Welcome to the Dobbs Ferry School District!

Registration for the Dobbs Ferry School District is now an online process.

Please read the following carefully before beginning the registration process.

If you have any questions, or want to schedule an appointment, please contact our Registrar at:

High School/Middle School
Ron Clamser at 914-693-1500 ext. 3025 or email clamserr@dfsd.org

Springhurst Elementary School
Cindy Esposito at 914-693-1503 ext. 1435 or email espositoc@dfsd.org

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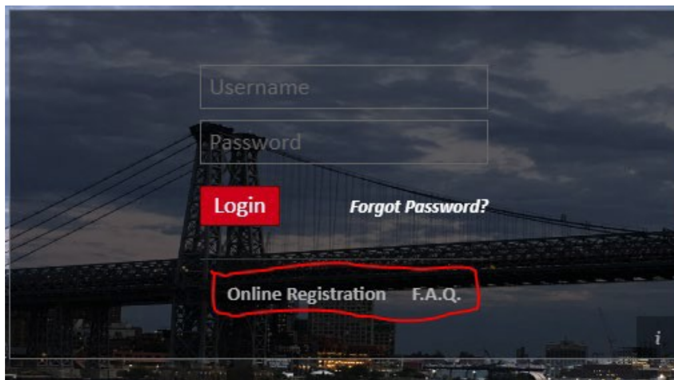
If this is your first child to enroll in the Dobbs Ferry School District.

Go to the **eSchoolData Online Registration** link at https://esdparentportal.lhric.org/dobbsferryufsd. This will bring you to the Dobbs Ferry Online Registration screen

Click on **Online Registration** as shown below and complete the form. This starts the registration process for your child. *(**No login is required** on the Parent Portal screen for online registration)*



If you already have children enrolled in the Dobbs Ferry School District and you have a Parent Portal account, log into the Parent Portal

Click on **Register New Student** (top right), as shown below:

- Once you have submitted the form, you will receive an email confirmation.
- Once this email is received, please contact the Registrar to schedule an appointment to submit the registration documentation required (see below).
- Your registration is not complete, and students cannot be scheduled, until this documentation has been received by the District.

Required Registration Documents & Forms

To register a student the following documents must be presented to the Registrar.
All required documents that need to be submitted are included in this packet.

Proof of Residency

You are asked to provide the following proofs of residency:

- **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 Bill
  - Water Bill
  - Driver's License/Picture ID
  - Oil Company Bill
  - Insurance Bill
  - Bank Statement
  - Voter Registration Card

Proof of Birth

To determine the student's age, you are asked to provide **ONE** of the following:

- Birth Certificate
- Passport

Proof of Custody

If you, as a parent or guardian, are separated, divorced, or have custody as the result of a court order agreement, a fully-executed copy of the court order or agreement must be submitted. Please provide **ONE** of the following;

- Court-issued Legal Guardianship Papers
- Court Order granting custody
- Court Appointment as Foster Parent
- Affidavits from parent surrendering control and person assuming responsibility for student

Parent's Statement

- PARENT'S STATEMENT - Please complete, sign, and notarize.

Academic Transcript/Record of Grades Release Form

Complete the applicable Records Release Authorization Form for each previous school your child attended:

- SPRINGHURST ELEMENTARY RECORDS RELEASE AUTHORIZATION FORM
- MIDDLE/HIGH SCHOOL RECORDS RELEASE AUTHORIZATION FORM
- **OTHER RECORDS**
  CURRENT REPORT CARD
  OFFICIAL HIGH SCHOOL TRANSCRIPT

Consent for Release of Preschool Information

For students entering Kindergarten complete the applicable Records Release Authorization Form for each previous school your child attended:

- CONSENT FOR RELEASE OF PRESCHOOL INFORMATION - We would like your permission to obtain information about your child's learning style, and basic academic and social skills from his or her preschool or daycare teacher. We find that communication with preschool personnel helps to facilitate the student's transition from preschool to elementary school. The preschool teacher is familiar with your child and many facets of his or her development and school life. Sharing this information with us assists in making class placement decisions, and can help the kindergarten teacher work effectively with your child during his/her first year in elementary school.

Acceptable Use Policy for Internet Access

- ACCEPTABLE USE POLICY - Please review the policy with your child, and return the last page signed by both the parent/guardian and student.

HEALTH FORMS & REQUIREMENTS

- WELCOME TO THE HEALTH OFFICE
- HEALTH & DENTAL REQUIREMENTS
- NYS IMMUNIZATION REQUIREMENTS FOR SCHOOL - **(All students entering Kindergarten & all students transferring into the District must present a verified copy of all immunizations.)**
- PHYSICAL HEALTH EXAM FORM (performed within the past 12 months)
- DENTAL CERTIFICATE
- AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION (if applicable)
- ALLERGY/MEDICATION ADMINISTRATION FORM (if applicable)
- ASTHMA MEDICATION ADMINISTRATION FORM (if applicable)

Home Language Questionaire (HLQ)

- HOME LANGUAGE QUESTIONAIRE (HLQ) - Please complete this form in order for us to determine how well your child understands, speaks, reads and writes English. This will help us provide the best possible education for your child. (Link to this form in other languages: http://www.nysed.gov/bilingual-ed/ell-identification-placementhome-language-questionnaire

Other Forms - if applicable

- STUDENT RESIDENCY QUESTIONAIRE - This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. If your current living arrangements are temporary due to loss of housing or economic hardship, please complete the Student Residency Questionnaire and bring to registration.
- 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 IEP documentation prior to meeting with Pupil Personnel Services.

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

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(s) 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 one 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 two 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**

2022-2023 Estimated State Education Department Non-Resident Tuition Rate

K-6	**$18,708**
7-12	**$19,415**

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_____

_________________________________ _________________________________

Signature of Parent *Notary Public*

175 Walgrove Avenue
Dobbs Ferry, NY 10522
t 914. 693-1503
f 914. 693-3188
http://dfsd.org/sh

SPRINGHURST RECORDS RELEASE AUTHORIZATION FORM

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

______________________________ ________________

Student Name Date of Birth

Name of former school: ____

Address of former school: ____

Fax No. ____________________ Email Address: _____________________

___ Permanent Record

___ Health Records

___ Report Cards

___ Disciplinary Records

___Attendance

___ Standardized Test Scores

___ Psychological Reports

___ ELL Service Record

(Include ESLAT Scores)

Please indicate whether or not this child has been designated as a CSE student by the committee of Special Education. ___Yes ___ No

Please forward records to: Springhurst Elementary School

175 Walgrove Avenue

Dobbs Ferry, NY 10522

FAX: 914-693-3188

Email: espositoc@dfsd.org

Parent/Guardian Signature: ____

Relationship to Student: ______________________ Date:_______________

505 Broadway
Dobbs Ferry, NY 10522
t 914.693-1500
f 914.693-5962
http://www.dfsd.org

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: ____

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

Dear Parent/Guardian,

We would like your permission to obtain information about your child's learning style, and basic academic and social skills from his or her preschool or day care teacher. We find that communication with preschool personnel helps to facilitate the student's transition from preschool to elementary school. The preschool teacher is familiar with your child and many facets of his or her development and school life.

Sharing this information with us assists in making class placement decisions, and can help the kindergarten teacher work effectively with your child during his/her first year in elementary school.

If you would like to give us permission to obtain information, please sign the consent form below and bring it with you at registration time.

Thank you for helping to make the transition from preschool to elementary school a smooth one for your child.

Sincerely,

Julia D. Drake
Principal

CONSENT FOR RELEASE OF PRESCHOOL INFORMATION

I give permission for Springhurst Elementary School to obtain information from the following preschool or day care center concerning my child:

Child's Name: ____

Preschool/Day Care: ____

Address: ____

Phone: ____

Email of Preschool Contact: ____

Parent/Guardian Signature: ______________________________Date: ____________

Dobbs Ferry Schools

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.

Dobbs Ferry Schools

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.

Revised 7/12/2012

505 Broadway
Dobbs Ferry, NY 10522
t 914. 693-1500
http://www.dfsd.org

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.

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, 1, 3, 5, 7, 9, & 11 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

Kelli Cronin, RN
Dobbs Ferry School District
cronink@dfsd.org

School Physician:

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

School Health Requirements for the 2021-2022 School Year
For New and Current Students

1. **Physicals:**
   Physical Exam Forms are required for students entering Kindergarten, Grades 1, 3, 5, 7, 9, and 11.

   Forms:
   In accordance with new NYS regulations, **only the Required NYS School Health Examination Form or an electronic health record equivalent can be accepted by the school for student physical exam forms**.

   Date of Physical Exams:
   Physical exams conducted by a NYS licensed medical provider within twelve months prior to the start of the 2021-2022 school year are acceptable. **This means any physical exam that was done before September 9, 2020 will not be accepted.**

   Physical Exam Forms must be submitted to the school health office by Tuesday, October 12, 2021.

   Link: Required NYS School Health Examination Form

2. **Immunizations:**
   Students must meet New York State Immunization Requirements for School Entrance/Attendance for the grade level they are entering. Requirements include correct intervals between vaccines, correct ages at which vaccines were received, as well as the correct number of doses.

   Generally, students entering Grade 6 need a Tdap vaccine; students entering Grade 7 need dose 1 of Menactra vaccine; students entering Grade 12 need dose 2 of Menactra vaccine. Check with your School Nurse to see if your child is up to date for the 2021-2022 School Year.

   Proof of up-to-date immunizations is due by Thursday, September 23, 2021.

   Any student who does not meet immunization requirements by September 23, 2021, may be referred to building administrators for exclusion from school.

   Links:
   2021-2022 School Year New York State Immunization Requirements for School Entrance/Attendance
   NYS DOH School Vaccinations Website
   School Immunization Q&A

3. **Medications:**
   ALL medication, including over-the-counter medication, prescription medication, medication that a student "self-carries," requires a medication order from a medical provider by way of a Medication Administration form.
   - Medication that can be given at home before or after school hours should be scheduled in this manner.
   - Please be sure each form is completed in its entirety before leaving the doctor's office and before submitting it to the Nurse's office.
   - Medication must be supplied by the parent/guardian in original over-the-counter or prescription packaging.

Links:
Medication Administration Form
Allergy Medication Administration Form
Asthma Medication Administration Form

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

<table>
<tr><th>Vaccines</th><th>Prekindergarten (Day Care, Head Start, Nursery or Pre-k)</th><th>Kindergarten and Grades 1, 2, 3, 4 and 5</th><th>Grades 6, 7, 8, 9, 10 and 11</th><th>Grade 12</th></tr>
<tr><td>Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]</td><td>4 doses</td><td>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</td><td colspan="2">3 doses</td></tr>
<tr><td>Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]</td><td colspan="2">Not applicable</td><td colspan="2">1 dose</td></tr>
<tr><td>Polio vaccine (IPV/OPV)[4]</td><td>3 doses</td><td colspan="3">4 doses
or 3 doses
if the 3rd dose was received at 4 years or older</td></tr>
<tr><td>Measles, Mumps and Rubella vaccine (MMR)[5]</td><td>1 dose</td><td colspan="3">2 doses</td></tr>
<tr><td>Hepatitis B vaccine[6]</td><td>3 doses</td><td colspan="3">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</td></tr>
<tr><td>Varicella (Chickenpox) vaccine[7]</td><td>1 dose</td><td colspan="3">2 doses</td></tr>
<tr><td>Meningococcal conjugate vaccine (MenACWY)[8]</td><td colspan="2">Not applicable</td><td>Grades 7, 8, 9, 10 and 11: 1 dose</td><td>2 doses
or 1 dose
if the dose was received at 16 years or older</td></tr>
<tr><td>Haemophilus influenzae type b conjugate vaccine (Hib)[9]</td><td>1 to 4 doses</td><td colspan="3">Not applicable</td></tr>
<tr><td>Pneumococcal Conjugate vaccine (PCV)[10]</td><td>1 to 4 doses</td><td colspan="3">Not applicable</td></tr>
</table>

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 ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V 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.

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.

MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS

Provider Medication Order Form | Office of School Health | School Year 2021-2022

Student Last Name First Name Middle

Date of birth ___/___/_____ (MM DD YYYY)

☐ Male ☐ Female

School **Grade**

HEALTH CARE PRACTITIONERS COMPLETE BELOW

1. Diagnosis: ____________ ICD-10 Code: ☐ _ _ _ . _ _ _

Medication: ____________ Generic and/or Brand Name

Preparation/Concentration: ____________

Dose: ____________ Route: ____________

Student Skill Level *(Select the most appropriate option):*

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision

In School Instructions

☐ Standing daily dose: at _ _: _ _ AM / PM and _ _: _ _ AM / PM

AND/OR

☐ PRN

____________ *specify signs, symptoms, or situations*

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in _ _ minutes or _ _hours for a maximum of __ times.

Conditions under which medication should not be given:

2. Diagnosis: ____________ ICD-10 Code: ☐ _ _ _ . _ _ _

Medication: ____________ Generic and/or Brand Name

Preparation/Concentration: ____________

Dose: ____________ Route: ____________

Student Skill Level *(Select the most appropriate option):*

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision

In School Instructions

☐ Standing daily dose: at _ _: _ _ AM / PM and _ _: _ _ AM / PM

AND/OR

☐ PRN

____________ *specify signs, symptoms, or situations*

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in _ _ minutes or _ _hours for a maximum of __ times.

Conditions under which medication should not be given:

3. Diagnosis: ____________ ICD-10 Code: ☐ _ _ _ . _ _ _

Medication: ____________ Generic and/or Brand Name

Preparation/Concentration: ____________

Dose: ____________ Route: ____________

Student Skill Level *(Select the most appropriate option):*

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision

In School Instructions

☐ Standing daily dose: at _ _: _ _ am / pm and _ _: _ _ AM / PM

AND/OR

☐ PRN

____________ *specify signs, symptoms, or situations*

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in _ _ minutes or _ _hours for a maximum of __ times.

Conditions under which medication should not be given:

Health Care Practitioner (Please Print) LAST NAME FIRST NAME Signature

Address | Tel. No. (_ _ _)_ _ _- _ _ _ _ | Fax. No (_ _ _)_ _ _- _ _ _ _

E-mail address | Cell phone (_ _ _)_ _ _- _ _ _ _

NYS License No **(Required)** ___ - ___ ___ ___ ___ ___ | NPI No. ___ ___ ___ ___ ___ ___ ___ ___ | Date ___/___/_____

PARENTS MUST SIGN PAGE 2 ➔

MEDICATION ADMINISTRATION FORM page 2

THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2021-2022

PARENTS/GUARDIANS FILL BELOW

By signing below, I agree to the following:

- I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner.
- I understand that:
    - I must give the school nurse my child's medicine.
    - All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will get another medicine for my child to use when he or she is not in school or is on a school trip.
        - Prescription medicine must have the original pharmacy label on the box or bottle.
    - No student is allowed to carry or give him or herself controlled substances.
    - I must immediately tell the school nurse about any change in my child's medicine or the doctor's instructions. I will give my child's school nurse a new medication administration form written by my child's health care practitioner.
    - The medication order in this medication administration form expires at the end of my child's school year. I will give my child's school nurse a new medication administration form at the beginning of every school year.

Student Last Name First	Date of Birth ___ / ___ / ______
Parent/Guardian Print Name:	Signature:
Date Signed ___ / ___ / ______	Cell Phone:
Other Phone:	Email:

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2021-2022

Student Last Name	First Name	Middle	**Date of birth** __/__/____ MM DD YYYY	☐ Male ☐ Female
		Weight ______		
School				**Grade**

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergy	Specify Allergy	Specify Allergy
☐ Allergy to	☐ Allergy to	☐ Allergy to

			Does this student have the ability to:		
History of asthma?	☐ Yes ***(If yes, student has an increased risk for a severe reaction)***	☐ No			
History of anaphylaxis?	☐ Yes Date __/__/____	☐ No	Self-Manage *(See 'Student Skill Level' below)*	☐ Yes	☐ No
If yes, system affected	☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic		Recognize signs of allergic reactions	☐ Yes	☐ No
Treatment	Date __/__/____		Recognize/avoid allergens independently	☐ Yes	☐ No
History of allergy testing?	☐ Yes *(attach copy of results)* Date __/__/____	☐ No	Comments:		

Select In School Medications

1. SEVERE REACTION

- **CALL 911**, Immediately administer:

☐ **Epinephrine** Auto-Injector 0.15 mg

☐ **Epinephrine** Auto-Injector 0.3 mg (retractable devices preferred) intramuscularly into the anterolateral of thigh for the following symptoms:

- Shortness of breath, wheezing, or coughing
- Pale or bluish skin color
- Weak pulse
- Many hives or redness over body
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Lip or tongue swelling that bothers breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Feeling of doom, confusion, altered consciousness or agitation

☐ Other:__________________

☐ If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):__________________
Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine.**

- If no improvement, or if symptoms recur, repeat in ______ minutes for maximum of _____ times (not to exceed a total of 3 doses)

Student Skill Level *(select the most appropriate option)*
☐ Dependent Student: nurse/nurse-trained staff must administer
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer

Practitioner's Initials

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

2. MILD REACTION:

- Give antihistamine: Name:________________ Preparation/Concentration:__________ Dose:________ Route: _______
  Frequency: ☐ **Q4** hours **or** ☐ **Q6** hours as needed for the following symptoms:
  - Itchy nose, sneezing, itchy mouth
  - A few hives
  - Mild stomach nausea or discomfort
  - Other: ____________
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine.

Student Skill Level *(select the most appropriate option)*
☐ Dependent Student: nurse must administer
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer

Practitioner's Initials

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

3. OTHER MEDICATION (e.g., inhaler/bronchodilator if child has asthma):

- Give Name:________________ Preparation/Concentration:__________ Dose: __________
  Route:__________ Frequency: Q________ ☐ minutes ☐ hours as needed

Specify signs, symptoms, or situations:__________________
If no improvement, indicate instructions:__________________
Conditions under which medication should not be given: __________________

Student Skill Level *(select the most appropriate option)*
☐ Nurse-Dependent Student: nurse must administer
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer

Practitioner's Initials

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Home Medications *(include over-the counter)*

Health Care Practitioner Name LAST (Please Print)	FIRST	Signature	Date __/__/____
Address		Tel. (___)___-____	Fax. (___)___-____
NYS License # **(Required)**	NPI # __ __ __ __ __ __ __ __ __ __		

PARENTS MUST SIGN PAGE 2 ➔

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM page 2

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2021-2022

PARENTS/GUARDIANS FILL BELOW

By signing below, I agree to the following:

- I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner.
- I understand that:
  - I must give the school nurse my child's medicine.
  - All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will get another medicine for my child to use when he or she is not in school or is on a school trip.
    - Prescription medicine must have the original pharmacy label on the box or bottle.
  - I must immediately tell the school nurse about any change in my child's medicine or the doctor's instructions. I will give my child's school nurse a new medication administration form written by my child's health care practitioner.
  - The medication order in this medication administration form expires at the end of my child's school year. I will give my child's school nurse a new medication administration form at the beginning of every school year.

Student Last Name First	Date of Birth ___/___/______
Parent/Guardian Print Name:	Signature:
Date Signed ___/___/______	Cell Phone:
Other Phone:	Email:

FOR SELF ADMINISTRATION OF MEDICINE:

- I confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing, and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school.
- I consent to the school nurse or trained school staff giving my child medicine if my child is temporarily unable to carry and give him or herself medicine.

Parent/Guardian Print Name:	Signature:
	Date Signed ___/___/______

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM page 2

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year

PARENTS/GUARDIANS FILL BELOW

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I understand that:

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  - Prescription medicine must have the original pharmacy label on the box or bottle.
- I must immediately tell the school nurse about any change in my child's medicine or the doctor's instructions. I will give my child's school nurse a new medication administration form written by my child's health care practitioner.
- The medication order in this medication administration form expires at the end of my child's school year. I will give my child's school nurse a new medication administration form at the beginning of every school year.

Student Last Name First **Parent/Guardian** Print Name:	Date of Birth / / Signature:
Date Signed / /	Cell Phone:
Other Phone:	Email:

FOR SELF ADMINISTRATION OF MEDICINE:

I confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying,storing, and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use,and for all results of my child's use of this medicine in school.

I consent to the school nurse or trained school staff giving my child medicine if my child is temporarily unable to carry and give him or herself medicine.

Parent/Guardian Print Name:	Signature:
	Date Signed / /

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2021-2022

Student Last Name First Name Middle Initial

Date of Birth __ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

☐ Male
☐ Female

Grade/Class ______

School Name

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis
☐ Asthma

Control *(see NAEPP Guidelines)*
☐ Well Controlled
☐ Not Controlled / Poorly Controlled
☐ Unknown

Severity *(see NAEPP Guidelines)*
☐ Intermittent
☐ Mild Persistent
☐ Moderate Persistent
☐ Severe Persistent

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

History of near-death asthma requiring mechanical ventilation	☐Y	☐N	☐U	
History of life-threatening asthma (loss of consciousness or hypoxic seizure)	☐Y	☐N	☐U	
History of asthma-related PICU admissions (ever)	☐Y	☐N	☐U	
Received oral steroids within past 12 months	☐Y	☐N	☐U	____ times last : __ __/__ __/__ __
History of asthma-related ER visits within past 12 months	☐Y	☐N	☐U	____ times
History of asthma-related hospitalizations within past 12 months	☐Y	☐N	☐U	____ times
History of food allergy or eczema, specify: ________________	☐Y	☐N	☐U	

Student Skill Level *(Select the most appropriate option)*
☐ Nurse-Dependent Student: nurse must administer medication
☐ Supervised Student: student self-administers under adult supervision
☐ Independent Student: student is self-carry / self-administer

[Practitioner Initials] *I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.*

Home Medications *(Include over the counter)*
☐ Reliever ____________________
☐ Controller ____________________
☐ Other ____________________

Quick Relief In-School Medication (Select ONE)

☐ **Albuterol MDI**
[*Ventolin® MDI can be provided by school for shared usage (plus individual spacer)*]:
☐ MDI w/ spacer
☐ DPI

☐ **Other**: Name: ______________ Strength: ______
Dose: _____ Route: ______ Time Interval: ☐____ hrs

In-School Instructions *(Check all that apply)*

☐ **Standard Order:** Give 2 puffs/1 AMP q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath ("asthma flare symptoms"). Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE**.
If in Respiratory Distress*: Call 911 and give 6 puffs/1 AMP; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** 2 puffs/1 AMP 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare** *(Within 5 days)*:
2 puffs/1 AMP @ noon for 5 days.

Special Instructions:

Controller Medications for In-School Administration
(Recommended for Persistent Asthma, per NAEPP Guidelines)

☐ **Fluticasone MDI**
[*Flovent® 110 mcg MDI can be provided by school for shared usage*]:
☐ MDI w/ spacer
☐ DPI

☐ **Other**: Name: ______________ Strength: ______
Dose: _____ Route: ______ Time Interval: ☐ ____ hrs

☐ **Standing Daily Dose:**
___ puffs/1AMP ONCE a day at ___ AM

Special Instructions:

Health Care Practitioner (Please Print Name)
Last First

Signature

Date __ __/__ __/__ __ __ __

Address

Tel. (_ _ _) _ _ _ - _ _ _ _

Fax (_ _ _) _ _ _ - _ _ _ _

NPI # _ _ _ _ _ _ _ _ _ _

Email Address

NYS License # **(Required)**

CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

PARENTS MUST SIGN PAGE 2 ➔

ASTHMA MEDICATION ADMINISTRATION FORM page 2

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2021-2022

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    - I must give the school nurse my child's medicine.
    - All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will get another medicine for my child to use when he or she is not in school or is on a school trip.
        - Prescription medicine must have the original pharmacy label on the box or bottle.
    - I must immediately tell the school nurse about any change in my child's medicine or the doctor's instructions. I will give my child's school nurse a new medication administration form written by my child's health care practitioner.
    - The medication order in this medication administration form expires at the end of my child's school year. I will give my child's school nurse a new medication administration form at the beginning of every school year.

Student Last Name First	Date of Birth ___/___/_____
Parent/Guardian Print Name:	Signature:
Date Signed ___/___/_____	Cell Phone:
Other Phone:	Email:

FOR SELF ADMINISTRATION OF MEDICINE:

- I confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing, and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school.
- I consent to the school nurse or trained school staff giving my child medicine if my child is temporarily unable to carry and give him or herself medicine.

Parent/Guardian Print Name:	Signature:
	Date Signed ___/___/_____

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:**
			❑ Male ❑ Female
Month	*Day*	*Year*	

PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to Student*

HOME LANGUAGE CODE ____________

Language Background

(Please check all that apply.)

Question		
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* ❑ Guardian(s) ____________ *specify*	❑ Father ____________ *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:

Dobbs Ferry School District

505 Broadway
Dobbs Ferry, NY 10598
t 914.693.1500
f 914.693.5952
http://www.dfsd.org

Student Residency Questionnaire

Name of School: ____

Name of Student: ____ Sex: ☐ Male
Last *First* *Middle* ☐ Female

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
Middle School – Sheila Kusi-Asare – 914-693-1500 ext. 3026

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*

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

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	______________________