



New Hartford Central School District
Universal Pre-Kindergarten
Registration Documents
2026-2027





Student Registration Requirements

Welcome to the New Hartford Central School District! We are excited that you are considering enrolling your child(ren) in our school district. The first step in this process is to provide the following information:

1. Original birth certificate
 2. Proof of residency:
 - a copy of a residential lease or proof of ownership of a house or condominium such as a deed or mortgage statement;
 - a statement signed by a landlord, property owner, or tenant from whom the adult leases or rents property, or with whom the adult shares property within the District (the District prefers a sworn statement, but this is not required);
 - some other signed statement from a third party establishing that the adult maintains a physical presence within the District.
- AND-**
- One other form of documentation of residency, including, but not limited to:
 - Paystub
 - Income tax form
 - Utility or other bills
 - Membership documents based on residency
 - Voter registration documents
 - Official driver's license, learner permit, or non-driver identification.
 - State or other government-issued identification or documents relating to government services or benefits
 3. Custody papers (if applicable)
 4. Academic records from your previous school (if applicable)
 5. Health records including immunizations
 6. Committee on Special Education (CSE) records (if applicable)
 7. Discipline records from your previous school (if applicable)
 8. Completed New Hartford Student Registration Packet.

Using one of the following options, please return the above information to the Office of Student Services, along with a phone number so you may be contacted if further information or clarification is needed:

- Via fax: 315-624-1236
- Via e-mail: schoolregistration@nhart.org
- Via U.S. mail: New Hartford Central School District, Office of Student Services, 33 Oxford Road, New Hartford, NY 13413
- Via in person: Please deliver the completed registration packet, along with the required documentation, to the respective school building(s) which your child(ren) will attend
- Any questions, please contact the Office of Student Services at 315-624-1231.

NEW HARTFORD CENTRAL SCHOOL DISTRICT STUDENT INFORMATION FORM

Student Information:

Last Name, First Name, Middle		Nickname	Date of Birth (MM/DD/Year)	Gender
Entering Grade	Ethnicity (Choose one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino		Place of Birth	Primary Language Spoken at Home
<p>Select one or more races from the following five racial groups. Mark at least ONE box.</p> <p><input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE: A person having origins in any of the original peoples of North America and who maintains a cultural identification through tribal affiliation or community recognition. E.g. Cherokee, Mohawk, Inuit.</p> <p><input type="checkbox"/> ASIAN: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.</p> <p><input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</p> <p><input type="checkbox"/> BLACK: A person having origins in any of the black racial groups of Africa.</p> <p><input type="checkbox"/> WHITE: A person having origins in any of the original peoples of Europe, North America, or the Middle East.</p>				

STUDENT RESIDENTIAL INFORMATION:

House #, Street Address		Apt.#	Student's Home Phone:	
City	State	Zip Code		
Mailing Address if different:				
Is this address a temporary living arrangement: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Resident of New Hartford School District: <input type="checkbox"/> Yes <input type="checkbox"/> No, please list District:				

ACADEMIC INFORMATION:

Has the student attended New Hartford Central School District in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No		
List Grade Levels Repeated:		
Last Two Schools Attended	School 1	School 2
Name of School		
Address of School		
Phone Number		
Grade Levels Completed		
Last Date of Attendance		
Name of Counselor or Contact Person		

Please describe any special education needs of the student: _____

Parent/Guardian Information (Primary Household)

Relationship to student	Gender	Custody? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Joint	Relationship to student	Gender	Custody? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Joint
Last Name, First Name			Last Name, First Name		
Home Phone			Home Phone		
Cell Phone			Cell Phone		
Work Phone			Work Phone		
Employer			Employer		
Email Address			Email Address		
Can you pick up student?			Can you pick up student?		
Residential Address SAME as Student If no, please complete the area below:			Residential Address SAME as Student If no, please complete the area below:		
House #/Street Name			House #/Street Name		
City/State/Zip Code			City/State/Zip Code		

Parent/Guardian Information (Secondary Household)

Relationship to student	Gender	Custody? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Joint	Relationship to student	Gender	Custody? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Joint
Last Name, First Name			Last Name, First Name		
Home Phone			Home Phone		
Cell Phone			Cell Phone		
Work Phone			Work Phone		
Employer			Employer		
Email Address			Email Address		
Can you pick up student?			Can you pick up student?		
Residential Address SAME as Student If no, please complete the area below:			Residential Address SAME as Student If no, please complete the area below:		
House #/Street Name			House #/Street Name		
City/State/Zip Code			City/State/Zip Code		

Emergency Contacts:

Name	Gender	Relationship	Home Phone	Work Phone	Cell Phone	Pick up from school
						<input type="checkbox"/> YES <input type="checkbox"/> NO
						<input type="checkbox"/> YES <input type="checkbox"/> NO

Siblings who will enroll (or are currently enrolled) in the New Hartford Central School District:

Name	DOB	Grade	School

Parent/Guardian Signature: _____

Date _____

**NEW HARTFORD CENTRAL SCHOOL DISTRICT
ADDITIONAL STUDENT INFORMATION**

****This information is required to meet New York State guidelines that require local school districts to screen all new entrants. This information will be treated as confidential.**

Name of Child: _____ DOB _____ Phone Number _____

Address: _____

I. Family Information

Parent Information	Name	DOB	Occupation/Employer	Marital Status
Parent/Guardian				
Parent/Guardian				
Sibling Information			School/Grade Level	In the home?
Sibling				
Sibling				
Sibling				
Sibling				

Is your child adopted: Yes No Is there any further information you would like to share regarding the adoption? _____

II. Developmental Information:

The child was born: Full-Term Cesarean Premature Birth Weight _____

Were there any complications at birth? _____

Milestones	Early	Typical	Late	Comments/Current Concerns
Teething		(6 months)		
Crawling		(9 months)		
Walking		(1 year)		
Toilet Trained		(2-3 yrs.)		

Was your child's development unusual in any way? _____

Please list any serious illness, operations, or injuries that your child has had and at what age:

Do you have any concerns about your child's eating habits or sleeping patterns: _____

Do you have concerns about your child's vision or hearing: YES NO

If yes, please explain: _____

If your child is **not** entering Kindergarten, please skip to Section IV
If your child **is** entering Kindergarten, please complete all sections

III. School Readiness:

Has your child attended nursery school? YES NO If yes, where? _____

Do you have any concerns about your child's readiness for school? (such as academic, social, or behavior management) _____

Does your child have independent self-care skills (e.g. toileting, dressing, etc.) YES NO

If no, please explain: _____

Have there been any major changes in the home (divorce, marriage, separation, death, etc.) that may affect your child? _____

IV. Speech/Language:

Has your child ever been enrolled in a speech or language therapy program? YES NO

If yes, where? _____ What was addressed: _____

Do you or others have difficulty understanding your child's speech? YES NO

Does your child pronounce any sounds incorrectly? YES NO Which sounds? _____

V. Evaluations/Services:

Has your child been evaluated for any other concerns? YES NO

If yes, what was the area of concern? _____

What was the outcome of the evaluation? _____

Does your child receive any services as a result of the evaluation? YES NO

If yes, where? _____

Do you have any concerns or comments that were not addressed? _____

Please do not hesitate to contact the Social Worker in your child's building if you wish to further elaborate on the information you have provided, or express any specific concerns.

All the information provided on this form will be treated as confidential.

Form completed by: _____ Date: _____



Dear Parents/Guardians,

Chapter 53 of the Education Law-1980 requires local school districts to screen all new entrants, including Kindergarten.

Screening is a preliminary method of distinguishing from the general population, those students, who may possibly have a handicapping condition or those who may be gifted. Screening should not be viewed as an in-depth method of assessing development. It is a quick method of determining overall performance and should indicate whether or not a comprehensive evaluation is necessary. Based upon the results of screening, students who are in need of further evaluation will be referred to appropriate school and medical personnel.

New Hartford's screening process will include:

1. A health examination by a licensed physician, or evidence of such, in the form of a health certificate.
2. Certificates of immunization or referral for immunizations
3. Request for a Dental Health Certificate for school entry (Grades K, 2, 4, 7 and 10)
4. Articulation skills and receptive and expressive language development
5. Cognitive development (learning strengths and weaknesses)
6. Motor development

Screening will be conducted under the following schedule:

1. Kindergarten-May/June
2. New Entrants-August/September
3. New Entrants after Sept. 1st-Individually as needed

When screening has been completed, you will receive a copy of the Screening Profile, which will contain the results of the testing. All data pertaining to your child(ren) will be treated in a confidential manner.

Your assistance and cooperation in supplying information and completing necessary forms will be appreciated. If you have any questions, please contact your building principal.

Thank you!

(FORM E4)



**New Hartford Central School District
Student Photo and Media Release Form**

The New Hartford Central School District promotes school programs, activities, awards, recognitions, and accomplishments of its students through publications and digital media. This includes, but is not limited to the use of photos and videos of students in newsletters, social media, promotional materials, the district website and any other form of publication, or broadcast media.

- I **give** the District permission to use a photo or video of my child in any and all publications and digital media.

- I **do not give** the District permission to use a photo or video of my child in any and all publications and digital media.

Student Name	School
Teacher	Grade

Parent/Guardian Name (please print) _____
Date

Parent/Guardian Signature

******If this form is not submitted to your child's respective building, the District assumes that it is permissible to use a photo and/or video of your child.***

2025-26 School Year

New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

All children must be age-appropriately immunized to attend school in New York State. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the [“ACIP-Recommended Child and Adolescent Immunization Schedule.”](#) Doses received before the minimum age or intervals shown on the schedule 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 gradeless classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)²	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older and the series was started at less than 1 year of age or 3 doses if 7 years or older and the series was started at 1 year or older	3 doses	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)³	Not applicable		1 dose given after age 10 years	
Polio vaccine (IPV/OPV)⁴	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)⁵	1 dose	2 doses		
Hepatitis B vaccine⁶	3 doses	3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 years through 15 years		
Varicella (Chickenpox) vaccine⁷	1 dose	2 doses		
Meningococcal conjugate vaccine (MenACWY)⁸	Not applicable		Grades 7, 8, 9, 10 and 11: 1 dose	Grade 12: 2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)⁹	1 to 4 doses	Not applicable		
Pneumococcal Conjugate vaccine (PCV)¹⁰	1 to 4 doses	Not applicable		

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.
*Serological titers are never accepted for tetanus, diphtheria, pertussis, meningococcal, haemophilus influenzae type b, and pneumococcal diseases.
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. 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.
 - d. For further information, refer to the [CDC Catch-Up Guidance for Children 4 Months through 6 Years of Age](#).
 - e. For further information, refer to the [CDC Catch-Up Guidance for Children 7 through 9 Years of Age](#).
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 11: 10 years; minimum age for grade 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 2025-26, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 11; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grade 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.
 - d. For further information, refer to the [CDC Catch-Up Guidance for Children 10 through 18 Years of Age](#).
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 New York State 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, must not be counted.
 - e. For further information, refer to the [CDC Catch-Up Guidance for Children 4 Months through 17 Years of Age](#).
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 pre-kindergarten. Two doses are required for grades kindergarten through 12.
 - c. Mumps: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.
 - d. Rubella: At least one dose is required for all grades (pre-kindergarten 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 through 12: 10 years).
 - a. One dose of meningococcal conjugate vaccine 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.
 - f. For further information, refer to the [CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age](#).
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 [CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age](#). *Depending on vaccine brand, schedule may change.

For further information, contact:

**New York State Department of Health
Division of Vaccine Excellence
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437**

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

New York State Department of Health/Division of Vaccine Excellence
health.ny.gov/immunization

Immunization Requirements for School Attendance Medical Exemption Statement for Children 0-18 Years of Age

NOTE: THIS EXEMPTION FORM APPLIES ONLY TO IMMUNIZATIONS REQUIRED FOR SCHOOL ATTENDANCE

Instructions:

1. Complete information (name, DOB etc.).
2. Indicate which vaccine(s) the medical exemption is referring to.
3. Complete contraindication/precaution information.
4. Complete date exemption ends, if applicable.
5. Complete medical provider information. Retain copy for file. Return original to facility or person requesting form.

-
1. Patient's Name _____
 2. Patient's Date of Birth _____
 3. Patient's Address _____
 4. Name of Educational Institution _____
-

Guidance for medical exemptions for vaccination can be obtained from the contraindications, indications, and precautions described in the vaccine manufacturers' package insert and by the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) available in the Centers for Disease Control and Prevention publication, Guide to Vaccine Contraindications and Precautions. This guide can be found at the following website: <http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm>.

Please indicate which vaccine(s) the medical exemption is referring to:

- | | |
|---|---|
| <input type="checkbox"/> Haemophilus Influenzae type b (Hib) | <input type="checkbox"/> Measles, Mumps, and Rubella (MMR) |
| <input type="checkbox"/> Polio (IPV or OPV) | <input type="checkbox"/> Varicella (Chickenpox) |
| <input type="checkbox"/> Hepatitis B (Hep B) | <input type="checkbox"/> Pneumococcal Conjugate Vaccine (PCV) |
| <input type="checkbox"/> Tetanus, Diphtheria, Pertussis (DTaP, DTP, Tdap) | <input type="checkbox"/> Meningococcal Vaccine (MenACWY) |

Please describe the patient's contraindication(s)/precaution(s) here: _____

Date exemption ends (if applicable) _____

A New York State licensed physician must complete this medical exemption statement and provide their information below:

Name (print) _____ NYS Medical License # _____

Address _____

Telephone _____

Signature _____ Date _____

For Institution Use ONLY: Medical Exemption Status Accepted Not Accepted Date: _____

New Hartford Central School District

Dr. Christopher Alinea
Julie Shankman, FNP

Marie Perrotta, RN
School Nurse Coordinator
New Hartford High School Nurse
315-624-1235

Jessica Wellington, RN
Myles Elementary School Nurse
315-624-1106

Alexandra Burney, BSN, RN
Perry Junior High School Nurse
315-738-9317

Nicole Getz, RN
Bradley Elementary School Nurse
315-624-1232

Cathy Clark, RN
Hughes Elementary School Nurse
315-738-9357

Health History Form

Child's Name		Birth Date		Gender	
Mother's Name			Father's Name		
Mailing Address:					
Parent Home Phone		Cell		Work	
Parent Home Phone		Cell		Work	

Please list siblings:

Name of Sibling	Age	School Sibling Attends	Grade

With whom does the child live? _____

Who is the legal guardian? _____

Perinatal and Development

Did the mother have any unusual problems/illness during pregnancy or birth? If yes, please explain

Please check if these factors were present:

Toxemia		Cesarean Section		Bleeding	
Fetal Problems		Infection		Labor Difficulties	

Please check accordingly

The infant was full term:		The infant was early:		The infant was late:	
---------------------------	--	-----------------------	--	----------------------	--

What was the infant's birth weight?	
-------------------------------------	--

Perinatal and Development (Continued)

Did the infant have any illness or problems while in the hospital?	If yes, please explain:

Please check:

1. How does this child's development compare with other children such as brother's, sister's or playmate's

Same Slower Faster

2. This child is usually:

Active Very Active Quiet

Please check all that apply:

Sore Throats <input type="checkbox"/>	Headaches <input type="checkbox"/>	Chicken Pox <input type="checkbox"/>	Date
Eye Problems <input type="checkbox"/>	High Fevers <input type="checkbox"/>		
Ear Infections <input type="checkbox"/>	Diabetes <input type="checkbox"/>		
Nosebleeds <input type="checkbox"/>	Heart Conditions <input type="checkbox"/>		
Poor Hearing <input type="checkbox"/>	Seizures <input type="checkbox"/>		

Allergies and Asthma

Medicine/Drugs	
Foods/Plants	
Bee/Wasp Stings	
Animals/Other	

Treatment recommended by MD for severe allergic response: _____

Allergies and Asthma (continued)

Please be aware we do not stock medications for severe allergic responses, parents are responsible for providing these medications to the school nurse with the doctor's orders.

Is the child having allergy shots? Yes No

Has asthma been diagnosed by a physician? Yes No

What treatment/medication have been prescribed? _____

Are there specific triggers causing an asthma episode? Yes No

Please describe the triggers: _____

Injuries, Illness and Surgery

Please list severe injuries, illness, or surgeries?

Injury/Illness/Surgery	Age	Hospital Yes/No	Length of Hospital Stay

Medications

List medications given daily:	List medications given frequently	List medications your child is allergic to?

If your child needs to take medication in school, please contact the school nurse for the district's protocol to have medication given in school.

Does this child have any disability or chronic illness? Yes/No	If yes, please explain
---	------------------------

<p>Are there any health concerns that you would like to discuss with the school nurse?</p>	<p>If yes, please explain:</p>
<p>Please provide a phone number(s) where you can be contacted.</p>	<p>Phone number(s)</p>
<p>Does any family member have any long-term illness such as diabetes, high blood pressure or heart disease?</p>	<p>If yes, please explain:</p>

New Hartford Central District School Health Services

Dr. Chris Alinea
Julie Shankman, FNP

Marie Pettorra, RN
School Nurse Coordinator
New Hartford Senior High School
(315) 624-1235

Jessica Wellington, RN
School Nurse
Myles Elementary School
(315) 624-1106

Alexandra Burney, BSN, RN
School Nurse
Perry Jr. High School
(315) 738-9317

Nicole Getz, RN
School Nurse
Bradley Elementary School
(315) 624-1232

Cathy Clark, RN
School Nurse
Hughes Elementary School
(315) 738-9357

DENTAL HEALTH CERTIFICATE

Dear Parent/Guardian:

New York State Law (chapter 281) asks schools to request proof of a dental examination in the following grades: school entry, K, 1, 3, 5, 7, 9, and 11. Please fill out this form and return to the School Nurse. This is a request and as such is optional.

Student Name: _____ **Grade** _____ **Teacher** _____

This student has had a complete dental exam on: Date: _____

Dentist Name _____
(please print or stamp)

Dentist Signature _____

Dentist Phone _____

Comments: _____

Thank you for your cooperation in this new health endeavor.

New Hartford Central School District

**Provider and Parent Permission to Administer Medication
at School/School Sponsored Events**

To Be Completed by Parent

Student Name _____ DOB _____

Grade _____ Teacher _____ School _____

I request that the school nurse administer the medication listed on this plan. I will provide the medication in the original pharmacy or over the counter container. This plan may be shared with the school staff caring for my child.

Parent/Guardian Signature _____ **Date** _____

Phone Number _____ **Email** _____

To Be Completed by Health Care Provider-Valid for 1 Year

Diagnosis _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations _____ ICD Code _____

Note: Medication will be administered as close to the prescribed time as possible, but may be administered up to one hour before or after the prescribed time, unless it is documented that it is a time sensitive medication. Please advise if there is a time-specific concern regarding administration.

Independent Carry and Use Attestation Attached (Required for independent carry and use)

NYS law required both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medications, epinephrine auto-injector, insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

Name/Title of Prescriber (Please Print) _____

Prescribers Signature _____

Date _____ Phone _____

New Hartford Central School District

PROVIDER AND PARENT PERMISSIONS REQUIRED FOR INDEPENDENT MEDICATION USE AND CARRY

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently use and carry their medication as required by NYS law. A provider order and parent/guardian permission is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name _____ **DOB** _____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication (s) listed below safely and effectively, and may carry and use this medication (which delivery device is needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications checked below:

This student is diagnosed with:

- Allergy and required Epinephrine Auto-Injector
- Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- Diabetes and required insulin/Glucagon/Diabetes Supplies
- _____ which requires rapid administration of
(state diagnosis) _____ (medication name)

Provider Signature: _____ **Date** _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may use and carry this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: _____ **Date** _____

Please return to the School Nurse with the Provider and Parent Permission to Administer Medication form.



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

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Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

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

STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
Month	Day	Year
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	_____	<input type="checkbox"/> Parent 2
		<i>specify</i>	<i>specify</i>
	<input type="checkbox"/> Guardian(s)	_____	<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not write
			<i>specify</i>

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? _____

Signature of Parent or of Person in Parental Relation

Month: _____ Day: _____ Year: _____
Date

Relationship to student: Parent Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: No Yes

**DATE OF INDIVIDUAL INTERVIEW: _____
 MO. DAY YR.

OUTCOME OF INDIVIDUAL INTERVIEW:
 ADMINISTER NYSITELL
 ENGLISH PROFICIENT
 REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ PROFICIENCY LEVEL ACHIEVED ON NYSITELL:
 MO. DAY YR. ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: