Dobbs Ferry School District
Independent Thinkers Change Worlds

505 Broadway
Dobbs Ferry, NY 10522
t 914. 693-1500
f 914. 693-5952
www.dfsd.org

MEMORANDUM

TO Dobbs Ferry UFSD Parents/Guardians

FROM Registrar

DATE June 1, 2018

RE New Student Registration Packet

Welcome to the Dobbs Ferry School District. We hope you and your family will be very happy in our community.

Included in this registration packet are the required documents and forms to be completed by you to register your child for school. Please note all of these documents are very important.

When all the registration forms applicable to your child are completed, please call to make an appointment to return them to the Registrar. The Registrar for middle/high school students, or families with students in both elementary and upper school, is located in the business office at the Dobbs Ferry Middle/High School. The registrar for elementary students (K-5) only is located in the main office at Springhurst Elementary school. The forms must be approved by the District's Residency Designee prior to scheduling an appointment with principals and guidance counselors. After the application is approved, you will be contacted by the Guidance Office (Middle or High School students) or the Main Office (Springhurst students) to schedule a meeting with the school nurse, school principal, and a guidance counselor to set up a schedule of classes.

If you have any questions or concerns, or to schedule an appointment, please contact Natasha Thomas in the business office at (914) 693-1500, ext. 3034 or email thomasn@dfsd.org or Brittany Bucci at Springhurst Elementary at (914)-693-1503, ext. 1435 or email buccib@dfsd.org.

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Dobbs Ferry Union Free School District
Verification of Residency
Parent/Guardian Information Sheet

Contact Registrar
Springhurst Elementary (914) 693-1503 ext. 1435
Middle/High School (914) 693-1500 ext. 3034

Welcome to the Dobbs Ferry School District. To register your child in the District, please provide the requested documentation that will allow the District to verify that the child is legally entitled to a tuition-free education in Dobbs Ferry. We have an obligation to our taxpayers to be sure that we are enrolling only those children who have a right to that education. Note that Education Law (Section 3202.1) states that the residence of the parent is the official residence of the student.

Legal Residence

Please present the District with proof that you do reside in the Dobbs Ferry School District. The documents that must be submitted will vary depending upon whether you own your home or rent/lease.

Homeowner

If you own your home, please submit a signed closing statement/deed or copy of a mortgage statement.

Renter

If you rent, please submit a signed, **Notarized** (by both tenant & landlord) lease.
If you do not have a lease, please call the Registrar to obtain a ***Landlord Affidavit***.

All of the requested forms as well as the list of documentation are available online at www.dfsd.org. Once you have completed the forms and secured the required documents, please contact the registrar's office at the telephone number above to schedule an appointment to submit your documents. Thank you.

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2018-2019 REGISTRATION DOCUMENTS & FORMS CHECKLIST

DOCUMENTS

- ❑ Three (3) Proofs of Residency
  (see **2018-19 Residency Requirements** for detailed list)
- ❑ Proof of Student's Age
- ❑ Academic Transcript/Record of Grades

FORMS

- ❑ **Parent's Statement**
  Please complete, sign, and notarize.
- ❑ **Student Residency Questionnaire**
  This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435.
- ❑ **Registration Form** (2-pages)
- ❑ **Academic Records Release Form**
  Please complete a form for <u>each</u> previous school your child has attended.
- ❑ **Acceptable Use Policy for Internet Access**
  Please review the policy, and return the last page which needs to be completed by parent/guardian <u>and</u> student.

Health Forms:

- ❑ **Physical Health Exam** (performed within the past 12-months)
- ❑ **Current Immunization Record**
- ❑ **Dental Certificate**
- ❑ **Authorization for the Administration of Medication** (if applicable)
- ❑ **Health History Form**
- ❑ **Committee on Special Education Authorization to Release Information**
  Please complete this form only if applicable. Students who are classified for Special Education must forward all I.E.P documentation prior to meeting with Pupil Personnel Services.

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2018-2019 SCHOOL REGISTRATION RESIDENCY REQUIREMENTS
(THREE (3) PROOFS REQUIRED)

Name of Student: _____ **GRADE:** _____

One of the following pertaining to a home in the District:

- ☐ **A Mortgage or Closing Statement**
- ☐ **Deed**
- ☐ **A Notarized (by both landlord and lessee) *Signed* Lease**
- ☐ **A Notarized Rent Receipt**

In addition, required in conjunction with the lease when the name on the lease is different from parent name and utilities are included in the rent, or in the absence of a lease:

- ☐ **Affidavit of Property Owner/Landlord**

In addition, copies of any two of the following documents must be submitted:

- ☐ **Property Tax Bill**
- ☐ **Telephone Bill**
- ☐ **Gas & Electric Utility**
- ☐ **Water Bill**
- ☐ **Driver's License/Picture ID**
- ☐ **Oil Company Bill**
- ☐ **Insurance Bill**
- ☐ **Bank Statement**
- ☐ **Voter Registration Card**

PROOF OF CUSTODY – If you, as a parent or guardian, are separated, divorced, or have custody as the result of a court order or agreement, a fully-executed copy of the court order or agreement must be submitted.

- ☐ **Court-issued Legal Guardianship Papers**
- ☐ **Court Order granting custody**
- ☐ **Court Appointment as Foster Parent**
- ☐ **Affidavits provided by the parent surrendering control and the person in parental relationship assuming legal responsibility for the student.**

In addition to the above, students claiming emancipation shall be required to submit their own affidavit and an affidavit from their parent(s) where deemed appropriate.

A copy of all proofs of residency provided for resident students shall be made part of the student's permanent record and a copy kept in the student's file.

APPROVED:

_____ _____

Date: ***Ron Clamser, Jr.***
Residency Designee

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State of New York:
County of Westchester

Parent's Statement

TO THE BOARD OF EDUCATION OF THE DOBBS FERRY UNION FREE SCHOOL DISTRICT

This is to certify that I, _____, being duly sworn, depose and say:

1. I understand that this statement is being made **Under the Penalties of Perjury**, so that

_____ _____ _____
(Name of Child(ren))

may be admitted to the schools of the Dobbs Ferry Public Schools.

2. I reside at _____,
(Address)

my legal residence. I further certify that I do not maintain another residence outside the boundaries of the Dobbs Ferry School District. (Attach a copy of <u>one</u> of the following proofs pertaining to a home (1) a mortgage or closing statement, (2) a deed, (3) a notarized signed lease or (4) a notarized rent receipt.

In addition, copies of any <u>two</u> of the following proofs of residency containing your name at the above address: (1) Westchester County tax bill, (2) telephone bill, (3) gas & electric bill, (4) water bill (5) driver's license/picture ID, (6) insurance bill, (7) bank statement, (8) voter registration card or (9) oil company bill.

3. My former address was: _____

_____

I understand that if the above mentioned child(ren) is (are) found not to be a legal resident(s) of the Dobbs Ferry Union Free School District, **I will be legally responsible for and will pay the school district's annual tuition rate retroactive on the first day of admission as follows:**

2018-2019 <u>Estimated</u> State Education Department Non-Resident Tuition Rate

K – 6 $16,209
7 – 12 $17,393

I also realize that theft of governmental services is a crime punishable under the State Penal Law, and that a false statement made in connection with this application will make me liable to criminal prosecution. I have been informed that the school district will make unannounced home visits for purposes of residency verification.

I further understand that if I move out of the home listed above, I will immediately notify the school district.

Sworn to and before me
this _____ day of _____, 20___

_____ _____
Notary Public *Signature of Parent*

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Student Residency Questionnaire

Name of School: _____

Name of Student: _____
Last *First* *Middle*

Birth Date ____/____/____ Age: _____ Sex: ___Male ___Female
Month Day Year

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive. The District's homeless liaisons are:

Springhurst Elementary – Patricia Clifford – 914-693-1503 ext. 1451
Middle/High School – Danielle Pecora – 914-693-1500 ext. 3320

1. Is your current address a temporary living arrangement? ☐ Yes ☐ No
2. Is this temporary arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No

If you answered YES to the above questions, please complete the remainder of this form.
If you answered NO, you may stop here.

Where is the student presently living? (Check one box.)
☐ In a motel
☐ In a shelter
☐ With more than one family in a house or apartment
☐ Moving from place to place
☐ In a place not designed for ordinary sleeping accommodations such as a car, park or campsite

Name of Parent(s)/Legal Guardian(s) _____

Address _____

Phone Number _____

Signature of Parent(s)/Legal Guardian(s) _____ Date _____

I certify the above-named student qualifies as a student in transition under the provisions of the McKinney-Vento Act.

_____ _____
Date *McKinney-Vento Liaison Signature*

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Office Use Only
Received: _____ **ID #:** _____
Date Enrolled: _____ **Grade Entering:** _____
Approved by: _____

REGISTRATION FORM

Name of Child: Last: _____ First _____ MI: _____

Home Address: No.: _____ Street Name: _____ Apt. No: _____

City: _____ State: _____ Zip: _____ **Home Telephone (required):** _____

Date of Birth: Month: _____ Day: _____ Year: _____ **Native Language:** _____

What is the preferred language of communication? _____

Gender: ☐Male ☐Female **Place of Birth:** City: _____ State: _____ Country: _____
If not born in the US, enter date student entered the US: _____

Are you Hispanic? ☐Yes ☐No **Ethnicity:** ***Select all that apply.*** ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Pacific Islander ☐ White

Ever Attended Dobbs Ferry Schools: ☐Yes ☐No **If yes, date last attended:** _____ **Grade:** _____

Name of Last School or Preschool Attended: _____ **Grade Attending / Completed:** _____

Has student been withdrawn from previous school? ☐Yes ☐No **If Yes, Withdrawal Date:** _____

School Address: _____ **School District:** _____

City: _____ **State:** _____ **Zip:** _____ **Telephone:** _____

Mother/Guardian Information:
Last Name: _____ First Name: _____ MI: _____

Address: No.: _____ Street Name: _____ Apt. No: _____

City: _____ State: _____ Zip: _____ Home Telephone: _____

Cell Phone: _____ Work Phone: _____ Email Address: _____

Relationship: ☐Mother ☐Grandmother ☐Aunt ☐Guardian ☐Other _____

Occupation: _____ Business Address: _____

Maiden Name: _____ Marital Status: ☐Single ☐ Married ☐ Divorced ☐Separated ☐ Widowed

Father/Guardian Information:
Last Name: _____ First Name: _____ MI: _____

Address: No.: _____ Street Name: _____ Apt. No: _____

City: _____ State: _____ Zip: _____ Home Telephone: _____

Cell Phone: _____ Work Phone: _____ Email Address: _____

Relationship: ☐Father ☐Grandfather ☐Uncle ☐Guardian ☐Other _____

Occupation: _____ Business Address: _____

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Name of Child: _____

Parents Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

If divorced or separated, who does the child reside with? ☐ Mother ☐ Father

Does other parent have joint custody? ☐ Yes ☐ No

Can child be released to either parent? ☐ Yes ☐ No

If divorced or separated, a certified copy of court order or custody documents must be submitted.

Does child temporarily live in Dobbs Ferry? ☐ Yes ☐ No
(*If yes, you must provide and attach written explanation.*)

Is your current address a temporary living arrangement? ☐ Yes ☐ No

Is this temporary living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No
(If yes, please complete the Student Residency Questionnaire. This questionnaire is intended to address the McKinney-Vento Act, USCA 42 Section 11302 (a.))

List all languages spoken in the home:

Primary: _____ Secondary: _____

List all other children residing in household up to 21 years of age:

Last Name	First Name	Date of Birth	Gender (M/F)	School	Grade

Doctor Information:

Doctor's Name	Phone Number

Emergency Contact Information - Other than parents/guardians:

Name	Relationship	Home Phone	Mobile Phone

Please answer the following questions for us to best service your child's needs.

1. **Has your child ever received specialized help from a speech therapist, learning disability specialist, or remedial reading specialist?** ☐ Yes ☐ No
2. **Has your child ever been reviewed by a Committee of Special Education because of suspected learning and/or behavioral difficulties?** ☐ Yes ☐ No
3. **Has your child ever been designated as a student with a handicapping condition?** ☐ Yes ☐ No
4. **Has your child ever received Academic Intervention Services (AIS)?** ☐ Yes ☐ No
5. **Has your child ever received English as a Second Language Services?** ☐ Yes ☐ No

Signature of Parent or Guardian:

Print Name: _____ **Signature:** _____

Relationship to Child: _____ **Date:** _____

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SPRINGHURST ELEMENTARY RECORDS RELEASE AUTHORIZATION

I hereby authorize you to forward all the following applicable records pertaining to my son/daughter

_____ _____
Student Name **Date of Birth**

Name of former school: _____

Address: _____

Phone/Fax No. _____

_____ **Permanent Record**

_____ **Attendance**

_____ **Health Records**

_____ **Standardized Test Scores**

_____ **Report Cards**

_____ **Psychological Reports**

_____ **Disciplinary Records**

_____ **ELL Service Record (including ESLAT Scores)**

Please indicate whether or not this child has been designated as a CSE student by the Committee on Special Education. _____ **Yes** _____ **No**

Please forward records to: Springhurst Elementary School
175 Walgrove Avenue
Dobbs Ferry, NY 10522
FAX: (914) 693-3188

Parent/Guardian Signature: _____

Relationship to Student: _____ **Date:** _____

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MIDDLE/HIGH SCHOOL RECORDS RELEASE AUTHORIZATION

Re: _____ **Date:** _____
(Student Name)

The above named student was a former pupil in your school and has registered in the Dobbs Ferry School District. Please send a copy of his/her academic records (transcript), standardized test scores, disciplinary records, and health records in order to facilitate the registration process and to determine the proper placement for this student. Also, please indicate whether this child has been designated a CSE student by the Committee on Special Education.

Below is a signed authorization from the parent/guardian to release this information to the Dobbs Ferry School District. Thank you.

MS/HS RELEASE AUTHORIZATION

As Parent/Guardian of _____, I hereby authorize:

_____
(Name of Former School)

_____
(Address)

_____
(Tel No.) / (Fax No.)

To release all records to: **Dobbs Ferry School District**
Guidance Department
505 Broadway
Dobbs Ferry, NY 10522
FAX: 914 693-1536

Student's Name: _____ **Current Grade:** _____

CSE Student: ___Yes ___No **If Yes:** ___ IEP ___ 504

Parent Signature: _____

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COMMITTEE ON SPECIAL EDUCATION
PERMISSION TO RELEASE/OBTAIN INFORMATION

Student Name: _____ **Date of Birth:** _____

I hereby authorize the Dobbs Ferry Union Free School District:

Release the following information to:

Name: _____

Agency: _____

Street: _____

City: _____ State: _____ Zip: _____

Obtain the following information from:

Name: _____

Agency: _____

Street: _____

City: _____ State: _____ Zip: _____

Communicate over the telephone with and/or to arrange a classroom observation by:

Name: _____

Agency: _____

Phone: _____

Most Recent	All	Specific Information or Dates	
☐	☐	_____	cumulative file records (report cards, general ed. records)
☐	☐	_____	standardized test scores (DRP, CMT, SAT, CMAT)
☐	☐	_____	educational evaluations
☐	☐	_____	psychological evaluations
☐	☐	_____	social work evaluations
☐	☐	_____	minutes of CSE/IEP Team meetings
☐	☐	_____	IEP
☐	☐	_____	Other, Specify _____
☐	☐	_____	Other, Specify _____

Parent/Guardian		Administrator Authorizing Release
_____	Name	_____
_____	Relationship/Position	_____
_____	Signature	_____
_____	Date	_____

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Student Network/Internet Agreement and Permission Form

Introduction

Dobbs Ferry is pleased to offer our students access to the District's computer technology resources. To use these resources, students and their parents/guardians must sign and return the attached form. Please read this document carefully, review its contents with your son or daughter, sign where appropriate and return to your child's school. Any questions or concerns about this permission form may be referred to the building principal.

General Network Use

The network is provided for students to conduct research, complete assignments, publish their work, and communicate with others. Access to network services is given to students who agree to act in a considerate and responsible manner. Students are responsible for good behavior on school computer networks just as they are in a classroom or a school hallway. As such, general school rules for behavior and communications apply, and users must comply with district standards and honor the agreements they have signed. Beyond the clarification of such standards, the district is not responsible for restricting, monitoring or controlling the communications of individuals utilizing the network.

Network storage areas are similar to school lockers. Network administrators may review files and communications to maintain system integrity and ensure that the system is used responsibly. Users should not expect that files stored on district servers will be private.

In general, when using school technology, students are **not** permitted to:

- Use others' passwords or share their passwords with others
- Damage or modify computers, operating systems or computer networks
- Send or display offensive messages or pictures
- Use obscene language
- Give personal information, such as complete name, phone number, address or photo
- Harass, insult or attack others
- Violate copyright laws
- Access others' folders or files without express permission
- Intentionally waste limited resources, such as paper or bandwidth
- Employ the network for commercial purposes, financial gain or fraud

Internet / World Wide Web / Social Networking / E-mail Access

Within reason, freedom of speech and access to information will be honored. Families should be warned that some material accessible via the Internet might contain items that are illegal, defamatory, inaccurate or potentially offensive to some people. While our intent is to make Internet access available to further educational goals and objectives, students may find ways to access other materials as well. Filtering software is in use to block content as specified in the Children's Internet Protection Act, but no filtering system is capable of blocking 100% of the inappropriate material available on the Internet. Dobbs Ferry believes that the benefits to students accessing the Internet and using social networking resources outweigh the disadvantages. By using these resources responsibly, opportunities for collaboration enable each student to become self-directed lifetime learners. Ultimately, parents and guardians of minors are responsible for setting and conveying the standards that their children should follow when using media and information sources.

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Student Network/Internet Agreement and Permission Form

Publishing to the World Wide Web

Although most of students' work at Dobbs Ferry will be done within a secure, password-protected portal, students will from time to time publish work to the web. This provides students with an opportunity to share their work with a wider audience, receive feedback from external professionals and share with the public what is going on at school. Students agree to only use their first names, not their last names or any other personal identifying information such as age, address, phone number, photos, etc. Students should also not publish work that contains copyrighted materials without proper permission and/or citation when appropriate.

Violations to this Policy

Violations may result in a loss of access as well as other disciplinary or legal action.

Student User Agreement:

As a user of the Dobbs Ferry computer network, I hereby agree to comply with the statements and expectations outlined in this document and to honor all relevant laws and restrictions.

Student Printed Name _____

Student Signature _____ Date _____

Parent/Guardian Permission for the Publication of Student Work to the World Wide Web:

I have spoken with my son or daughter about the responsibilities outlined above when using school technology resources.

Parent Printed Name _____

Parent Signature _____ Date _____

These permissions are granted for an indefinite period of time, unless otherwise requested.

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Dear Parents/Guardians,

Welcome to the Dobbs Ferry School District!

New York State law (law effective July 1, 2018) requires a physical examination for all students **entering Kindergarten, Grades 1, 3, 5, 7, 9 and 11, and all students transferring into the Dobbs Ferry School District.**

The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner and on the approved NYS Student Health Examination Form for School. If you have already had a physical examination completed for the 2018-19 school year on a different form, it will be accepted. **In 2019-2020, ONLY the approved form will be accepted.**

All students entering Kindergarten and all students transferring into the district must present a verified copy of all immunizations. Students whose immunization records are already on file only need to present proof of additional immunizations that they receive.

A dental certificate which states your child has been seen by a dentist or dental hygienist is requested for students entering Kindergarten, Grades 1, 3, 5, 7, 9 and 11, and students transferring into the school district.

- A copy of the physical examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts K , 1st , 3rd, 5th, 7th, 9th, & 11th grades. If a copy is not given to the school within 30 days, the school will contact you.
- For your convenience, a physical exam form and dental certificate for your health care providers is available on the Health Services page of the school's website.
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the time of your child's appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office. We appreciate your time in collaborating with us to maintain a healthy community and to provide your child and our student with the necessary documentation as required by law.

School Nurses:

Cara de Leon, RN
Middle School & High School
deleonc@dfsd.org
Phone: 914-693-1500, ext. 3046 / Fax: 914-693-1536

Gina DiMaria, RN
Springhurst Elementary School
dimariag@dfsd.org
Phone: 914-693-1503, ext. 1467 / Fax: 914-693-3188

School Physician:

Pediatrics on Hudson
615 Broadway
Hastings-on-Hudson, NY 10706
914-963-1663
www.pediatricsonhudson.com

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE 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:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached; ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached; ☐ Intermittent ☐ Persistent ☐ Other: _____

Seizures ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached; ☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached; ☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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 **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle

☐ Concussion – Last Occurrence: _____

☐ Mental Health: _____

☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

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

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

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

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

2018-19 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). For grades pre-k through 10, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: intervals between doses of polio vaccine DO NOT need to be reviewed for grades 5, 11 and 12.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 11 and 12. 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 and 4	Grade 5	Grades 6, 7, 8, 9 and 10	Grades 11 and 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 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	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**3 doses**
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**	**1 dose**	**2 doses**	**1 dose**
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**			**Grades 7, 8 and 9: 1 dose**	**Grade 12: 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, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. 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.
   b. If the fourth dose of DTaP was administered at 4 years or older, 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 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. A Tdap vaccine (or incorrectly administered DTaP vaccine) received at 7 years or older will meet the 6th grade Tdap requirement.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap. A dose received at 7 years or older will meet this requirement.
   b. 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. Intervals between the doses of polio vaccine do not need to be reviewed for grades 5, 11 and 12 in the 2018-19 school year.
   e. If both OPV and IPV were administered as part of a series, the total number of doses and intervals between doses is the same as that recommended for the U.S. IPV schedule. If only OPV was administered, and all doses were given before age 4 years, 1 dose of IPV should be given at 4 years or older and at least 6 months after the last OPV dose.

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 and grades 11 and 12. Two doses are required for grades kindergarten through 10.
   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.
   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. (Minimum age: 6 weeks)
   a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7, 8 and 9.
   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 of age 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. 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

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ 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/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

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

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

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

Dentist's/ Dental Hygienist's name and address

(please print or stamp) **Dentist's/Dental Hygienist's Signature**

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

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

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

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

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

II. Treatment Needs (check all that apply)

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

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

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

Dobbs Ferry School District
Independent Thinkers Change Worlds

Middle & High School Health Office
505 Broadway
Dobbs Ferry, NY 10522
t 914. 693-1500, ext. 3046
f 914. 693-1536
deleonc@dfsd.org

Springhurst Elementary Health Office
175 Walgrove Avenue
Dobbs Ferry, NY 10522
t 914. 693-1500, ext. 1467
f 914. 693-3188
dimariag@dfsd.org

REQUEST FORM FOR ADMINISTRATION OF MEDICATION TO STUDENT IN SCHOOL

Medication of any kind (over the counter (OTC) & prescription) cannot legally be dispensed to any child in school without a health care provider's order and written parent/guardian consent. Medication must be in original pharmacy labeled container or original OTC packaging and brought in by an adult. Medications that can be taken at home before/after school should be arranged in this manner. NYS law permits students to independently carry and use their own respiratory rescue medication, epinephrine auto-injector, or diabetes medication/management supplies with additional health care provider and parent/guardian permissions. New medication orders are required each school year. Medication must be picked up at the end of the school year or be discarded.

Section A: Written Parent/Guardian Consent (To Be Completed by Parent)

Student Name: _____ DOB: _____ Grade: _____

I request that my child receive the medication prescribed below by our licensed health care provider. The medication is to be furnished by me in original pharmacy labeled container or original OTC packaging. The school nurse may contact the prescriber as needed.

Print Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

Section B: Health Care Provider's Order (To Be Completed by Health Care Provider)

Diagnosis: _____

Medication: _____

Dose: _____ Route: _____ Time(s): _____

Duration of treatment: Valid for 20___ - 20___ School Year OR Start date: _____ End date: _____

Possible adverse reaction or side effects: _____

Print Physician Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

Address: _____

Physician's Stamp

Section C: (IF APPLICABLE) Health Care Provider and Parent/Guardian Permissions Required for Independent Medication Carry and Use of Rescue Medications (To Be Completed by Health Care Provider and Parent/Guardian)

Health Care Provider Permission for Independent Carry and Use of Rescue Medications

I attest that this student has demonstrated to me that they can self-administer the rescue medication(s) checked below safely and effectively, and may carry and use this rescue medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

- ☐ Allergy and requires Epinephrine Auto-injector
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ☐ _____ which requires rapid administration of _____
  (State Diagnosis) (Medication Name)

Physician Signature: _____ Date: _____

Parent/Guardian Permission for Independent Carry and Use of Rescue Medications

I agree that my child can use their rescue medication effectively and may carry and use this rescue medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Parent/Guardian Signature: _____ Date: _____