Oceanside Union Free School District

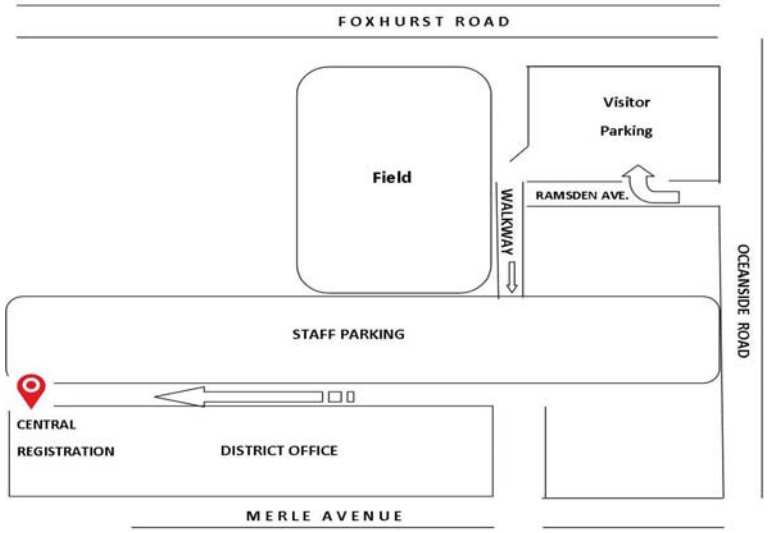
Registration of New Students

Students under the age of 17 will NOT be registered unless parent or legal guardian with a photo ID is present.

School age children who move into the district should be registered as soon as possible. Students who will be entering Kindergarten in the fall, may register after October 15 of the current year. All registrations are by appointment only. Our Registration Office is located at:

Oceanside District Office
145 Merle Avenue
Oceanside, NY 11572
516-678-6238

Please call for an appointment.



Registration will only occur if the following from columns A, B, C and D is provided. All items provided must be ORIGINAL and not photo copies.

(A) (B)

Proof of Residency

ANY <u>ONE</u> OF:

House Deed
Mortgage Statement
Notorized Lease
Residential Parental Affidavit and Residential Homeowner Affidavit

ANY <u>TWO</u> OF:

Pay stub
Income tax form
Utility or other bills
Membership documents (e.g., library cards) based upon residency
Voter registration document(s)
Official driver's license, learner's permit or non-driver identification
State or other government issued identification
Documents issued by federal, state or local agencies (e.g., local social service agency, Federal Office of Refugee Resettlement)
Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers

Residency may be subject to further verification and approval via sworn affidavit.

(C)

Birth

ANY ONE OF:

Birth Certificate
Baptismal Certificate

If these records are not available, the District shall consider one of the following:

Passport
Official driver's license
State or other government issued identification
School photo identification with date of birth
Consulate identification card
Hospital or health records
Military dependent identification card
Documents issued by federal, state or local agencies (e.g., local social service agency, Federal Office Of Refugee Resettlement)
Court orders or other court-issued documents
Native American tribal document
Records from non-profit international aid agencies and voluntary agencies

(D)

Immunizations

ANY ONE OF:

Certificate of Immunization signed by physician
Certificate of Immunization signed by an official of health clinic
District's Physical Examination Form signed by a physician.

After registering all children at the Registration Office, you will be given information about contacting the individual schools that your children will attend.

ALL INCOMING OCEANSIDE HIGH SCHOOL STUDENTS

THE FOLLOWING MUST BE COMPLETED BEFORE RECEIVING A SCHEDULE FOR ATTENDANCE

Call the Guidance department at the number listed below to obtain an appointment to meet with your child's guidance counselor. It is advised that both the parent and child attend this meeting.

If your last name is between A – K call 516-678-7537
If your last name is between L – Z call 516-678-7540

- ✓ You must provide the Guidance counselor with a copy of your child's latest transcript and/or report card from his/her previous school. A schedule **CANNOT** be created unless these vital documents are provided.

Sworn Affidavits

In the event that the deed or lease where you and your children reside is **NOT** is your name, **NOTORIZED** sworn affidavits are required. The following steps must be taken before making an appointment with our Assiatant Superintendent for Business, Mr. Christopher Van Cott. No Affidavits will be accepted at our Central Registration office without Mr. Van Cotts's approval.

- ☐ **Parental Affidavit** – This must be filled out and notorized by the student's parents
- ☐ **Homeowners Affidavit** – This must be filled out and notorized by the person whose name appears on the deed. Please note that if the lease for a rental is not in your name, the homeowner's affidavit MUST be completed by the Landlord or Management company **ONLY**. Notorized affidavits filled out by the buildings superintendent will **NOT** be accepted.

- ☐ **Schedule an appointment with:**

Mr. Christopher Van Cott
Assistant Superintendent for Business
145 Merle Avenue
Oceanside, New York 11572
516-678-1209

PLEASE CALL MR. VAN COTT
FOR AN APPOINTMENT - 678-1209

PARENTAL AFFIDAVIT

State of New York
County of Nassau

To: Oceanside School District

I, _____ swear that my child/children _____

_____ and I permanently reside at _____

at the home of _____

Is the tenant a relative of the homeowner? Yes_____ No_____

If yes, state the relationship_____.

I am signing this affidavit with full knowledge of the laws of perjury.

_____
Parent

Sworn to before me this _____
day of _____.

_____
Notary Public

IMPORTANT NOTICE

PENAL LAW SECTION 210.05: A person is guilty of perjury in the third degree when he swears falsely. Perjury in the third degree is a Class A misdemeanor. A Class A misdemeanor is punishable by up to six months in prison or a fine up to $1,000. All misdemeanor convictions carry a $60.00 surcharge in addition to any other penalty or fine imposed.

The District reserves the right to collect full tuition for false registration statements. This could include a lien on subject property.

PLEASE CALL MR. VAN COTT
FOR AN APPOINTMENT - 678-1209

HOMEOWNER AFFIDAVIT

State of New York
County of Nassau

To: Oceanside School District

I, _____ swear that _____

and her/his children_____, permanently
Names of Children

reside at _____.

Is the tenant a relative of the homeowner? Yes_____ No_____

If yes, state the relationship_____.

I am signing this affidavit with full knowledge of the laws of perjury.

_____
Homeowner

Sworn to before me this _____
day of _____.

_____
Notary Public

IMPORTANT NOTICE
PENAL LAW SECTION 210.05: A person is guilty of perjury in the third degree when he swears falsely. Perjury in the third degree is a Class A misdemeanor. A Class A misdemeanor is punishable by up to six months in prison or a fine up to $1,000. All misdemeanor convictions carry a $60.00 surcharge in addition to any other penalty or fine imposed.

The District reserves the right to collect full tuition for false registration statements. This could include a lien on subject property.

OCEANSIDE UNION FREE SCHOOL DISTRICT

REGISTRATION FORMS

The registration forms are broken down into two categories:

- ❑ **FAMILY – Pages 1 & 2 are filled out based on Household information.**

- ❑ **STUDENT – Pages 3, 4, 5 & 6 are filled out for <u>EACH</u> school age child In your household that you are registering.**

    - ❑ **HOME LANGUAGE QUESTIONNAIRE**
    - ❑ **McKINNEY-VENTO HOMELESS ASSISTANCE ACT**
    - ❑ **RECORDS RELEASE FORM**
    - ❑ **MEDICAL FORM**

When you arrive at the registration office you should have:

☑ **Original documentation for all proof of residency, birth and immunization.**

☑ **Forms filled out clearly and neatly.**

Thank you in advance for your cooperation.

OCEANSIDE UNION FREE SCHOOL DISTRICT

REGISTRATION INFORMATION

FAMILY

PLEASE PRINT INFORMATION CLEARLY

PARENT/GUARDIAN:

1	**Gender**	**2**	**Gender**
Name: _____	M F	Name: _____	M F
Address: _____		Address: _____	
_____		_____	
Home#: _____		Home#: _____	
Cell#: _____		Cell#: _____	
Work# _____		Work# _____	

CHILDREN IN FAMILY: ***List all children in the house including Pre-School***

Name: (Last, First, Middle)	Date of Birth	Gender	Grade	RELATIONSHIP TO GUARDIAN **1**	**2**

NON - HOUSEHOLD MEMBERS: (Emergency Contacts)

Name: (Last, First, Middle)	Gender	Home Phone	Cell Phone	Relationship

MOTHER:

NAME: (Last, First) **NAME IF REMARRIED: (Last, First)**

_____ _____

as it appears on the birth certificate

Language mother speaks:_____

(A)

E-Mail address: _____

(C)

FATHER:

NAME: (Last, First)

_____

as it appears on the birth certificate

Language father speaks:_____

(A)

E-Mail address: _____

(C)

STEP PARENT:

STEP MOTHER NAME: (Last, First) **STEP FATHER NAME: (Last, First)**

_____ _____

Language step parent speaks:_____

(A)

E-Mail address: _____

(C)

For Kindergarten Office Use:
Screening Date: _____
Screening Time: _____
Home School: _____
Circle one: Full Half
Currently attending #6 4yr old Pre-K? Yes No

For Secondary School Office Use:
Guidance Counselor:

_____
DOE into 9th Grade: _____
(if applicable)

For Office use:
Date: _____
Student Registered by:
_____
Grade: _____ School: _____

ID # _____

OCEANSIDE UNION FREE SCHOOL DISTRICT
Oceanside, New York

STUDENT REGISTRATION FORM

CHILD'S NAME:_____MALE_____ FEMALE_____
(Last) (First) (Middle)
Child's name must be recorded as it appears on the Birth Certificate or Baptismal record.

DATE OF BIRTH:_____ **PLACE OF BIRTH (State/Country)**:_____
IF CHILD WAS BORN OUTSIDE OF THE USA:
DATE OF ENTRY INTO USA: _____ INTO SCHOOL IN USA:_____ INTO AN OCEANSIDE SCHOOL:_____

CHILD's ETHNICITY: **Hispanic: YES**, Hispanic _____**NO**, not Hispanic_____
*Please check **ALL** that apply*
White_____ Black or African American_____ Native Hawaiian or other Pacific Islander_____
American Indian/Alaskan Native _____ Asian _____

LANGUAGE SPOKEN BY CHILD AT HOME: _____

DOES THIS STUDENT HAVE A PARENT NOT LIVING AT THE STUDENT'S ADDRESS? IF YES:

NAME: _____ MAILINGS _____Yes _____No

_____ _____
(Street) (City) (State) (Zip) (Telephone Number)

PARENTS' MARITAL STATUS: Married Separated Divorced If divorced or separated, any legal restrictions? YES NO (court papers must be provided)

1. Has your child ever been in Oceanside Schools before? When: _____ School #: ____ Re-entry Date _____
2. Has your child ever attended a public school in New York State? Yes_____ No _____
3. Have you or your child ever registered under a different name? Yes _____ No _____

   If yes, please indicate: NAME _____

   DATE_____ SCHOOL _____
4. Has your child ever been seen by the school psychologist? Yes ____ No _____
5. Has your child ever had an independent psychological evaluation? Yes ____ No ____
6. Has your child ever been reviewed by the Committee on Special Education (CSE) or the Committee on Preschool Special Education (CPSE) and/or received any special education service (e.g. special class, resource room, speech/language therapy, etc.)? Yes_____ No ____ **(B)**

   If yes, please explain_____
7. Has your child ever received remedial help in school other than what is indicated above? Yes____ No ___

   If yes, please explain _____

8. **PREVIOUS SCHOOLS ATTENDED**:

	FIRST SCHOOL	SECOND SCHOOL
NAME OF SCHOOL:	_____	_____
LOCATION:	_____	_____
TELEPHONE #:	_____	_____
DATES ATTENDED:	_____	_____
STARTING GRADE: / ENDING GRADE:	_____ / _____	____ / ____

	THIRD SCHOOL	FOURTH SCHOOL
NAME OF SCHOOL:	_____	_____
LOCATION:	_____	_____
TELEPHONE #:	_____	_____
DATES ATTENDED:	_____	_____
STARTING GRADE: / ENDING GRADE:	_____ / _____	____ / ____

IMPORTANT MEDICAL INFORMATION – This section MUST be completed

Name of Child's Doctor: _____ Phone Number: _____

Doctor's Address: _____ City: _____ State: ____ Zip: _____

DOES YOUR CHILD HAVE ANY:

Hearing Problems: YES_____ NO_____ Name of treating physician: _____

Vision Problems YES_____ NO_____ Name of treating physician: _____

Learning Problems: YES_____ NO_____ Name of service provider: _____

Speech Problems:YES_____ NO_____ Name of service provider: _____

Documented Allergies YES_____ NO _____ Please List any Allergies: _____

FOR OFFICE USE ONLY

Please check (_) that you have seen and taken copies of the following required paperwork:

PROOF OF AGE: (check one): Birth Certificate: _____ Baptismal Record:_____

PRIMARY PROOF OF RESIDENCE (TYPE): _____
Secondary #1 _____
Secondary #2 _____

Parent is requested to report back with additional information by: _____

Parent is requested to make an appointment with the Assistant Superintendent for Business: _____

Application is complete and child is placed into school #: _____ GRADE: _____

Name of School Official registering this student: _____

Initials of staff member receiving this form: _____

To be completed only by the SCHOOL NURSE from the required documentation:

Date of Immunization: _____ Date of Physical: _____

To be completed by District office only: LUNCH STATUS: _____

LEP/ESL Information: # of Years of service: _____
Releases obtained: _____Sent to: _____

AIS Services: GRADE: _____

PROGRAM SERVICES: _____

START DATE: _____ END DATE:_____ END REASON (CODE): _____

A _____ B _____ C _____ D _____

OCEANSIDE SCHOOL DISTRICT REGISTRATION FORM ATTACHMENT

ALL REGISTRANTS MUST FILL OUT PART A

Homeless Child:

(a) a child or youth who lacks a fixed, regular and adequate nighttime residence, including a child who is sharing the housing of other persons due to a loss of housing, economic hardship or similar reason; living in motels, hotels, trailer parks or camping grounds due to lack of alternative adequate accommodations; abandoned in hospitals; awaiting foster care placement or

(b) a child or youth who has a primary nighttime location that is a supervised, publicly or privately operated shelter designed to provide temporary living accommodations; or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings;

Unaccompanied Youth: a homeless child for whom no parent or person in parental relation is available or who is living in a residential facility for runaway or homeless youth.

Sect. 725 Definition
McKinney-Vento Homeless Assistance Act

PART A

Name _____Date_____

Is enrollment related to homelessness or loss of permanent housing? Yes_____No_____
Is enrollment related to status as unaccompanied youth? Yes_____No_____

(If you checked yes to either of the above, please fill out PART B)

PART B

Please indicate the living arrangements of the child or unaccompanied youth:

_____living in a shelter
_____living with relatives or others due to lack of housing
_____living in a abandoned apartment/building, in a hotel/motel, camping ground, car train/bus station, or similar situation due to lack of adequate housing
_____temporarily housed in a shelter awaiting an OCFS permanent foster care placement

Date and school of last attendance_____
Address before child became homeless_____
Are you requesting any services, such as transportation, from the district? Yes_____No_____
If yes, what services are you requesting? _____

_____

FOR OFFICE USE ONLY

Homeless Liason Signature_____Date_____
Family received STAC Form: Yes_____No_____

OCEANSIDE UNION FREE SCHOOL DISTRICT

RELEASE OF RECORDS AND INFORMATION

In accordance with the federal Family Educational Rights and Privacy Act ("FERPA"), it is the practice of the Oceanside Union Free School District ("District") to request and/or receive any and all education records, including disciplinary records, from the former schools of all students who transfer into the District.

The District reserves the right to consider a student's past disciplinary record when imposing discipline for misconduct committed in Oceanside.

With this understanding, please complete the subsequent release form.

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colon-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*	

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 QUALIFIED 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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

OCEANSIDE UNION FREE SCHOOL DISTRICT
CONSENT FOR RELEASE OF RECORDS AND INFORMATION

STUDENT'S NAME:_____ DOB:_____GRADE:_____
OCEANSIDE SCHOOL #:_____ADDRESS:_____PHONE:_____
FAX: _____

☐ **NEW STUDENT** ☐ **TRANSFERRING STUDENT**

NEW STUDENT FIRST DAY IN ATTENDANCE:_____

Previous Address:_____ New Address: _____
_____ _____

Previous School: _____
Address: _____
_____
Phone: _____

I _____authorize copies of all educational and health records be provided to Oceanside School District. Please include:

Attendance Records	Health Records	Psychological	Scholastic Grades	Speech/Language
Disciplinary Records	IEP	Related Service Reports	Social History	Standardized Testing

I also consent to having evaluations / records released to CSE/CPSE of the Oceanside School District. I understand that all records will be kept confidential and that access will be limited to school personnel who work with my child (i.e.: CSE/CPSE members, building principal, psychologist, social worker, regular or special education teachers and related service providers) and will not be given to any other agency / individual without my written consent. I also consent to having school and CSE/CPSE representatives who work with my child speak with the school / agency named above. I understand that consent is voluntary and can be reconsidered at any time by contacting the CSE/CPSE office in writing.

_____ _____ _____
Signature of Parent/Guardian **Relation to Student** **Date**

TRANSFERRING STUDENT LAST DAY IN ATTENDANCE:_____

Current Address: _____ New Address: _____
_____ _____

New School: _____
Address: _____
_____
Phone: _____

I _____authorize Oceanside School District to release all student records to the School / Agency listed above including:

Attendance Records	Health Records	Psychological	Scholastic Grades	Speech/Language
Disciplinary Records	IEP	Related Service Reports	Social History	Standardized Testing

I also consent to having school and CSE/CPSE representatives who work with my child (i.e.: CSE/CPSE members, building principal, psychologist, social worker, regular or special education teachers and related service providers) speak with the school / agency named above. I understand that my consent is voluntary and I may withdraw consent for future communications at any time by contacting the CSE/CPSE office in writing.

_____ _____ _____
Signature of Parent/Guardian **Relation to Student** **Date**

OCEANSIDE UNION FREE SCHOOL DISTRICT

145 Merle Avenue, Oceanside, New York 11572-2206

Phyllis S. Harrington, Ed.D.
Superintendent of Schools
Ph: 516-678-1215 Fax: 516-678-7503
pharrington@oceansideschools.org

Jill DeRosa, Ed.D.
Assistant Superintendent for Human Resources, Student Services and Community Activities
Ph: 516-678-1213 Fax: 516-678-2145
jderosa@oceansideschools.org

MEDICAL AND DENTAL EXAMINATION FORMS

Dear Parents/Guardians:

New York State Education Law requires that all students in public schools be examined by a health care provider upon entrance into school and in Kindergarten, 2nd, 4th, 7th and 10th grades. While the law does not specifically require an examination in other grades, we encourage annual physical examinations. Enclosed you will find a health appraisal form that may be used by your own physician, physician assistant, or nurse practitioner licensed to practice in New York State. Please return it along with a current immunization record.

Health examinations include height and weight measurement. These numbers are used to determine body mass index or "BMI." Recent changes to the New York State Education Law require that BMI and weight status group be included as part of the student's school health examination. A sample of school districts will be selected to take part in a survey by the New York State Department of Health. If our school is selected to be part of the survey, we will be reporting summary information to the New York State Department of Health about our students' weight status groups. Information about individual students and student names are not provided. However, you may still choose to have your child's information excluded from this survey report by written request to me or your child's school nurse by the last day in September.

Enclosed you will also find a dental form. Both the medical and dental forms should be returned to school as soon as possible. These forms are acceptable for the current school year if the examination date is no longer than 12 months prior to the 1st day of school in September.

Best wishes for a happy and healthy summer.

Sincerely,

Jill DeRosa, Ed. D.
Assistant Superintendent for Human Resources,
Student Services and Community Activities

Distribution: New students and all students entering Kindergarten, 2nd, 4th, 7th and 10th grades.

OCEANSIDE UNION FREE SCHOOL DISTRICT, 145 MERLE AVE., OCEANSIDE, NY 11572, P: 516-678-1200, F: 516-678-2145

HEALTH APPRAISAL FORM

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

School: _____ **Gender:** ❑ M ❑ F **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

❑ Immunization record attached

Elevated Lead ❑ Yes ❑ No ❑ Not done Date: _____

PPD ❑ Positive ❑ Negative ❑ Not done Date: _____

Sickle Cell Screen ❑ Positive ❑ Negative ❑ Not done Date: _____

Significant Medical/Surgical History: ❑ See attached _____

Specify current diseases: ❑ Asthma Diabetes: ❑ Type 1 ❑ Type 2 ❑ Hyperlipidemia ❑ Hypertension
❑ Other: _____

Allergies: ❑ **LIFE THREATENING** ❑ Food: _____ ❑ Insect: _____ ❑ Other: _____
❑ Seasonal ❑ Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

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

❑ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❑ Negative ❑ Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): ❑ None ❑ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ❑ Yes ❑ No Student may self carry and self administer medication ❑ Yes ❑ No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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

❑ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**

___ Limited contact: cheerleading, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.

___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

❑ **Specify medical accommodations needed for school**: _____ ❑ None

❑ **Known or suspected disability:** _____ ❑ Please monitor

❑ **Restrictions:** _____

(Provider's Stamp below)

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

NYSED requires an annual physical exam for new entrants and students entering Kindergarten, 2nd, 4th, 7th and 10th grades.

OCEANSIDE UNION FREE SCHOOL DISTRICT

145 Merle Avenue, Oceanside, New York 11572-2206

Phyllis S. Harrington, Ed.D.
Superintendent of Schools
Ph:516-678-1215 Fax: 516-678-7503
pharrington@oceansideschools.org

Jill DeRosa, Ed.D.
Assistant Superintendent for Human Resources, Student Services and Community Activities
Ph: 516-678-1213 Fax: 516-678-2145
jderosa@oceansideschools.org

DENTAL EXAMINATION FORM

Child's Name _____

School _____ Grade _____

Teacher's Name _____

Dental Examination Date _____

Comments _____

_____

Dentist Signature _____

Dentist Stamp

OCEANSIDE UNION FREE SCHOOL DISTRICT
145 Merle Avenue, Oceanside, New York 11572-2206

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Assistant Superintendent for Human Resources, Student Services and Community Activities
Ph: 516-678-1213 Fax: 516-678-2145
jderosa@oceansideschools.org

SCOLIOSIS EXAMINATION FORM

Dear Parents/Guardians:

In October, the Oceanside School District will begin its annual screening for scoliosis (curvature of the spine) for all students in grades 5 through 9. This is mandated by Section 136.3 of the State Education Law. The school nurse, physical education teacher or school physician, will conduct the screening. Screening will be conducted individually with assurance of privacy for each child. Boys will be required to undress to the waist. Girls should wear appropriate undergarments as tops must be removed. If scoliosis is suspected, you will be notified by the school nurse.

If you would prefer to have your child examined by your private health care provider, please have the health care provider complete the form below. Please note, however, that the law requires screening within the school year, which starts in September. Therefore, valid forms for the 2015/2016 school year will be dated September 1, 2015 and later.

Sincerely,

Jill DeRosa, Ed. D.
Assistant Superintendent for Human Resources,
Student Services and Community Activities

SCOLIOSIS EXAMINATION FORM

On _____, I examined _____
(Exam Date) (Student's Full Name)

For scoliosis and found:

_____ No evidence of scoliosis.
_____ Possible or minimal scoliosis requiring only observation at this time.
_____ Significant scoliosis, which I am treating.
_____ Significant scoliosis, which I am referring to: _____

_____
Provider's Signature

_____
Provider's Stamp

Distribution: All students entering 5th, 6th, 8th and 9th grades.
(The Health Appraisal Form should be used for students entering 7th and 10th grades.)

OCEANSIDE UNION FREE SCHOOL DISTRICT

Oceanside, N.Y. 11572

PRE-K & KINDERGARTEN INTAKE FORM

Child's Name: _____ Date of Birth: _____

Address: _____ Male ____ Female ____

_____ Home Phone: _____

Parent(s)/Guardian(s)--Please list below:

Mother's Name: _____

Mother's Occupation _____ Business/Cell No: _____

Father's Name: _____

Father's Occupation _____ Business/Cell No: _____

Guardian(s) Name(s) (if applicable): _____

Guardian's Occupation _____ Business/Cell No: _____

Current Marital Status of Parent(s)/Guardian(s)--Please Circle <u>One</u>: Married Single Parent

Not Married Widowed Divorced Separated Other_____

Names and Ages of Siblings, if any, please list:

_____ _____

_____ _____

_____ _____

Did your child attend a **4-year-old** pre-school/nursery/daycare program (please circle)? Yes No

If yes, name of school/program: _____

Address: _____ Phone No: _____

Number of days per week: _____ Number of hours per day: _____

Did your child attend a **3-year-old** pre-school/nursery/daycare program (please circle)? Yes No

If yes, name of school/program: _____

Address: _____ Phone No: _____

Number of days per week: _____ Number of hours per day: _____

Has your child been hospitalized at all since birth, or had any serious illnesses/injuries? Yes No

If yes, please explain, noting reason and date: _____

_____

_____

Does your child have any significant allergies (e.g., food allergies, seasonal allergies) that could affect his/her in-school performance? Yes No

If yes, please explain and note how your child reacts to the allergies: _____

_____

_____

Is your child under any medical treatment now, and is he/she taking any medication? Yes No

If yes, please explain and list current medications: _____

_____

_____

Does your child suffer from frequent colds or ear infections? Yes No

If yes, please explain: _____

Do you have any concerns about your child's vision? Yes No

If yes, please explain: _____

Has your child ever been seen by an eye doctor (e.g., optometrist, ophthalmologist)? Yes No

If yes, please provide doctor's name, and the results of the examination: _____

_____

Do you have any concerns about your child's hearing? Yes No

If yes, please explain: _____

Has your child's hearing ever been tested? Yes No

If yes, when? _____Where? _____

What were the results/recommendations? _____

_____

Has your child ever seen a dentist? Yes No

If yes, please state reason, date and results: _____

_____

Do you have any other significant health concerns about your child? Yes No

If yes, please explain: _____

_____

Does your child receive, or have a history of receiving services through

Early Intervention (EI) or the Committee on Preschool Special Education (CPSE)? Yes No

If yes, please explain/list: _____

_____

_____

Does a parent, sibling, or close relative receive, or have a history of receiving special education services? Yes No

If yes, please explain: _____

_____

Are there any languages, **other than English**, spoken in the home (including caretakers, grandparents, etc.)? Yes No

If yes, please indicate what language is spoken, and by whom (e.g., Spanish, Grandparents)?

_____

If your child speaks a language **other than English**, do you have any concerns about his/her speech and language development in that language? Yes No

If yes, please explain: _____

_____

Do you have any significant concerns about your child's ability to learn (e.g., pre-academic skills, thinking, problem-solving skills, following directions)? Yes No

If yes, please explain: _____

_____

Do you have any significant concerns about your child's speech and language development (e.g., talking or understanding)? Yes No

If yes, please explain: _____

_____

Do you have any significant concerns about your child's motor skills (e.g., coloring, cutting, drawing, walking, running, balancing)? Yes No

If yes, please explain: _____

_____

Do you have any significant concerns about your child's self-care skills (e.g., toileting, feeding, dressing)? Yes No

If yes, please explain: _____

_____

Do you have any significant concerns about your child's social-emotional skills (e.g., separation anxiety, ability to play/interact with others)? Yes No

If yes, please explain: _____

_____

Do you have any significant concerns about your child's activity level and/or attention span (e.g., excitable, impulsive, difficulty sitting still, inattentive, easily distracted)? Yes No

If yes, please explain: _____

_____

Is there any information about your family that you feel would be important to share with the school team? Yes No

If yes, please explain: _____

_____

Please note any additional concerns you have regarding your child, or any information you think would be helpful to know about your child as he/she gets ready to come to kindergarten:

_____

_____

I understand that all information provided will be treated confidentially

Name of Person Completing Form: _____

Relationship to Child: _____

Signature: _____ Date: _____

Revised 10/12