

**VOORHEESVILLE ELEMENTARY SCHOOL
129 MAPLE AVENUE
VOORHEESVILLE, NEW YORK 12186**

PHONE: (518) 765-2382
FAX: (518) 765-3842
WEB ADDRESS: Voorheesville.org

MR. JEFFREY P. VIVENZIO
Principal

Dear Parent or Guardian:

Welcome to the Voorheesville Central School District! Please take some time and carefully complete, in detail, each of the following documents. Along with a completed registration packet, the following documentation is also required in order to enroll your child within the Voorheesville Central School District.

- Your child's original birth certificate.
- Your child's official immunization record (signed and stamped by physician or clinic staff).
- A physical examination record (signed and stamped by physician or clinic staff).
- Custody papers, if applicable. (If the student is not your biological child, you must present documentation that proves a permanent and total transfer of custody and control has been achieved.)
- Three (3) original proofs of residency within the school district. This information must include the name and address of a parent or guardian as well as be dated within the previous 30 days. This must include:
 - A deed or other documentation of real property ownership.
 - A lease or rental agreement.Examples of two other proofs of residency:
 - A utility bill in the parent's name showing the address within the district.
 - The address on the parent's driver's license.
 - A record of the parent's voter registration.
 - A recent income tax return showing the parent's name and address within the district.
 - A current paycheck stub showing the parent's name and address within the district.

If you have any questions while completing the registration application, please do not hesitate to contact me at school.

Sincerely,

Mr. Jeffrey P. Vivenzio
Principal

KINDERGARTEN REGISTRATION AND SCREENING 2023

Monday, May 8 and Tuesday, May 9, 2023

Please bring the following when you come for Kindergarten Registration Screening :

1. **YOUR CHILD** who will enter Kindergarten in September, 2022
2. **NOTORIZED** Affidavit of Residency
3. **PROOF** of residency (3 forms, *one being ORIGINAL lease or ORIGINAL deed or other documentation of real property ownership*).
4. **BIRTH CERTIFICATE** – must be original
5. **PROOF** of guardianship (if applicable)
6. **COMPLETED** registration packet, *ALL* forms
7. **COMPLETED** transportation forms
8. **PROOF** of immunizations
9. **COMPLETED** Emergency Health Information Form (front and back)
10. **RECENT** physical exam form completed by a physician (*Physical exam must be dated within a year of the 1st day of school*)
11. **GLASSES**, if applicable
12. **COMPLETED** pre-kindergarten questionnaire

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

www.voorheesville.org



NOTICE TO PARENTS

SPECIAL EDUCATION SERVICES

If you suspect that your child may have a disability and due to that disability may require special education supports, services or accommodations, you have the right to contact the District for information on options, and/or you may refer your child to the District's Committee on Special Education or Section 504 Team for an evaluation, and a determination as to whether your child is eligible to receive special education services, related services, accommodations and/or other program aids and services. More information regarding your rights is set forth in the New York State Education Department's *Parents Guide to Special Education in New York State for Children Ages 3-21*, available at <http://www.p12.nysed.gov/specialed/publications/policy/parentsguide.pdf>

To refer your child to the Committee on Special Education, or to obtain more information regarding the District's special education process, including services and programs, please contact:

Karen Jones
Pupil Personnel Services Director
Voorheesville Central School District
PO Box 468
129 Maple Avenue
Voorheesville, NY 12186
Phone: 518-765-2382, ext. 501
Email: kjones@voorheesville.org

Student Name: _____

Grade _____

REQUIREMENTS FOR REGISTRATION

(To be completed by Registrar)

Date Verified

PROOF OF RESIDENCY: A minimum of three (3) documents verifying residency will be required. The following are examples of acceptable documents.

Initial

1. If renter, original lease which includes landlord's name, address and telephone number OR
2. Original contract to build or buy which includes seller, realtor and name/address of realtor.
3. Utility bill with current name and address.
4. License and car registration with current name and address.
3. Paycheck with current name and address.
4. Certificate of occupancy issued by town/village.
5. Automobile insurance policy with current name and address.
6. Credit Union account statement with current name and address.
7. Voter registration card with current name and address.
8. Telephone bill with current name and address.

PROOF OF GUARDIANSHIP (Parent/Registrar)

Date Verified

Initial

1. Court papers if granting custody.
2. Assuming custody of child: two sets of documents – one by parent transferring custody, one by parent assuming custody.
3. Homeless: STAC form
4. HUD Section 8 housing
5. D.S.S. Benefit Certificate

STUDENT INFORMATION (Parent/Registrar)

Date Verified

Initial

1. Child's birth certificate with seal from Court (not hospital) or certified copy.

ADDITIONAL INFORMATION (Parent – Home School)

Date Verified

Initial

1. Complete Household Information form. _____
2. Complete information request/release form _____
 - a. Student transcript and current report card/grades, IEP, Special needs.
3. Student's immunization/health/dental records.
Nurse _____ Date: ____/____/____
4. Transportation Request Form. _____

AFFIDAVIT OF RESIDENCY

Date Verified

Initial

- Making an apparently false sworn statement is a second degree Class A misdemeanor under Section 210.35 of the Penal Law
- The parent/guardian will be billed for tuition if the child is a non-resident not entitled to attend the schools of the Voorheesville Central School District.

VOORHEESVILLE CENTRAL SCHOOL DISTRICT
HOUSEHOLD INFORMATION

CPSE ONLY

St. Id#

Date

Area of Concern

Is the child in permanent housing? ☐ In permanent housing

If the child is not in permanent housing; please indicate his/her current living situation:

- ☐ In a shelter ☐ In a hotel/motel ☐ 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 car, park, bus or train station, or campsite
☐ Other temporary living situation (Including situations for seasonal employment) Describe: _____
☐ Temporarily housed in a shelter awaiting foster care placement

Student Name: _____ (M or F) DOB: _____ Grade Entering _____
Physical Address: _____ Home Phone: _____
City/Zip Code: _____ IS THIS A CELL NUMBER? YES NO
Mailing address (if applicable) _____

Own _____ Rent _____ Lease _____ Other/Please explain: _____

Have you ever attended VCSD before? Yes or No

Parents/Guardians

Name and relationship to student:

1) _____ relationship: _____ occupation/employer: _____
2) _____ relationship: _____ occupation/employer: _____

Parent/Guardian(s) in active Military status: Yes _____ No _____

If parent/guardians are separated, what legal arrangements are in place :

Joint Custody Sole Custody Visitation Rights Foster Students

If applicable, name and contact information of parent **NOT** residing with child:

Phone: _____

Duplicate mailings requested: Yes No
(PLEASE CIRCLE ONE)

NOTE : A complete certified copy of the court custody decision bearing its case number and including the official stamp and signature are required.

Contact Information: Please list, in order, contact information for people (and their relationship to the child) to be notified should your child become ill. (Parents/Guardians should be first, followed by people to contact if parents aren't available.) Please list what type of phone the number is, for example: C=cell, H=home, W=work.

1)	Relationship	#1:	#2:	#3:
2)	Relationship	#1:	#2:	#3:
3)	Relationship	#1:	#2:	#3:
4)	Relationship	#1:	#2:	#3:

Children being registered and name of last school attended:

1)	_____	DOB: _____	Grade: _____
2)	_____	DOB: _____	Grade: _____
3)	_____	DOB: _____	Grade: _____
4)	_____	DOB: _____	Grade: _____

Other children in household: Please list all children living in the household (not of school age or beyond school age).

1)	_____	DOB: _____
2)	_____	DOB: _____
3)	_____	DOB: _____
4)	_____	DOB: _____

E-mail address: Please list any e-mail addresses that we may use to contact you.

Name: _____ e-mail address: _____

Name: _____ e-mail address: _____

Name: _____ e-mail address: _____

I understand that if I provide false information on the registration forms and/or on the supporting materials that I may be committing the crime of perjury in the third degree (a class A misdemeanor); if I provided false information on these forms to the Voorheesville Central School District with the intent to defraud the District, I may be committing the crime of perjury in the second degree (a class E Felony); and I may be prosecuted on the criminal charges for such false information.

Signature of parent/guardian _____ Date _____

If any of the above information changes, please be sure to contact the school as soon as possible to provide updated information.

AFFIDAVIT OF RESIDENCY
Voorheesville Central School District

State of New York _____ County of _____
_____ being duly sworn, deposes and says:
(Name of Parent)

1. I reside at _____
(Legal Residence of Parent)
_____ Telephone Number _____

2. _____ is/are my _____
(Name of Child/Children) (Relationship)

and he/she has been living with me at the above address since _____
(Relevant Date)

3. If your child's/children's other parent does not reside at the same location, then provide the following information:

(Other Parent's Name) (Address) (Phone Number)

4. I make this affidavit for the purpose of establishing residency within the Voorheesville Central School District.

Complete Either 5A or 5B

5A. In support of the above, as a home owner, I have attached the most recent copy of at least three of the following proofs of residency. Place a check in front of each item attached.

___ Property tax bill ___ Telephone bill ___ Water tax bill
___ Electric bill ___ Bank statement ___ Voter Registration Card
___ Other (specify) _____

5B. In support of the above, as a renter, I have attached the original and current lease including the landlord's name, address, and telephone number and most recent copy of at least two of the following proofs of my residency. Place a check mark in front of each item attached.

___ National Grid bill with current name and address
___ License and car registration with current name and address
___ Paycheck with current name and address
___ Certificate of occupancy issued by town/village
___ Automobile insurance policy with current name and address
___ Bank/Credit Union account statement with current name and address
___ Voter registration card with current name and address

6. If you are a renter, complete the following: Landlord's name _____
Landlord's phone number _____

Sworn to before me this _____
(Signature of Resident Adult)

Day of _____ 20____

(Notary Public)

Anyone providing false information on this affidavit of residency is subject to criminal charge.

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

www.voorheesville.org

Jeffrey Vivenzio

Principal/District Registrar
(518) 765-2382, Ext. 504



Information Packet

Print Student's Name _____ **Grade** _____

Please sign and date below that you have reviewed the following items together.

1. Code of Conduct (Voorheesville.org/about-us/policies-and-procedures/)

Print Parent's/Guardian's Name Parent's/Guardian's Signature Date

Print Student's Name Student's Signature Date

2. Computer Network Policy found here:
Voorheesville.org/departments/technology

Print Parent's/Guardian's Name Parent's/Guardian's Signature Date

Print Student's Name Student's Signature Date

Please complete and return the following items if applicable:

1. Family Application for Free and Reduced Price School Meals
Voorheesville.org/departments/food-services/

VOORHEESVILLE CENTRAL SCHOOL REQUEST FOR TRANSPORTATION

Student Last name _____ First name _____ Middle Initial _____ Grade _____

Residential Address _____

Mailing Address if Different than Residential Address

Date of Birth ____/____/____ Male or Female Are there siblings currently in school? Yes / No

Full Name of Parent / Guardians	Relationship to Student	Home Phone	Work Phone	Cell Phone	Email Address
1)					
2)					

Resides With: ☐ Both Parents ☐ Father ☐ Mother ☐ Other _____

Emergency Contacts	Relationship to Student	Home Phone	Work Phone	Cell Phone	Email Address
1)					
2)					

*Special Pick Up Point or Drop Off Point **IF** different from Home Address:*

PICK UP POINT Name _____
 Address: _____
 Phone: _____

DROP OFF POINT Name _____
 Address: _____
 Phone: _____

Is there anything that the Transportation Department needs to be made aware of? (such as allergies, motion sickness, etc.)

Transportation Use Only

Siblings Y / N	Data Entered Y / N	Geocoded Y / N	Routed Y / N
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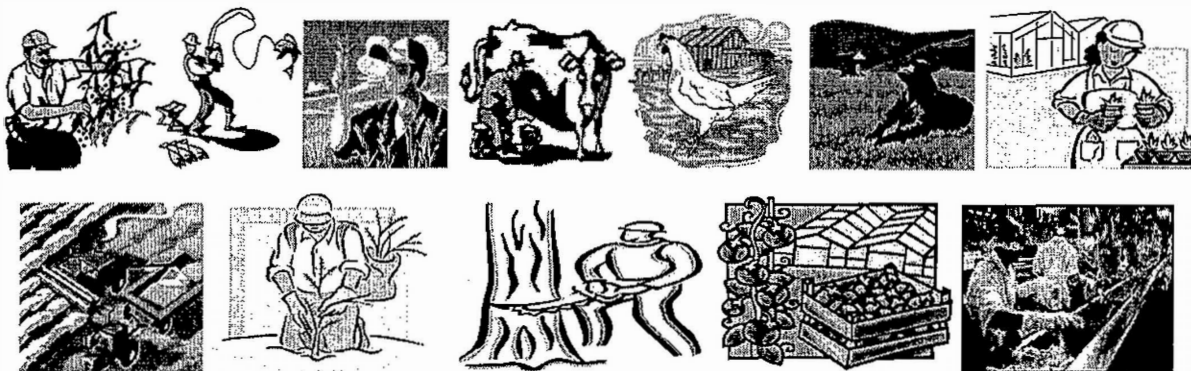
NEW YORK STATE MIGRANT EDUCATION PROGRAM
IDENTIFICATION & RECRUITMENT OFFICE
PARENT SURVEY

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

Please take few minutes to complete this questionnaire.

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

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



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

Parent/Guardian Name: _____

Home address: _____

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

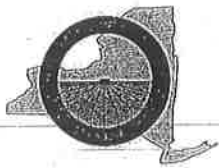
Previous Address: _____

Student name: _____ Age _____ Grade _____

Student name: _____ Age _____ Grade _____

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





PROGRAMA DE EDUCACIÓN PARA MIGRANTES DEL ESTADO DE NEW YORK

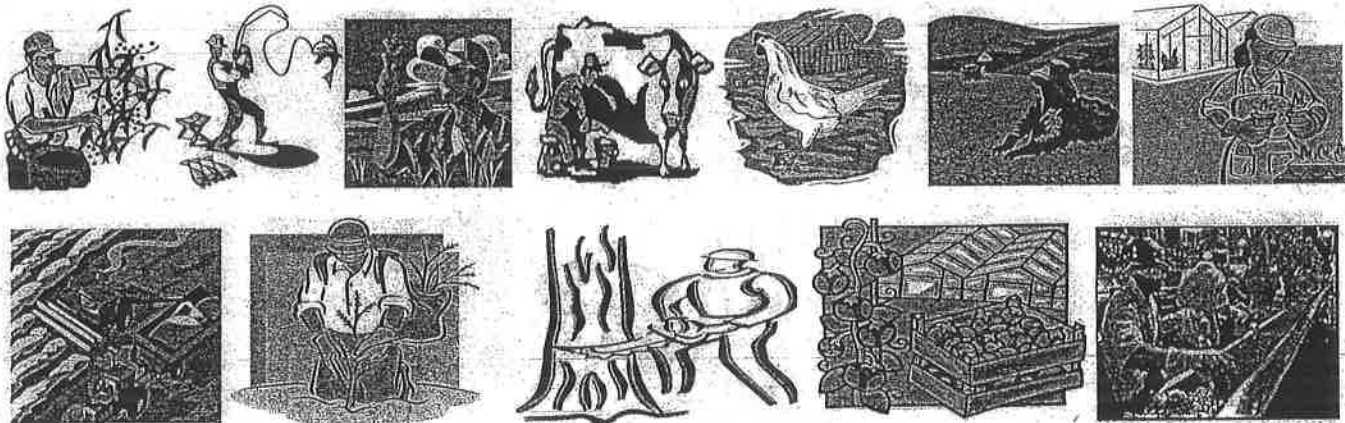
OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Acta de Educación Elemental y Secundaria (ESEA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, sin importar su nacionalidad o estado legal. Este programa es gratuito para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito en la escuela, excursiones; programa de verano; actividades de involucramiento para padres, programa de emergencias y referidos a otras organizaciones o agencias.

Por favor tome unos minutos para completar este cuestionario.

¿Usted o algún miembro de su familia ha trabajado o buscado trabajo en algunas de las siguientes ocupaciones en los pasados 3 años?

- ☐ Cualquier trabajo agrícola (como plantando, seleccionando, o cosechando frutas o vegetales, cultivando o cortando flores o árboles, trabajo en lechería u otro rancho de animales, pescando, etc.)
- ☐ Trabajando en la cultivación o procesamiento de los árboles.
- ☐ Trabajando en una planta de procesamiento, empacando, lavando o cortando vegetales, frutas o carnes,



Si usted contestó que sí, por favor complete la siguiente información:

Nombre del Padre/Encargado: _____

Dirección Física: _____

Teléfono: (____)-____-____ Mejor tiempo para ser contactado _____ AM/PM

Dirección anterior: _____

Nombre del estudiante: _____ Edad _____ Grado _____

Nombre del estudiante: _____ Edad _____ Grado _____

Para someter este referido, por favor envíelo por fax a 518-289-5623, o por correo a NYS Migrant Education Program- Identification & Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY





Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

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

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

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section		
STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
Month	Day	Year
<input type="checkbox"/> Male		
<input type="checkbox"/> Female		
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name		First Name
		Relation to Student

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?
☐ English ☐ Other specify
2. What was the first language your child learned?
☐ English ☐ Other specify
3. What is the Home Language of each parent/guardian?
☐ Mother specify ☐ Father specify
☐ Guardian(s) specify
4. What language(s) does your child understand?
☐ English ☐ Other specify
5. What language(s) does your child speak?
☐ English ☐ Other ☐ Does not speak specify
6. What language(s) does your child read?
☐ English ☐ Other ☐ Does not read specify
7. What language(s) does your child write?
☐ English ☐ Other ☐ Does not write specify

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: ☐ Mother ☐ Father ☐ Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____

POSITION: _____

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

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

NAME: _____

POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ No ☐ Yes

**DATE OF INDIVIDUAL

INTERVIEW: _____

MO

DAY

YR

OUTCOME OF

INDIVIDUAL

INTERVIEW:

☐ ADMINISTER NYSITELL

☐ ENGLISH PROFICIENT

☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____

POSITION: _____

DATE OF NYSITELL
ADMINISTRATION: _____

MO

DAY

YR

PROFICIENCY LEVEL

ACHIEVED ON

NYSITELL:

☐ ENTERING

☐ EMERGING

☐ TRANSITIONING

☐ EXPANDING

☐ COMMANDING

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

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

VOORHEESVILLE, NEW YORK 12186

BOARD OF EDUCATION

Rachel Gilker
PRESIDENT

Rob Samson
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DISTRICT OFFICE

JAMES SOUTHARD
ASSISTANT SUPERINTENDENT
FOR FINANCE & OPERATIONS

CHRISTY RIVENBURG
TREASURER
JESSICA TABAKIAN
CLERK

PHONE: (518) 765-3313

FAX: (518) 765-2751

To All Parents / Guardians:

The Voorheesville Central School District has adopted a policy which requires the collection and recording of the ethnic identity of students in the Voorheesville Central School District in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and Federal Education Departments
- Plan educational programs and make sure that they are readily available to all students.
- Analyze differences in academic performance, attendance, and completion of school.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the back of this page. Put a check (✓) in the box for the category or categories which best describes your child. The Voorheesville Central School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the students appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff: This form will be filed in the student's permanent record as confidential information.

To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below:

The Family Education Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student's name or student identification number.

PLEASE COMPLETE THE FORM ON THE REVERSE SIDE OF THIS PAGE

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

STUDENT RACIAL AND ETHNIC IDENTIFICATION

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Name of School

School District Student Identification Number;

Date of Birth (Month/Day/Year):

Student Name: Last First, Middle;

Grade Level:

DIRECTIONS TO PARENT / GUARDIAN

PLEASE ANSWER QUESTIONS (1) AND (2). PLEASE READ THEM BEFORE YOU RESPOND. (For question (1), check [✓] the box that best described your child). Check [✓] only ONE box.

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

- ☐ YES, Hispanic
☐ NO, not Hispanic

2. Select one or more races from the following five racial groups (For question check [✓] all groups that apply to your child; check [✓] at least ONE box).

- ☐ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- ☐ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **BLACK OR AFRICAN AMERICAN:** A person having origins in any of the Black racial groups of Africa.
- ☐ **WHITE:** A person having origins in any or the original peoples of Europe, North Africa, or the Middle East.

Signature of Parent / Guardian / Other

Date

Relationship to Student (Please check one box below)

- ☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify): _____

See reverse for important message to Parents / Guardians
and Confidentiality Procedures and Regulations

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

www.voorheesville.org

Jeffrey Vivenzio

Principal/District Registrar
(518) 765- 2382, Ext.502



Dear Parents/Guardians :

There are a number of instances throughout the school year where there are opportunities for photographs for school events. They may be taken by a teacher documenting projects or field trips, and used in teacher web publications or newsletters.

At times we may use these photos for educational purposes or publicity to highlight the many wonderful things that go on in our school. *We will **not** specifically identify students in the photographs placed in newsletters or the district website.* On occasion a photographer from a newspaper may be here for an event. *If* they would like to identify students for the newspaper, we will ask for permission specific to the instance.

If for any reason you do not want your child's photograph used, please return the form below . Feel free to call me with any questions.

I **DO NOT** wish to have my child's photograph used for publicity or other educational purposes.

Student Name : _____

Grade and Teacher : _____

Parent/Guardian Signature: _____ Date _____

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

School Health Services

Dear Parent or Guardian :

As a part of your child's requirements for school, NYSED requires an annual New York State physical exam for students in grades K,1,3, and 5 as well as those entering the school district for the first time. A law was recently enacted that expands health screenings to include the dental health of students in New York State.

In addition, when we require that your child have a physical examination, we will be requesting a dental certificate as well. There is a sample certificate available for you to take to your child's dentist and once it is completed, it should be returned to the School Nurse as it will be filed in our child's Cumulative Health Record.

Thank you for your cooperation in this new health endeavor. Our students benefit when we work together to promote the health and achievement of all students.

Please call the school's Health Office if you have any questions or concerns.

Megan Pooler, RN – Middle/High School 765-3314 ext 210

Kelsey Lyons, RN – Elementary School 765-2382 ext 506

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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: Date of last seizure: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Lead Level Required Grades Pre- K & K		Date		
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$				

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

☐ **Assessment/Abnormalities Noted/Recommendations:** Diagnoses/Problems (list) ICD-10 Code*

☐ **Additional Information Attached**

*Required only for students with an IEP receiving Medicaid

Name:	DOB:
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SCREENINGS				
Vision (w/correction if prescribed)	Right	Left	Referral	Not Done
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Near Vision Acuity	20/	20/		<input type="checkbox"/>
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Notes				
Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	Negative <input type="checkbox"/>	Positive <input type="checkbox"/>	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	Not Done <input type="checkbox"/>

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK	
<input type="checkbox"/> Student may participate in all activities without restrictions.	
<input type="checkbox"/> Student is restricted from participation in:	
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.	
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.	
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.	
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V	Age of First Menses (if applicable) : _____
<input type="checkbox"/> Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.	

MEDICATIONS
<input type="checkbox"/> Order Form for Medication(s) Needed at School Attached

IMMUNIZATIONS
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS

HEALTH CARE PROVIDER
Medical Provider Signature:
Provider Name: <i>(please print)</i>
Provider Address:
Phone:
Fax:

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

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first oral health assessment? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

VOORHEESVILLE ELEMENTARY SCHOOL
EMERGENCY HEALTH INFORMATION

Name of Student _____ DOB _____ Age _____
(Last) (First)

Home Address _____

Grade _____ Teacher _____ Home Phone _____

*Parent/Guardian _____ Located at _____
(During school hours) (Phone number)

*Parent/Guardian _____ Located at _____
(During school hours) (Phone number)

*Step-Parent _____ Located at _____
or Guardian (During school hours) (Phone number)

*Please put a priority as to who you would like called first.

In the event of early dismissal, illness or injury, if parents/guardians cannot be reached, contact the following for care/transportation:

**NOTE: PLEASE ADVISE THESE INDIVIDUALS YOU ARE LISTING THEM FOR
EMERGENCY CARE IN CASE THE SCHOOL IS UNABLE TO REACH YOU.**

1. _____ at _____
(Phone Number)

Or _____ at _____
(Phone Number)

2. Child's Physician _____ at _____

3. Family Dentist _____ at _____

4. Hospital _____ (in event of serious injury)

5. Has your child had medical, dental or surgical treatment, or any other serious illness or injury ?

Parent/Guardian Signature _____ Date _____

OVER

Has your child ever had any of the following? Please give dates

Anemia	Pneumonia	Chicken Pox
Rheumatic Fever	Diabetes	Rheumatic Fever
Tuberculosis	Mumps	Epilepsy
Nephritis	Contact with TB	Heart Disease
Bladder Infection	Whooping Cough	Orthopedic Injuries

1. Does your child have asthma and if so what makes him/her wheeze or get short of breath? _____

2. Please list any medication your child takes _____

3. Please list any allergies your child has and the medication (if any) they are taking

4. Does your child have or has had a history of chest pain with exertion? Please explain _____

5. Does your child have a history of fainting with exertion? Please explain

6. Does your child have a history of shortness of breath with exertion? Please explain _____

7. Does your child have a family history related to cardiac cause? Please explain

8. Does your child have chronic/frequent ear infections? _____
 - a. If so, does your child have tubes in their ears? _____
9. Any problems with toilet training for bladder or bowels? _____
10. Does your child wear glasses? If so, all the time or for classwork? _____
11. Is there anything concerning the health of your child which the school should know so that we may better understand your child's health needs?

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

New York State Education Law requires that every child have a physical examination upon entering the school district for the first time, as well as in grades 2 and 4. The school offers school physicals for students in grades 2, 4, 7 and 10. However, if you wish to have your child examined by your own physician (or pediatrician), who may know your child best, you are free to do so. If you choose an exam by your private physician he/she must fill out the attached form to be returned to school. **A recent medical exam, completed within the past 12 months, is acceptable.** In this case, you may mail the form to your doctor requesting them to complete it and return it to school.

The school physician does not diagnosis medical problems. These will be reported to you immediately and you will be advised to bring them to the attention of your family doctor. We will request a report of your physician's findings and treatments.

Please check the appropriate statement below and return this form to school as soon as possible. If I do not receive a response from you, I will make arrangements to have your child examined by the school physician.

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

Student's Name _____ Grade _____

I prefer to have my child examined by the school physician, Dr. Silverman.

I prefer to have my child examined by our private physician. Private physician's appointment date is _____. (Bring the attached form to this appointment and have the physician fill it out and return it to school .)

My child was examined by Dr. _____.
on _____. I will have the physician fill out the form
and return it to school.

Parent's Signature

Thank you,

Kelsey Lyons, R.N.
Elementary School Nurse

Megan Pooler, R.N.
Middle/High School Nurse

VOORHEESVILLE ELEMENTARY SCHOOL
129 Maple Avenue
Voorheesville, New York 12186

The Voorheesville Elementary School has implemented a program to further ensure your child's safety. In conjunction with the Missing Children Registry Laws, we seek your cooperation in our Absence Call-In Procedure.

On any day your child is not attending school or will be later than 8:40, parents are to call the elementary school attendance office at 765-2382 ext. 514 **before 9:00 a.m.** Since many missing children incidents occur between school and home, your phone call will assure us that your child is safe. If we have not received notification from home, parent(s) of absent children will be contacted by the school for verification.

To implement this program, please complete the form below and return with the registration package.

VOORHEESVILLE ELEMENTARY SCHOOL
129 Maple Avenue
Voorheesville, New York 12186

I understand that *for my child's safety*, in the event of his/her absence or tardiness I will notify the school **before 9:00 a.m.**

Child's Name

Grade

Telephone Number – Home & Work

Person for school to contact if I have not called in the morning of my child's absence.

Parent/Guardian Signature Date

**VOORHEESVILLE ELEMENTARY SCHOOL
PRE-K SCREENING QUESTIONNAIRE**

Child's Name: _____

Date: _____

Form Completed by: _____

Relationship: _____

Do you have any concerns about your child's development (speech, fine/gross motor, social/emotional) and his/her anticipated entry into kindergarten?

Is there any information you would like to share with us that you feel may influence your child's adjustment to school? (ex. changes affecting your family; moving, separate households, new baby, illness etc.)

Has your child had any of the following pre-K experiences?

Type	Ages	Location/Name
<input type="checkbox"/> Home Day Care		
<input type="checkbox"/> Day Care Facility		
<input type="checkbox"/> Nursery/Preschool		
<input type="checkbox"/> Other		

Has your child participated in any other pre-K group activities?

<input type="checkbox"/> Play Groups	<input type="checkbox"/> Story Hour	<input type="checkbox"/> Instructional programs (soccer, T-ball)	<input type="checkbox"/> Other
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Do you give permission for your child's pre-k teacher(s) to be contacted, if necessary for information relevant to educational programming? Y_____ N_____ Teacher Name: _____

Telephone: _____ Your Signature _____

Has your child received any of the following therapy services via Early Intervention services or through the Committee for Preschool Special Education (CPSE)?

<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Other services
-----------------------------------------	-------------------------------------------	-----------------------------------------------	-----------------------------------------

Is a language other than English spoken in the home? If so to what extent? _____

Are there other children entering our kindergarten program who are related to your child? Please indicate name(s) and relationship (cousin etc.) _____

Voorheesville Elementary School



General Speech (Articulation) Activities For Any Sound

1. Play listening games for your sound at the beginning of words.
2. Walk around your home and find objects that contain your sound. You may wish to collect some in a box or bag. Pretend it's a shopping trip for certain items.
3. Make a scrapbook of pictures of words with your sound by leafing through old magazines, newspapers, and catalogs. Cut out pictures that contain the target sound and paste on construction paper.
4. When riding in the car, search for as many things as possible that begin with your sound. Practice pronouncing these words.
5. Sit in front of a mirror and watch the formation of your tongue, teeth, and lips for certain sounds. See if your child can initiate upward, downward, protrusion and lateral tongue movements. Play "Simon Says" with your mouth.
6. Use a tape recorder to practice saying words and listening to oneself.
7. Find books and songs and TV programs whose titles contain the child's difficult sound. Reinforce by reading, singing, and watching.
8. Any informal sound activity is good. If your child is not ready to respond to these efforts, don't worry. His/her time will come!!