KI) in the event of a nuclear emergency, please fill out and return this form to your child’s school.

In the event of a radiological emergency, I request that my child receive one dose of Potassium Iodide (KI).

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current School and Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent’s Name (Please Print)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent’s Signature</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To be filed by nurse in student’s health record.

*Please see attached chart

1086 East Main Street • Shrub Oak, New York 10588
Tel: 914-245-1700 • Fax: 914-245-4391 • www.lakelandschools.org
To the Parent/Guardian of:

This is to inform you that the recommended dosage of Potassium Iodide (KI) has been changed. Please refer to the chart below:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>KI Dosage</th>
<th>Number of ml liquid (65 mg/ml)</th>
<th>Number of 65-mg tablets</th>
<th>Number of 130-mg tablets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults over 18 years</td>
<td>130 mg</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Over 12-18 years and over 150 pounds</td>
<td>130 mg</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Over 12 – 18 years and less than 150 pounds</td>
<td>65 mg</td>
<td>1</td>
<td>1</td>
<td>½</td>
</tr>
<tr>
<td>Over 3 – 12 years</td>
<td>65 mg</td>
<td>1</td>
<td>1</td>
<td>½</td>
</tr>
<tr>
<td>Over 1 month to 3 years</td>
<td>32 mg</td>
<td>0.5</td>
<td>½</td>
<td>¼</td>
</tr>
<tr>
<td>Birth – 1 month</td>
<td>16 mg</td>
<td>0.25</td>
<td>¼</td>
<td>1/8</td>
</tr>
</tbody>
</table>

It will not be necessary for you to fill out another permission form. Since weight is a changing factor we have determined that it would be safest to continue to keep the middle school and the high school students at the 130 mgm. dose. This dose is considered to be safe. The elementary students who weigh less than 150 pounds will receive the 65 mgm. doses.

If you have any questions please call your school nurse.

Sincerely,

MaryEllen Herzog
Assistant Superintendent for Pupil Personnel Services

MEH:ct
TRANSPORTATION DATA SHEET  FAX TO 528-1839

TO BE FILLED OUT BY SCHOOL  TO BE FILLED OUT BY TRANSPORTATION
SCHOOL ___________ AM BUS # ____  RT # _______
STUDENT ID_________ PM BUS # ____  RT # _______
GRADE ____________ PICKUP TIME__________________
PICKUP LOCATION________________

STUDENT’S NAME
FIRST _______________________________ LAST _______________________________

DATE OF BIRTH _______________________________ GENDER ☐ MALE ☐ FEMALE

FATHER’S NAME
FIRST _______________________________ LAST _______________________________

HOME PHONE (____) ___________________ CELL ______________________________

MOTHER’S NAME
FIRST _______________________________ LAST _______________________________

HOME PHONE (____) ___________________ CELL ______________________________

ADDRESS
HOUSE NUMBER/STREET _______________________________
CITY _______________________________
STATE _______________________________ ZIP __________________

MAILING ADDRESS (IF DIFFERENT)
HOUSE NUMBER/STREET/P.O. BOX _______________________________
CITY _______________________________
STATE _______________________________ ZIP __________________

EMERGENCY CONTACT INFORMATION
NAME __________________________ PHONE NUMBER __________________

NAME __________________________ PHONE NUMBER __________________
FOOD SERVICE
NEW STUDENT REGISTRATION

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

Please print all information clearly:

Student Identification Number: __________________ Homeroom Number: __________________
For School Office Personnel Only For School Office Personnel Only

School Name: ______________ Grade:______ Student Date of Birth:________________

Students
Name: (First) ______________ (Middle)__________ (Last)_______________________

Address: Street _______________________________________________________________

City/Town:__________________________ Zip Code:________________________________

Parent/Guardian Name: (First)_______________ (Last)____________________________

Parent/Guardian Email Address: ________________________________________________

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

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

Student was transferred from (previous district name):______________________________
PHOTO/VIDEO PERMISSION FORM

Throughout the school year, the Lakeland Central School District (LCSD) celebrates the accomplishments of its students. As a part of this, the Lakeland Central School District may use photographs and/or videotape recordings of your child, as well as the following types of information regarding my child, in articles about the School District in local newspapers, the District newsletter, the District website, the Yearbook, the district’s Social Media sites (Facebook, etc.), and by both local television stations and the district cable television channel during the 2015-2016 school year.

- Name
- Participation in activities and sports
- Degrees, honors and awards received
- Photographs, digital images and/or videotapes of child participation in school and school-related activities
- Interviews regarding school-related activities

This form provides you with the opportunity to let us know if you DO NOT wish your son/daughter to be included in such coverage – including photographs, videos, or samples of her/his work.

Please return this form only if you DO NOT wish your son/daughter to be included, as described, in any media coverage. It should be returned to the main office of your son’s/daughter’s school.

IF YOU DO NOT WISH TO HAVE THIS INFORMATION USED BY THE LAKELAND CENTRAL SCHOOL DISTRICT IN THE MANNER DESCRIBED ABOVE, PLEASE COMPLETE THIS SECTION:

I do not want the types of information described above regarding my child, _______________________ given

Name of Student
to local newspapers, used in District newsletters, the District website, the Yearbook or given to local television stations and the district’s cable channel during the 2015-2016 school year.

Date: _____________________ Signed: _____________________

Parent/Guardian

Print Name: _____________________

Parent/Guardian

Relationship to child: _____________________

PLEASE RETURN THIS FORM TO: ____________________________ LAKELAND CENTRAL SCHOOL DISTRICT AT: ___________________________________________ AS SOON AS POSSIBLE.
Dear Parent or Guardian:

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

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

Thank you for your cooperation regarding this matter.

Sincerely,

Dwayne Hoffmann
Director, Information Technology
Policy Information

Series 6000 - Instruction

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

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

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

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

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

Internet Safety

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

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

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

Parents, staff members and student must be aware that it is the responsibility of the user to monitor his/her own access to the internet and to use sound judgment. However, the District, through its staff members, technology and systems reviews, shall monitor online activities of
students while in school, including but not limited to use of e-mail, chat rooms and other forms of direct electronic communication, "hacking" and other unlawful activities by minors, and access to materials harmful to minors.

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

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

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

**Privacy**

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

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

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

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

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

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

(c) Taken as a whole, lacks serious literary, artistic, political or scientific value as to minors.
LAKELAND CENTRAL SCHOOL DISTRICT
RULES AND CODE OF ETHICS AGREEMENT
FOR NETWORK, INTERNET AND EMAIL USERS

Section 1: To be signed by student

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

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

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

Student’s Name
(Please Print) ___________________________ Grade __________

Signature __________________________________ Date __________

Section 2: To be signed by parent or guardian

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

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

___________ Network/Internet _____________ District Email

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

Parent’s name (Please print) ________________________________________

Parent’s Signature __________________________________ Date __________

Copy to student’s folder and Computer Facilitator.
AUTOMATED PHONE MESSAGE

In an effort to keep parents/guardians of children in the Lakeland Central School District informed, the district has implemented a “School to Home Messaging System.” This automated system, “SchoolConnects”, delivers approximately 1,000 thirty-second messages in ten minutes. SchoolConnects allows the district to call and/or email parents/guardians in the event of an emergency (delayed opening, early dismissal, and full day closing) and any other event that requires timely school to parent/guardian communication. SchoolConnect allows for additional phone numbers, such as cell phone and direct business numbers, in the event you are not at home when the announcement is made. Any additional numbers must be direct-line numbers, numbers that don’t have extensions and/or other people who normally answer the phone.

If you would like to provide additional contact numbers (direct lines) and an email address, please do so below. Return any additional contact information to your child’s school building. This information will be added to the Student Information System and uploaded into the SchoolConnects system. If no response is received, SchoolConnects will only call the home phone number. In the future, if any of your contact information changes, please inform your child’s school as soon as possible.

Additional Contact Numbers including area code:

(1) ________________________________

(2) ________________________________

Email address: ________________________________

Parent/Guardian signature: ____________________ Date: ____________________