

**Valley Stream UFSD Thirteen  
Business Office  
585 N Corona Avenue  
Valley Stream, NY 11580**

Adrienne Robb-Fund, Ed.D.  
SUPERINTENDENT OF SCHOOLS

**NICHOLAS J. LUCIANO**  
RESIDENCY OFFICER  
516-872-5694

New residents may register school-age children by obtaining a registration packet from their school or at the central registration office at 1 Kent Rd., 2<sup>nd</sup> floor behind Memorial JHS. **Upon completion of the packet, registration is held at 1 Kent Rd. on Monday, Tuesday and Wednesday, from 9AM to 11AM, except during school closing.** All registration packets will be reviewed before the student is able to attend school. Students entering sixth grade must show proof of varicella vaccine or proof of disease signed and stamped by a doctor. The central registration office phone number is (516) 872-5694

**\*\*\*ALL NECESSARY FORMS MUST BE RETURNED IN PERSON TO THE VSCHSD RESIDENCY OFFICE.\*\*\***

**Note: The school retains the right to temporarily delay completion of this registration pending evaluation of the facts presented in any portion of this application.**

**REGISTRATION INSTRUCTIONS  
IF YOU ARE THE CHILD'S NATURAL PARENT:**

The following documents **MUST** be presented at the time of registration, along with proper forms:

1. Child's **ORIGINAL** birth certificate;
2. Certificate of immunization in English, signed by a physician or health facility;
3. **IF YOU OWN A HOME**, you must attach your **ORIGINAL** house deed, **AND** your current mortgage statement or current realty tax receipt, **PLUS** one of the following: LIPA bill, water bill, cable/satellite bill, telephone bill, homeowner's insurance policy or car insurance policy. **Affidavit Forms "A" and "B" must be attached.**
4. **IF YOU ARE RENTING OR LEASING** an apartment or home, submit your lease or rental agreement and completed **Affidavit Form "C."** Provide the school with **TWO ORIGINALS** of the following: LIPA bill, cable/satellite bill, telephone bill, car insurance policy, voter registration card. Your landlord **MUST** complete **Form "B"** and submit required proof of ownership as listed in item #3 above.
5. **IF YOU ARE RENTING, BUT DO NOT HAVE A WRITTEN RENTAL OR LEASE AGREEMENT**, or are otherwise residing in a district resident's home, complete **Affidavit Form "C," PLUS** two additional proofs of residency from item 4. Your landlord **MUST** complete **Form "B"** and submit required proofs of ownership, as listed in item #3 above.
6. Your child's last report card.
7. Proof of health insurance coverage.
8. **ALL** residency affidavits **MUST** be notarized.
9. Parent, guardian or custodian **MUST** produce a **VALID** photo ID.
10. It is not necessary to bring your child to registration. If possible, please have the children stay at home.

**ALL REGISTRATION PACKETS MUST INCLUDE COMPLETED FORMS "A" AND "B."**

We thank you for your cooperation in making the registration a smooth process for all involved.

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SUPERINTENDENT OF SCHOOLS

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RESIDENCY OFFICER  
516-872-5694

**REGISTRATION INSTRUCTIONS**

**IF YOU ARE THE CHILD'S GUARDIAN/CUSTODIAN:**

The following documents **MUST** be presented at the time of registration, along with proper forms:

11. Child's **ORIGINAL** birth certificate;
12. Certificate of immunization in English, signed by a physician or health facility;
13. **IF YOU OWN A HOME**, you must submit your **ORIGINAL** house deed, **AND** your current mortgage statement or current realty tax receipt, **PLUS** one of the following: LIPA bill, water bill, cable/satellite bill, telephone bill, homeowner's insurance policy or car insurance policy. **Affidavit Forms "A" and "B" must be attached.**
14. **IF YOU ARE RENTING OR LEASING** an apartment or home, submit your lease or rental agreement and completed **Affidavit Form "C."** Provide the school with **TWO ORIGINALS** of the following: LIPA bill, cable/satellite bill, telephone bill, car insurance policy, voter registration card. Your landlord **MUST** complete **Form "B"** and submit required proof of ownership as listed in item #3 above.
15. **IF YOU ARE RENTING, BUT DO NOT HAVE A WRITTEN RENTAL OR LEASE AGREEMENT**, or are otherwise residing in a district resident's home, complete **Affidavit Form "C," PLUS** two additional proofs of residency from item 4. Your landlord **MUST** complete **Form "B"** and submit required proofs of ownership, as listed in item #3 above.
16. **YOU MUST COMPLETE CUSTODIAL AFFIDAVIT FORM "D."**
17. Children in Foster Care must submit a copy of form DSS 2999 or BSW 241 at the time of registration.
18. Your child's last report card.
19. Proof of health insurance coverage.
20. **ALL** residency affidavits **MUST** be notarized.
21. Parent, guardian or custodian **MUST** produce a **VALID** photo ID.
22. It is not necessary to bring your child to registration. If possible, please have the children stay at home.

**ALL REGISTRATION PACKETS MUST INCLUDE COMPLETED FORMS "A" AND "B."**

We thank you for your cooperation in making the registration a smooth process for all involved.

**VALLEY STREAM UFSD THIRTEEN**  
**Registration Information**  
**FORM A**

<u>Office Use Only</u>			
School _____	ID# _____	RM# _____	Dem. _____

**WARNING: ANY PERSON OR PERSONS, WHO PROVIDE WILLFULLY FALSE INFORMATION REGARDING RESIDENCE, WILL BE SUBJECT TO CRIMINAL PENALTIES. A FALSE STATEMENT REGARDING RESIDENCE OR ENTITLEMENT TO A TUITION FREE EDUCATION FROM THE DISTRICT IS PUNISHABLE AS A CLASS A MISDEMEANOR. IN ADDITION, IF IT IS DETERMINED THAT A REGISTRANT'S CHILD RESIDES OUTSIDE OF THE DISTRICT, THE DISTRICT MAY TAKE LEGAL ACTION TO COLLECT TUITION CHARGES IF THE STUDENT IS NOT LEGALLY ENTITLED TO RECEIVE A TUITION FREE EDUCATION FROM THE DISTRICT. THE DISTRICT RESERVES THE RIGHT TO INVESTIGATE ANY STUDENT'S RESIDENCY BY ANY LEGAL MEANS AVAILABLE, INCLUDING BUT NOT LIMITED TO PUBLIC RECORDS, SITE VISITS AND OTHER LAWFUL METHODS OF INVESTIGATION.**

Pupil's Name \_\_\_\_\_ M \_\_\_ F \_\_\_ Date of Birth \_\_\_\_\_

Age \_\_\_\_\_ Grade \_\_\_\_\_ Country of Birth \_\_\_\_\_ City \_\_\_\_\_

State/ Country \_\_\_\_\_ Date Of US Entry \_\_\_\_\_ Years in US Schools \_\_\_\_\_

Language Spoken \_\_\_\_\_

Other Languages Spoken at Home \_\_\_\_\_

Present Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Own \_\_\_\_\_ Rent \_\_\_\_\_ Homeless \_\_\_\_\_ Yes \_\_\_ No

Previous Address \_\_\_\_\_

Last School Attended \_\_\_\_\_ Grade \_\_\_\_\_

Address of Previous School \_\_\_\_\_

Special Ed (Please check Yes or No ) \_\_\_\_\_ Yes \_\_\_\_\_ No (IF YES, PLEASE PROVIDE A COPY OF THE CURRENT IEP (INDIVIDUAL EDUCATION PROGRAM))

Child resides with: both parents ( ) mother only ( ) father only ( ) guardian ( ) foster parent ( ) custodial agreement on record ( )

**PARENTS Status:** ( ) Married ( ) Divorced ( ) Separated ( ) Never Married

**Mother's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Ethnicity** \_\_\_\_\_

**Address** \_\_\_\_\_

**Social Security #** \_\_\_\_\_ **Home Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

**Employer's Name** \_\_\_\_\_ **Business Phone** \_\_\_\_\_



**STUDENT RACIAL AND ETHNIC IDENTIFICATION  
FORM A(1)**

To the Parent/Guardian: Valley Stream Union Free School District Thirteen has adopted a policy which requires the collection and recording of the ethnic identity of the students in Valley Stream Union Free School District Thirteen in accordance with federal categories and definitions. The information will be used to:

- Report information to the State and Federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Study the movements of students in different ethnic groups as they move from school to school
- Analyze differences in academic performance, attendance and completion of school.

We need your help in order to accomplish this task. Valley Stream Union Free School District Thirteen understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If the information requested is not provided on this form a student records officer from the school or district will be required to identify the group to which the student appears to be, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

**DIRECTIONS TO PARENT/GUARDIAN**

PLEASE ANSWER QUESTIONS (1) and (2). PLEASE READ THEM ALL BEFORE YOU RESPOND. [For question one (1) check (  ) mark in the box that best describes your child.] Check (  ) only ONE box.

- |  |
|--|
| <p>1. Is the student Hispanic, Latino, or Spanish origin? Hispanic, Latino, or Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or</p> <p>2. origin, regardless of race.</p> |
|--|

- |  |
|--|
| <p><input type="checkbox"/> YES, Hispanic</p> <p><input type="checkbox"/> NO, Not Hispanic</p> |
|--|

2. Select one or more races from the following five racial groups. [For question two (2) check ( ✓ ) all groups that apply to your child; check ( ✓ ) at least ONE box]:

AMERICAN INDIAN OR ALASKAN NATIVE: A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition, e.g. Cherokee, Mohawk, Inuit.

ASIAN: A person having origins in any of the origins of the original peoples of the Far East, Southeast Asia, or Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Island, Thailand, and Vietnam.

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: A person having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands.

BLACK: A person having origins in any of the black racial groups of Africa.

WHITE: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

\_\_\_\_\_  
Signature of Parent/Guardian/Other

\_\_\_\_\_  
Date

Relationship to Student:  Mother  Father  Guardian  Other (Specify) \_\_\_\_\_





**RENTER'S/NON-OWNER'S AFFIDAVIT  
FORM C**

\_\_\_\_\_  
**STUDENT'S NAME (PRINT, LAST NAME FIRST)**

\_\_\_\_\_, Social Security # \_\_\_\_\_, being duly sworn, deposes and says:  
Renter/Non-Owner's Name

1) I understand that this statement is being made UNDER THE PENALTIES OF PERJURY, in order that \_\_\_\_\_ (Name of Child/Ward) may be admitted to the schools of the Valley Stream Union Free School District 13 as a District resident. I further understand that if my child/ward is found not to be a legitimate resident of Valley Stream Union Free School District 13, that **I WILL BE LEGALLY RESPONSIBLE FOR AND WILL BE BILLED THE SCHOOL DISTRICT'S ANNUAL TUITION RATE. , PER CHILD, RETRO ACTIVE TO FIRST DAY OF ADMISSION.** 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 the purposes of residency verification.

2) I \_\_\_\_\_, AM THE (PARENT/GUARDIAN/CUSTODIAL PARENT/STEP-PARENT) of the above named Child/Ward. I reside at **(state address and specify the exact nature of the space: basement apartment, second floor apartment, number of rooms, etc.)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

with my Child/Ward and **(LIST EACH AND EVERY OTHER PERSON LIVING AT THE ABOVE ADDRESS**

- |          |          |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

This is my actual and only permanent residence. My Child/Ward lives with me and said address is his/her actual and only permanent residence.

3) My last address was \_\_\_\_\_ where I lived with **(LIST EACH AND EVERY PERSON WHO LIVED AT THE ABOVE ADDRESS):**

- |          |          |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |



**CUSTODIAL AFFIDAVIT  
FORM D**

\_\_\_\_\_  
**STUDENT'S NAME (PRINT LAST NAME FIRST)**

**WARNING: ANY PERSON OR PERSONS, WHO PROVIDE WILLFULLY FALSE INFORMATION REGARDING RESIDENCE, WILL BE SUBJECT TO CRIMINAL PENALTIES. A FALSE STATEMENT REGARDING RESIDENCE OR ENTITLEMENT TO A TUITION FREE EDUCATION FROM THE DISTRICT IS PUNISHABLE AS A CLASS A MISDEMEANOR. IN ADDITION, IT IS DETERMINED THAT A REGISTRANT'S CHILD RESIDES OUTSIDE OF THE DISTRICT, THE DISTRICT MAY TAKE LEGAL ACTION TO COLLECT TUITION CHARGES IF THE STUDENT IS NOT LEGALLY ENTITLED TO RECEIVE A TUITION FREE EDUCATION FROM THE DISTRICT. THE DISTRICT RESERVES THE RIGHT TO INVESTIGATE ANY STUDENT'S RESIDENCY BY ANY LEGAL MEANS AVAILABLE, INCLUDING BUT NOT LIMITED TO PUBLIC RECORDS, SITE VISITS AND OTHER LAWFUL METHODS OF INVESTIGATION.**

1. \_\_\_\_\_(NAME OF CUSTODIAN), \_\_\_\_\_(SS#).,  
BEING DULY SWORN, DEPOSES AND SAYS:

2. I LIVE AT \_\_\_\_\_  
\_\_\_\_\_(FULL NAME OF CHILD) IS  
MY \_\_\_\_\_(CHILD'S RELATIONSHIP TO CUSTODIAN)AND HE/SHE HAS  
BEEN LIVING WITH ME SINCE \_\_\_\_\_(DATE).

3. \_\_\_\_\_(NAME OF CHILD) INTENDS TO RESIDE WITH ME FOR  
\_\_\_\_\_(LENGTH OF TIME).

4. THIS LIVING ARRANGEMENT IS \_\_\_\_\_ PERMANENT \_\_\_\_\_ TEMPORARY  
IF TEMPORARY, THE ARRANGEMENT WILL BE TERMINATED ON \_\_\_\_\_  
PLEASE EXPLAIN:

5. DESCRIBE THE REASON(S) AND PURPOSE FOR SURRENDERING THE CARE, CUSTODY  
AND CONTROL OF THE CHILD TO YOU.

6. FORMER ADDRESS(ES) WHERE CHILD HAS LIVED:

STREET                      CITY                      STATE                      DATES                      WITH WHOM

7. \_\_\_\_\_(NAME OF CHILD) DOES NOT LIVE AT ANY OTHER ADDRESS.

8. FOOD, CLOTHING, AND ALL OTHER NECESSITIES ARE PROVIDED TO  
\_\_\_\_\_(NAME OF CHILD) BY \_\_\_\_\_

9. WILL THE CHILD BE SPENDING OVERNIGHT, WEEKENDS, HOLIDAYS, OR VACATIONS  
ELSEWHERE? IF SO, PLEASE EXPLAIN: \_\_\_\_\_

10. DOES EACH PARENT INTEND TO REMAIN AT HIS/HER PRESENT ADDRESS? PLEASE  
EXPLAIN: \_\_\_\_\_

11. WHERE IS EACH PARENT REGISTERED TO VOTE? MOTHER \_\_\_\_\_  
FATHER \_\_\_\_\_

12. WHAT COURT ORDERS HAVE BEEN MADE WITH RESPECT TO THE CHILD'S  
GUARDIANSHIP OR CUSTODY? (ATTACH A COPY OF ALL SUCH ORDERS)

\_\_\_\_\_

13. IF THE GUARDIAN HAS ANY OTHER CHILDREN, SUPPLY THE FOLLOWING  
INFORMATION:

NAME	AGE	ADDRESS	RELATIONSHIP TO GUARDIAN	SCHOOL
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

14. I \_\_\_\_\_ (NAME OF CUSTODIAN) ASSUME FULL  
RESPONSIBILITY FOR ALL MATTERS RELATING TO \_\_\_\_\_ (NAME OF  
CHILD'S) EDUCATION AND MEDICAL CARE.

15. STATEMENT OF OTHER RELEVANT FACTS

\_\_\_\_\_

**THE QUESTIONS "A" THROUGH "F" MUST BE ANSWERED WHEN APPLICATION FOR  
ADMISSION IS FILED BY PERSONS OTHER THAN A NATURAL PARENT.(GUARDIAN)**

- A) WHY IS THE CHILD NOT LIVING WITH HIS/HER NATURAL OR ADOPTIVE  
PARENTS? \_\_\_\_\_
- B) DOES THE STUDENT LIVE IN YOUR HOME EXCLUSIVELY? \_\_\_\_\_
- C) HOW OFTEN WILL THE PARENTS SEE THE CHILD? \_\_\_\_\_
- D) WHAT PERCENTAGE OF FINANCIAL SUPPORT WILL BE MADE BY THE NATURAL  
PARENTS? \_\_\_\_\_
- E) WHAT PERCENTAGE OF FINANCIAL SUPPORT WILL BE MADE BY YOU? \_\_\_\_\_

**THE SCHOOL RETAINS THE RIGHT TO TEMPORARILY DELAY COMPLETION OF THIS REGISTRATION,  
PENDING EVALUATION OF THE FACTS PRESENTED IN THIS OR ANY OTHER PORTION OF THIS  
APPLICAION.**

**I UNDERSTAND THAT THE INFORMATION IN THIS APPLICAION IS TRUE AND CORRECT. I UNDERSTAND  
THAT THE STATEMENTS IN THIS APPLICATION ARE SUBJECT TO VERIFICAION BY THE SCHOOL  
DISTRICTAND THAT FALSE STATEMENTS WILL BE SUBJECT TO TUITION. I ALSO UNDERSTAND THAT IT  
IS MY RESPONSIBILITY TO NOTIFY THE SCHOOL OF ANY CHANGES, AND/OR CIRCUMSTANCES  
AFFECTING THIS APPLICATION.**

**I ALSO UNDERSTAND THAT ANY FALSE STATEMENTS MADE ARE PUNISHABLE AS A CLASS "A"  
MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW OF OF THE STATE OF NEW YORK.**

\_\_\_\_\_  
NON-CUSTODIAL PARENTS SIGNATURE

\_\_\_\_\_  
CUSTODIAN'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

SWORN TO BEFORE ME THIS  
\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_

SWORN TO BEFORE ME THIS  
\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_

\_\_\_\_\_  
NOTARY PUBLIC

\_\_\_\_\_  
NOTARY PUBLIC

**FORM E  
PARENTS AFFIDAVIT**

State of New York)

ss:

County of Nassau)

I \_\_\_\_\_ being sworn, depose and says:  
(Name of parent)

1. I am the parent of \_\_\_\_\_ who resides with \_\_\_\_\_

(Custodian Name)

at \_\_\_\_\_  
(Custodian / Child Address)

2. I reside at \_\_\_\_\_  
(Domicile of Parent)

3. The reason(s) why the child is not living with me are the following:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. I have asked the custodial parent named above to assume full responsibility for the custody and control of my child because:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. I intend this arrangement to be permanent because (Be specific).

\_\_\_\_\_

---

6. I relinquish full custody, control and support of my child,

\_\_\_\_\_  
(Name of Child)

to the custodian, who is \_\_\_\_\_ (describe the relationship of  
Custodial to child) including the right to make all decisions pertaining to the child's health, welfare  
and education and the obligation for financial support

\_\_\_\_\_ Yes \_\_\_\_\_ No

7. This living arrangement will be in effect \_\_\_\_\_ (date) to \_\_\_\_\_ (date).

- This affidavit should be completed by both parents, or where not possible and appropriate, by the Legal Guardian.

**(Turn Over)**

8. I understand that this statement is being made **UNDER THE PENALTIES OF PERJURY**, in order that \_\_\_\_\_ may be admitted to the schools of the Valley Stream Union Free  
(First and Last Name of Child)

School District Thirteen as a district resident I further understand that if my child is found not to be a legitimate resident of the Valley Stream Union Free School District Thirteen, that **THE CHILD WILL BE IMMEDIATELY DISCHARGED AND THAT I WILL BE LEGALLY RESPONSIBLE FOR AND WILL BE BILLED THE SCHOOL DISTRICTS ANNUAL TUITION RATE OF APPROXIMATELY \$ \_\_\_\_\_ PER YEAR, PER CHILD**, retroactive to the first day of admission. I also realize that theft of government services is a crime punishable under State Penal Law and that a false statement made in connection with this application will make me liable to criminal prosecution.

WHEREFORE, it is respectfully requested that you recognize \_\_\_\_\_  
(Name of Custodian)  
as the custodian and caretaker of my child \_\_\_\_\_ and recognize his/her  
actual domicile to be that of \_\_\_\_\_ who lives  
(Name of Custodian)  
at \_\_\_\_\_  
(Address of Custodian)

Signature of Parent: \_\_\_\_\_

Sworn to before me

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_

NOTARY PUBLIC

**VALLEY STREAM UNION FREE SCHOOL DISTRICT THIRTEEN**  
Contact Verification for Students

11/08

**Surname** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Student Name:** \_\_\_\_\_ **Gender** M F **DOB** \_\_\_/\_\_\_/\_\_\_ **School:** \_\_\_\_\_ **Grade:** \_\_\_ **Date Entered District:** \_\_\_/\_\_\_/\_\_\_

Parent / Guardian

*Name*

*Relationship*

*Address*

*Home Phone*

*Work Phone*

*Cell Phone*

*email Address*

**Emergency Contacts --> Please list at least two Emergency Contacts**

*Name*

*Relationship*

*Home Phone*

*Work Phone*

*Cell Phone*

*email Address*

*Address*

**Student Allergies**

*Any Known Allergies* \_\_\_\_\_ *Allergic Reactions:* \_\_\_\_\_

*Does your child take medication on a regular* \_\_\_\_\_ *Specify* \_\_\_\_\_

**Other medical conditions**

*Physicians Name:* \_\_\_\_\_ *Phone#* \_\_\_\_\_

*In case of an accident or serious illness, we will make every effort to contact you and/or your emergency contacts. If unable to reach you, we will provide the emergency care deemed necessary. I give my permission for the school nurse to share health information with appropriate personnel.*

*Parent/Guardian* \_\_\_\_\_ *Date:* \_\_\_\_\_



## 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*

*English. Your assistance in answering these questions is greatly appreciated.*

*Thank You*

TO BE COMPLETED BY SCHOOL PERSONNEL			
DISTRICT	<i>Please print or type clearly</i>		
SCHOOL	GRADE		
STUDENT NAME			
DATE OF BIRTH	Month:	Day:	Year
STUDENT IDENTIFICATION NUMBER			
COUNTRY OF BIRTH / ANCESTRY			
NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.			
NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION			
DETERMINATION:	~ Possible LEP ~ English Proficient		

(~ boxes that apply)

1. What language(s) is spoken in the student's home or residence?	~ English	~ Other	<i>specify</i>
2. What language(s) are spoken most of the time to the student, in the home or residence?	~ English	~ Other	<i>specify</i>
3. What language(s) does the student understand?	~ English	~ Other	<i>specify</i>
4. What language(s) does the student speak?	~ English	~ Other	<i>specify</i>
5. What language(s) does the student read?	~ English	~ Other	~ Does Not Read <i>specify</i>
6. What language(s) does the student write?	~ English	~ Other	~ Does Not Write <i>specify</i>
7. In your opinion, how well does the student understand, speak, read and write English?			
	<i>Very well</i>	<i>Only a little</i>	<i>Not at all</i>
<b>Understands English</b>	~	~	~
<b>Speaks English</b>	~	<input type="checkbox"/>	<input type="checkbox"/>
<b>Reads English</b>	~	<input type="checkbox"/>	<input type="checkbox"/>
<b>Writes English</b>	~	<input type="checkbox"/>	<input type="checkbox"/>

Month: Day: Year:

Signature of Parent/Guardian/Other

Date

# Valley Stream Union Free School District Thirteen

*NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).*

*This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. Rev. 10/3/07*

## HEALTH APPRAISAL FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Gender:  M  F Grade: \_\_\_\_\_

### IMMUNIZATIONS / HEALTH HISTORY

- Immunization record attached Sickle Cell Screen:  Positive  Negative  Not done Date: \_\_\_\_\_  
 No immunizations given today PPD:  Positive  Negative  Not done Date: \_\_\_\_\_  
 Immunizations given since last Health Appraisal: Elevated Lead:  Yes  No  Not done Date: \_\_\_\_\_  
Dental Referral:  Yes  No  Not done Date: \_\_\_\_\_

Significant Medical/Surgical History:  See attached

Specify current diseases:  Asthma Diabetes:  Type 1  Type 2 Hyperlipidemia  Hypertension  
 Other: \_\_\_\_\_

Allergies:  LIFE THREATENING  Food: \_\_\_\_\_  Insect: \_\_\_\_\_  Other: \_\_\_\_\_  
 Seasonal  Medication: \_\_\_\_\_

### PHYSICAL EXAM

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Date of Exam: \_\_\_\_\_  
Referral: \_\_\_\_\_

Body Mass Index: \_\_\_\_\_ . \_\_\_\_\_ Vision - without glasses/contact lenses R L  
Weight Status Category (BMI Percentile): Vision - with glasses/contact lenses R L  
 less than 5<sup>th</sup>  5<sup>th</sup> through 49<sup>th</sup>  50<sup>th</sup> through 84<sup>th</sup> Vision - Near Point R L  
 85<sup>th</sup> through 94<sup>th</sup>  95<sup>th</sup> through 98<sup>th</sup>  99<sup>th</sup> and higher Hearing  Pass 20 db sc both ears or: R L

**EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V Scoliosis:  Negative  Positive  
Specify any abnormality (use reverse side if needed): \_\_\_\_\_

### MEDICATIONS

Medications (list all):  None  Additional medications listed on reverse of form  
Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_  
Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_  
Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

If AM dose is missed at home: \_\_\_\_\_

I assess this student to be self-directed  Yes  No Student may self carry and self administer medication  Yes  No  
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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

- Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**  
\_\_\_\_ Limited contact: gymnastics, volleyball, handball, baseball, softball, dodgeball, pillow polo, kickball, basketball, soccer  
\_\_\_\_ Non-contact: badminton, bowl, golf, tennis, dance, track, run, walk, jump rope, warm-up exercises, tumbling, jumping.  
 **Specify medical accommodations needed for school:**  None  
 **Known or suspected disability:**  Please monitor  
 **Restrictions:**  Please monitor  
 **Protective equipment required:**  Athletic Cup  Sport goggles/impact resistant eyewear  Other: \_\_\_\_\_

Provider's Signature  
Provider's Name/Address:  
Parent Signature:  
(stamp below)

Phone:  
Fax:  
Date:

CERTIFICATE OF IMMUNIZATION

-----  
Child's Name

-----  
Date of Birth

**1. DPT Vaccine**

1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_ 3. \_\_\_/\_\_\_/\_\_\_ 4. \_\_\_/\_\_\_/\_\_\_ 5. \_\_\_/\_\_\_/\_\_\_ 6. \_\_\_/\_\_\_/\_\_\_

OR DTaP Vaccine

1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_ 3. \_\_\_/\_\_\_/\_\_\_ 4. \_\_\_/\_\_\_/\_\_\_ 5. \_\_\_/\_\_\_/\_\_\_

OR Td

1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_ 3. \_\_\_/\_\_\_/\_\_\_ 4. \_\_\_/\_\_\_/\_\_\_ 5. \_\_\_/\_\_\_/\_\_\_

For Sixth (6) Grade Entrance (Effective Sept 2007)

Tdap 1. \_\_\_/\_\_\_/\_\_\_

**2. Polio (OPV)** 1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_ 3. \_\_\_/\_\_\_/\_\_\_ 4. \_\_\_/\_\_\_/\_\_\_ 5. \_\_\_/\_\_\_/\_\_\_

**Or IPV or e-IPV** 1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_ 3. \_\_\_/\_\_\_/\_\_\_ 4. \_\_\_/\_\_\_/\_\_\_

**3. MMR Vaccine**

1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_

or

Measles 1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_

Mumps 1. \_\_\_/\_\_\_/\_\_\_

Rubella 1. \_\_\_/\_\_\_/\_\_\_

**4. Hepatitis B**

1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_ 3. \_\_\_/\_\_\_/\_\_\_

**5. Varicella Vaccine**

\_\_\_/\_\_\_/\_\_\_

or Disease

\_\_\_/\_\_\_/\_\_\_

or Antibody Titer level \_\_\_/\_\_\_/\_\_\_ Results: \_\_\_\_\_

**6. HIB Vaccine**

1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_ 3. \_\_\_/\_\_\_/\_\_\_ 4. \_\_\_/\_\_\_/\_\_\_

**7. Lead Test** \_\_\_/\_\_\_/\_\_\_ Result \_\_\_\_\_

**8. Mantoux Test** \_\_\_/\_\_\_/\_\_\_ Result \_\_\_\_\_ or Tine Test \_\_\_/\_\_\_/\_\_\_ Results \_\_\_\_\_

**9. Hepatitis A** 1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_

**10. Prevnar Vaccine** 1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_ 3. \_\_\_/\_\_\_/\_\_\_ 4. \_\_\_/\_\_\_/\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician and/or Health Facility

\_\_\_\_\_  
Print Name & Address

\_\_\_\_\_  
Stamp

*\* Please Attach Letters for Medical Exemption \**



VALLEY STREAM UNION FREE SCHOOL DISTRICT

HEALTH RECORD

(This form must be filled out in its entirety)

School: James A. Dever \_\_\_\_\_ Howell Road \_\_\_\_\_ Wheeler Avenue \_\_\_\_\_ Willow Road \_\_\_\_\_

HISTORY : Date \_\_\_\_\_

Pupil Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Telephone No. \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mothers' Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Family Doctor \_\_\_\_\_ Address \_\_\_\_\_

Phone No. \_\_\_\_\_

\*\*\*\*\*

Has your child had any of the following diseases?

Table with 2 columns: Disease Name, Date. Rows include Asthma/Allergies, Diabetes, Chicken Pox, Ear Condition, Frequent Colds/Sore Throats, German Measles, Heart Disease, Measles, Mumps, Pneumonia, Rheumatic Fever, Scarlet Fever, Seizure Disorder, Tuberculosis, Vision Problems, Whooping Cough.

Operations \_\_\_\_\_ Type of Operations \_\_\_\_\_ Date \_\_\_\_\_

Serious Injuries \_\_\_\_\_ Type of Injury \_\_\_\_\_ Date \_\_\_\_\_

Was there an unusual pregnancy and/or delivery with this child? Explain \_\_\_\_\_

Is your child taking medication on a regular basis? Explain: (Please exclude vitamins.) \_\_\_\_\_

Please give any other information that you feel the school authorities should know pertaining to the health of your child. \_\_\_\_\_

Valley Stream Union Free School District Thirteen Health Office

**Information Update for Your Child's School Nurse**

Students Name \_\_\_\_\_

We would like to provide optimum care of your child, therefore we need some additional information. If your child has recently had any immunizations or examination by a private physician/clinic or is taking any medication, please help us by providing this information. **All incoming students must have a physical examination dated after June 1 of the current school year.**

**Immunizations:**

**Physical Examination:** Please have you physician complete the white form included in the Registration Packet.

Are there any medications your child is currently taking **at home?**

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Time(s) given \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Time(s) given \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Time(s) given \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Time(s) given \_\_\_\_\_

Is there any other information that you feel will help us to understand and care for your child?

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This form must be returned directly to the Health Office of the school your child is attending before the first day of school.

Thank you for your care and support.

Sincerely,  
The Valley Stream District Thirteen Nurses

# Dental Health Certificate

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

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

Child's Name: Last First Middle

Birth Date: / / Sex:  Male  Female Will this be your child's first visit to a dentist?  Yes  No  
Month Day Year

School: Name Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities?  Yes  No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature Date

## Section 2. To be completed by the Dentist

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

- Yes, The student listed above is in fit condition of dental health to permit 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 name and address (please print or stamp) Dentist's Signature

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

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

- Yes  No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
- Yes  No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].
- Yes  No **Dental Sealants Present**

Other problems (Specify): \_\_\_\_\_

### III. Treatment Needs (check all that apply)

- No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
- May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
- Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.