WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

Dear Parent/Guardian,

Enclosed are the documents that are necessary to complete in order to refer your child to the Committee on Preschool Special Education. Your preschool child must be registered with the Wappingers Central School District before your request for an evaluation can be processed.

Enclosed please find a registration packet, including:

- Registration forms and a letter detailing the documents you will need to provide at the time of your registration appointment.
- Consent forms for you to complete and sign, along with the list of approved preschool evaluation agencies that contract with Dutchess County.
- Prior Written Notice reviewing the evaluation request, and Part B Procedural Safeguard Notice, both of which are for your files.

Once you have gathered your appropriate documents, **please call central registration at 845-298-5000 x40132 to schedule an appointment.** Your request for referral to the CPSE will be processed once your registration is complete.

Forms to bring with you to the registration appointment:

- Complete registration packet, including all necessary registration forms
  - Proof of residency, your child's original birth certificate, recent physical examination record, immunizations, and guardianship or custody papers (if applicable)
- Sign and complete "Request for consent to Evaluate" form
  - Be sure to indicate your choice for evaluating agency on this form
- Complete "Referral to Committee on Preschool Special Education" form
- Any additional medical and/or preschool documents that may be helpful in identifying your child's abilities and areas of concern

Forms to keep for your records:

- Prior Written Notice reviewing the evaluation request
- Part B Procedural Safeguard Notice

Please contact the preschool special education office with any questions.

Regards,

Committee on Preschool Special Education Chairperson

(845) 298-5260 x14027

Committee on Preschool Special Education
25 Corporate Park Drive • P.O. Box 396 • Hopewell Junction, NY 12533 • (845) 298-5260 x14027 • Fax (845) 227-1771

Prior Written Notice
Proposed Referral and Request for Consent for Evaluation

Dear Parent/Guardian:

The purpose of this notice is to inform you, in writing, of the school district's recommendation(s) regarding the identification, evaluation, educational placement and/or provision of special education services to your child.

SUBJECT OF THIS NOTICE:
Your child has been referred to the Committee on Preschool Special Education.

DESCRIPTION OF ACTION PROPOSED OR REFUSED:
The Committee on Preschool Special Education is requesting consent to conduct an evaluation to determine initial eligibility for preschool special education services.

EXPLANATION OF WHY THE ACTION IS PROPOSED OR REFUSED:
This referral was initiated in response to concerns about your child's progress.

DESCRIPTION OF EACH EVALUATION PROCEDURE, ASSESSMENT, RECORD, OR REPORT USED IN THE DECISION TO PROPOSE OR REFUSE THE ACTION:
A social history, observation and psychological evaluation. If needed, a speech and language evaluation, an educational assessment, and/or motor abilities assessment. If applicable, review of current provider reports and/or medical records.

DESCRIPTION OF THE PROPOSED INITIAL OR REEVALUATION AND THE USES TO BE MADE OF THE INFORMATION:
Psychological Evaluation
Assesses such areas as development, organization, memory, learning and other personality characteristics.
Social History
A report of information about the child, the child's family and environment that may be influencing performance in age appropriate activities.

***If needed, evaluations can include:**
Speech/Language Evaluation
Educational Evaluation
Occupational Therapy Evaluation
Physical Therapy Evaluation

DESCRIPTION OF ANY OTHER OPTIONS CONSIDERED AND THE REASONS WHY THOSE OPTIONS WERE REJECTED:
There were no other options considered at this time.

DESCRIPTION OF OTHER FACTORS THAT ARE RELEVANT TO THE PROPOSED OR REFUSED ACTION:
There were no other factors relevant at this time.

YOU HAVE PROTECTION UNDER THE PROCEDURAL SAFEGUARDS OF THE REGULATIONS OF THE COMMISSIONER OF EDUCATION. (CLICK BELOW)

Procedural Safeguards Notice

SOURCES YOU MAY CONTACT TO OBTAIN ASSISTANCE IN UNDERSTANDING THE SPECIAL EDUCATION PROCESS:
For more information on Special Education rules and processes please contact your Area Special Education Office. They can answer any questions you have. You can also contact the following agencies.

The Hudson Valley Region NYSED Special Education Parent Center Contact information is:
The Westchester Institute for Human Development, Cedarwood Hall, Room 326, Valhalla, NY 10595.
Phone 914-493-7665, Fax 914-493-7899. Website: www.hvsepc.org
The center provides information, resources and strategies to assist parents of children with disabilities.

The District Special Education Office is located at: 25 Corporate Park Drive, Hopewell Junction, NY 12533.
Phone 845-298-5000 ext. 40103

A Parent Guide to Special Education is available on NYSED web site:
http://www.p12.nysed.gov/specialed/publications/policy/parentsguide.pdf

ADDITIONAL INFORMATION RELATED TO THE SUBJECT OF THE NOTICE:
Your written consent to the proposed initial evaluation is requested and a consent form is enclosed. You have the right to consent or to withhold consent to the initial evaluation of your child. If you consent, please sign and return the enclosed form as soon as possible so that we can address your child's learning needs in a timely manner.

You must select an approved evaluation site to conduct an initial evaluation of your child. Enclosed is a list of approved evaluation sites and the procedures you must follow to select a program that is available to conduct the evaluation of your child within the time period required by State regulations.

You may also submit evaluation information which will be considered by the Committee as part of the initial evaluation.

When the evaluation is completed, you will have the opportunity to discuss the test results and meet with the Committee on Preschool Special Education. You will receive a written notice of the date, time and location of the Committee meeting, and we encourage your attendance.

You have the right to address the Committee, either in person or in writing, on the appropriateness of the Committee's recommendations. If you have any questions or would like to request a meeting to further discuss information contained in this notice, please contact Lauren Broadbelt or Dr. Leah Raftis at 845-298-5260 ext. 14027.

Sincerely,

Committee for Preschool Special Education Chairperson

Encl.: 1. Consent for Initial Evaluation
2. List of Approved Evaluators
3. Procedures to Select an Approved Evaluator

WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

25 Corporate Park Drive • P.O. Box 396 • Hopewell Junction, NY 12533 • (845)298-5260 x14027 • Fax (845) 227-1771

REFERRAL TO COMMITTEE ON PRESCHOOL SPECIAL EDUCATION (CPSE)

CHILD'S NAME: _____

DATE OF BIRTH: _____

Dear CPSE Chairperson,

I am writing to refer my child to the Committee on Preschool Special Education. I am requesting that you conduct an initial evaluation to determine whether my child has a disability that is affecting his/her ability to participate appropriately in activities. I am concerned about my child's development in the following areas:

_____ Cognitive/Learning
_____ Speech and Language
_____ Fine Motor
_____ Gross Motor
_____ Attention
_____ Social Emotional Development/ Play
_____ Adaptive/Self Help
_____ Other _____

List pertinent medical diagnoses, as well as previous programs and/or services (Early Intervention, private services, etc.):

_____
_____
_____

Sincerely,

_____
(Parent/ Guardian Signature)

Please Print:

Name of Parent/Guardian: _____

Address: _____

Telephone Number: _____

Email Address: _____

WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

25 Corporate Park Drive • P.O. Box 396 • Hopewell Junction, NY 12533 • (845) 298-5260 x14027 • Fax (845) 227-1771

REQUEST FOR CONSENT TO EVALUATE

CHILD'S NAME: _____

DATE OF BIRTH: _____

Please check your choice below and fill in the information requested.

____ I consent for my child to be evaluated by the Committee on Preschool Special Education (CPSE).
The evaluations will include: Social History, Psychological Evaluation, Observation and any supplemental evaluations deemed necessary based on concerns and needs.

Evaluating Agency Choice: _____
Name of Parent/Guardian: _____
Telephone number: _____
Email address: _____

Parent/Guardian Signature: _____

OR

____ I DO NOT CONSENT for my child to be evaluated.

OR

____ I request a conference to discuss the proposed evaluation of my child. I understand that no evaluation will take place until this conference is held. Please contact me to schedule a date for a conference.
Signature of Parent: _____

Office Use Only
Initials: _____

Date:_____

WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

AUTHORIZATION TO REQUEST AND/OR RELEASE CONFIDENTIAL INFORMATION

Student's Name: _____**Sex (M) __ (F) ___ Birthdate:** _____

Address: _____

I, the undersigned parent/guardian or eligible student, hereby give my written consent to the Wappingers Central School District

CHECK	*SERVICES*	*PROVIDER*
( )	Counseling	Certified School Counselor
( )	Psychological	Certified School Psychologist
( )	Social Worker	Certified School Social Worker

to request, receive and/or release medical, psychological, psychiatric, academic, and any other records deemed necessary concerning my child:

To the following Person and/or Agency:

Name: _____

Address: _____

_____

Telephone: _____

For the purpose of (e.g., providing a recommendation, providing information about, etc.):

_____

My consent is subject to revocation at any time and, unless an earlier date is specified, my consent expires after one (1) year from the date of my signature.

DATE OF REVOCATION, IF OTHER THAN ONE (1) YEAR: _____

- **If there are any additional parties (e.g., agency, hospital, or professional personnel that have serviced the client) to whom the receiving person or agency may disclose the information contained in the student records, please list the names, addresses and nature of each party's interest below.**

  1. _____
  2. _____
  3. _____

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS.

Signed: _____ **Date:** _____

Relationship to client: _____

Dutchess County Preschool Special Education
2020-2021 SY List of NYS SED Approved Preschool Providers

- Dutchess County Evaluation Agencies -

***CBC – Case by Case**

Provider Name	Contact Name	Phone #	Mailing Address	Virtual	In-person
Abilities First Preschool	Sue Rea	(845) 298-2090	167 Myers Corners Road, Suite 104 Wappingers Falls, NY 12590	X	x
Achieve Beyond Child & Parent Services (Bilinguals Inc.)	Tara Ramondelli	(914) 328-2868 *English & Multi lang. available	333 Westchester Avenue, Suite W 202, White Plains, NY 10604	X	CBC
Astor Services For Children & Families	Lauren Sweeney	(845) 452-4167 *Spanish Available	50 Delafield St., Poughkeepsie, NY 12601	X	x
HTA Of New York	Leslie Lupetin	(845) 528-2011 *Spanish available	11 Peekskill Hollow Road, Putnam Valley, NY 10579	X	CBC
Mid Hudson Valley Early Education Center	Mary Thompson Marisa Wolpert	(845) 431-8815 *Spanish available (845) 431-8292	115 Delafield Street, Poughkeepsie, NY 12603	X	x
Milestones for Munchkins (with Kinderwise)	Katharine Bolender	(914) 774-3608	534 Route 6, Mahopac, NY 10541	X	CBC
Kathleen C. Phillips (Carriage House)	Lonnie Wong-Trufanoff	(845) 462-6701	50 Springside Ave, Poughkeepsie, NY 12603	X	NO

- Neighboring Counties Evaluation Agencies –

***CBC – Case by Case**

Provider Name	Contact Name	Phone #	Mailing Address	Virtual	In-person
Center for Spectrum Services	Leah Siuta	(845) 336-2616	70 Kukuk Lane, Kingston, NY 12401	X	CBC
Learning Together, Inc. (formerly EEC)	Kathy Masloski	(845) 883-5151	40 Park Lane, Highland, NY 12528	X	CBC
Liberty POST Hudson Valley	April Castellano	(845) 458-8661	301 Main Street, Suite B, Goshen, NY 10924	X	CBC
The Arc of Orange Co. (formerly AHRC) Educational Learning Experience	Tracy Feil Beth Laub	(845) 344-2292 x-4149	1145 Little Britain Road, New Windsor, NY 12553	X	CBC
Partnership for Education	Claudia Stedge	(845) 247-8777	268 W Saugerties Rd, Saugerties, NY 12477	X	CBC
WSHV – Wraparound Services of the Hudson Valley (formerly CP of Ulster Co.)	Ashlee Quisnell	(845) 336-7235	P.O. Box 1488 Tuytenbridge Road, Kingston 12401	X	NO

EVALUATING AGENCIES (Continued)					
Provider Name	**Contact Name**	**Phone #**	**Mailing Address**	**Virtual**	**In-person**
Putnam & Southern Dutchess UCP (Hudson Valley Early Childhood Center)	Rhona Hanshaft Aimee Martine (x5555)	(845) 878-9078	40 Jon Barrett Road Patterson, NY 12563(mailing) 15 Mount Ebo Road South, Brewster, NY 10509 (school)	X	x
Westchester Community Opportunity Program, Inc. (WestCOP)	Vernex Harding	(914) 243-0501	2269 Saw Mill River Road, Elmsford, NY 10523 (office)	X	CBC

- Preschool Augmentative Communication Evaluation Agencies (PACE) –

***CBC-Case by Case**

Provider Name	Contact Name	Phone #	Location – Site Based Service	Virtual	In-person
Mid Hudson Valley Early Education Center	Margaret Slomin	(845) 483-5682	Poughkeepsie, Beacon	X	X

- Itinerant Related Services: OCCUPATIONAL THERAPY –

***CBC-Case by Case**

Provider Name	Contact Name	Contact Phone #	Mailing Address	Virtual	In-person
A Bit of Communicating Speech and OT Services (ABC)	Jenny Cohowicz Aimee Riley	(845) 592-0681	2537 Route 52, Hopewell Jct., NY 12533	X	CBC
Abilities First, Inc.	Sue Rea	(845) 298-2090	167 Myers Corners Road, Suite 104 Wappingers Falls, NY 12590	X	x
Achieve Beyond Child & Parent Services (Bilinguals Inc.)	Tara Ramondelli	(914) 328-2868 Multi languages & English available	333 Westchester Avenue, Suite W 202, White Plains, NY 10604	X	CBC
All About Kids (formerly Interactive Therapy Group)	Maureen Finnerty	(845) 495-0517, ext. 701	87 E. Main St., Suite 1, Washingtonville, NY 10992	X	NO
All About Rehab Management	Karen Finnerty	(845) 453-2385	706 Old Route 22, Dover Plains, NY 12522	X	CBC
All Kids Excel OT Services, PLLC	Danielle Wertman	(914) 441-8465	750 Milltown Road, Brewster, NY 10509	X	CBC

Educación Especial Preescolar del Condado de Dutchess

Lista del Año Escolar 2020-2021 de Proveedores Preescolares Aprobados por el Departamento de Educación Especial del Estado de Nueva York

- Agencias Evaluadoras Sirviendo al Condado de Dutchess -

* CPC – Caso por Caso

Nombre del Proveedor	Contacto	Número de Teléfono	Locación	Virtual	En - persona
Abilities First Preschool	Sue Rea	(845) 298-2090	167 Myers Corners Road, Suite 104 Wappingers Falls, NY 12590	X	x
Achieve Beyond Child & Parent Services (Bilinguals Inc.)	Tara Ramondelli	(914) 328-2868 *ingles y otros idiomas disponibles.	333 Westchester Avenue, Suite W 202, White Plains, NY 10604	X	CPC
Astor Services For Children & Families	Lauren Sweeney	(845) 452-4167 *español disponible.	50 Delafield St., Poughkeepsie, NY 12601	X	x
HTA Of New York	Leslie Lupetin	(845) 528-2011 *espanol disponible	11 Peekskill Hollow Road, Putnam Valley, NY 10579	X	CPC
Mid Hudson Valley Early Education Center	Mary Thompson Marisa Wolpert	(845) 431-8815 *español disponible. (845) 431-8292	115 Delafield Street, Poughkeepsie, NY 12603	X	CPC
Milestones for Munchkins (en colaboración con Kinderwise Learning Associates)	Katharine Bolender	(914) 774-3608	534 Route 6, Mahopac, NY 10541	X	CPC
Kathleen C. Phillips (Carriage House)	Lonnie Wong-Trufanoff	(845) 462-6701	50 Springside Avenue, Poughkeepsie, NY 12603	X	NO

- Agencias Evaluadoras Sirviendo a los Condados Vecinos de Dutchess –

*** CPC – Caso por Caso**

Nombre del Proveedor	Contacto	Número de Teléfono	Locación	Virtual	En-persona
Center for Spectrum Services	Leah Siuta	(845) 336-2616	70 Kukuk Lane, Kingston, NY 12401	X	CPC
CP of Ulster County (Wraparound Srvs of the Hudson Valley)	Ashelee Quisnell	(845) 336-7235	P.O. Box 1488 Tuytenbridge Road, Kingston, NY 12401	X	CPC
Learning Together, Inc. (anteriormente EEC)	Kathy Masloski	(845) 883-5151	40 Park Lane, Highland, NY 12528	X	CPC
Liberty POST Hudson Valley	LauraZaferakis April Castellano	(845) 458-8661	301 Main Street, Suite B, Goshen, NY 10924	X	CPC
The Arc of Orange Co. (anteriormente AHRC)	Tracy Feil Beth Laub	(845) 344-2292, ext. 4149	1145 Little Britain Road, New Windsor, NY 12553	X	CPC
Partnership for Education	Claudia Stedge	(845) 247-8777	268 W Saugerties Rd, Saugerties, NY 12477	X	CPC

AGENCIAS EVALUADORAS (Cont.)					
Nombre del Proveedor	**Contacto**	**Número de Teléfono**	**Locación**	**Virtual**	**En-persona**
Putnam & Southern Dutchess UCP (Hudson Valley Early Childhood Center)	Rhona Hanshaft Aimee Martine	(845) 878-9078 (x5555, Aimee)	40 Jon Barrett Road Patterson, NY 12563 (dirección de correo) 15 Mount Ebo Road South, Brewster, NY 10509 (escuela)	X	x
Westchester Community Opportunity Program, Inc. (WestCOP)	Cheryl Rosenfeld	(914) 243-0501	2269 Saw Mill River Road, Elmsford, NY 10523 (oficina)	X	NO

– Agencias que Ofrecen Evaluaciones de la Comunicación Aumentativa – (Preschool Augmentative Communication Evaluations—PACE)

***CPC – Caso por Caso**

Nombre de Proveedor	Contacto	Número de Teléfono	Locación	Virtual	En-persona
Mid Hudson Valley Early Education Center (MVEEC)	Margaret Slomin	(845) 483-5682 (845) 431-8815	Poughkeepsie, Beacon	X	x

– Servicios Relacionados (Itinerant Related Services): TERAPIA OCUPACIONAL –

***CPC – Caso por Caso**

Nombre de Proveedor	Contacto	Número de Teléfono	Locación	Virtual	En-persona
A Bit of Communicating Speech and OT Services (ABC)	Jenny Cohowicz Aimee Riley	(845) 592-0681	2537 Route 52, Hopewell jct, NY 12533	X	CPC
Abilities First	Sue Rea	(845) 298-2090	167 Myers Corners Road, Suite 104 Wappingers Falls, NY 12590	X	CPC
Achieve Beyond Child & Parent Services (Bilinguals Inc.)	Tara Ramondelli	(914) 328-2868 *ingles y otros idiomas disponibles.	333 Westchester Avenue, Suite W 202, White Plains, NY 10604	X	CPC
All About Kids (Anteriormente Interactive Therapy Group)	Maureen Finnerty	(845) 495-0517, ext. 701	87 E. Main St., Suite 1, Washingtonville, NY 10992	X	NO
All About Rehab Management	Karen Finnerty	(845) 453-2385	706 Old Route 22, Dover Plains, NY12522	X	CPC
All Kids Excel OT Services, PLLC	Danielle Wertman	(914) 441-8465	750 Milltown Road, Brewster, NY 10509	X	CPC
TERAPIA OCUPACIONAL (Cont.)					

WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

Parent Retain for their Records

GUIDELINES FOR REGISTERING YOUR CHILD

Proof of Residency

All new students seeking enrollment in the Wappingers Central School District must provide proper documentation and/or information to establish residency.

Within three (3) business days of your child's initial enrollment, your documentation and/or information will be reviewed to make a final residency decision. If a determination of non-residency is made, you will be notified in writing.

The following is documentation that may be used to establish residency **(Note: This is not intended to be an exhaustive list, and the District may consider other documentation and/or information, as appropriate):**

- A copy of a residential lease or proof of ownership of a home, such as a deed or a mortgage statement.
- A notarized or signed statement by a third-party landlord, owner or tenant from whom the parent(s), guardian(s) or person(s) in parental relation leases or with whom they share property within the District.
- Other forms of documentation include:
  - Pay Stubs
  - Federal or NYS Income Tax, W-2 or Earnings Statement
  - Utility Bill
  - Voter Registration Notification Card
  - Official driver's license, learner's permit or non-driver identification
  - Documents issued by federal, state or local agencies (such as social services agency)
  - Government-issued identification
  - Membership document based on residency

If you are not the natural parent but have legal guardianship of the student(s), please provide us with any available relevant documents or complete custody affidavit (Click here for Parent Affidavit/ Custodial Affidavit Forms or visit https://goo.gl/H4NCmC .)

Proof of Age

In accordance with the NYS Education Law, the District requires documentation verifying your child's age. Acceptable documentation may include a birth certificate or record of baptism, including a certified transcript of a foreign birth certificate or record of baptism. When this information is unavailable, the District may accept a passport, including a foreign passport, to determine the child's age. If the previously listed documentation is not available, the District may consider the following documents or recorded evidence if in existence two (2) or more years, except an affidavit of age, to determine a child's age:

- State or other government-issued identification
- School photo identification with date of birth
- Consulate identification card
- Hospital or health records
- Official driver's license
- Military dependent identification card
- Documents issued by federal, state or local agencies
- Court orders or other court-issued documents
- Native American tribal document

Documentation Relating to Legal Custody and Special Circumstances
If there are any other special circumstances such as custody agreements or orders of protection, please submit those documents to us. They will be copied and filed in the student's records. The schools cannot refuse to release a child to a parent/legal guardian unless there are court documents on file with the District to the contrary.

Proof of Health Examination & Immunizations
In accordance with the Commissioner's Regulations, students entering public school at any grade are required to have a satisfactory health examination conducted no more than 12 months before the first day of the school year in question. If an acceptable health certificate is not provided within 30 days, the District's physician will conduct the examination. The District does not require a health certificate if they or their parents object claiming a conflict with their genuine and sincere religious beliefs. This exemption request must be in writing and supporting documentation provided.

Immunization records or documentation of exemption are also required for every student entering or attending public schools in accordance with New York State Public Health Law. The Public Health Law allows for a limited period of attendance for 14 days without proof of immunization, upon a showing that the student is making a good faith effort to obtain the necessary immunizations and/or documentation verifying the immunizations. "(Note: when the child is transferring from another state or country, the 14-day period may be extended to not more than 30 days). Please refer to the next page for the schedule of immunizations required of students.

Warning: Any person or persons, who willfully provide false information regarding residence, may be subject to criminal penalties. A false statement regarding residence or entitlement to a tuition-free education from the Wappingers Central School District may be punishable as a Class A misdemeanor. In addition, if it is determined that a registrant's child resides outside of the Wappingers Central School District, the District may take legal action to collect tuition charges. The tuition of $9,495.00 (Regular Ed. K-6); $10,324.00 (Regular Ed. 7-12); $35,090.00 (Special Ed. K-6); $35,919.00 (Special Ed. 7-12) per child per year 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.

_____ _____

Parent/Guardian Signature & Date Signature of Witness (WCSD)

Signature of parent/guardian will confirm that they have read and understand the residency policy of the Wappingers Central School District and the consequences they might incur if false information is wrongfully provided.

For Office Use Only: Please Return Form to Main Office Student Cumulative Folder

WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

Registration Data Sheet

(Shaded areas to be completed by WCSD Personnel)

Student's Last Name First Middle	**Student ID #**	**Yr. Grad.**	**Building**	**HR**	**Entry Date**	**New OR Repeat**

Student's Street Address House No. (Lot)	Apt. No.	City	State	Zip Code

Mailing Address (If Different) Street	Apt. No.	City	State	Zip Code

Gender	Proof of Age (Birth Certificate or Other)	Home Phone #

Birth Date	Country	City	State/Province	Zip

School Name	**Grade**	**Teacher**	**Date Student First Entered 9th Grade**

Parent 1/Guardian 1 Name	Parent 1/Guardian 1 Address – If different than child	Emergency Phone #

Parent 1/Guardian 1 Occupation	Place Of Employment	Work Phone # 1	Cell Phone #

Parent 1/Guardian Email Address:

Parent 2/Guardian 2 Name	Parent 2/Guardian 2 Address – If different than child	Emergency Phone #

Parent 2/Guardian 2 Occupation	Place Of Employment	Work Phone # 1	Cell Phone #

Parent 2/Guardian Email Address:

Child Living with Biological/Natural Parents ☐ **YES** ☐ **NO**	Language Spoken at Home	Language of Student

Custody Clarified	**Limited Release**	**O T H E R** ☐**Social Service Form DSS – 2999 Completed; Agency** _____ ☐**Foster Child Report Completed** ☐**Designation for Homeless Child Form Completed** ☐**Migrant** ☐ **Exchange Student**	**Ethnicity:** ☐ **Hispanic** ☐ **Non-Hispanic**

What Are Your Living Arrangements?	**Verification of Legal Residency**	**Race:** ☐ **White** ☐ **Black** ☐ **Asian** ☐ **American Indian/Alaskan Native** ☐ **Native Hawaiian/Pacific Islander**

Schools Previously Attended	**City, State, Country**	**Dates**	**Grade (s)**

Previously Retained ☐ Yes ☐ No	**If yes, what grade(s)?**	**If Previously Attended School in Wappingers Central School District, What School and When Attended?**

Comments

ANY MEDICAL CONDITION OF WHICH THE HEALTH OFFICE SHOULD BE AWARE ☐ **YES** ☐ **NO**

OTHER CHILDREN

Name	Birth Date	School	Grade	Name	Birth Date	School	Grade

Signatures:

_____ Administrator

_____ **Counselor**

_____ **Parent** *(Signature indicates you are aware that a general screening of all new students is required in NYS)*

_____ **Student**

REV.17/18

For Office Use Only: Please Return Form to Main Office Student Cumulative Folder

WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

Department of Special Education and Student Services
(845) 298-5000 ext. 40132 Fax (845) 897-2482

Temporary Residence REFERRAL (McKinney-Vento Program)

All parents/guardians must sign the form to indicate they have read the form. Students in temporary housing conditions may be eligible for additional school supports. Eligibility can be determined by completing the information below. Additional information may be needed.

Parent Name: _____ **Signature:** _____

Currently are you and/or your children in any of the following housing situations? ☐ Yes ☐ No

If you checked ***Yes*** above, please indicate your housing situation below.

☐ Shelter ☐ Hotel/Motel ☐Unsheltered, in a car or campsite ☐Awaiting foster care

☐ Child NOT living with parent or guardian ☐Temporarily living with another family or others

Current Address: _____

Address prior to temporary housing. _____

Transportation required? ☐ Yes ☐ No **Date of housing change.** _____

Reason for current living situation: _____

Previous School and District: _____

Name of Child and School ID	Date of Birth	M/F	Grade	School Attending in WCSD

_____ _____ _____

Parent/Guardian Name Signature (if done in person) Date

Address if different from above: _____

Name of person completing the form _____ Title: _____

Date Completed: _____

Office Use Only		
Please fax form to Richard Zipp at: 897-2482 for approval.	Contact Laura Brundage: 298-5240 x11020 with questions.	
APPROVED BY:	*Informed Transportation:* ☐ Yes	*Sent to schools above:* ☐ Yes

2020-21 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

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

Dose requirements MUST be read with the footnotes of this schedule

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

NEW YORK STATE | Department of Health

IMMUNIZATIONS

New York State Law Section 2164 requires these immunizations for admission to school K-12
(Born on or after 1/1/2005)

New York State Law requires immunizations for all students against Dipththeria, Pertussis, Tetanus, Poliomyelitis, Measles, Mumps, Rubella, Hepatitis B, and Varicella. Meningococcal meningitis for grades 7 and 12. Haemophilus influenzae type b and Pneumonococcal conjugate for Pre K. **Have your family physician complete the information on page 7 in this packet. Please bring the completed page 7 with you at the time of registration.**

Exemption to the immunization law is allowed for medical reasons. Medical exemption must be certified in writing by your physician. This MUST BE renewed each school year.

The mandate requires you to comply with the law since schools are bound to refuse admission to your child if the records of immunization are not available.

Immunization	Number of Doses
Polio	3-4 doses and the last dose must be given after age 4 years prior to Kindergarten
Hepatitis B	3 doses at specific intervals*
Diptheria/Pertussis/Tetanus	4-5 doses and the last dose must be given after age 4 years prior to Kindergarten
Measles/Mumps/Rubella	2 doses received prior Kindergarten
Tdap	Students 11 years or older entering Grades 6 through 12 are required to have one dose of Tdap. Students who are 10 years old in Grade 6 and who have not received a Tdap vaccine may enter but must receive the vaccine when they turn 11 years old.
Varicella	2 doses for incoming Kindergarteners through Grade 12
Meningococcal	1st dose required prior to admission into Grades 7 through 11 and 2nd dose required prior to entrance to Grade 12. 2nd dose not required if 1st dose was given at age 16 or older.

***Hepatitis B doses must be given with 4 weeks between 1st and 2nd doses, 8 weeks in between 2nd and 3rd doses, 16 weeks between 1st and 3rd dose.**

PROOF OF IMMUNIZATION SHOULD BE PRESENTED AT REGISTRATION.

Proof of immunization must be any of 1 of the 3 items listed below:

- An immunization certificate signed by your health care provider
- Immunization Registry report (NYSIIS or CIR from NYC) from your health care provider or your county health department
- A blood test (titer) lab report that proves your child is immune to the diseases
- For varicella (chickenpox), a note from your health care provider which says your child had the disease is also acceptable.

WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

_____SCHOOL Date_____

IMMUNIZATION REPORT

Student's Name _____ DOB _____

Dear Doctor:

Please record all immunizations to date:

DPT/DTaP 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ DT.B _____ Td_____
Tdap 1 _____
POLIO 1 _____ 2 _____ 3 _____ 4 _____ 5 _____
MMR 1 _____ 2 _____
HEPATITIS B 1 _____ 2 _____ 3 _____
VARICELLA 1 _____ 2 _____
Meningococcal 1 _____ 2 _____
HEPATITIS A 1 _____ 2 _____
HIB 1 _____ 2 _____ 3 _____ 4 _____
PCV 1 _____ 2 _____ 3 _____ 4 _____
TUBERCULIN TINE _____ _____ _____ _____ PPD _____ _____ _____ _____

Lead Screening _____ Date _____

_____
MD Signature

Medical Exemption:

If requesting a medical exemption, please complete the following page.

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 grade 6: 10 years; minimum age for grades 7 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 2020-2021, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grade 6; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 7 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. 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 grade 7: 10 years; minimum age for grades 8 through 12: 6 weeks).

   a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) 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 IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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

STUDENT INFORMATION

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

HEALTH HISTORY

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

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

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

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

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

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

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

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:	DOB:

SCREENINGS

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

Recommendations:

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

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

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

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

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

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

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

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

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

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

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

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

HEALTH CARE PROVIDER

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

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

SCHOOL HEALTH SERVICES
WAPPINGERS CENTRAL SCHOOL DISTRICT
_____SCHOOL

REQUEST FOR MEDICAL EXEMPTION TO IMMUNIZATION FORM

Student Name: _____DOB: _____ Grade: _____ ID#: _____

To Be Completed By Health Care Provider Every School Year

Immunization/s which cannot be administered:

☐ DPT/DTaP/Tdap	☐ Polio	☐ MMR
☐ Hepatitis B	☐ Varicella	☐ Meningococcal Meningitis

Reason for exemption: _____
_____

Name of licensed provider (Please print or use stamp) _____

Provider signature _____ Date _____

Provider phone _____

NYSDOH Public Health Law requires adequate dose or doses of immunizing agents against diphtheria, pertussis, tetanus, poliomyelitis, mumps, measles, rubella, hepatitis B, meningococcal meningitis and varicella for school entry.

New York State Law Section 66-1.3 (7) (c)-Requirement for School Admission permits medical exemption to required immunizations if the parent/guardian provides a certificate from a physician, licensed to practice medicine in New York State, that one or more of the required immunizations may be detrimental to the child's health.

The Centers for Disease Control's (CDC) resources on contraindications to vaccination can be found at: http://www.immunize.org/catg.d/p3072a.pdf .

Your certificate should include:

- The specific immunization that is medically contraindicated
- The reason for the medical contraindication

Please return this form to the school Health Office. It will then be sent to the WCSD Medical Director for approval.

This document will be filed with the student's cumulative health record.

Languages other than English can be downloaded by clicking here or visiting https://goo.gl/MmHWuj.

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:

Month *Day* *Year*

GENDER:

❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

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

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School *Address*	

For Office Use Only: Please Return Form to Lizzette Ruiz-Giovinazzi, Director of English as a New Language (ENL)

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:

WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

RELEASE OF STUDENT INFORMATION

Date: _____

Dear Educator,

The following student has enrolled in Kindergarten in the Wappingers Central School District. P**lease forward copies of records, including report cards, health, and any other pertinent information to the address indicated below.**

Thank you for your attention to this request.

Student Name: _____ Date of Birth: _____

Current Address: _____

School: _____ Grade: _____

I hereby authorize the release of the above mentioned records and any other pertinent information concerning my child.

SIGNATURE OF PARENT/GUARDIAN _____DATE _____

Wappingers Central School District

Please fax records to 845-896-1459
If you need to call the Central Registrar, please dial **845-298-5000 x 40132**.

Check all that apply
- ☐ Birth Certificate
- ☐ Immunizations
- ☐ IEP/504
- ☐ Transcript

Previous school information:
Name of School:_____

Address: _____

Telephone (_____)_____ Fax: (_____) _____

Please Return Requested Records to:
Wappingers CSD Central Registration c/o Susan Aboshanab
PO Box 396
Hopewell Junction, NY 12533

WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

School Health Services

_____SCHOOL

For Office Use Only: Please Return Form to Health Office

HEALTH DATA SHEET

Student _____ Date of Birth _____Gender ____
Parent 1 Name _____ Parent 2 Name_____
Parent 1 Phone # Home _____ Work _____ Cell _____
Parent 2 Phone # Home _____ Work _____ Cell _____
Parent 1 Address _____
Parent 2 Address _____

With whom does this child live?
☐ Both Parents ☐ Parent _____ ☐ Guardian _____ Other_____
Print Name *Print Name* *Print Name*

Student's Physician _____ Phone # _____

Emergency Contact if parent/guardian cannot be reached:

Name _____ Relationship to Student _____
Phone # _____

PRENATAL AND DEVELOPMENTAL HISTORY

Did the mother have any unusual problems/illness during the pregnancy or the birth such as breech, forceps or Cesarean delivery? ☐ Yes ☐ No If yes, please explain briefly:
_____
_____

Was this infant born: ☐ Full term ☐ Premature ☐ Post mature
What was this infant's birth weight? _____ lb. _____ oz.
Did this infant have any sickness or problems while in the hospital, such as jaundice, apnea spells or convulsions? ☐ Yes ☐ No If yes, please explain briefly: _____
_____

Please give an approximate age at which this child: sat up alone _____ walked _____
said single words _____ said sentences _____ was toilet trained _____
Please briefly describe this child's overall development in relation to his/her other siblings:___
_____

WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

School Health Services: HEALTH CONDITIONS

For Office Use Only: Please Return Form to Health Office

Please check any that are a chronic problem.

☐ Diabetes ☐ Seizures ☐ Epilepsy ☐ Heart Problems

If your child has any of the above, please contact the school nurse.

☐ High Fevers ☐ Eye Problems ☐ Poor Vision ☐ Poor Hearing ☐ Crossed Eyes
☐ Tubes in Ears ☐ Bed wetting ☐ Bowel Problems ☐ Toothaches ☐ Dental Infections
☐ Frequent Ear Infections ☐ Frequent Headaches ☐ Frequent Nosebleeds
☐ Frequent Sore Throats ☐ Other _____

MEDICAL INFORMATION

Does this child have any allergies? ☐ Yes ☐ No

If yes, to what? _____
What are the child's triggers to this/these allergies? _____

What are the child's reactions to this/these allergies?_____

What treatment or medication does this child require for this/these allergies?
_____

Does this child have asthma that has been diagnosed by a physician? ☐ Yes ☐ No
If yes, what treatment and/or medication has been prescribed? _____
_____

Does this child have any medical condition other than listed above? ☐ Yes ☐ No
If yes, please explain. _____
_____

INJURIES, ILLNESSES, AND SURGERIES

Please list any severe injuries, illnesses and/or surgeries: _____
_____
_____

WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

ADDITIONAL INFORMATION

For Office Use Only: Please Return Form to Health Office

Is this child on daily medication? ☐ Yes ☐ No
If yes, please list._____

_____

Is this child on medication on a regular basis, but not daily? ☐ Yes ☐ No
If yes, please list. _____

_____

Do any family members have any long-term illness, such as diabetes, cancer, high blood pressure, etc.? ☐ Yes ☐ No If yes, please list the illness and the relationship of the person to this child. _____
_____

Do you have any other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? ☐ Yes ☐ No

If yes, please explain. _____

_____

Completed by: _____ Date: _____

Relationship to child: _____

Would you like a conference with the school nurse? ☐ Yes ☐ No

WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

School Health Services

Parent Retain for their Records

New York State Law, as well as local regulations, strictly outlines the rules that schools must follow concerning medication administered in school.

The overall guideline is that such dispensing of medication must be kept to a minimum; therefore, it is administered only with specific written physician's order and only when deemed necessary to be given during school hours.
Nurses are required to follow these regulations:

1. The nurse should administer medication only as necessary.
2. Instructions for administering medication must be in writing from the physician and include:
    a. The name of the student
    b. Medical condition of the student
    c. The name of the medication
    d. The medication dosage and time the medication is to be given
    e. A list of possible side effects
3. A Parent Permission form must be filled out by the parent/guardian.
4. Medication MUST be brought to the school by the parent/guardian. It may NOT be sent to the school with the student. All medication MUST be in a properly labeled original container.
5. New prescriptions and physician's orders are required at the beginning of each school year.
6. All unused medication must be picked up by the parent/guardian within 7 days after it is no longer needed or it will be disposed of.
7. All prescribed medications will be kept in a locked cabinet and dispensed only by authorized personnel.
8. If, at any time, the physician wishes to change the dosage, he/she must submit this request in writing.
    a. A verbal or telephone request/order from the physician or parent is not acceptable.
9. Special guidelines apply to field trips. Contact the school nurse for specific information.
10. The term "medications" is a broad one referring to both prescription and non-prescription (over-the-counter) drugs and treatments.

Student Records/Directory Information (FERPA Rights)
Annual Notification

The Board of Education recognizes the legal requirement to maintain the confidentiality of student records. The procedures for ensuring the confidentiality of student records shall be consistent with state and federal law, including the Family Educational Rights and Privacy Act of 1974 (FERPA) and its implementing regulations.

The Board also recognizes its responsibility to ensure the orderly retention and disposition of the district's student records in accordance with Schedule ED-1 as adopted by the Board in policy 1120.

The Superintendent of Schools shall be responsible for ensuring that all requirements under federal statutes and Commissioner's Regulations be carried out by the district.

Annual Notification
At the beginning of each school year, the district will publish a notification that informs parents, guardians and eligible students currently in attendance of their rights under FERPA and the procedures for exercising those rights. This notice may be published in a newspaper, handbook or other school bulletin or publication. This notice will also be provided to parents, guardians, and eligible students who enroll during the school year.

The notice will include a statement that the parent or eligible student has a right to:

1. inspect and review the student's education records;
2. request that records be amended to ensure that they are not inaccurate, misleading, or otherwise in violation of the students privacy or other rights;
3. consent to disclosure of personally identifiable information contained in the student's education records, except to the extent that FERPA authorizes disclosure without consent; and
4. file a complaint with the U.S. Department of Education alleging failure of the district to comply with FERPA and its regulations; and

In addition, the annual notice will inform parents/guardians and eligible students:

1. that it is the district's policy to disclose personally identifiable information from student records, without consent, to other school officials within the district whom the district has determined to have legitimate educational interests. For purposes of this policy, a school official is a person employed by the district as an administrator, supervisor, instructor, or support staff member (including health or medical staff and law

enforcement unit personnel; a member of the Board of Education; a person or company with whom the district has contracted to perform a special task such as an attorney, auditor, medical consultant, or therapist; or a parent or student serving on an official committee, such as a disciplinary or grievance committee, or assisting another school official performing his or her tasks). A school official has a legitimate educational interest if the official needs to review a student record in order to fulfill his/her professional responsibilities.

2. that, upon request, the district will disclose education records without consent to officials of another school district in which a student seeks or intends to enroll.
3. of the procedure for exercising the right to inspect, review and request amendment of student records.

The district shall arrange to provide translations of this notice to non-English speaking parent(s) or guardian(s) or eligible student(s) in their native language or dominant mode of communication.

BLACKBOARD MASS NOTIFICATION SYSTEM DIRECTIONS

Dear Parents and Guardians,

Welcome to Wappingers Central School District! Our District is committed to providing timely communication to all of our families and staff. Blackboard Connect allows our District to share information with parents and staff members on matters such as attendance, general interest activities, as well as building and District emergencies. In addition to allowing the District to communicate with traditional email, telephone and text messages, Blackboard Connect has a mobile app customized for our District.

New families will receive an email once they have registered their child with the District. You will receive an email from Blackboard with the Parent ID and a temporary password to log into the account. Simply follow the steps below to login to your account through the secure Blackboard Connect web site or by downloading the mobile app.

We invite all families to download the FREE District Blackboard app through the iTunes store or Google Play. Blackboard Connect allows you to control how the District contacts you.

Steps for updating your account from a computer:

Enter the following URL into your web browser: https://wappingersschools.parentlink.net/main/login

1. Enter the Parent ID and temporary password provided by the District in a separate email. The system does provide the possibility of logging into your account with your Facebook or Google account, if you choose. The first time you login, the system will prompt you to change your password. Passwords must be a minimum of six characters. Once you type in your new password, retype it to confirm, click on save.

[**Note**: Blackboard Connect has a strict privacy policy and does not sell or distribute your contact information to any 3rd party.]

2. Once you've logged into your account, you're ready to customize your contact preferences. Locate the **Account** tab located on the right-hand sign of the screen (in the black bar and click to open. The first tab (**Account Info**) allows you to update your first and last name, gender and select the language you would prefer to receive your emails. Under "Delivery addresses" you can add, remove or update email addresses or phone numbers by selecting Add. A dropdown box appears to select if you want to add a phone number, Text/SMS, email address, and mailing address. Make sure that you click **SAVE** when you are done making changes to customize how the District communicates to you, click on the **Delivery Preferences. Once opened you will see**

Emergency, Attendance, Balance, Survey and Other. For each type of contact you have entered (phone number, Text/SMS, email address, and mailing address) you can uncheck a box by clicking on the green icons to the right. If you place your mouse over each icon, the type of notification will appear. The contact choices in the order they appear are **push notification** (this would be to a mobile device), **text/SMS**, **phone** and **email address**). Once you select a notification type, any contact information you have added will appear. If you do not want a number called or email address used, simply uncheck the box. You must have at least one contact selected for each category.

Download the FREE mobile app in three easy steps.

1. On your smartphone go to the
    a. iTunes App Store (Click or go to: http://bit.ly/WCSDApp or
    b. Google Play (Click or go to: http://bit.ly/WCSDGoogleApp.
2. Search for Wappingers CSD
3. Then select our Wappingers app for free download
4. Once download, login using the parent ID and temporary password (unless you have already updated your password) sent via email from the District.
5. From an iPhone device, go to Settings and choose Follow Schools to customize which the notifications you want to receive. You can have notifications sent to your mobile device from the specific schools you choose and the District.
6. From an Android device, go to Settings and choose

School news in the palm of your hand, your new WCSD mobile app is just a few taps away. Download it today!

Thank you for staying connected to our District. We hope you enjoy Blackboard Connect!

DUTCHESS COUNTY DEPARTMENT OF BEHAVIORAL AND COMMUNITY HEALTH
PRESCHOOL SPECIAL EDUCATION
STUDENT TRANSPORTATION FORM

Children placed by the CPSE in special education preschools are eligible for transportation assistance, in the form of parent transportation reimbursement or bussing. Bussing will begin when the Dutchess County Department of Community and Behavioral Health (DCDCBH) has received written notification of approval from the school district **AND this form is returned to DCDCBH.**

Date form filled out _____

Child's Name_____ **School District**_____

Special Ed Preschool / Site _____

Days_____ **Time**_____

Date of Birth_____ **Start Date**_____

Please select your transportation choice (Parent Transportation **or** Bus Service) below:

PARENT TRANSPORTATION

Education law encourages parents to transport their own children and provides for parent reimbursement for these expenses, if necessary.

Parent transportation is the typical experience for a preschool child attending an early childhood program. It provides parents with regular opportunity to talk with the child's teachers and therapists.

[ ] I will transport my child to preschool
I am not requesting reimbursement.

[ ] I will transport my child to and from preschool.
[ ] Please send me information about reimbursement at the following address:

Name_____
Street_____
City/State/Zip_____
Phone_____

[ ] I will transport my child one-way. Please send me information on reimbursement.

_____
Parent signature & date

BUS SERVICE

For families unable to provide transportation to a school where the CPSE has placed the child, bus service is available. Bussing can be arranged from the child's home or childcare location, but the bus must pick up or drop off the child at the same location every day of the week that the child attends the program. **Child's Weight**_____

[ ] I am requesting bus transportation because:

_____
_____

Pick up location

Street_____
Town_____
Phone_____
Contact Person_____

SPECIAL BUSSING NEEDS? (wheelchair, medical conditions, etc.)

_____

Drop off (if different)

Street_____
Town_____
Phone_____
Contact Person_____

_____
Parent signature & date

PARENT CONTACT INFO

Home Phone#_____ Work Phone#_____

Cell Phone# _____ Other # _____

Return to: Preschool Special Education, Dutchess County Dept. of Behavioral and Community Health, 85 Civic Center Plaza- Suite 106, Poughkeepsie, NY 12601 or FAX to 845-486-3554 Attn: Preschool.