ARDSLEY UNION FREE SCHOOL DISTRICT
500 FARM ROAD, ARDSLEY, NEW YORK 10502
Phone (914)295-5500 • Fax (914)295-5976
www.ardsleyschools.org

NEW STUDENT REGISTRATION PACKET

Welcome to the Ardsley School District. Included in this registration packet are the forms to be completed by you to register your child for school. When all the registration forms are complete, please call to make an appointment to return them with the required documents to:

Ardsley Union Free School District
Administrative Office
500 Farm Road
Ardsley, New York 10502

If you have any questions, or to schedule an appointment to return your registration packet, please call Fran Monteleone at 914-295-5564, or email fmonteleone@ardsleyschools.org

Required Documents:

- Student's Birth Certificate, or Passport, or Record of Baptism
- NYS Health Examination Form with Immunization Record (completed within the past 12 months by a New York State physician)
- Copy of student's last Report Card
- Deed or Mortgage Statement or *Residential Lease/Rental Agreement

  *If you are renting/leasing an apartment or house, Registration Affidavit and Landlord Affidavit are required.

  *If you are living with a family member or friend, Registration Affidavit and Residency Affidavit are required.
- Utility bill or other bill/document that states your residence (as soon as available)
- Proof of Custody (This applies to parents who are separated or divorced and for children not living with biological/adoptive parents.)
- For out of district tuition students, first and last month tuition payments are due at the time of registration.

ARDSLEY UNION FREE SCHOOL DISTRICT
STUDENT RACIAL AND ETHNIC IDENTIFICATION

To the Parent/Guardian: 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. The Ardsley Union Free School District has adopted a policy which requires the collection and recording of the ethnic identity of students in the Ardsley Union Free 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.
- Study the movement of students in different ethnic groups as they move from school to school.
- Analyze differences in academic performance, attendance and completion of school.

The Ardsley Union Free 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 behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

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

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

NEW STUDENT REGISTRATION FORM: ARDSLEY UNION FREE SCHOOL DISTRICT

Student # _____ **STUDENT INFORMATION** **Registration Date**_____
Anticipated Grade_____

Household Surname_____

Student's Name (Last)_____ (First)_____ (Middle)_____

Nickname_____ Date of Birth_____ Sex _____

Address_____ City_____ State_____ Zip_____

Home Phone #_____ Student's Place of Birth _____

Dominant Language_____

Ethnicity (for NCLB): Is the student Hispanic, Latino or of Spanish Origin? □ Yes, Hispanic □ No, not Hispanic

Race (Select one or more): □ American Indian or Alaska Native □ Asian □ Black □ White
□ Native Hawaiian or Pacific Islander

Physician_____ Phone_____ Hospital Preferred _____

School Attended Last: District Address Grades/Dates

_____

Was student previously registered at Ardsley School District_____ Grades/Dates_____

FAMILY/GUARDIAN INFORMATION

Parent/Guardian Name (Last)_____ (First)_____ (Middle)_____

Address_____ City_____ State_____ Zip_____

Place of Birth_____ Language(s) spoken at home_____

Phone Numbers: (please number in order of priority) Relationship to Student:_____

( )Home Phone _____ ( )Cell Phone _____ ( )Work Phone_____

E-mail Address (Home) _____ (Work) _____

Employer or Nature of Business & Address_____

****

Parent/Guardian Name (Last)_____ (First)_____ (Middle)_____

Address_____ City_____ State_____ Zip_____

Place of Birth_____ Language(s) spoken at home_____

Phone Numbers: (please number in order of priority) Relationship to Student:_____

( )Home Phone _____ ( )Cell Phone _____ ( )Work Phone _____

E-mail Address (Home) _____ (Work) _____

Employer or Nature of Business & Address_____

****

Parents' Marital Status: Single_____ Married_____ Separated_____ Divorced_____ Widow(er)_____

Name of Custodial Parent_____ Evidence_____

Address of Last Residence_____ Home School District_____

Previous Phone #_____ Date Left Previous Residence_____

Date moved into the Ardsley Union Free School District_____

If a tuition student, date enrolled in home school district_____

Date of student's first attendance in New York State school_____

Date entered 9th grade (if applicable)_____

Has your child ever been suspended YES____ NO____ If yes, please detail_____
Has your child ever been expelled YES____ NO____ If yes, please detail_____
Has your child ever been convicted of a crime YES____ NO____ If yes, please detail_____

OTHER CHILDREN IN HOUSEHOLD

Name (Last, First, Middle)	Sex	Birth Date	Place of Birth	Name & Address of School last attended, or by whom employed	Grade

Does your child require any accommodation: Yes_____ No_____ If yes, please detail_____

Does your child receive special services or accommodations through the Committee on Preschool Special Education, Committee on Special Education, or Section 504: Yes_____ No_____
If yes, please detail_____
Evaluation Performed Yes_____ No_____
Please provide a copy of the Individualized Education Program (IEP) or Section 504 Accommodation Plan when returning this form along with all evaluations.

The answers you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act/Title I.

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

Are you, or is anyone in your family, a migrant worker or have been a migrant worker during the past 3 years?
□ Yes □ No

I understand that the District will seek restitution for tuition if it is determined that my child(ren) are not resident students of the Ardsley Union Free School District. I agree to pay such tuition.

Registered by_____ _____
Print Name & Relationship **Signature**

.....

FOR OFFICE USE ONLY

Proof of Age_____ Proof of Residency_____ By_____
Records Sent for – Date_____ Received – Date_____ Family Paying Tuition (√ if applicable) _____
Grade Assigned:_____ Homeroom:_____ School District Residence_____
Home School Paying Tuition (√ if applicable)_____

Rev. 10/01/2020

Ardsley Union Free School District
Student Emergency Form

Student Information:

Student Name: _____ _____ _____
Last First Middle

School:_____ **Grade**_____

DOB: _____/_____/_____ **Sex:** **M** or **F**

Address: _____

City, State, Zip _____, _____, _____ **Tel. #:** _____-_____-_____

Family Information:

To Parent/Guardian: To serve your child in case of Accident or Sudden Illness it is necessary that you furnish the following information for emergency calls:

	First & Last Name	Business Address	Bus. Phone	Cell Phone
Parent:	_____		___-___-___	___-___-___
Parent:	_____		___-___-___	___-___-___
Guardian:	_____		___-___-___	___-___-___

Language spoken at home: _____

Neighbor/Relative Contact Information:

List two (2) neighbors or nearby relatives who will assume temporary care of your child, if you cannot be reached:

Neighbor/Relative #1	Neighbor/Relative #2
Name_____	**Name**_____
Address_____	**Address**_____
Daytime Phone ___-___-___	**Daytime Phone** ___-___-___
Cell Phone ___-___-___	**Cell Phone** ___-___-___

Medical Information:

List any health conditions such as heart disease, diabetes, epilepsy, severe allergies, eye or ear problem or chronic condition, etc._____

Medical Contacts:

1st Choice _____ Phone: ___-___-___
Physician's First and Last Name Physician's Phone #

2nd Choice _____ Phone: ___-___-___
Physician's First and Last Name Physician's Phone #

Preferred Hospital:_____ Phone: ___-___-___

I (We), the undersigned do hereby authorize officials of the Ardsley School District to contact directly the persons named above and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event physicians, other persons named above, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of said child.

I (We) will not hold the school district financially responsible for the emergency care and/or transportation of said child.

_____ _____ _____
Signature of Parent or Guardian Date Teacher's Name

The parents/guardians will have equal access to this student in the case of accident or sudden illness, unless you provide proof of other arrangements. If you have any questions about this, please call the school nurse or the student's guidance counselor.

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:

Month *Day* *Year*

GENDER:
❑ 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:

IN-COMING STUDENT QUESTIONNAIRE

Student Name: _____ DOB: _____

Parents/Guardian: _____

Telephone: ( ) _____ Cell: ( ) _____

e-Mail address: _____

Previous School(s) (most recent first):

_____ Grades completed at this school: _____

_____ Grades completed at this school: _____

_____ Grades completed at this school: _____

Contact Person at most recent school (Guidance, Principal, Teacher, etc.): _____

Phone: ( ) _____

Does your child have an IEP or 504? IEP _____ 504 _____

List designation and accommodations: _____

_____

Does your child receive additional services (AIS, counseling, academic support, etc.): _____

_____

Any medications taken regularly: _____

Have there been any concerns regarding learning and/or emotional difficulties: _____

_____

Has attendance in school been a concern: _____

Has your child experienced any behavioral concerns (detentions, suspensions, lateness, etc.): _____

_____

Are there any academic placement concerns you wish to discuss: _____

_____

What is the primary language spoken at home? _____

What are your child's strengths and weaknesses? _____

_____

Is there any other important information you want to share with us? _____

_____

For non-Ardsley resident seeking enrollment on a tuition basis, please describe why you are seeking a transfer:

_____

_____

_____

SCREENING PROGRAM
SOCIAL DEVELOPMENTAL HISTORY

Date:_____

Name of Child:_____ Parent's Name:_____

Date of Birth:_____ Parent's Name:_____

Name of Nursery School:_____ Address:_____

_____

Phone Number:_____

Is your child presently taking any medication:

Yes_____ No_____ Please List_____

_____

1. (a) Have you ever suspected that your child may have defective eyesight?

_____

(b) Has he or she ever been seen by an eye specialist?

_____

(c) If so, what was the results of the examination and recommendations, if any?

_____

2. (a) Have you ever suspected that he or she may have defective hearing?

_____

(b) Has he or she ever had his or hearing tested outside of school?
Yes_____ No_____ Date_____

(c) If so, what was the result of the examination and recommendations, if any:

_____

3. (a) Has your child had any other screening or evaluations?
Yes_____ No_____ Date_____

(b) If yes, what were the results?_____

4. (a) Has your child been hospitalized at all since birth?
Yes_____ No_____ Date:_____

(b) If yes, what was the reason?_____
_____

(c) Any other serious illness or injuries?_____
_____

5. Up to now, have you been satisfied with your child's progress in general?_____
If not, why?_____

6. In what areas do you feel your child needs to improve?_____
_____

7. Does your child make and keep friends easily?_____
If not, please explain_____

8. Does your child adjust well to new situations? (for example: moving to a new neighborhood, going to a new school, making new friends)_____
_____

9. Has your child ever been assigned to work with:
a. a learning disabilities teacher_____
b. a remedial reading teacher _____
c. a remedial math teacher_____
d. a guidance counselor_____
e. a psychologist_____
f. the principal or assistant principal_____
g. a speech or language therapist_____

10. List any special talents your child may have_____
_____
_____

11. Additional Comments:_____
_____
_____

I understand that all reports and testing results will be treated confidential.

_____ _____
Date Parent/Guardian Signature

ARDSLEY UNION FREE SCHOOL DISTRICT
500 FARM ROAD, ARDSLEY, NEW YORK 10502
(914)295-5500 • FAX (914)295-5976
www.ardsleyschools.org

PERMISSION TO RELEASE SCHOOL RECORDS

DATE: _____

TO: _____
(Name of School Last Attended)

_____
(Address of School)

Fax: _____

I give my permission for the release of the following records of my child:

_____
(Name of Child)

Scholastic _____

Health _____

Psychological _____

Other _____

Please send at once to: (please check one)

☐ Concord Road School
2 Concord Road
Ardsley, New York 10502
Phone: 914-231-0800
Fax: 914-231-0877

☐ Ardsley Middle School
700 Ashford Avenue
Ardsley, New York 10502
Phone: 914-295-5600
Fax: 914-295-5676

☐ Ardsley High School
300 Farm Road
Ardsley, New York 10502
Phone: 914-295-5800
Fax: 914-295-5977

_____ _____
Parent/Guardian Signature Relationship

_____
Address

_____

ARDSLEY SCHOOL DISTRICT
NEW STUDENT INFORMATION FORM

Dear New Ardsley School District Family:

Please complete this form so it may be forwarded to the Ardsley PTA's Welcome Liaison for New Families.

Date: _____

Family Name: _____

Address _____

_____

_____

Phone _____

Cell Phone _____

E-Mail _____

Children:

Name _____ Grade _____

Name _____ Grade _____

Name _____ Grade _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	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: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

LaboratoryTesting	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	With Correction ☐Yes ☐ No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: 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.

Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐ Not Done

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	Negative	Positive	Referral	Not Done
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed** – required for Dominick Murray Sudden Cardiac Arrest Prevention Act

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

If Restrictions Apply – Complete the information below

☐ **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 ONLY 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

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	IMMUNIZATIONS
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Medical Provider Signature:	Date:
Provider Name: *(please print)*	Office Stamp
Provider Address:	
Phone: Fax:	

Please Return This Form to Your Child's School Health Office When Completed.

Dental Health Form

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

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

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

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

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

Dentist's name and address (please print or stamp) Dentist's Signature

Optional Sections - If you agree to release this information to school, parent please initial here. ☐

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

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

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

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify): _____

III. Treatment Needs (check all that apply)

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

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

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

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 518-289-5623, 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 envolvimiento 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 12020