Plainview-Old Bethpage Central School District

Administration Offices

106 Washington Avenue, Plainview, New York 11803

Phone: 516-434-3045
Fax: 516-937-6313

Bonnie McGowan, Registrar
Registration Room B6

bmcgowan@pobschools.org

Dear Parents/Guardians:

Welcome to the Plainview-Old Bethpage School District!

Attached you will find our registration packet. In order to facilitate the registration process, it is necessary to complete all the enclosed documents. In addition to our completed and notarized forms, the following documentation will be required at the time of registration.

Photo Identification of parent/guardian
Proof of residence: see instructions
Original Birth Certificate, Passport or Baptismal Certificate
Immunization Record
School Records

Kindly call Bonnie McGowan at 516-434-3045 to schedule a registration appointment. I am a Notary Public and can notarize your signature when document is signed in front of me. Thank you.

Sincerely,

Bonnie McGowan

Bonnie McGowan
Registrar

PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT
SCHOOL REGISTRATION FORMS AND INSTRUCTIONS

I UNDERSTAND THAT ANY FALSE STATEMENTS MADE HEREIN ARE PUNISHABLE AS A CLASS 'A' MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW OF THE STATE OF NEW YORK AND MAY BE REFERRED TO THE OFFICE OF THE DISTRICT ATTORNEY.

1. **ORIGINAL** DOCUMENTATION: (ITEMS "A" THROUGH "D" APPLY TO ALL APPLICANTS)

A. PROOF OF BIRTH – (ONE OF THE FOLLOWING DOCUMENTS):
1-**BIRTH CERTIFICATE**
IF UNAVAILABLE –
1-PASSPORT/VISA OR BAPTISMAL CERTIFICATE

B. PROOF OF PARENTAL RELATIONSHIP: (ONE OF THE FOLLOWING DOCUMENTS):
1-DRIVERS LICENSE WITH PICTURE ID OF PARENT REGISTERING STUDENT(S)
IF UNAVAILABLE ONE OF THE FOLLOWING:
1-BIRTH CERTIFICATE W/PARENT(S) NAME(S), ALONG WITH PARENTS' PHOTO ID
2-BAPTISMAL CERTIFICATE W/PARENT(S) NAME(S), ALONG WITH PARENTS' PHOTO ID
3-DULY EXECUTED COURT DOCUMENTS PROVING LEGAL GUARDIANSHIP, AND THE LEGAL GUARDIAN'S PHOTO ID
4-DULY EXECUTED ADOPTION DOCUMENTS, ALONG WITH ADOPTIVE PARENTS' PHOTO ID
5-DULY EXECUTED COURT CUSTODY DOCUMENTS, ALONG WITH CUSTODIANS' PHOTO ID

C. PROOF OF IMMUNIZATION: (ONE OF THE FOLLOWING DOCUMENTS):
1-DOCTOR'S MEDICAL CERTIFICATION OF IMMUNIZATION (WITHIN THE LAST YEAR); if unavailable
1-PREVIOUS SCHOOL RECORD OR TRANSCRIPT OF IMMUNIZATION

D. PROOF OF RESIDENCY:
(HOMEOWNERS)-(FORM 'A' NOTARIZED & THREE OF THE FOLLOWING ORIGINAL DOCUMENTS):
1-HOUSE DEED
2-REAL ESTATE TAX BILL (FROM NASSAU COUNTY, TOWN OF OYSTER BAY, OR SCHOOL DISTRICT)
3-UTILITY BILL (PSEG, NATIONAL GRID, OIL, ETC.)
4-WATER BILL
5-COPY OF INCOME TAX RETURN
6-MORTGAGE STATEMENT OR PAYMENT BOOK SHOWING ADDRESS

(RENTERS)-(FORMS A, B, C-NOTARIZED & ALL OF THE FOLLOWING DOCUMENTS):
1-LEASE OR RENTAL AGREEMENT (IF AVAILABLE)
2-PSEG, NATIONAL GRID, OIL (IF AVAILABLE)
3-WATER BILL (IF AVAILABLE)
4-COMPLETED OWNER'S/LESSOR'S AFFIDAVIT (FORM B) AND ONE OF THE PROOFS LISTED IN D ABOVE THAT HAS THE HOMEOWNER'S NAME
5-COMPLETED RENTER'S NON-OWNER'S AFFIDAVIT (FORM C)

E. ONLY IF STUDENT IS A FOSTER CHILD-(ONE OF THE FOLLOWING DOCUMENTS):
1-COPY OF FORM BSW-241
2-COPY OF FORM DDS-2999

F. ONLY IF PARENTS ARE DIVORCED OR SEPARATED-(ONE OF THE FOLLOWING DOCUMENTS):
1-COPY OF COURT ORDER OR DIVORCE PAPERS OR CUSTODIAL AFFIDAVIT (FORM D)

2. **ALL APPLICANTS** (PARENTS, LEGAL GUARDIANS, FOSTER PARENTS) MUST COMPLETE, SIGN & NOTARIZE FORM A OF THE REGISTRATION APPLICATION
3. ALL RENTERS/NON-OWNERS MUST COMPLETE, SIGN & NOTARIZE FORMS A & C
4. FORM B MUST BE COMPLETED, SIGNED & NOTARIZED BY THE PROPERTY OWNER **(OTHER THAN SELF)**
5. LAST REPORT CARD AND TRANSCRIPT (GRADES 1-12)

PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT
REGISTRATION APPLICATION (FORM A)
ALL APPLICANTS MUST COMPLETE SECTION 1, 2, AND 4

SECTION 1-STUDENT INFORMATION: MUST BE COMPLETED IN FULL BY ALL APPLICANTS

STUDENT'S NAME_____ DOB____/____/____ GRADE_____
(LAST, FIRST, MIDDLE INITIAL)

ADDRESS_____ OWN/RENT_____

HOME TELEPHONE #_____ YEAR MOVED TO THIS ADDRESS_____

IEP/504? (Special Education) YES___NO___ CITIZEN? YES___NO___STUDENT'S PRIMARY LANGUAGE_____

MALE___FEMALE___ COUNTRY OF BIRTH_____ IMMIGRATION DATE_____

LAST SCHOOL ATTENDED_____ DATE STARTED_____ DATE ENDED_____
SCHOOL ADDRESS_____ GRADE ATTENDED_____
WERE SPECIAL EDUCATION SERVICES PROVIDED?____(IF YES, PROVIDE COPY OF CURRENT IEP)
HAS STUDENT EVER ATTENDED SCHOOL IN POB CSD SCHOOL?____IF YES, WHERE?_____

ETHNICITY: AMERICAN INDIAN OR ALASKA NATIVE____ NATIVE HAWAIIN OR OTHER PACIFIC ISLANDER____
ASIAN____ BLACK OR AFRICAN AMERICAN____ BLACK (NOT HISPANIC ORIGIN)____

WHITE____ HISPANIC/BLACK____ HISPANIC/WHITE____ HISPANIC/OTHER____

SECTION 2 – FAMILY INFORMATION: MUST BE COMPLETED IN FULL BY ALL APPLICANTS

PARENT/GUARDIAN NAME:_____ COUNTRY OF BIRTH_____
(LAST, FIRST)
ADDRESS_____ HOME PHONE #_____
PERSONAL E-MAIL ADDRESS_____ CELL #_____

NAME OF EMPLOYMENT_____ OCCUPATION_____
BUSINESS ADDRESS_____ BUSINES PHONE #_____

NATURAL PARENT___LEGAL GUARDIAN___FOSTER PARENT___PERSON IN PARENTAL RELATIONSHIP_

PARENT/GUARDIAN NAME:_____ COUNTRY OF BIRTH_____
(LAST, FIRST)
ADDRESS_____ HOME PHONE #_____
PERSONAL E-MAIL ADDRESS_____ CELL #_____

NAME OF EMPLOYMENT_____ OCCUPATION_____
BUSINESS ADDRESS_____ BUSINES PHONE #_____

NATURAL PARENT___LEGAL GUARDIAN___FOSTER PARENT___PERSON IN PARENTAL RELATIONSHIP_

SIBLINGS:
_____DOB__/__/__CSE/504?___SCHOOL/GRADE_____
_____DOB__/__/__CSE/504?___SCHOOL/GRADE_____
_____DOB__/__/__CSE/504?___SCHOOL/GRADE_____

PARENT(S) MARITAL STATUS: MARRIED____ SINGLE____ DIVORCED____ SEPARATED ____ WIDOWED____

INTERPRETER NEEDED FOR EITHER PARENT?_____IF YES, WHAT LANGUAGE? _____

OTHER ADULTS LIVING AT THIS ADDRESS:
NAMES_____ RELATIONSHIP TO STUDENT_____

(PLEASE COMPLETE SECTION 3 IF APPLICABLE AND SECTION 4 ON THE REVERSE SIDE)

SECTION 3: MUST BE COMPLETED BY PERSON **OTHER THAN A NATURAL PARENT** CLAIMING A CUSTODIAL/GUARDIAN RELATIONSHIP WITHOUT A COURT ORDER, WHEN FILING APPLICATION FOR ADMISSION.

HAS THE STUDENT RECEIVED FINANCIAL SUPPORT FROM EITHER PARENT DURING PAST YEAR? YES____ NO____

IF YES, COMPLETE/CHECK THE FOLLOWING:

FATHER___APPROXIMATE DOLLAR AMOUNT $_____ DATES: FROM___/___/___TO___/___/___
MOTHER___APPROXIMATE DOLLAR AMOUNT $_____ DATES: FROM___/___/___TO___/___/___

IF NO, PROVIDE INFORMATION OF PERSON THAT SUPPLIED FINANCIAL SUPPORT:

NAME_____SSN ---------- _____ DOB_____/_____/_____
LAST, FIRST, MI

HOME ADDRESS:_____PHONE:_____
STREET TOWN STATE ZIP

EMPLOYER NAME_____PHONE:_____
EMPLOYER ADDRESS_____
STREET TOWN STATE ZIP

IS STUDENT COVERED UNDER ANY HEALTH, DENTAL, OR ACCIDENT INSURANCE? YES_____ NO_____
IF YES, PLEASE COMPLETE BELOW:

NAME OF POLICYHOLDER:_____SSN ---------- _____ DOB_____/_____/_____
LAST, FIRST, MI

HOME ADDRESS_____ PHONE #_____
STREET TOWN STATE ZIP
INSURANCE COMPANY GROUP_____ POLICY # _____

IS STUDENT LISTED AS AN EXEMPTION IN ANYONE'S FEDERAL/STATE TAX RETURN? YES_____NO_____
IF YES, PLEASE ATTACH THAT PORTION OF INCOME TAX RETURN CONFIRMING THIS INFORMATION.

PLEASE ATTACH COPIES OF THAT PORTION OF BOTH PARENTS' COMPLETED FEDERAL/STATE INCOME TAX RETURNS FOR THE LAST THREE YEARS LISTING THEIR DEPENDENT EXEMPTIONS.

SECTION 4 – SIGNATURE AND NOTARY: MUST BE COMPLETED IN FULL BY ALL APPLICANTS

NOTE: THE FOLLOWING STATEMENT, SIGNATURE REQUIREMENT, AND NOTARIZATION REQUIREMENT APPLY TO ALL SECTIONS OF FORM A. NO APPLICATION WILL BE ACCEPTED WITHOUT THE REQUIRED SIGNATURES.

THE STATEMENTS CONTAINED IN THIS APPLICATION ARE TRUE. I UNDERSTAND THAT THE STATEMENTS IN THIS APPLICATION ARE SUBJECT TO VERIFICATION BY THE SCHOOL DISTRICT AND THAT FALSE STATEMENTS COULD SUBJECT ME TO TRANSPORTATION AND/OR TUITION CHARGES WHERE APPLICABLE. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY THE SCHOOL OF ANY CHANGES, AND/OR CIRCUMSTANCES AFFECTING THIS APPLICATION.

_____
DATE

_____
NOTARIZED SIGNATURE

Sworn to before me this
_____day of_____, 20_.

_____
Notary Public

PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT

OWNER'S/LESSOR'S AFFIDAVIT (FORM "B")

ANY REGISTRANT WHO RENTS THEIR PRIVATE HOME OR APARTMENT FROM ANOTHER RESIDENT OF THE DISTRICT MUST HAVE THIS FORM COMPLETED BY HOMEOWNER OR LANDLORD

I UNDERSTAND THAT ANY FALSE STATEMENTS MADE HEREIN ARE PUNISHABLE AS A CLASS 'A' MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW OF THE STATE OF NEW YORK AND MAY BE REFERRED TO THE OFFICE OF THE DISTRICT ATTORNEY.

_____
STUDENT'S NAME (LAST, FIRST)

STATE OF NEW YORK)
) ss.:
COUNTY OF)

_____, BEING DULY SWORN, DEPOSES AND SAYS:
NAME OF OWNER/LESSOR

1) I AM THE LEGAL OWNER OF _____.
(Address) STREET TOWN STATE ZIP

2) TO THE BEST OF MY KNOWLEDGE, THE ABOVE MENTIONED PROPERTY IS THE CURRENT RESIDENCE OF _____AND_____.
NAME OF PARENT/GUARDIAN NAME OF STUDENT

3) THE TERMS AND CONDITIONS OF TENANCY ARE AS FOLLOWS: (LEASE TERM, RESIDENCY COMMENCEMENT DATE, RENT, LEASE TERMINATION DATE, ETC.)

_____

_____

_____

4) THE FOLLOWING NAMES INCLUDE *ALL* OTHER PERSONS LIVING AT THIS ADDRESS:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

PLEASE ATTACH A COPY OF PROOF OF HOME OWNERSHIP FROM SECTION 'D' ON PAGE 2.

SWORN TO BEFORE ME
THIS _____ DAY OF _____ 20__

_____
SIGNATURE OF OWNER/LESSOR

_____
NOTARY PUBLIC

PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT

RENTER'S/NON-OWNER'S AFFIDAVIT (FORM "C")

ANY REGISTRANT WHO RENTS THEIR PRIVATE HOME OR APARTMENT FROM ANOTHER RESIDENT OF THE DISTRICT MUST COMPLETE THIS FORM

I UNDERSTAND THAT ANY FALSE STATEMENTS MADE HEREIN ARE PUNISHABLE AS A CLASS 'A' MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW OF THE STATE OF NEW YORK AND MAY BE REFERRED TO THE OFFICE OF THE DISTRICT ATTORNEY.

_____
STUDENT'S NAME (LAST, FIRST)

STATE OF NEW YORK)
) ss.:
COUNTY OF)

_____, BEING DULY SWORN, DEPOSES AND SAYS:
NAME OF RENTER/NON-OWNER

1) WITH FULL UNDERSTANDING OF THE REQUIREMENTS FOR ENROLLMENT, I REQUEST THAT MY CHILD _____ BE ADMITTED TO THE SCHOOLS OF THE PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT AS A DISTRICT RESIDENT. I FURTHER UNDERSTAND THAT IF MY CHILD IS FOUND NOT TO BE A LEGITIMATE RESIDENT OF THE PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT, **I WILL BE LEGALLY RESPONSIBLE FOR AND WILL BE BILLED THE SCHOOL DISTRICT'S ANNUAL TUITION RATE RETROACTIVE TO THE FIRST DAY OF ADMISSION.** I HAVE BEEN INFORMED THAT THE SCHOOL DISTRICT WILL MAKE UNANNOUNCED HOME VISITS FOR PURPOSES OF RESIDENCY VERIFICATION.

2) I _____ AM THE [PARENT/GUARDIAN/CUSTODIAL PARENT] OF THE ABOVE-NAMED CHILD. I RESIDE AT [STATE ADDRESS AND SPECIFY THE EXACT NATURE OF THE SPACE i.e., BASEMENT APARTMENT, SECOND FLOOR APARTMENT, NUMBER OF ROOMS, ETC.]:

_____

_____

3) THE TERMS AND CONDITIONS OF TENANCY ARE AS FOLLOWS: (LEASE TERM, RENT, RESIDENCE COMMENCEMENT DATE, LEASE TERMINATION DATE, ETC.)

_____

_____

_____

4) LIST ALL OTHER PERSONS LIVING AT THE ABOVE ADDRESS:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

PLEASE ATTACH A COPY OF FORMAL LEASE OR OTHER RENTAL AGREEMENT.

PREVIOUS ADDRESS:_____
(STREET) (TOWN) (STATE) (ZIP)

PREVIOUS PHONE #: _____

SWORN TO BEFORE ME
THIS _____ DAY OF _____ 20____

_____
SIGNATURE OF RENTER/NON-OWNER

_____
NOTARY PUBLIC

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

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

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

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

Home Language Questionnaire (HLQ)

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

STUDENT NAME:		
First	*Middle*	*Last*
DATE OF BIRTH:		GENDER:
		❑ Male ❑ Female
Month	*Day*	*Year*
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:

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

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

Address: _____ Phone: _____

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

Where is the student currently living? (*Please check **one** box.*)

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____
- ☐ In permanent housing

_____
Print name of Parent, Guardian, or
Student (for unaccompanied homeless youth)

_____
Signature of Parent, Guardian, or
Student (for unaccompanied homeless youth)

_____
Date

CUESTIONARIO DE VIVIENDA

Nombre del Distrito Escolar: _____

Nombre de la Escuela: _____

Nombre del Estudiante: _____
Apellido Primer Nombre Segundo Nombre

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

Dirección: _____ Teléfono: _____

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

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

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

  _____

- ❑ En un hogar permanente

_____ _____

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

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

_____

Fecha

PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT
PLAINVIEW, NEW YORK 11803

OFFICE OF THE SCHOOL NURSE

MEDICATION POLICY

Dear Parents/Guardians:

Under certain circumstances, it may be necessary for your child to take INTERNAL MEDICATION, EITHER PRESCRIPTION OR NON-PRESCRIPTION, during the school day. Following are the New York State laws regarding the administration of all medications:

1. A written request from your family physician must accompany the medication indicating the dosage, frequency, time, duration and any side effects of the medication.

2. A written request from the parent to administer the medication must also accompany the medication. A new form MUST be filled out by the family physician and written permission obtained from the parent for any CHANGE OF MEDICATION OR DOSAGE.

3. Medication must come in the original pharmacist's container. Many pharmacists are aware that medication may need to be taken in school and will dispense it in two(2) containers if requested to do so. **PARENTS** MUST BRING THE MEDICATION TO THE NURSE.

4. Children may never bring **medicated cough drops** or any other medication to school. These precautions are advocated to protect all children in the school, as well as your child, and to comply with the directives of the State Education Department.

THE ABOVE PROCEDURES MUST BE REPEATED FOR EACH SCHOOL YEAR

Please be assured that these requirements are for the safety of your child. Under no circumstances will medication be given if the above requirements are not met.

Physician or parental permission by phone is not permissible. Permission forms may be obtained from the School Nurse.

At the end of the school year, PARENTS must pick up all medication.

Thank you for your cooperation in this matter.

Nursing Staff

(10/8/2021)

2021-22 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for **each** vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]	**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses or 2 doses** of **adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9, 10 and 11: 1 dose**	**2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.

   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.

   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 and 7: 10 years; minimum age for grades 8 through 12: 7 years)

   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.

   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2021-2022, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 and 7; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 8 through 12.

   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)

   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.

   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)

   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine

   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).

   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)

   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 and 8: 10 years; minimum age for grades 9 through 12: 6 weeks).

   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.

   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.

   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.

   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.

   d. If dose 1 was received at 15 months or older, only 1 dose is required.

   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)

   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.

   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.

   d. If one dose of vaccine was received at 24 months or older, no further doses are required.

   e. PCV is not required for children 5 years or older.

   f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

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

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

STUDENT INFORMATION

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

HEALTH HISTORY

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

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

BMI_____kg/m2

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

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

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL				

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

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

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

Name:	DOB:

SCREENINGS

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

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

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

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

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

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

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

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

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

☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

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

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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

OPTIONAL INFORMATION

SUPPLEMENTARY INFORMATION QUESTIONNAIRE PART 1
STUDENT'S NAME _____
ADDRESS: _____

THE FOLLOWING INFORMATION REGARDING YOUR CHILD'S DEVELOPMENT WILL BE EXTREMELY HELPFUL IN UNDERSTANDING YOUR CHILD AND WILL ENABLE OUR SCHOOL TO PROVIDE THE BEST EDUCATONAL ENVIRONMENT TO MEET HIS/HER INDIVIDUAL NEEDS.

WHEN ANSWERING THE FOLLOWING QUESTIONS, PLEASE DO NOT LEAVE BLANKS.
WRITE *NO, NONE, NOT KNOWN* OR *NOT APPLICABLE [N/A].*

DEVELOPMENTAL HISTORY

A. PREGNANCY
ILLNESS DURING PREGNANCY: TOXEMIA _____ HIGH BLOOD PRESSURE _____
ACCIDENTS _____
UNUSUAL OCCURRENCES _____

B. DELIVERY
FULL TERM _____ PREMATURE _____ MONTH _____ BIRTH WEIGHT _____ LBS. _____ OZS.
NATURAL BIRTH _____ BREECH _____ FORCEPS _____ CESAREAN SECTION _____
CONDITION OF INFANT AT BIRTH _____
ANY CONGENITAL DEFORMITIES _____

C. POST NATAL FEATURES
DESCRIBE ANY FEEDING PROBLEMS _____
AGE BABY HELD HEAD UP _____ AGE SAT WITHOUT SUPPORT _____ AGE BEGAN CREEPING _____
AGE BEGAN WALKING _____ AGE SAID FIRST UNDERSTANDABLE WORDS _____
AGE OF ANY SERIOUS ILLNESS _____ DESCRIBE _____
AGE OF HIGH TEMPERATURES _____ DESCRIBE _____
AGE OF ANY SURGERY _____ DESCRIBE _____
AGE OF ANY ACCIDENTS _____ DESCRIBE _____
AGE OF ANY HOSPITALIZATIONS _____ DESCRIBE _____
AGE TOILET TRAINING COMPLETED _____ DOES CHILD PRESENTLY WET THE BED? _____
ANY CONVULSIONS _____ AGE BEGAN _____ TYPE _____ FREQUENCY _____
UNDER WHAT CIRCUMSTANCES _____
DATE OF LAST SEIZURE _____ MEDICATION REQUIRED _____
DESCRIBE ANY ALLERGIES OR ASTHMA _____
MEDICATION FOR ALLERGIES/ASTHMA REQUIRED IN SCHOOL _____
LIST ANY OTHER MEDICATION _____

HEALTH HISTORY

	DATE		DATE		DATE
CHICKEN POX	____	SCARLETT FEVER	____	PNEUMONIA	____
GERMAN MEASLES (RUBELLA)	____	WHOOPING COUGH	____	MEASLES	____
HEART CONDITION	____	MUMPS	____	POLIOMYELITIS	____
BLADDER CONDITION	____	DIABETES	____	SEIZURES	____
TUBERCULOSIS OR CONTACT	____	EAR CONDITION	____	OTHER	____

HAS YOUR CHILD BEEN TESTED FOR SICKLE CELL ANEMIA? _____ RESULTS _____

HAS YOUR CHILD BEEN EXAMINED BY AN EYE DOCTOR? _____ RESULTS _____

OPTIONAL INFORMATION

SUPPLEMENTARY INFORMATION QUESTIONNAIRE PART 2
STUDENT'S NAME _____

PRE-SCHOOL EXPERIENCE

NURSERY SCHOOL ATTENDED _____ NUMBER OF YEARS ____
KINDERGARTEN ATTENDED _____ NUMBER OF YEARS ____
DAY CAMP ATTENDED _____ NUMBER OF YEARS ____

LANGUAGE OTHER THAN ENGLISH SPOKEN AT HOME _____ BY CHILD _____

ANY OTHER INFORMATION YOU WISH TO SHARE ABOUT YOUR CHILD _____

_____
_____
_____
_____
_____

PARENTS' CONTACT INFORMATION

_____
[NAME] [HOME #] [BUSINESS/CELL #]

_____
[NAME] [HOME #] [BUSINESS/CELL #]

PHYSICIAN TO BE CALLED IN AN EMERGENCY

_____
[NAME] [ADDRESS] [PHONE]

PEOPLE TO BE CONTACTED IN AN EMERGENCY [IF PARENTS CANNOT BE REACHED]

_____
[NAME] [ADDRESS] [PHONE]

_____
[NAME] [ADDRESS] [PHONE]

PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT
OFFICE OF THE SCHOOL NURSE

DENTAL HEALTH CERTIFICATE

STUDENT'S NAME _____
SCHOOL _____ TEACHER _____

Dear Parent or Guardian:

We recommend that each student visit the dentist every six (6) months in order to prevent tooth decay, as well as remedy it. However, we request only one dental form during the school year.

TO BE COMPLETED BY DENTIST

THIS IS TO CERTIFY THAT THE EXAMINATION IS COMPLETE, AND I HEREBY INFORM YOU THAT:

[PLEASE CHECK ANY THAT APPLY]

NO TREATMENT IS NECESSARY _____
TREATMENT IS ADVISED AND IN PROCESS _____
TREATMENT IS COMPLETED _____

MALOCCLUSION IS PRESENT _____
MALOCCLUSION IS NOT PRESENT _____

ORTHODONTIA IS IN PROGRESS _____

OTHER COMMENTS _____
_____
_____

DATE: _____

_____
[DENTIST'S SIGNATURE]

_____
[DENTIST'S NAME PRINTED]

_____
[ADDRESS]

_____
[PHONE #]

PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT
OFFICE OF THE SCHOOL NURSE

PRE-SCHOOL VISION EXAMINATION

STUDENT'S NAME _____

Dear Parent or Guardian:

A thorough vision examination is urged prior to kindergarten entrance for each child and periodically thereafter as recommended by your eye specialist. What a child can see determines his entire growth and development.

Sight is recognized by educators and psychologists as the most important of the senses involved in learning. Unless eye deficiencies are detected and proper treatment obtained, a child cannot benefit fully from the educational opportunities offered to him/her. Now is the time to schedule an examination by an eye specialist so that if your child must adjust to glasses, patching an eye, or eye exercise, this adjustment can be completed before the start of school.

REPORT OF EYE SPECIALIST

DIAGNOSIS

_____

_____

_____

VISUAL ACUITY WITHOUT CORRECTION RIGHT _____ LEFT _____
VISUAL ACUITY WITH CORRECTION RIGHT _____ LEFT _____
GLASSES PRESCRIBED YES _____ NO _____
CONDITIONS UNDER WHICH GLASSES SHOULD BE WORN _____

_____

NON-SHATTERABLE LENSES? _____ DATE OF RE-EXAMINATION _____

RECOMMENDATIONS/REMARKS _____

_____

_____

ADDITIONAL INFORMATION REGARDING CHILD WHO HAS A VISUAL HANDICAP

CORRECTED NEAR VISUAL ACUITY RIGHT _____ LEFT _____

HAS CHILD BEEN EXAMINED FOR LOW VISION LENSES _____

PERIPHERAL VISION RIGHT _____ LEFT _____
DEGREE AND LOCATION OF RESTRICTED FIELDS _____

SPECIFY ANY PHYSICAL LIMITATIONS BECAUSE OF EYE CONDITION _____

_____

_____ _____
DATE OF EXAMINATION EXAMINER'S SIGNATURE AND TITLE

_____ _____
EXAMINER'S PRINTED NAME ADDRESS AND PHONE