

**Voorheesville Central School District &  
The YMCA of the Capital District**

**2026-27 UPK 4-Year Old Program Information**

The Voorheesville Central School District is pleased to announce that our community-based partner (CBO) for our 2026-27 4-year-old UPK program is The YMCA of the Capital District.

Contingent on NYS Education Department's grant funding, the district will be collaborating on one classroom for four-year-olds. The class is designed to meet the needs of 20 students. The goal is to begin the program on Sept. 8, 2026.

This program is free for all who participate.

The UPK class will be held at Christ the King Early Learning Center, 20 Sumpter Avenue, Albany. The program will run from 8 a.m. – 1 p.m., Monday – Friday.

Transportation to and from the program is not provided.

*Please Note: While before and after care through the YMCA will be an option for this program additional fees will apply.*

**Applications for this program must be received by May 31, 2026.**

Placements are limited and will be assigned through a lottery system if oversubscribed.

Applications not initially selected will be placed on a waiting list and called when a space becomes available.

If your application is selected, you will receive an acceptance letter/call by June 12, 2026.

**Where can I obtain a registration packet for the UPK program?** Information and registration materials can be found at [www.voorheesville.org](http://www.voorheesville.org) or can be picked up at the Voorheesville Elementary School main office between 8 a.m. and 3 p.m.

**Questions?** If you have questions about the UPK program or registration, please contact Jeffrey Vivenzio at 518-765-2382 x504 or by email at [jvivenzio@voorheesville.org](mailto:jvivenzio@voorheesville.org)

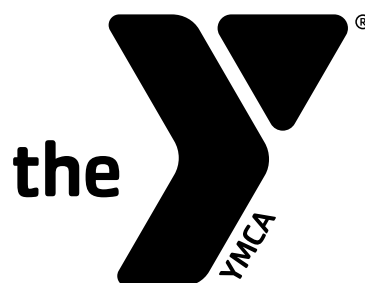


PLEASE COMPLETE AND RETURN THE ITEMS IN THIS REGISTRATION PACKET, ALONG WITH THE FOLLOWING:

- 1. Completed Application.**
- 2. Proof of Residency.** Acceptable proof of residence includes mortgage or property tax statement, copy of lease, or notarized statement from landlord, and two other proofs of residency (i.e. utility bill, driver's license and/or car registration, current paycheck stub showing parent's name and address within the district, voter registration card.)
- 3. Child's Birth Certificate.** Children must be four years of age by December 1, 2026 to attend the 2026-27 pre-K program.
- 4. Physical examination record,** signed and stamped by physician or clinic staff.
- 5. Child's Immunization Record.**
- 6. Custody Paperwork.** 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. If applicable, please attach a complete certified copy of the court decision bearing its case number, official stamp and signature. It is the responsibility of the parent/legal guardian to inform Voorheesville CSD of any subsequent modifications during the child's enrollment.

Completed applications and supporting documents can be dropped off at Voorheesville Elementary School, 8 a.m. - 3 p.m., Monday-Friday or emailed to Joanne Murphy, secretary to the district registrar, at [jmurphy@voorheesville.org](mailto:jmurphy@voorheesville.org).

**Packets must be received by May 31, 2026 to be considered for the lottery.**



**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 homeowner 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  
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: \_\_\_\_\_ (Male Female Non-Binary) 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: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_

Duplicate mailings requested: Yes No

**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 | _____ |

**Children being registered and name of last school attended:**

- 1) \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_  
2) \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_  
3) \_\_\_\_\_ 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.**



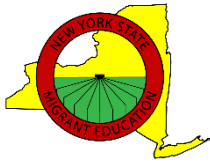
## NOTICE TO PARENTS

### 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 <https://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](mailto:kjones@voorheesville.org)



# 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

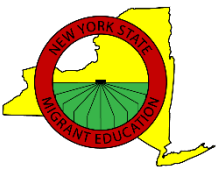
Previous Address: \_\_\_\_\_

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, empackando, 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 607-436-3606, o por correo a NYS Migrant Education Program- Identification & Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020**





Office of P12

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.*

<b>STUDENT NAME:</b>		
First	Middle	Last
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
Month	Day	Year
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other:
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other:
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1 _____ <small>specify</small>	<input type="checkbox"/> Parent 2 _____ <small>specify</small>
	<input type="checkbox"/> Guardian(s) _____ <small>specify</small>	
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other:
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other: <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other: <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other: <input type="checkbox"/> 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:

**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

Relationship 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:  Yes  No

\*\*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:

# 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.

<p>1. <b>Is the student Hispanic, Latino, or of Spanish origin?</b> 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.</p> <p><input type="checkbox"/> YES, Hispanic</p> <p><input type="checkbox"/> NO, not Hispanic</p>
<p>2. Select one or more races from the following five racial groups (Check all groups that apply to your child; check at least ONE box).</p> <p><input type="checkbox"/> <b>AMERICAN INDIAN OR ALASKA NATIVE:</b> 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.</p> <p><input type="checkbox"/> <b>ASIAN:</b> 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.</p> <p><input type="checkbox"/> <b>NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:</b> A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</p> <p><input type="checkbox"/> <b>BLACK OR AFRICAN AMERICAN:</b> A person having origins in any of the Black racial groups of Africa.</p> <p><input type="checkbox"/> <b>WHITE:</b> A person having origins in any or the original peoples of Europe, North Africa, or the Middle East.</p>

\_\_\_\_\_  
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  
**Health and Dental Examination Requirements**

Dear Parent or Guardian :

New York State law requires a health examination for all students **entering the school district for the first time and when entering Pre-K or K, 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup>, 7<sup>th</sup>, 9<sup>th</sup> and 11<sup>th</sup> grade**. The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time. The school will provide you with a list of dentists and registered dental hygienists who offer dental services on a free or reduced cost basis if you ask for it.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school and when your child starts Pre-K or K, 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup>, 7<sup>th</sup>, 9<sup>th</sup> & 11<sup>th</sup> grades, If a copy is not given to the school within 30 days, the school will contact you.
- If your child has an appointment for an exam during this school year that is after the first 30 days of school, please notify the Health Office with the date.
- For your convenience, a physical exam form and dental certificate for your health care providers can be found at <https://www.voorheesville.org/Page/432>
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the time of your child's appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office. Forms may also be faxed or emailed.

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

Erin Goodale, RN – Middle/High School (518) 765-3314 ext 2104

[egoodale@voorheesville.org](mailto:egoodale@voorheesville.org) fax (518) 765-5547

Sarah O'Leary, FNP-BC, MSN, RN – Elementary School (518) 765-2382 ext 4209

[soleary@voorheesville.org](mailto:soleary@voorheesville.org) fax (518)765-3842

**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**

<b>Allergies</b> <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
<b>Asthma</b> <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
<b>Seizures</b> <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
<b>Diabetes</b> <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**

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>List Other Pertinent Medical Concerns</b> (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"/>		
<b>Lead Level Required Grades Pre-K &amp; K</b>			<b>Date</b>	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$				

**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

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
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Additional Information Attached      \*Required only for students with an IEP receiving Medicaid





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 \_\_\_\_\_  
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)

1. Child's Physician \_\_\_\_\_ at \_\_\_\_\_

2. Family Dentist \_\_\_\_\_ at \_\_\_\_\_

3. Hospital \_\_\_\_\_ (in event of serious injury)

4. 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**

www.voorheesville.org

**Jeffrey Vivenzio**

Principal/District Registrar  
(518) 765- 2382, Ext.4000



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.**

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

Student Name : \_\_\_\_\_

Grade and Teacher : \_\_\_\_\_

Parent/GuardianSignature:\_\_\_\_\_Date\_\_\_\_\_