LAWRENCE AVENUE ELEMENTARY PRE-KINDERGARTEN APPLICATION 2018-2019
APPLICATION DEADLINE IS MAY 4, 2018

For office use only

Student ID# _____ ☐ A.M. Session ☐ P.M. Session Bus# In:____ Bus# Out:____

Entry Date: _____ ☐ Email Account ☐ SIS Account ☐ Parent Email Account

☐ Immunizations ☐ Birth Certificate ☐ Proof of Residency School Physical: ☐ Yes ☐ No

***************Your child must turn four on or before December 1, 2018*************

Please note complete enrollment packets will be considered first for placement. You must provide birth certificate, proof of residency and immunizations to be considered complete.

STUDENT INFORMATION

Student Name: _____ D.O.B.:_____ Age: __ Sex: M F

Does your child attend daycare or Headstart? Yes ___ No ____

If Yes Where?_____

Place of Birth _____

Ethnic Origin: ☐ White ☐ Asian ☐ American Indian/Alaskan Native ☐ Hispanic/Black

☐ Hispanic/White ☐ Native Hawaiian/Other Pacific-Islander

Child resides with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other

Father/Guardian Name: _____ Receives Mailings: ☐ Yes ☐ No

Home Address: _____
Route, Box, or Street # Road or Street Name Town State Zip

Mailing Address(if different) _____
Route, Box, or Street # Road or Street Name Town State Zip

Home Phone: _____ Cell Phone:_____

Place of Employment:_____ Work#_____

Mother/Guardian Name:_____ Receives Mailings: ☐ Yes ☐ No

Home Address: _____
Route, Box, or Street # Road or Street Name Town State Zip

Mailing Address(if different) _____
Route, Box, or Street # Road or Street Name Town State Zip

Home Phone: _____ Cell Phone:_____

Place of Employment:_____ Work #_____

Continued on Back

Step-Parent Information:

IF APPLICABLE: Can step-parent listed below pick up child from school? ☐ Yes ☐ No

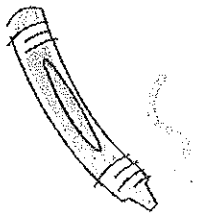
Step-Mother Name: _____ Work #_____

Step-Father Name: _____ Work # _____

Other siblings in household:

Full Name	Date of Birth	Age	Male/Female

Our School uses email to update parents of events and other news. Please provide an email address you check regularly if you wish to receive information:



Primary Email Address: _____

EMERGENCY/ ALTERNATE CONTACT INFORMATION

Other than yourself, please list two alternative people who may be contacted in case of an emergency or illness if we are unable to reach you **first**.

Name:_____ Name:_____

Phone#/Relation:_____/_____ Phone#/Relation:_____/_____

Can pick up child? ☐ Yes ☐ No Can pick up child? ☐ Yes ☐ No

Please answer the following questions about your child.

Do you have any concerns regarding your child's health or development (i.e., speech, vision, hearing, or physical need)? If yes, please explain. _____

_____

_____

Does your child currently receive any support services (i.e., speech, OT, PT, etc)? If yes, please be specific. _____

Do you have any concerns about recent occurrences in your family (i.e., recent move, new siblings(s), separation of parents, etc.)? _____

_____

LAWRENCE AVENUE ELEMENTARY PRE-KINDERGARTEN APPLICATION 2018-2019
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CUSTODY INFORMATION

(If there is legal custody arrangements check questions below):

_____ I have provided the Potsdam Central School District with the most recent custody documents and will continue to provide the district with any updates or changes that are made to these documents in the future. ***(Enrollment Clerk initials to verify receipt of custody documents:*** _____)

_____ I have **NOT** provided Potsdam Central School District with custody documents and am aware that both parents on my child(ren)('s) birth certificate will have the same legal parental rights until I present the district with such custody papers stating contrary.

Please inform us of any situations that we need to be aware of: _____

_____

Notice: (New York State Penal Law Section 210.45) – A person is guilty of making a punishable false written statement when (s)he knowingly makes a false statement, which (s)he does not believe to be true, in a written instrument bearing a legally authorized form notice to the effect that false statements made therein are punishable. Making a punishable false written statement is a Class A Misdemeanor.

RESIDENCY QUESTIONS

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

☐ In permanent housing ☐ In a shelter ☐ In a hotel/motel

☐ In a car, park, bus, train, or campsite

☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")

If you checked off other than permanent housing: Would you like to meet with our Homeless Liaison to discuss services you may be eligible to receive? ☐ Yes ☐ No

If yes, please provide best phone number to reach you: _____

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TRANSPORTATION INFORMATION

The Principal and Director of Transportation will determine the session your child will attend.

If your child attends the A.M. session (8:30 – 11:10 a.m.):

Pick-up Address will be (List Street):_____

Drop-off Address will be (List Street): _____

If your child attends the P.M. session (12:30 – 3:05 p.m.):

Pick-up Address will be (List Street):_____

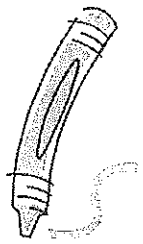
Drop-off Address will be (List Street): _____

Emergency Closing Information: _____

_____

PLEASE SIGN BELOW

In the event that your child is selected to participate in the Pre-Kindergarten Program, I agree to complete all the necessary medical and dental requirements for my child to attend. I have read and completed the form, and to the best of my knowledge this information is true and correct.



_____ _____

Date Parent/Guardian Signature

FIELD TRIP PERMISSION

This child has my permission to go on field trips taken as part of the school program under the supervision of a teacher.

_____ _____

Date Parent/Guardian Signature

Office Use Only: AM_____
Bus # In_____ Bus # Out_____

Office Use Only: PM_____
Bus # In_____ Bus # Out_____

POTSDAM CENTRAL SCHOOL
QUESTIONNAIRE REGARDING SPECIAL EDUCATION

Today's Date: _____

Name of student: _____ Grade:_____

Previous School:_____

_____ My student has an active IEP from a previous district

_____ My student has previously received Special Education Services (Please Explain)

_____

_____

_____ My student has not previously received Special Education Services

Parent Name: _____ Signature:_____

QUESTIONNAIRE REGARDING 504 PLAN

_____ My student has an active 504 Plan from a previous school district

_____ My student had a 504 Plan in the past (Please Explain)

_____

_____

_____ My student has not had a 504 Plan

Parent Name: _____ Signature:_____

If applicable: Please provide your CIN# (Medicaid #):

CIN#:_____

POTSDAM CENTRAL SCHOOL
ELEMENTARY STUDENT HEALTH DATA FORM

OFFICE USE ONLY:

Shots Entered: □ Yes □ No Physical Entered: □ Yes □ No School Doctor to do Physicals: □ Yes □ No

Name of student: _____ Age:_____ Birthdate:_____

Address:_____ Phone Number:_____

Child's Doctor Name and Address: _____

_____

Were the any issues during pregnancy, labor and /or delivery for this child? □ Yes □ No

If "yes", please describe:_____

Did this child meet all developmental milestones on time? (crawling, speaking, walking, etc.) □ Yes □ No

If "no" please explain:_____

Does this child have an ongoing health concerns? (asthma, diabetes, etc.) □ Yes □ No

If "yes", please explain:_____

Does this child have any allergies? □ Yes □ No

If "yes", please list:_____

Has the allergy required emergency treatment? □ Yes □ No

If "yes", please explain:_____

Are the child's immunizations up to date? □ Yes □ No **(if no, please see school nurse)**

Is there a history of any hospitalizations, significant injuries, or surgery? □ Yes □ No

If "yes", please describe:_____

Does this child take any medication regularly at home? □ Yes □ No

Name and purpose of medication(s) _____

Requires medication at school - □ Yes □ No

** **Any student requiring medication at school, even on an as-needed basis, will need a doctor's order. Please contact the school nurse for more information.****

Are there any current medical concerns/issues? □ Yes □ No (check all that apply)

		Explain
Head		
Nose		
Eyes		
Throat		
Neck		
Chest		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Neurological		
Musculoskeletal		
*Other *		

Are there any issues in the home that might affect this child's learning?

_____

_____

Describe child's eating habits: _____

Who lives with this child in his/her primary household? _____

_____

Does child spend a significant amount of time in another household? □ Yes □ No

If "yes", please explain: _____

Who has legal custody of this child? _____

Describe any custody arrangements: _____

******* NYSED requires an annual physical exam for **new entrants** and students in grades **K, 2, 4, 7, and 10.** For your convenience, we offer physicals by our licensed school doctor. Do you wish to have the school doctor provide a physical for your child at the grade levels listed that are mandated by NYSED? **********

_____ Yes, I request to have the school provide physicals for my child

_____ No, my family doctor will provide physicals for my child and will mail the completed physical form back to:

Potsdam Central School
Attention: Elementary Nurse
29 Leroy Street
Potsdam, NY 13617

Parent/Guardian Signature: _____ Date: _____

POTSDAM CENTRAL SCHOOL DENTAL HEALTH CERTIFICATE

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 start the school, ask your dentist to fill out Section 2. Return completed form to the schools' 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 and 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 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 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 the student' ability to chew, speak, or focus on school activities including pain, swelling, or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

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

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

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

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

☐Yes ☐No Untreated Caries – Does this child have an open cavity? [At least ½ mm of tooth s 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 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.

POTSDAM CENTRAL SCHOOL
Health Certificate/Appraisal Form

Note: To be filled out by physician only if you choose to NOT have our school physician give your child a physical.

Name:_____ DOB:_____ Grade:_____ Gender: M F

~~IMMUNIZATIONS:~~

___ Immunization record attached
___ No Immunization given today
___ Immunizations reported to NYSIIS

Immunizations given today:_____

Will return on _____ to receive _____

HEATH HISTORY

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not Done Date:_____
PPD: ☐ Positive ☐ Negative ☐ Not Done Date:_____
Elevated Lead: ☐ Positive ☐ Negative ☐ Not Done Date:_____
Dental Referral: ☐ Positive ☐ Negative ☐ Not Done Date:_____

Significant Medical/Surgical History:

_____

_____

Specify Current Diseases

☐ Asthma (☐ Intermittent or ☐ Persistent)
Quick relief inhaler ☐ Yes ☐ No
Asthma action plan ☐ Yes ☐ No
☐ Type 1 Diabetes ☐ Type 2 Diabetes
☐ Hyperlipidemia ☐ Hypertension

☐ Other: _____

ALERGIES: ☐ None ☐ Non Life-Threatening ☐ Life-Threatening

Type: ☐ Food ☐ Insect ☐ Latex ☐ Medication ☐ Seasonal/Environmental ☐ Other: _____

PHYSICAL EXAM:

Height:_____ Weight:_____ BP:_____ Pulse:_____ Respirations:_____

Body Mass Index: _____ Weight Status Category (BMI Percentile):

☐ < 5th ☐ 85th – 94th
☐ 5th - 49th ☐ 95th - 98th
☐ 50th – 84th ☐ 99th & Higher

Scoliosis: ☐ Negative ☐ Positive
Degree of deviation: _____

Angle of trunk rotation via scoliometer: _____

Distance acuity	R	L	Referral
Distance acuity with lenses	R	L	☐ Yes ☐ No
Vision- Near Vision	R	L	
Vision- Color perception	☐ Pass	☐ Fail	
Hearing:	R	L	
☐ 20 db sc both ears or:			☐ Yes ☐ No

Circle Developmental stage (ONLY for selection classification for 7th & 8th graders)

☐ EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V.

MEDICATIONS:

Medications (list all): ☐ None

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed: _____

____ I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/package with my child's name on it.

Parent/Guardian Signature: _____ **Date:** _____

____ Parent permission and provider consent is required for students to self-administer & self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below.

Parent/Guardian Signature: _____ **Date:** _____

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK QUALIFICATION/ CSE CONSIDERATION

☐ Free from contagions & physically qualified for all activities (phys ed, athletics, playground, work & school

☐ Expected Body Contact (full or limited: football, wrestling, basketball, ice/field/floor hockey, baseball, softball

☐ Strenuous: cross-country, gymnastics, track & field, swim, diving, crew, ski, cheering, tennis, badminton, fencing

☐ Non-contact/Non-Strenuous: bowling, golfing, table tennis, archery, riflery, shuffleboard, walking

☐ Protective equipment required: ☐ Athletic cup ☐ Sport/Safety Goggles ☐ Other: _____

☐ Medical/prosthetic device: _____

☐ Recommendations/restrictions: _____

Provider's Signature: _____ Phone: _____ Fax: _____

Provider's Name/Address: _____

Parent Signature: _____ Date: _____

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

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*

❑ Male
❑ 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	*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: ❑ **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:

Immunization Requirements for Pre-Kindergarten Students
2017-2018 School Year

February 22, 2018

Dear Parent/Guardian,

New York State Law Section 2164 requires certain immunizations (shots) to enter Pre-kindergarten and attend school. Please check with your health care provider as soon as possible to make sure that your child has all the needed immunizations. They are listed below.

Required Immunizations for Pre-Kindergarten

Immunization	Number of Doses
Polio	3
Hepatitis B	3
Diphtheria/Tetanus/Pertussis	4
Measles/Mumps/Rubella	1
Varicella (Chickenpox)	1
Haemophilus Influenzae	1 to 4
Pneumococcal Conjugate	1 to 4

Proof of immunization should be sent to the school nurse where your child will be attending pre-kindergarten.

Proof of immunization must be **any 1 of the 3** items listed below:

- An immunization certificate signed by your healthcare provider
- Immunization Registry report (NYSIIS or CIR from NYC) from your healthcare provider or your county health department
- A blood test (titer) lab report that proves your child is immune to the diseases
    - For varicella (chickenpox), a note from your healthcare provider (MD, NP, PA) which says your child had the disease is also acceptable.

If you have questions or concerns about immunizations, please contact the school health staff.

Lawrence Avenue Elementary
Amy Mangual, RN
Phone: 315-265-2000 ext. 244 Fax: 315-265-5458
amangual@potsdam.k12.ny.us

Sincerely,

Jennifer Gray

Jennifer Gray, Principal