STUDENT REGISTRATION PACKET

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Tel: 914-245-1700 • Fax: 914-245-1589 • www.lakelandschools.org

Student Registration Packet

Table of Contents

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

Student Name: _____ Student ID #: _____
Grade: _____ Homeroom: _____
Email: _____

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 data sheets to the Transportation Departments with all student Demographic data completed. _____

      1. Transportation Department returns the data sheet with bus information by fax to the secretary. _____

NOTE: REGISTRATION GENERALLY TAKES UP TO THREE (3) 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.

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	Property Insurance Certificate
Utility bill	Fuel Oil bill
Recent W2 Form	Driver's License, Learner's Permit, Non-Driver ID
Cable TV bill	*(with new address)*

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

AND

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

AND

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

Utility bill	Property Insurance Certificate
Fuel Oil bill	Cable TV bill
Recent W2 Form	Letters from Agencies or caseworkers
DSS Budget Sheet	
Section 8 or Municipal Housing Statement	
Driver's License, Learner's Permit, Non-Driver ID	
(with new address)	

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	Cable TV bill
W2 Form	Section 8 or Municipal Housing Statement
DSS Budget Sheet	Letters from Agencies or caseworkers
Checkbook, bank statement	Credit card statement
Car insurance statement/card	Car loan statements
Cellular phone or telephone bills	

Driver's License, Learner's Permit, Non-Driver ID (*with new address*)

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 cannot accept any registration that does NOT include an *ORIGINAL* birth certificate.

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at the top page of registration materials that the district shares with families. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the **student is not required to submit proof of residency** and other required documents that may be part of the registration packet.

HOUSING QUESTIONNAIRE

Name of LEA: Lakeland Central School District

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____ *Month Day Year* Grade: ____ *(preschool-12)* ID#: _____ *(optional)*

Address: _____ Phone: _____

Email: _____

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 **ANY box other than "In Permanent Housing" is checked,** , then the student/family should be immediately referred to the MV Liaison. In such cases, **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.

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

ATENCIÓN ESCUELAS Y DISTRITOS: Ofrezca asistencia a los estudiantes y familias para completar este formulario. Este formulario debería de ser incluido como la primera página de los materiales de inscripción que el distrito comparte con familias. No incluya este formulario en el paquete de inscripción sin advertencias apropiadas. Por ejemplo, tendrá que cambiar partes del paquete de inscripción que requieren que se entreguen prueba de inscripción antes de matricular. Estudiantes elegibles según el Acto de McKinney-Vento, no necesitan entregar prueba de residencia y otros documentos normalmente requeridos antes de matricular.

CUESTIONARIO DE VIVIENDA

Nombre del Distrito Escolar: Distrito Escolar Central De Lakeland

Nombre de la Escuela: _____

Nombre del Estudiante: _____
Apellido Primer Nombre Segundo Nombre

Género: ☐ Hombre ☐ Mujer Fecha de Nacimiento: _____ / _____ / _____ Grado:_____ ID#: _____
Mes *Día* *Año* *(jardín de infantes – 12)* *(opciónal)*

Dirección: _____ Teléfono: _____

Su respuesta abajo permitirá al distrito escolar definir los servicios que puede aprovechar su hijo/hija según el Acto de McKinney-Vento. Los estudiantes elegibles tienen derecho a la inscripción inmediata en la escuela, aun si ellos no tienen los documentos necesarios tales como: prueba de residencia, documentos escolares, documentos de inmunización, o partida de nacimiento. Los estudiantes elegibles según el Acto de McKinney-Vento tienen además derecho al transporte gratuito y otros servicios que ofrece el distrito escolar.

¿Donde está el estudiante viviendo actualmente? (*Por favor marque **una** caja*.)

- ❑ En un refugio
- ❑ Con otra familia o otra persona debido a la pérdida del hogar o a dificultades económicas
- ❑ En un hotel/motel
- ❑ En un carro, parque, autobús, tren, o camping
- ❑ Otra vivienda temporal (Por favor describa):

  _____

- ❑ En un hogar permanente

_____ _____
Nombre de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento) **Firma** de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

_____
Fecha

Si CUALQUIER caja que no sea "En un hogar permanente" está marcada, **no se requieren prueba de domicilio** u otros documentos normalmente requeridos para inscripción **y el estudiante debe ser matriculado inmediatamente**. Después de que el estudiante sea matriculado, el distrito o la escuela debe pedir los documentos escolares, incluyendo los documentos de inmunización, al distrito o la escuela anterior. El enlace del distrito debe ayudar al estudiante conseguir cualquier otro documento necesario o inmunización.

ATENCIÓN ESCUELAS Y DISTRITOS: Si el estudiante **NO** vive en un hogar permanente, favor de asegúrese que una Formulario de Designación sea completado.

LAKELAND CENTRAL SCHOOL DISTRICT

STUDENT NAME: _____ **DATE:** _____
STUDENT ID #:_____ **GRADE:** _____ **HOMEROOM:** _____
SCHOOL: _____
EMAIL: _____

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)**_____

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 _____

Parent/Guardian's Dominant Language_____

Need for interpreter for school meetings _____ YES _____NO

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

___ Custodial Parent (Parent Student resides with) (If separated or divorced, provide a Certified Copy of any Separation Agreement, Divorce Decree or Custody Order OR Complete LCSD Care, Custody and Control Form)

___ 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: _____

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

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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:

Name	Birthdate	Relationship	School of Attendance	Grade
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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 2/18

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

Elisa Alvarez, Associate Commissioner Office of
Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Person in Parental Relation:
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.

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*

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?	❑ Parent 1 _____ *specify*	❑ Parent 2 _____ *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

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

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

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

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

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

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

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

Relationship to student: ❑ Parent ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

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

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

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

**DATE OF INDIVIDUAL INTERVIEW: _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

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

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

Office of Bilingual Education and World Languages

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Cuestionario de Idioma del Hogar (Home Language Questionnaire - HLQ)

Estimados padres o persona en relación parental:
Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura de él o ella, 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.

NOMBRE DEL ESTUDIANTE:		
Nombre	*Segundo nombre*	*Apellido*
FECHA DE NACIMIENTO:		GÉNERO:
		❑ Masculino ❑ Femenino
Mes *Día* *Año*		
INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL		
Apellido	*Primer Nombre*	*Relación con el estudiante*

HOME LANGUAGE CODE

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?	❑ Padre 1 *especifique*	❑ Padre 2 *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

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*	

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 descríbalos.

*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 (Individualized Education Program - IEP)? ❑ 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 de un padre o de la persona en relación paternal *Fecha*

Relación con el estudiante: ❑ 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:** _____ (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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

ENTERING HEALTH HISTORY **LAKELAND CENTRAL SCHOOL DISTRICT** **ENTERING GRADE** _____
CONFIDENTIAL INFORMATION **SHRUB OAK, NEW YORK** **TO BE COMPLETED BY PARENT/GUARDIAN**

NAME_____SEX M_____ F_____BIRTHDATE_____BIRTHPLACE_____

ADDRESS_____ HOME PHONE ( )_____

FATHER'S NAME_____HOME ( )_____ WORK ( ) _____CELL ( )_____

MOTHER'S NAME_____HOME ( )_____ WORK ( ) _____CELL ( )_____

Child resides with: _____

EMERGENCY – PERSON TO CONTACT if parent is not available.

(1) NAME_____HOME ( )_____ WORK ( )_____ CELL ( )_____

Is child covered by health insurance? _____ Yes _____ No

Physician_____Phone (____)_____Dentist _____Phone (___)_____

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.schoolhealthservicesny.com/files/filesystem/ImmunizationRegulationRevisions.pdf *

Has your child resided outside the UNITED STATES for more than TWO (2) months? YES_____ NO_____

If yes where? _____

TO BE COMPLETED BY PARENT/GUARDIAN 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**.

Condition	Yes	No	Comment if "Yes"
Allergy __ food __ Insect __Latex __ ____ medication ____ seasonal ____ other			Specify allergen(s): _____ Specify previous symptoms: _____
Has the allergy required emergency treatment?			Treatment Prescribed: _____
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/Developmental problems			
Bladder and/or bowel problems			
Bleeding problems			
Cerebral Palsy			
COVID-19: Has your child ever tested positive?			
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: _____

TO BE COMPLETED BY PARENT/GUARDIAN

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: _____ Cyanosis: _____ Jaundice: _____ Feeding Habits: _____ Bladder_____ Bowel_____

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.

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. http://www.health.ny.gov/publications/2370.pdf

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

2022-23 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

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). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. 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

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]	**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**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		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]	49 **Not applicable**		**Grades 7, 8, 9, 10 and 11: 1 dose**	**2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or 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 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years 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 and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, 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 7 years and older 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 or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6, 7 and 8: 10 years; minimum age for grades 9 through 12: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2022-2023, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6, 7 and 8; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 9 through 12.
   c. 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 old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years 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 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.

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. Two doses are required for grades kindergarten through 12.
   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 age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).
   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 younger 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 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7, 8 and 9: 10 years; minimum age for grades 10 through 12: 6 weeks).
   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

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.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years 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.
   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. PCV is not required for children 5 years or older.
   f. 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

Año escolar 2022-2023
Requisitos de vacunación del estado de Nueva York para inscribirse/asistir a la escuela[1]

NOTAS:
Los niños que están en prekindergarten deben tener las vacunas correspondientes a su edad. La cantidad de dosis depende del programa recomendado por el Comité Asesor sobre Prácticas de Vacunación (Advisory Committee on Immunization Practices, ACIP). Los intervalos entre las dosis de vacunas deben corresponder al programa de vacunación recomendado por el ACIP para personas de 0 a 18 años. Las dosis aplicadas antes de la edad mínima o de los intervalos mínimos no son válidas y no se tienen en cuenta al calcular la cantidad de dosis que se mencionan abajo. Consulte las notas al pie de página para obtener información específica sobre **cada** vacuna. Los niños que se inscriben en clases sin grado deben cumplir los requisitos de vacunación de los grados para los que son equivalentes en edad.

Se DEBEN leer los requisitos de dosis con las notas al pie de página de este programa

Vacunas	Prekindergarten (guardería infantil, programa Head Start, guardería o pre-K)	Kindergarten y 1.º, 2.º, 3.º, 4.º y 5.º grado	6.º, 7.º, 8.º, 9.º, 10.º y 11.º grado	12.º grado
Vacuna con toxoide diftérico y tetánico y vacuna contra la tos ferina (DTaP/DTP/Tdap/Td)[2]	**4 dosis**	**5 dosis o 4 dosis** si la cuarta dosis se aplicó a los 4 años de edad o más, o **3 dosis** si tiene 7 años o más y la serie se inició a partir del año	**3 dosis**	
Refuerzo de la vacuna con toxoide diftérico y tetánico y la vacuna contra la tos ferina (Tdap) para adolescentes[3]	**No corresponde**		**1 dosis**	
Vacuna antipoliomielítica (IPV/OPV)[4]	**3 dosis**	**4 dosis o 3 dosis** si la tercera dosis se aplicó a los 4 años de edad o más		
Vacuna contra sarampión, paperas y rubéola (MMR)[5]	**1 dosis**	**2 dosis**		
Vacuna contra la hepatitis B[6]	**3 dosis**	**3 dosis o 2 dosis** de **la vacuna contra la hepatitis B para adultos** (Recombivax) para niños que recibieron las dosis en intervalos de al menos 4 meses entre los 11 y los 15 años de edad		
Vacuna contra la varicela[7]	**1 dosis**	**2 dosis**		
Vacuna antimeningocócica conjugada (MenACWY)[8]	**No corresponde**		**7.º, 8.º, 9.º, 10.º y 11.º grado: 1 dosis**	**2 dosis o 1 dosis** si la dosis se aplicó a los 16 años de edad o más
Vacuna conjugada contra Haemophilus influenzae tipo B (Hib)[9]	**1 a 4 dosis**	**No corresponde**		
Vacuna neumocócica conjugada (PCV)[10]	**1 a 4 dosis**	**No corresponde**		

1. Una constancia serológica demostrada de anticuerpos contra el sarampión, las paperas o la rubéola o una confirmación de laboratorio de dichas enfermedades son pruebas aceptables de la inmunidad ante estas. Las pruebas serológicas para la poliomielitis son una prueba aceptable de la inmunidad solo si la prueba se hizo antes del 1 de septiembre de 2019 y los tres serotipos dieron positivo. Un análisis de sangre con resultado positivo para el anticuerpo de superficie contra la hepatitis B es una prueba aceptable de la inmunidad ante la hepatitis B. Una constancia serológica demostrada de anticuerpos contra la varicela, una confirmación de laboratorio de varicela o el diagnóstico de un médico, un asistente médico o un enfermero de práctica avanzada de que un niño tuvo varicela son pruebas aceptables de la inmunidad ante la varicela.

2. Vacuna con toxoide diftérico y tetánico y tos ferina acelular (DTaP). (Edad mínima: 6 semanas)
   a. Los niños que comienzan la serie a tiempo deben recibir una serie de 5 dosis de la vacuna DTaP a los 2 meses, 4 meses, 6 meses y entre los 15 y 18 meses de edad, y a los 4 años de edad o más. La cuarta dosis puede aplicarse a partir de los 12 meses de edad, siempre que hayan transcurrido por lo menos 6 meses desde la tercera dosis. Sin embargo, no es necesario que se repita la cuarta dosis de DTaP si se aplicó al menos 4 meses después de la tercera dosis de DTaP. La última dosis de la serie debe aplicarse a partir del cuarto año de edad y al menos 6 meses después de la dosis anterior.
   b. Si la cuarta dosis de DTaP se aplicó a los 4 años de edad o más, y al menos 6 meses después de la tercera dosis, no se requiere la quinta dosis (de refuerzo) de la vacuna DTaP.
   c. Para los niños nacidos antes del 1/1/2005, solo se requiere inmunidad a la difteria y las dosis de DT y Td pueden cumplir este requisito.
   d. Los niños mayores de 7 años que no estén completamente vacunados con la serie de vacunas DTaP para niños deben recibir la vacuna Tdap como primera dosis de la serie de actualización; si se necesitan dosis adicionales, use la vacuna Td o Tdap. Si les aplicaron la primera dosis antes de su primer año de edad, deben aplicarse 4 dosis, siempre que la dosis final se aplique a los 4 años de edad o más. Si les aplicaron la primera dosis a partir de su primer año de edad, deben aplicarse 3 dosis, siempre que la dosis final se aplique a los 4 años o más.

3. Refuerzo de la vacuna con toxoides tetánico y diftérico y de la vacuna contra la tos ferina acelular (Tdap) para adolescentes. (Edad mínima para 6.º, 7.º y 8.º grado: 10 años; edad mínima para 9.º a 12.º grado: 7 años)
   a. Los estudiantes mayores de 11 años que ingresan a los grados de 6.º a 12.º deben recibir una dosis de Tdap.
   b. Además del requisito para 6.º a 12.º grado, la vacuna Tdap también se puede aplicar como parte de la serie de vacunas de actualización para estudiantes mayores de 7 años que no estén totalmente vacunados con la serie de vacunas DTaP para niños, como se describió arriba. En el año escolar 2022-2023, solo las dosis de Tdap aplicadas a los 10 años o más cumplirán el requisito de Tdap para los estudiantes en los grados 6.º, 7.º y 8.º; sin embargo, las dosis de Tdap aplicadas a los 7 años o más cumplirán el requisito para los estudiantes en los grados 9.º a 12.º.
   c. Los estudiantes que tienen 10 años de edad en 6.º grado y que aún no recibieron la vacuna Tdap cumplen los requisitos hasta que tengan 11 años.

4. Vacuna antipoliomielítica inactivada (IPV) o vacuna antipoliomielítica oral (OPV). (Edad mínima: 6 semanas)
   a. Los niños que comienzan la serie a tiempo deben recibir una serie de IPV a los 2 meses, 4 meses y entre los 6 y 18 meses de edad, y a los 4 años de edad o más. La última dosis de la serie debe aplicarse a partir del cuarto año de edad y al menos 6 meses después de la dosis anterior.
   b. Para los estudiantes que recibieron la cuarta dosis antes de su cuarto año de edad y antes del 7 de agosto de 2010, es suficiente aplicar 4 dosis con al menos 4 semanas de diferencia.
   c. Si la tercera dosis de la vacuna antipoliomielítica se aplicó a los 4 años de edad o más y por lo menos 6 meses después de la dosis anterior, no se requerirá la cuarta dosis.
   d. Para los niños con antecedentes de OPV, solo la OPV trivalente (tOPV) se tiene en cuenta para los requisitos de la vacuna antipoliomielítica en las escuelas del Estado de Nueva York. Las dosis de OPV aplicadas antes del 1 de abril de 2016 deben incluirse a menos que se indiquen específicamente como monovalentes, bivalentes o como aplicadas durante una campaña de vacunación contra el virus de la poliomielitis. Las dosis de OPV aplicadas a partir del 1 de abril de 2016 no deben incluirse.

5. Vacuna contra sarampión, paperas y rubéola (MMR). (Edad mínima: 12 meses)
   a. La primera dosis de la vacuna MMR debe haberse aplicado a partir del primer año de edad. Para considerarse válida, la segunda dosis debe haberse aplicado al menos 28 días (4 semanas) después de la primera dosis.
   b. Sarampión: Se necesita una dosis para prekindergarten. Se necesitan dos dosis para los grados de kindergarten hasta 12.º.
   c. Paperas: Se necesita una dosis para prekindergarten. Se necesitan dos dosis para los grados de kindergarten hasta 12.º.
   d. Rubéola: Se necesita por lo menos una dosis para todos los grados (prekindergarten hasta 12.º grado).

6. Vacuna contra la hepatitis B
   a. La primera dosis puede aplicarse al nacer o en cualquier momento después. La segunda dosis debe aplicarse al menos 4 semanas (28 días) después de la primera dosis. La tercera dosis debe aplicarse al menos 8 semanas después de la segunda dosis Y al menos 16 semanas después de la primera dosis, PERO no antes de las 24 semanas (cuando se apliquen 4 dosis, reemplazar “cuarta dosis” por “tercera dosis” en estos cálculos).
   b. Dos dosis de la vacuna contra la hepatitis B para adultos (Recombivax) aplicadas con al menos 4 semanas de diferencia entre los 11 y 15 años cumplirán el requisito.

7. Vacuna contra la varicela. (Edad mínima: 12 meses)
   a. La primera dosis de la vacuna contra la varicela debe haberse aplicado a partir del primer año. Para considerarse válida, la segunda dosis debe haberse aplicado al menos 28 días (4 semanas) después de la primera dosis.
   b. Para los niños menores de 13 años, el intervalo mínimo recomendado entre dosis es de 3 meses (si la segunda dosis se aplicó por lo menos 4 semanas después de la primera dosis, se puede aceptar como válida); para los mayores de 13 años, el intervalo mínimo es de 4 semanas.

8. Vacuna antimeningocócica conjugada ACWY (MenACWY). (Edad mínima para 7.º, 8.º y 9.º grado: 10 años; edad mínima para 10.º a 12.º grado: 6 semanas).
   a. Se requiere una dosis de la vacuna antimeningocócica conjugada (Menactra, Menveo o MenQuadfi) para los estudiantes que ingresan a los grados 7.º, 8.º, 9.º, 10.º y 11.º.
   b. Para los estudiantes del 12.º grado, si la primera dosis de la vacuna antimeningocócica conjugada se aplicó a los 16 años o más, no se requiere la segunda dosis (de refuerzo).
   c. La segunda dosis debe haberse aplicado a los 16 años o más. El intervalo mínimo entre dosis es de 8 semanas.

9. Vacuna conjugada contra Haemophilus influenzae tipo b (Hib). (Edad mínima: 6 semanas)
   a. Los niños que comienzan la serie a tiempo deben recibir la vacuna Hib a los 2 meses, 4 meses, 6 meses y entre los 12 y 15 meses de edad. Los niños mayores de 15 meses deben ponerse al día según el programa de actualización del ACIP. La dosis final debe aplicarse a partir de los 12 meses.
   b. Si se aplicaron 2 dosis de vacuna antes de los 12 meses de edad, solo se requieren 3 dosis si la tercera dosis se aplica entre los 12 y 15 meses de edad y al menos 8 semanas después de la segunda dosis.
   c. Si la primera dosis se recibió entre los 12 y 14 meses de edad, solo se requieren 2 dosis si la segunda dosis se aplicó al menos 8 semanas después de la primera dosis.
   d. Si se aplicó la primera dosis a los 15 meses de edad o más, solo se requiere 1 dosis.
   e. No se requiere la vacuna Hib para niños mayores de 5 años.

10. Vacuna neumocócica conjugada (PCV). (Edad mínima: 6 semanas)
   a. Los niños que comienzan la serie a tiempo deben recibir la vacuna PCV a los 2 meses, 4 meses, 6 meses y entre los 12 y 15 meses de edad. Los niños mayores de 15 meses deben ponerse al día según el programa de actualización del ACIP. La dosis final debe aplicarse a partir de los 12 meses.
   b. Los niños no vacunados de 7 a 11 meses de edad deben recibir 2 dosis, con al menos 4 semanas de diferencia, seguidas de una tercera dosis entre los 12 y los 15 meses de edad.
   c. Los niños no vacunados de 12 a 23 meses de edad deben recibir 2 dosis de la vacuna con al menos 8 semanas de diferencia.
   d. Si se recibió una dosis de la vacuna a los 24 meses de edad o más, no se requieren dosis adicionales.
   e. La PCV no es obligatoria para los niños mayores de 5 años.
   f. Para tener más información, consulte la tabla de PCV que está en el Folleto de instrucciones para encuestas escolares, en: www.health.ny.gov/prevention/immunization/schools

Para obtener más información, comuníquese con:

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

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

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

STUDENT INFORMATION

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

HEALTH HISTORY

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

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

BMI_____kg/m2

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

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

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	List 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 µg/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: ☐ Additional Information Attached	Diagnoses/Problems (list) ICD-10 Code* *Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

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

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

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

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

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

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

☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.

☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.

☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.

☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <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, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

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

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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

Dental Health Certificate- Optional

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

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

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: Name

Grade

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

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

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

Parent's Signature_____ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

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

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

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

Dentist's/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist's Signature

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

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

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

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

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

II. Treatment Needs (check all that apply)

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

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

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

Lakeland Central School District

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

Dear Parent/Guardian:

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 the age appropriate dose*of Potassium Iodide (KI) in the event of a nuclear emergency, please complete the permission form below and return it 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,

Karen Gagliardi, Ed.D.
Superintendent of Schools

If you would like your child to receive an age appropriate dose* (see attached table) of Potassium Iodide (KI) in the event of a nuclear emergency, please complete this form and return it **to your child's school.**

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

Child's Name _____ Date of Birth _____

Current School and Grade _____

Parent's Name (Please Print _____

Parent's Signature _____ Date Signed _____

1086 East Main Street • Shrub Oak, New York 10588
Tel: 914-245-1700 • Fax: 914-245-1589 • www.lakelandschools.org

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

***Please see attached chart**

Recommended Doses of KI for Different Age Groups				
Age Group	KI Dosage	Number of ml liquid (65 mg/ml)	Number of 65-mg tablets	Number of 130-mg tablets
Adults over 18 years	130 mg	2	2	1
Between 12-18 years and over 150 pounds	130 mg	2	2	1
Between 12-18 years and less than 150 pounds	65 mg	1	1	½
Between 3-12 years	65 mg	1	1	½
Between 1 month to 3 years	32 mg	0.5	½	¼
Birth – 1 month	16 mg	0.25	¼	1/8

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

Dear Parent or Guardian:

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

Instruction

Computer and Internet Use and Internet Safety

The Board of Education encourages the use of the District's computer systems and the Internet and its services ("District technology") in order to support open research and education in the School District. The use of the District's technology 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 District's computer systems and technology, 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 District's technology Therefore, prior to using the District's systems and Internet access, each student and staff member must either sign a user agreement or agree to the terms of use electronically. In the case of students, the student's parent or guardian must also sign the user agreement or agree to the terms of use electronically.

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.

Electronic/Digital Communications

Electronic/digital communications are not private, are subject to disclosure under the Freedom of Information Law, may be subject to disclosure in litigation and are subject to the records retention requirements of the District. Therefore, Board members and employees are required to use the District's designated email system, including the District provided email address, for all communications regarding District business.

Internet Safety

The District, in accordance with the Children's Internet Protection Act (CIPA), shall procure and implement the use of technology protection measures that block or filter Internet access by:

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

[1] The term "harmful to minors" under CIPA 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.

Adopted: June 12, 1997
Revised: August 16, 2001
Revised: November 18, 2004
Revised: June 14, 2012
Revised: November 21, 2013
Revised: December 14, 2017
Revised: March 15, 2018

The District will install this filtering or blocking technology on all newly acquired computers with Internet access 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.

The District's Director of Technology shall monitor and examine District technology to ensure compliance with this policy and accompanying regulations.

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.

Adopted: June 12, 1997
Revised: August 16, 2001
Revised: November 18, 2004
Revised: June 14, 2012
Revised: November 21, 2013
Revised: December 14, 2017
Revised: March 15, 2018

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

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.

06/07

MEDIA OPT-OUT 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, digital images and/or video recordings of your child, as well as the following types of information regarding your child, in articles about the School District in local newspapers, the district emails, the district website, the yearbook, the district's social media channels (Facebook, Instagram, Twitter, etc.), and by both local television stations and the district cable television channel.

- 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 child to be included in such coverage – including photographs, digital images, videos, or samples of their work.

Please note that this notice will remain in effect for the duration on your child's education within the LCSD. If at any time you choose for your child's information to be included, a written notice must be provided to the school your child currently attends.

Any student 18 years of age or older must sign and file a new form with the District if they do not wish disclosure of their image or work.

My signature below notifies the Lakeland Central School District that I **DO NOT wish the disclosure of my child's information as described above. This applies only to students under the age of 18.**

Name of Student: _____

Please check applicable box(es):

I **DO NOT** want the information described above to be used in:

- ☐ the district's social media handles, district emails, the district website, local newspapers, local television stations, and the district's cable channel
- ☐ the school yearbook

Parent/Guardian or Eligible Student Signature (18 or older): _____

Relationship to Student: _____

Date: _____

TRANSPORTATION START DATE:

DATE: _____

LAKELAND CENTRAL SCHOOL DISTRICT
1086 East Main Street
Shrub Oak, NY 10588
(914) 245-1700

TRANSPORTATION START DATE:

_____

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_____

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

STATE OF NEW YORK)
) SS.:
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:

Last Name	**First Name**
_____	_____
_____	_____
_____	_____

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 #

Subscribed and 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.

LAKELAND CENTRAL SCHOOL DISTRICT
THIRD PARTY AFFIDAVIT REGARDING RESIDENCY

STATE OF NEW YORK)
) SS.:
COUNTY OF _____)

I, _____, being duly sworn, say:

1. I reside at: _____

_____.

2. I know _____ and understand that he/she/they
(Name[s] of Parent[s] or Guardian[s])

wish[es] to enroll the following child[ren] in the Lakeland Central School District:

_____

_____

_____

_____

3. I know _____ and the above-named children to
(Name[s] of Parent[s] or Guardian[s])

reside at _____, an address

within the Lakeland Central School District. They have resided with me since

_____.

I do _____ do not _____ reside at this address. (check one)

The above-named parent[s] and children do ____ do not ____ pay rent. (check one)

The above-named parent[s] and children pay the following bills: (check all that apply)
_____ Utilities
_____ Telephone
_____ Cable
_____ Other (please detail) _____
_____ They pay no bills

4. The basis of my knowledge is:

_____

_____

_____

I affirm that the information provided on this form is true and correct and that the statements made in this document are being made under the penalties of perjury. I understand that the District may investigate any allegation contained in this document and may ask for written proof of any statement.

I further 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.

_____

(Signature of Third Party Resident)

Subscribed and sworn to before me
this ___ day of _____, 20___

_____

NOTARY PUBLIC

REQUEST FOR RECORDS

Student Name: _____

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

TRANSFER NOTIFICATION

This form must be completed for all transfer students and submitted to:

_____

UPON RECEIPT OF PART ONE IN THE SECTION OFFICE, ***THE STUDENT IS ELIGIBLE TO PRACTICE; BUT CANNOT PARTICIPATE IN A CONTEST UNTIL APPROVED BY THE SECTION.***

Please check one: **(The required supporting documentation must be attached.)**

☐ **Waiver Request** *Financial: Requires documented proof of a significant loss of income or a significant increase in expenses. OR Health & Safety: Written documentation from the Superintendent of Schools or HS Principal of the sending school indicating the specific circumstances which necessitated the transfer and must be accompanied by a DASA report,*

☐ **Return to School District of Residence (RSDR)** (No change of residence. School registration change only.) Student is returning to a school within the district boundaries of his/her residence.

☐ **Divorced/Legally Separated Parents** *A student from divorced or legally separated parents who moves into a new school district with one of the aforementioned parents is exempt provided it occurs once every six months. The legal separation agreement must address custody, child support, spouses support and distribution of assets and be filed with the County Clerk or issued by a Judge.*

☐ **Homeless** Student declared homeless by the Superintendent under McKinney-Vento Legislation [NYSED 100.2].

☐ **Residency Change** *NYSPHSAA transfer/residency policy states: Refer to By-Law & Eligibility Standards #30. (A residency is changed when one is abandoned and another one established through action and intent. Residency requires one's physical presence as an inhabitant and the intent to remain indefinitely. The mere renting of property within the District does not confer residency.* ***The Superintendent determines residency for enrollment, but this more restrictive requirement is needed for athletic eligibility per NYSPHSAA regulations.***

☐ ***Other Transfer Exemption:*** _____

By signing this document I attest that our previous residence has been abandoned by the immediate family and our current residence has been established through action and intent. I attest that the immediate family will be physically residing at our current address as inhabitants and intent to main indefinitely. I attest that the student has transferred without inducement, recruitment or having sought an athletic advantage or to avoid discipline at the sending school.

Parent Signature: _____ Date: _____

Parent's Name (Please type): _____

PART ONE

TO BE COMPLETED BY STUDENT'S RECEIVING SCHOOL

Receiving School:			
Students Name:			
Transfer Date:	Birthdate:	Grade Level:	Date Entered 9th Grade:
Receiving School		Students Name:	
Student/Family Previous Address:			
Student/Family Previous Address:			
Parent I name & address:			
Parent II name & address:			
Name of Sending School:			
Did student participate in athletics at sending school: ☐ Yes or ☐ No			
The undersigned herby certify that the student named herein has transferred to his/her present school without inducement, recruitment or having sought an athletic advantage or to avoid discipline at the sending school. The receiving school's administration is responsible for verification for these and other eligibility requirements.			
Superintendent's Signature: Date:			
Principal Signature: Date:			
Athletic Director Signature: Date:			

PART TWO TO BE COMPLETED **BY SCHOOL STUDENT PREVIOUSLY ATTENDED**
AND RETURNED TO STUDENT'S PRESENT SCHOOL

Students Name:	Date Entered 9th Grade:
Did student repeat any grades? ☐ Yes or ☐ No If yes, which ones?	
Name of School(s) Attended Prior to Transfer:	
Date of entrance to this school Date of withdrawal from this school:	
Student's address while attending the above school:	
With whom did student reside at this address (name?)	
Relationship of this (these) person(s)?	

PART THREE - **TRANSFER STUDENT SPORT HISTORY (Please include all sports student participated in.)**

	Year	Sport	Level	APP'd (Sel.Class)	School
7th Grade			☐ Mod. ☐ JV ☐ Var.	☐ Yes ☐ No	
			☐ Mod. ☐ JV ☐ Var.	☐ Yes ☐ No	
			☐ Mod. ☐ JV ☐ Var.	☐ Yes ☐ No	
8th Grade			☐ Mod. ☐ JV ☐ Var.	☐ Yes ☐ No	
			☐ Mod. ☐ JV ☐ Var.	☐ Yes ☐ No	
			☐ Mod. ☐ JV ☐ Var.	☐ Yes ☐ No	
9th Grade			☐ Mod. ☐ JV ☐ Var.		
			☐ Mod. ☐ JV ☐ Var.		
			☐ Mod. ☐ JV ☐ Var.		
10th Grade			☐ Mod. ☐ JV ☐ Var.		
			☐ Mod. ☐ JV ☐ Var.		
			☐ Mod. ☐ JV ☐ Var.		
11th Grade			☐ Mod. ☐ JV ☐ Var.		
			☐ Mod. ☐ JV ☐ Var.		
			☐ Mod. ☐ JV ☐ Var.		
12th Grade			☐ Mod. ☐ JV ☐ Var.		
			☐ Mod. ☐ JV ☐ Var.		
			☐ Mod. ☐ JV ☐ Var.		

The undersigned have no knowledge that the student named herein has transferred to his/her present school without inducement, recruitment or having sought an athletic advantage or to avoid discipline at the sending school.

Superintendent's Signature:	Date:
Principal Signature:	Date:
Athletic Director Signature:	Date:

Section VI Executive Director Signature:	Date:

revised: 4/2016 S6 12/8/16 5/2/17

LAKELAND CENTRAL SCHOOL DISTRICT
Educating Today for a Better Tomorrow

Food Services

Magalie Porretto
Food Service Director

Janet Hernandez
Assistant Food Service Director

Dear Parent/Guardian,

Welcome to the Lakeland Central School District! The Food Service Department would like to take this opportunity to highlight the importance of submitting a free/ reduced price meal application when you first enroll in a new school district along with some helpful information.

All families are strongly encouraged at time of enrollment to complete a household application for Free and Reduced-Price Meals. Eligible students receive free of charge one breakfast and one lunch daily. Submitting your application can be done by completing the provided paper application or online at www.myschoolapps.com/Application. Eligible students must submit a new application at the start of every school year to recertify benefits. If you have questions or require assistance completing your application please call (914)603-9055.

For students that don't qualify for free/reduced price meals and for the purchase of a la carte items paying can be done several ways. You can bring in cash daily, deposit money to your child's account online (using myschoolbucks.com), or send in a check to school with your child made payable to the "Lakeland School Lunch Fund".

- All students who don't have money to purchase breakfast or lunch will be permitted to charge meals to their student account unless a parent/guardian provides written instructions to withhold meals.
- Students cannot charge a la carte items, extra entrée's, or second meals. This includes students who are eligible for free or reduced-price meals.

More and more children are developing allergies or sensitivity to various foods. Please be sure to provide your school nurse with a physician's note and Allergy Action Plan indicating what your child is allergic to. Healthcare provider notes and Allergy Action Plans must be updated annually with the school nurse.

Additional information, monthly menus, and other resources are available at www.lakelandschools.org.

If you have any questions, or need additional information, please do not hesitate to contact me. I look forward to serving your children. Thank you.

Sincerely,

Magalie Porretto

Magalie Porretto
Food Service Director

APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, complete only one application for your household using the instructions below. Sign the application and return the application to Rosemaire Elio 1086 East Main Street, Shrub Oak, NY 10588. If you have a foster child in your household, you may include them on your application. A separate application is not needed. Call the school if you need help: (914)603-9055. Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

PART 1 ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE APPLICATION FOR YOUR HOUSEHOLD.

(1) Print the names of the children, including foster children, for whom you are applying on one application.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, or if you believe any child meets the description for homeless, migrant, runaway (a school staff will confirm this eligibility).

PART 2 HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.

(1) List a current SNAP, TANF or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. The case number is provided on your benefit letter.
(2) An adult household member must sign the application in PART 4. SKIP PART 3. Do not list names of household members or income if you list a SNAP case number, TANF or FDPIR number.

PART 3 ALL OTHER HOUSEHOLDS MUST COMPLETE THESE PARTS AND ALL OF PART 4.

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box.** The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.
(3) Enter the total number of household members in the box provided. This number should include all adults and children in the household and should reflect the members listed in PART 1 and PART 3.
(4) The application must include the last four digits only of the social security number of the adult who signs **PART 4** if Part 3 is completed. If the adult does not have a social security number, check the box. **If you listed a SNAP, TANF or FDPIR number, a social security number is not needed.**
(5) An adult household member must sign the application in PART 4.

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). To determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

USE OF INFORMATION STATEMENT

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not submit all needed information, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the primary wage earner or other adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs.

We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

DISCRIMINATION COMPLAINTS

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.

Date Withdrew_____ F _____R _____D_____

2022-2023 Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and **return it to the address listed below.** Call (**914)603-9055,** if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: **Lakeland Central School District – Attention Food Service**
1086 East Main Street
Shrub Oak, NY 10588

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	Homeless Migrant, Runaway
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. **Skip to Part 4, and sign the application.**

Name: _____ CASE #: _____

3. Report all income for ALL Household Members (Skip this step if you answered 'yes' to step 2)

All Household Members (including yourself and all children that have income).
List all Household members not listed in Step 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any other source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of household member	Earnings from work before deductions ***Amount / How Often***	Child Support, Alimony ***Amount / How Often***	Pensions, Retirement Payments ***Amount / How Often***	Other Income, Social Security ***Amount / How Often***	No Income
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐

Total Household Members (Children and Adults) ☐☐

***Last Four Digits of Social Security Number:** XXX-XX- __ __ __ __ I do not have a SS# ☐

*When completing section 3, an adult household member must provide the last four digits of their Social Security Number (SS#) or mark the "I do not have a SS# box" before the application can be approved.

4. Signature: An adult household member must sign this application before it can be approved.
I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school will get federal funds; the school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.
Signature: _____ **Date:** _____
Email Address: _____
Home Phone: _____ Work Phone: _____ Home Address: _____

5. Ethnicity and Race are optional; responding to this section does not affect your children's eligibility for free or reduced price meals.

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
Race (Check one or more): ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Island ☐White

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

☐ SNAP/TANF/Foster
☐ Income Household: Total Household Income/How Often: _____/_____ Household Size: _____
☐ Free Meals ☐ Reduced Price Meals ☐ Denied/Paid
Signature of Reviewing Official_____ **Date Notice Sent:** _____

FREE AND REDUCED PRICE MEAL APPLICATION FACT SHEET

When filling out the application form, please pay careful attention to these helpful hints.

SNAP/TANF/FDPIR case number: This must be the complete valid case number supplied to you by the agency including all numbers and letters, for example, E123456, or whatever combination is used in your county. Refer to a letter you received from your local Department of Social Services for your case number or contact them for your number.

Foster Child: A child who is living with a family but who is under the legal care of the welfare agency or court may be listed on your family application. List the child's "personal use" income. This includes only those funds provided by the agency which are identified for the personal use of the child, such as personal spending allowances, money received by his/her family, or from a job. Funds provided for housing, food and care, medical, and therapeutic needs are not considered income to the foster child. Write "0" if the child has no personal use income.

Household: A group of related or non-related people who are living in one house and share income and expenses.

Adult Family Members: All related and non-related people who are 21 years of age and older living in your house.

Financially Independent: A person is financially independent and a separate economic unit/household when his or her earnings and expenses are not shared by the family/household. Separate economic units in the same residence are characterized by prorating expenses and by economic independence from one another.

Current Gross Income: Money earned or received at the present time by each member of your household before deductions. Examples of deductions are federal tax, State tax, and Social Security deductions. If you have more than one job, you must list the income from all jobs. If you receive income from more than one source (wage, alimony, child support, etc.), you must list the income from all sources. Only farmers, self-employed workers, migrant workers, and other seasonal employees may use their income for the past 12 months reported from their 1040 Tax Forms.

Examples of gross income are:

- Wages, salaries, tips, commissions, or income from self-employment
- Net farm income – gross sales minus expenses only – not losses
- Pensions, annuities, or other retirement income including Social Security retirement benefits
- Unemployment compensation
- Welfare payments (does not include value of SNAP)
- Public Assistance payments
- Adoption assistance
- Supplemental Security Income (SSI) or Social Security Survivor's Benefits
- Alimony or child support payments
- Disability benefits, including workman's compensation
- Veteran's subsistence benefits
- Interest or dividend income
- Cash withdrawn from savings, investments, trusts, and other resources which would be available to pay for a child's meals
- Other cash income

Income Exclusions: The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care Development (Block Grant) Fund should not be considered as income for this program.

If you have any questions or need help in filling out the application form, please contact:

Rosemarie Elio: Accounting Clerk

Telephone Number: (914)603-9055

LAKELAND CENTRAL SCHOOL DISTRICT
Educating Today for a Better Tomorrow

Food Services

Magalie Porretto
Food Service Director

Janet Hernandez
Assistant Food Service Director

Estimado padre/tutor:

¡Bienvenido al Distrito Escolar Central de Lakeland! El Departamento de Servicio de Alimentos quisiera aprovechar esta oportunidad para resaltar la importancia de presentar una solicitud de comida gratis oa precio reducido cuando se inscribe por primera vez en un nuevo distrito escolar junto con información útil.

Se recomienda encarecidamente a todas las familias que, en el momento de la inscripción, completen una solicitud del hogar para recibir comidas gratuitas oa precio reducido. Los estudiantes elegibles reciben gratis un desayuno y un almuerzo diario. Puede enviar su solicitud completando la solicitud en papel provista o en línea en www.myschoolapps.com/Application. Los estudiantes elegibles deben presentar una nueva solicitud al comienzo de cada año escolar para volver a certificar los beneficios. Si tiene preguntas o necesita ayuda para completar su solicitud, llame al (914)603-9055.

Para los estudiantes que no califican para comidas gratis/a precio reducido y para la compra de artículos a la carta, el pago se puede hacer de varias maneras. Puede traer dinero en efectivo todos los días, depositar dinero en la cuenta de su hijo en línea (usando myschoolbucks.com) o enviar un cheque a la escuela con su hijo a nombre de "Lakeland School Lunch Fund".

- A todos los estudiantes que no tengan dinero para comprar el desayuno o el almuerzo se les permitirá cargar las comidas a su cuenta de estudiante a menos que un padre/tutor proporcione instrucciones por escrito para retener las comidas.
- Los estudiantes no pueden cobrar artículos a la carta, platos principales adicionales o segundas comidas. Esto incluye a los estudiantes que son elegibles para recibir comidas gratis oa precio reducido.

Cada vez más niños desarrollan alergias o sensibilidad a diversos alimentos. Asegúrese de proporcionarle a la enfermera de la escuela una nota del médico y un plan de acción contra alergias que indique a qué es alérgico su hijo. Las notas del proveedor de atención médica y los Planes de acción para alergias deben actualizarse anualmente con la enfermera de la escuela.

Información adicional, menús mensuales y otros recursos están disponibles en www.lakelandschools.org.

Si tiene alguna pregunta o necesita información adicional, no dude en ponerse en contacto conmigo. Miro adelante a servir a sus niños. Gracias.

Atentamente,

Magalie Porretto

Magalie Porretto
Directora del Servicio de Alimentos

INSTRUCCIONES DE SOLICITUD

Para solicitar comidas gratuitas o precio reducido, llene sólo una solicitud de su hogar siguiendo las instrucciones. Firme la solicitud y envíela a Rosemaire Elio 1086 East Main Street, Shrub Oak, NY 10588. Si tiene un hijo de crianza en su hogar, usted puede incluir en su solicitud. Llame a la escuela si necesita ayuda: (914)603-9055. Asegure de que toda la información se proporciona. Si no lo hace puede resultar en la denegación de beneficios para su hijo o retrasos innecesarios en la aprobación de su solicitud.

PARTE 1 TODOS LOS HOGARES NECESITEN COMPLETAR LA Información. NO LLENE MAS DE UNA SOLICITUD PARA SU HOGAR.

(1) Imprima los nombres de los niños para usted está aplicando en una sola aplicación.
(2) Liste su grado y escuela.
(3) Marque el bloque para indicar un hijo de crianza que vive en su hogar, o si usted cree y niño cumple con la descripción para personas sin hogar, migrante, o escapado de casa (personal de la escuela confirmará esta elegibilidad).

PARTE 2 HOGARES CON CUPONES DE ALIMENTOS, TANF O FDPIR DEBE COMPLETE PARTE 2 Y FIRME PARTE 4

(1) Liste un presente SNAP, TANF, o FDPIR (Programa de Distribución de Alimentos en Reservaciones Indígenas) caso número de alguien viviendo en su hogar. El número del caso esta proporcionado en su tarjeta de beneficios.
(2) Un miembro adulto del hogar necesite firmar la solicitud en PARTE 4. Omita PARTE 3. No liste nombres de miembros del hogar o ingresos si lista un caso número de SNAP, TANF o FDPIR número.

PARTE 3 TODOS OTROS HOGARES NECESITEN LLENAR ESAS PARTES Y TODOS DE PARTE 4.

(1) Escriba los nombres de todos en su hogar, sean o no recibe ingresos. Incluya su nombre y los niños que usted está solicitando, todos los otros niños, su marido(a), abuelos, e otras personas en su hogar (familia o no). Utilice otra hoja de papel si necesita más espacio.
(2) Escriba la cantidad de ingresos Corrientes de cada miembro del hogar recibe, antes de impuestos o otras deducciones, e indique de donde vino, tales como sueldo, asistencia social, pensiones e otros ingresos. Si el ingreso corriente es más o menos del normal, indique el ingreso normal de esa persona. **Especifique la frecuencia con la cantidad de ingreso que se recibe: semanal, cada dos semanas, dos veces cada mes, o mensual.** El valor de cuidado de niños, proporcionado u arreglado, o cualquier cantidad recibida como pago por cuidado de niños o reembolso de los gastos incurridos por ese cuidado bajo de Cuidado de Niños y Subvención de Desarrollo Bloque, TANF y Programas de Cuidado de Niños de Riesgos **no** deben ser considerados como ingresos para este programa.
(3) Pon el número total de miembros de la familia en la cajita. Este número debe incluir todos los adultos y niños en el hogar, y debe reflejar los miembros enumerados en parte 1 y parte 3.
(4) La aplicación debe contener sólo los últimos cuatros dígitos del Numero de Seguridad Social del adulto que firme PARTE 4 si Parte 3 está llenando. Si el adulto no tenga un Numeró de Seguridad Social, marque la cajita. Si usted listó un número de SNAP, TANF o FDPIR, un número de Seguridad Social no es necesario.
(5) Un miembro adulto del hogar tiene que firmar la aplicación en Parte 4.

OTROS BENEFICIOS: Su hijo(a) puede ser elegible por beneficios como Medicaid o Programa de Seguro Médico para Niños (PSMN). Para determinar si su hijo(a) es elegible, funcionarios del programa necesitan información desde la solicitud de comidas gratis o precio reducido. Su consentimiento escrito se requiere antes de que cualquier información pueda ser puesta en libertad. Por favor, refiérase a la Carta de Revelación Paternal y Declaración de Consentimiento para obtener información sobre otros beneficios.

USO DE INFORMACIÓN DECLARACIÓN

USO DE INFORMACIÓN DECLARACIÓN: El Richard B. Russell Ley Nacional de Almuerzo Escolar exige la información en esta solicitud. Usted no necesita dar la información, pero si no lo hace, nosotros no podemos aprobar su hijo(a) por comidas gratis o a precios reducidos. Debe incluir los últimos cuatro dígitos del número de Seguridad Social del miembro adulto asalariado primario del hogar o cualquier adulto en el hogar que firme la aplicación. Los últimos cuatro dígitos del número de Seguridad Social no son necesarios si usted está solicitando para un hijo de crianza o usted lista un numero de Cupones de Alimentos, Temporal Asistencia para Familias Necesitadas (TANF) o el Programa de Distribución de Alimentos en Reservaciones Indígenas (PDARI) u otro identificador PDARI para su niño o cuando usted indica que el miembro adulto del hogar que firma la solicitud no tiene número de Seguridad Social. Nosotros usaremos su información para determinar si su niño es elegible para recibir comidas gratis o a precio reducido, y para la administración y la ejecución de los programas de almuerzo y desayuno. Es posible que compartiremos su información de elegibilidad con programas de educación, salud, y nutrición para ayudarles a evaluar, financiar, o determinar beneficios para sus programas, auditores para revisar programas, y funcionarios del orden para ayudarles a investigar violaciones de las reglas del programa.

AVISO DE NO DISCRIMINACIÓN

De conformidad con la Ley Federal de Derechos Civiles y los reglamentos y políticas de derechos civiles del Departamento de Agricultura de los EE. UU. (USDA, por sus siglas en ingles), se prohíbe que el USDA, sus agencias, oficinas, empleados e instituciones que participan o administran programas del USDA discriminen sobre la base de raza, color, nacionalidad, sexo, discapacidad, edad, o en represalia o venganza por actividades previas de derechos civiles en algún programa o actividad realizados o financiados por el USDA.

Las personas con discapacidades que necesiten medios alternativos para la comunicación de la información del programa (por ejemplo, sistema Braille, letras grandes, cintas de audio, lenguaje de seas americano, etc.), deben ponerse en contacto con la agencia (estatal o local) en la que solicitaron los beneficios. Las personas sordas, con dificultades de audición o discapacidades del habla pueden comunicarse con el USDA por medio del Federal Relay Service [Servicio Federal de Retransmisión] al (800) 877-8339. Además, la información del programa se puede proporcionar en otros idiomas.

Para presentar una denuncia de discriminación, complete el Formulario de Denuncia de Discriminación del Programa del USDA, (AD-3027) que está disponible en linea en:http://www.ocio.usda.gov/sites/default/files/docs/2012/Spanish_Form_508_Compliant_6_8_12_0.pdf. y en cualquier oficina del USDA, o bien escriba una carta dirigida al USDA e incluya en la carta toda la información solicitada en el formulario. Para solicitar una copia del formulario de denuncia, llame al (866) 632-9992. Haga llegar su formulario lleno o carta al USDA por:

(1) correo: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; o

(3) correo electrónico: program.intake@usda.gov.

Esta institución es un proveedor que ofrece igualdad de oportunidades.

Date Withdrew_____ F ____R _____D_____

2022-2023 Solicitud de Familia para las Comidas Escolares y Leche Gratis o Precios Reducidos

Para solicitar por comidas gratuitas o precios reducidos para sus niños, lea las instrucciones en el reverse, complete este formulario para su hogar, firme su nombre y volver a. Llame (914)603-9055 si usted necesita ayuda. Nombres adicionales se pueden ser listados en un documento separado.

Devuelva aplicaciones completas a: **Lakeland Central School District – Attention Food Service**
1086 East Main Street
Shrub Oak, NY 10588

1. Lista todos los niños en su hogar que asisten una escuela:

Nombre del estudiante	Escuela	Grado/Profesor(a)	Hijo/a de crianza	Sin Ingreso, Emigrante, Fugitivo
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR beneficios:
Si alguien en su hogar recibe cupones de alimentos, o beneficios de TANF o FDPIR, liste su nombre y CASO # aquí. Vaya a la parte 4, y firme la solicitud.

Nombre: _____ CASO #_____

3. Informe todos los ingresos para TODOS los miembros del hogar (Omita este paso si usted respondió 'sí' al paso 2)

Todos los miembros del hogar (incluyendo a ti mismo y todos los niños que tienen ingresos).
Lista todos los miembros de la Familia no aparece en el paso 1 (incluido usted mismo) incluso si no reciben ingresos. Por cada miembro de su familia, si no reciben ingresos, informe los ingresos totales de cada fuente en su conjunto sólo dólares. Si no reciben cualquier otra fuente de ingresos, escriba ' 0 '. Si introduce ' 0' o dejar los campos en blanco, está certificando (prometedor) que no hay informe de ingresos.

Nombre del miembro del hogar	Ganancias del trabajo antes de las deducciones ***Cantidad/Frecuencia***	La manutención de menores, pensión alimenticia ***Cantidad/Frecuencia***	Pensiones, los pagos de jubilación ***Cantidad/Frecuencia***	Otros ingresos, Seguridad Social ***Cantidad/Frecuencia***	Sin Ingreso, Emigrante, Fugitivo
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ /_____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ /_____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ /_____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ /_____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐

Totales miembros de la familia (niños y adultos) ☐☐

Últimos cuatros dígitos del Numero de Seguridad Social: XXX-XX- __ __ __ __

No tengo un SS# ☐

* Al completar la sección 3, un miembro de adulto del hogar tiene que proveer los últimos cuatro dígitos de su número de Seguro Social (SS#), o marcar el " no tengo un numero de SS#" antes de que la aplicación puede ser aprobada.

4. Firma: Un miembro adulto del hogar tiene que firmar esta aplicación antes de que puede ser aprobado.
Certifico (prometo) que toda la información en esta aplicación es verdadera y que todos los ingresos están reportado. Entiendo que les doy esta información para que la escuela recibirá fondos federales; los funcionarios de la escuela pueden verificar la información, y si yo doy intencionalmente información falsa, puedo ser procesado bajo leyes federales y estatales aplicables, y mis hijos pueden perder beneficios de comida.

Firma: _____ **Fecha:** _____
Dirección de correo electrónico: _____
Teléfono de la casa: _____Teléfono del trabajo: _____ Dirección de la casa:_____

5. Estamos obligados a solicitar información sobre la raza de sus niños y su origen étnico. Esta información es importante y ayudaa garantizar que servimos completamente a nuestra comunidad. Responder a esta sección es opcional y sus niños seguirán teniendo derecho a solicitar comidas escolares gratis o a precio reducido.
Grupo étnico : ☐ Hispano o latino ☐No hispano o latino
Raza (marque una o más): ☐Indio americano o nativo de Alaska ☐Asiático ☐Negro o afroamericano ☐Nativo de Hawái u otra isla del Pacífico ☐Blanco

NO ESCRIBA DEBAJO ESTA LINEA- PARA USO DE LA ESCUUELA

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

☐ SNAP/TANF/Foster
☐ Income Household: Total Household Income/How Often: _____/_____
☐ Free Meals ☐ Reduced Price Meals ☐ Denied/Paid Household Size: _____
Signature of Reviewing Official_____ **Date Notice Sent:**_____

HOJA INFORMATIVA DE SOLICITUD DE COMIDA GRATUITA O A PRECIO REDUCIDO

Al completar el formulario de solicitud, preste especial atención a estos útiles consejos.

Número de caso SNAP/TANF/FDPIR: Este debe ser el número de caso válido completo que le proporcionó la agencia, incluidos todos los números y letras, por ejemplo, E123456, o cualquier combinación que se use en su condado. Consulte una carta que recibió de su Departamento de Servicios Sociales local para obtener su número de caso o comuníquese con ellos para obtener su número.

Niño de crianza: Un niño que vive con una familia pero que está bajo el cuidado legal de la agencia de asistencia social o del tribunal puede figurar en su solicitud familiar. Indique los ingresos de "uso personal" del niño. Esto incluye solo aquellos fondos proporcionados por la agencia que se identifican para el uso personal del niño, como asignaciones para gastos personales, dinero recibido por su familia o de un trabajo. Los fondos proporcionados para vivienda, alimentos y cuidados, necesidades médicas y terapéuticas no se consideran ingresos para el niño de crianza. Escriba "0" si el niño no tiene ingresos para uso personal.

Hogar: Un grupo de personas relacionadas o no relacionadas que viven en una casa y comparten ingresos y gastos.

Miembros adultos de la familia: todas las personas relacionadas y no relacionadas que tienen 21 años de edad o más y viven en su casa.

Financieramente independiente: Una persona es financieramente independiente y una unidad económica/hogar separada cuando sus ingresos y gastos no son compartidos por la familia/hogar. Las unidades económicas separadas en una misma residencia se caracterizan por el prorrateo de gastos y por la independencia económica entre sí.

Ingreso bruto actual: dinero ganado o recibido en el momento actual por cada miembro de su hogar antes de las deducciones. Ejemplos de deducciones son impuestos federales, impuestos estatales y deducciones del Seguro Social. Si tiene más de un trabajo, debe enumerar los ingresos de todos los trabajos. Si recibe ingresos de más de una fuente (salario, pensión alimenticia, pensión alimenticia, etc.), debe enumerar los ingresos de todas las fuentes. Solo los agricultores, los trabajadores por cuenta propia, los trabajadores migrantes y otros empleados de temporada pueden usar sus ingresos de los últimos 12 meses informados en sus formularios de impuestos 1040.

Ejemplos de ingresos brutos son:

- Sueldos, salarios, propinas, comisiones o ingresos del trabajo por cuenta propia
- Ingreso agrícola neto: ventas brutas menos gastos solamente, no pérdidas
- Pensiones, anualidades u otros ingresos de jubilación, incluidos los beneficios de jubilación del Seguro Social
- Compensacion por desempleo
- Pagos de asistencia social (no incluye el valor de SNAP)
- Pagos de Asistencia Pública
- Asistencia de adopción
- Seguridad de Ingreso Suplementario (SSI) o Beneficios del Seguro Social para Sobrevivientes
- Pagos de pensión alimenticia o manutención de niños
- Beneficios por discapacidad, incluida la compensación del trabajador
- Beneficios de subsistencia de veteranos
- Ingresos por intereses o dividendos
- Efectivo retirado de ahorros, inversiones, fideicomisos y otros recursos que estarían disponibles para pagar las comidas de un niño
- Otros ingresos en efectivo

Exclusiones de ingresos: el valor de cualquier cuidado infantil proporcionado u organizado, o cualquier monto recibido como pago por dicho cuidado infantil o reembolso de los costos incurridos por dicho cuidado bajo el Fondo de desarrollo de cuidado infantil (subvención en bloque) no debe considerarse como ingreso para este programa. .

Si tiene alguna pregunta o necesita ayuda para completar el formulario de solicitud, comuníquese con:

Rosemarie Elio: empleada de contabilidad

Teléfono: (914)603-9055