

**VOORHEESVILLE ELEMENTARY SCHOOL  
129 MAPLE AVENUE  
VOORHEESVILLE, NEW YORK 12186**

PHONE: (518) 765-2382  
FAX: (518) 765-3842  
WEB ADDRESS: Voorheesville.org

**MR. JEFFREY P. VIVENZIO**  
Principal

Dear Parent or Guardian:

Welcome to the Voorheesville Central School District! Please take some time and carefully complete, in detail, each of the following documents. Along with a completed registration packet, the following documentation is also required in order to enroll your child within the Voorheesville Central School District.

- Your child's **original** birth certificate.
- Your child's official immunization record (signed and stamped by physician or clinic staff).
- A physical examination record (signed and stamped by physician or clinic staff).
- Custody papers, if applicable. (If the student is not your biological child, you must present documentation that proves a permanent and total transfer of custody and control has been achieved.)
- Three (3) **original** proofs of residency within the school district. This information **must** include the name and address of a parent or guardian as well as be dated within the previous 30 days. This **must** include:
  - A deed or other documentation of real property ownership.
  - A lease or rental agreement.Examples of two other proofs of residency:
  - A utility bill in the parent's name showing the address within the district.
  - The address on the parent's driver's license.
  - A record of the parent's voter registration.
  - A recent income tax return showing the parent's name and address within the district.
  - A current paycheck stub showing the parent's name and address within the district.

**Important note regarding students entering Kindergarten:** Each May, VCSD conducts Kindergarten Registration Screening. Please check the [school calendar](#) for upcoming dates or contact the registration office at (518)-765-2382 Ext. 504.

If you have any questions while completing the registration application, please do not hesitate to contact me at school.

Sincerely,

Mr. Jeffrey P. Vivenzio  
Principal/District Registrar



## NOTICE TO PARENTS

### SPECIAL EDUCATION SERVICES

If you suspect that your child may have a disability and due to that disability may require special education supports, services or accommodations, you have the right to contact the District for information on options, and/or you may refer your child to the District's Committee on Special Education or Section 504 Team for an evaluation, and a determination as to whether your child is eligible to receive special education services, related services, accommodations and/or other program aids and services. More information regarding your rights is set forth in the New York State Education Department's *Parents Guide to Special Education in New York State for Children Ages 3-21*, available at <https://www.p12.nysed.gov/specialed/publications/policy/parentsguide.pdf>

To refer your child to the Committee on Special Education, or to obtain more information regarding the District's special education process, including services and programs, please contact:

Karen Jones  
Pupil Personnel Services Director  
Voorheesville Central School District  
PO Box 468  
129 Maple Avenue  
Voorheesville, NY 12186  
Phone: 518-765-2382, ext. 501  
Email: [kjones@voorheesville.org](mailto:kjones@voorheesville.org)

VOORHEESVILLE CENTRAL SCHOOL DISTRICT  
HOUSEHOLD INFORMATION

**CPSE ONLY**  
St. Id#  
Date  
Area of Concern

Is the child in permanent housing?  In permanent housing

If the child is not in permanent housing; please indicate his/her current living situation:

- In a shelter  In a hotel/motel  With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled up")  In a car, park, bus or train station, or campsite  
 Other temporary living situation (Including situations for seasonal employment) Describe: \_\_\_\_\_  
 Temporarily housed in a shelter awaiting foster care placement

Student Name: \_\_\_\_\_ (Male Female Non-Binary) DOB: \_\_\_\_\_ Grade Entering: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City/Zip Code: \_\_\_\_\_ IS THIS A CELL NUMBER? YES NO

Mailing address (if applicable) \_\_\_\_\_

Own \_\_\_ Rent \_\_\_ Lease \_\_\_ Other/Please explain: \_\_\_\_\_

Have you ever attended VCSD before? Yes or No

**Parents/Guardians**

Name and relationship to student:

1. \_\_\_\_\_ relationship: \_\_\_\_\_ occupation/employer: \_\_\_\_\_  
2. \_\_\_\_\_ relationship: \_\_\_\_\_ occupation/employer: \_\_\_\_\_

Parent/Guardian(s) in active Military status: Yes \_\_\_ No \_\_\_

If parent/guardians are separated, what legal arrangements are in place:

Joint Custody Sole Custody Visitation Rights Foster Students

If applicable, name and contact information of parent **NOT** residing with child:

\_\_\_\_\_  
Phone: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_

Duplicate mailings requested: Yes No

**NOTE: A complete certified copy of the court custody decision bearing its case number and including the official stamp and signature are required.**

**Contact Information:** Please list, in order, contact information for people (and their relationship to the child) to be notified should your child become ill. (Parents/Guardians should be first, followed by people to contact if parents aren't available.) Please list what type of phone the number is, for example: C=cell, H=home, W=work.

- 1) \_\_\_\_\_ Relationship \_\_\_\_\_ #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
2) \_\_\_\_\_ Relationship \_\_\_\_\_ #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
3) \_\_\_\_\_ Relationship \_\_\_\_\_ #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

**Children being registered and name of last school attended:**

- 1) \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_  
2) \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_  
3) \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

**Other children in household:** Please list all children living in the household (not of school age or beyond school age)

- 1) \_\_\_\_\_ DOB: \_\_\_\_\_  
2) \_\_\_\_\_ DOB: \_\_\_\_\_  
3) \_\_\_\_\_ DOB: \_\_\_\_\_  
4) \_\_\_\_\_ DOB: \_\_\_\_\_

**E-mail address:** Please list any e-mail addresses that we may use to contact you:

Name: \_\_\_\_\_ e-mail address: \_\_\_\_\_

Name: \_\_\_\_\_ e-mail address: \_\_\_\_\_

Name: \_\_\_\_\_ e-mail address: \_\_\_\_\_

I understand that if I provide false information on the registration forms and/or on the supporting materials that I may be committing the crime of perjury in the third degree (a class A misdemeanor); If I provided false information on these forms to the Voorheesville Central School District with the intent to defraud the District, I may be committing the crime of perjury in the second degree (a class E Felony); and I may be prosecuted on the criminal charges for such false information.

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**If any of the above information changes, please be sure to contact the school as soon as possible to provide updated information.**

AFFIDAVIT OF RESIDENCY  
Voorheesville Central School District

State of New York

County of \_\_\_\_\_

\_\_\_\_\_ being duly sworn, deposes and says:  
(Name of Parent)

1. I reside at \_\_\_\_\_  
(Legal Residence of Parent)

Telephone Number \_\_\_\_\_

2. \_\_\_\_\_ is/are my \_\_\_\_\_  
(Name of Child/Children) (Relationship)

and he/she has been living with me at the above address since \_\_\_\_\_  
(Relevant Date)

3. If your child's/children's other parent does not reside at the same location, then provide the following information:

\_\_\_\_\_  
(Other Parent's Name) (Address) (Phone Number)

4. I make this affidavit for the purpose of establishing residency within the Voorheesville Central School District.

Complete Either 5A or 5B

5A. In support of the above, as a homeowner I have attached the most recent copy of at least three of the following proofs of residency. Place a check in front of each item attached.

- |                            |                     |                              |
|----------------------------|---------------------|------------------------------|
| ____ Property tax bill     | ____ Telephone bill | ____ Water tax bill          |
| ____ Electric bill         | ____ Bank Statement | ____ Voter Registration Card |
| ____ Other (specify) _____ |                     |                              |

5B. In support of the above, as a renter, I have attached the original and current lease including the landlord's name, address, and telephone number and most recent copy of at least two of the following proofs of my residency. Place a check mark in front of each item attached.

- \_\_\_\_ National Grid bill with current name and address
- \_\_\_\_ License and car registration with current name and address
- \_\_\_\_ Paycheck with current name and address
- \_\_\_\_ Certificate of occupancy issued by town/village
- \_\_\_\_ Automobile insurance policy with current name and address
- \_\_\_\_ Bank/Credit Union account statement with current name and address
- \_\_\_\_ Voter registration card with current name and address

6. If you are a renter, complete the following: Landlord's name \_\_\_\_\_  
Landlord's phone number \_\_\_\_\_

Sworn to before me this \_\_\_\_\_  
(Signature of Resident Adult)

Day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
(Notary Public)

*Anyone providing false information on this affidavit of residency is subject to criminal charge.*

**Jeffrey Vivenzio**  
Principal/District Registrar  
(518) 765-2382, Ext. 504



## Information Packet

Print Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Please sign and date below that you have reviewed the following items together.

1. **Code of Conduct** ([Voorheesville.org/about-us/policies-and-procedures/](http://Voorheesville.org/about-us/policies-and-procedures/))

\_\_\_\_\_  
Print Parent's/Guardian's Name      Parent's/Guardian's Signature      Date

\_\_\_\_\_  
Print Student's Name      Student's Signature      Date

2. **Computer Network Policy found here:**  
<https://www.voorheesville.org/departments/technology/>

\_\_\_\_\_  
Print Parent's/Guardian's Name      Parent's Guardian's Signature      Date

\_\_\_\_\_  
Print Student's Name      Student's Signature      Date

Please complete and return the following items if applicable:

1. Family Application for Free and Reduced Price School Meals  
[Voorheesville.org/departments/food-services/](http://Voorheesville.org/departments/food-services/)

## VOORHEESVILLE CENTRAL SCHOOL REQUEST FOR TRANSPORTATION

Student Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_ Grade \_\_\_\_\_

Mailing Address if Different than Residential Address:

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

Date of Birth \_\_/\_\_/\_\_

Male Female  
non-Binary

Are there siblings currently in school? Yes/ No

Full Name of Parent/ Guardians	Relationship to Student	Home Phone	Work Phone	Cell Phone	Email Address
1)					
2)					

Resides With:  Both Parents  Father  Mother  Other :

Emergency Contacts	Relationship to Student	Home Phone	Work Phone	Cell Phone	Email Address
1)					
2)					

*Special Pick Up Point or Drop Off Point **IF** different from Home Address:*

**PICK UP POINT** Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

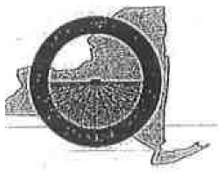
**DROP OFF POINT** Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Is there anything that the Transportation Department needs to be made aware of? (such as allergies, motion sickness, etc.)

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

\*\*Transportation Use Only\*\*

Siblings Y / N	Data Entered Y/N	Geocoded Y/N	Routed Y/N
----------------	------------------	--------------	------------



**NEW YORK STATE MIGRANT EDUCATION PROGRAM  
IDENTIFICATION & RECRUITMENT OFFICE  
PARENT SURVEY**

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, regardless of their nationality or legal status. This program is free of charge to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

*Please take a few minutes to complete this questionnaire.*

**Has anyone in your family worked, or looked for work at the following occupations during the past 3 years?**

- Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- Work related to logging, harvesting, or initial processing of trees.
- Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



*If you answer YES, please provide your contact information below:*

Parent/Guardian Name: \_\_\_\_\_

Home address: \_\_\_\_\_

Telephone number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Best time to be reached: \_\_\_\_\_ AM/PM

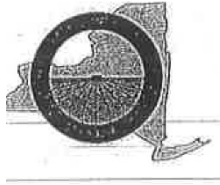
Previous Address: \_\_\_\_\_

Student name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Student name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

To submit this referral please fax to 607-436-3606, or by mail to  
NYS Migrant Education Program Identification and Recruitment Office:  
100 Saratoga Village Blvd, Suite 41,  
Ballston Spa, NY 12020.





# NEWYORK STATE MIGRANT EDUCATION PROGRAM OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Acta de Educación Elemental y Secundaria (ESEA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, sin importar su nacionalidad o estado legal. Este programa es gratuito para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito en la escuela, excursiones, programa de verano, actividades de involucramiento para padres, programa de emergencias y referidos a otras organizaciones o agencias.

**Por favor tome unos minutos para completar este cuestionario.**

**¿Usted o algún miembro de su familia ha trabajado o buscado trabajo en algunas de las siguientes ocupaciones en los pasados 3 años?**

- Cualquier trabajo agrícola (como plantando, seleccionando, o cosechando frutas o vegetales, cultivando o cortando flores o árboles, trabajo en lechería u otro rancho de animales, pescando, etc.)
- Trabajando en la cultivación o procesamiento de los árboles.
- Trabajando en una planta de procesamiento, empacando, lavando o cortando vegetales, frutas o carnes.

**Si usted contestó que sí, por favor complete la siguiente información:**



Nombre del Padre/Encargado: \_\_\_\_\_

Dirección Física: \_\_\_\_\_

Teléfono: \_\_\_\_\_ Mejor tiempo para ser contactado: \_\_\_\_\_ AM/PM

Dirección anterior: \_\_\_\_\_

Nombre del estudiante: \_\_\_\_\_ Edad \_\_\_\_ Grado \_\_\_\_

Nombre del estudiante: \_\_\_\_\_ Edad \_\_\_\_ Grado \_\_\_\_

Para someter este referido, por favor envíelo por fax a 607-436-3606, o por correo a  
NYS Migrant Education Program- Identification & Recruitment Office  
100 Saratoga Village Blvd,  
Suite 41,  
Ballston Spa, NY 12020



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

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

HOME LANGUAGE CODE

### Language Background

*(Please check all that apply.)*

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

**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*

Relationship student:  Parent  Other: \_\_\_\_\_

**OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ**

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_

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

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

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_

ORAL INTERVIEW NECESSARY:  Yes  No

\*\*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:

# VOORHEESVILLE CENTRAL SCHOOL DISTRICT

VOORHEESVILLE, NEW YORK 12186

**MR. FRANK MACRI**  
Superintendent of Schools

**DISTRICT OFFICE**

JAMES SOUTHARD  
**ASSISTANT SUPERINTENDENT FOR FINANCE &  
OPERATIONS**

CHRISTY RIVENBURG **TREASURER**  
JESSICA TABAKIAN  
**CLERK**

**PHONE:** (518) 765-3313

**FAX:** (518) 765-2751

To All Parents / Guardians:

The Voorheesville Central School District has adopted a policy which requires the collection and recording of the ethnic identity of students in the Voorheesville Central School District in accordance with the federal categories and definitions. The information will be used to:

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

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the back of this page. Put a check ( ✓ ) in the box for the category or categories which best describes your child. The Voorheesville Central School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the students appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

## CONFIDENTIALITY PROCEDURES AND REGULATIONS

**To School Staff:** This form will be filed in the student's permanent record as confidential information.

**To the Parent/Guardian:** The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below:

**The Family Education Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student's name or student identification number.**

PLEASE COMPLETE THE FORM ON THE REVERSE SIDE OF THIS PAGE.

# VOORHEESVILLE CENTRAL SCHOOL DISTRICT

## STUDENT RACIAL AND ETHNIC IDENTIFICATION

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Name of School
----------------

School District Student Identification Number:	Date of Birth (Month/Day/Year)
------------------------------------------------	--------------------------------

Student Name: Last First, Middle:	Grade Level:
-----------------------------------	--------------

### DIRECTIONS TO PARENT/ GUARDIAN

PLEASE ANSWER QUESTIONS (1) AND (2). PLEASE READ THEM BEFORE YOU RESPOND. (For question (1), check the box that best described your child). Check only ONE box.

1. <b>Is the student Hispanic, Latino, or of Spanish origin?</b> Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race. <input type="checkbox"/> YES, Hispanic <input type="checkbox"/> NO, not Hispanic
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

2. Select one or more races from the following five racial groups (Check all groups that apply to your child; check at least ONE box). <input type="checkbox"/> <b>AMERICAN INDIAN OR ALASKA NATIVE:</b> A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. <input type="checkbox"/> <b>ASIAN:</b> A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. <input type="checkbox"/> <b>NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:</b> A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. <input type="checkbox"/> <b>BLACK OR AFRICAN AMERICAN:</b> A person having origins in any of the Black racial groups of Africa. <input type="checkbox"/> <b>WHITE:</b> A person having origins in any or the original peoples of Europe, North Africa, or the Middle East.
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

---

Signature of Parent/ Guardian/ Other	Date
--------------------------------------	------

Relationship to Student (Please check one box below)

<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Guardian	<input type="checkbox"/> Other (Specify): _____
---------------------------------	---------------------------------	-----------------------------------	-------------------------------------------------

**See reverse for important message to Parents / Guardians and Confidentiality Procedures and Regulations**

**VOORHEESVILLE CENTRAL SCHOOL DISTRICT**  
www.voorheesville.org

**Jeffrey Vivenzio**  
Principal/District Registrar  
(518) 765- 2382, Ext.502



Dear Parents/Guardians:

There are many instances throughout the school year where there are opportunities for photographs for school events. Pictures may be taken to document classroom projects, field trips, club activities or similar events. At times we may use these photos for educational purposes or publicity to highlight the many wonderful things that go on in our school. In most cases, students will be unidentified or only identified using first names and last initials. Students who are recognized for outstanding achievement, service or awards may be identified by their full names.

**If for any reason you do not want your child's photograph used, please return the form below. Feel free to call me with any questions.**

---

I DO NOT wish to have my child's photograph used for publicity or other educational purposes.

Student Name: \_\_\_\_\_

Grade and Teacher: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# **VOORHEESVILLE CENTRAL SCHOOL DISTRICT**

## School Health Services

Dear Parent or Guardian:

As a part of your child's requirements for school, NYSED requires an annual New York State physical exam for students in grades K,1,3, and 5 as well as those entering the school district for the first time. A law was recently enacted that expands health screenings to include the dental health of students in New York State.

In addition, when we require that your child have a physical examination, we will be requesting a dental certificate as well. There is a sample certificate available for you to take to your child's dentist and once it is completed, it should be returned to the School Nurse as it will be filed in our child's Cumulative Health Record.

Thank you for your cooperation in this new health endeavor. Our students benefit when we work together to promote the health and achievement of all students.

Please call the school's Health Office if you have any questions or concerns.

Middle/High School Health Office (518) 765-3314 ext 210

Elementary School (518) 765-2382 ext 506

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM  
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR  
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

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

**STUDENT INFORMATION**

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

**HEALTH HISTORY**

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

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

BMI \_\_\_\_\_ kg/m<sup>2</sup>

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

**Hyperlipidemia:**  Yes  Not Done      **Hypertension:**  Yes  Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Lead Level</b> Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g}/\text{dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

**System Review Within Normal Limits**

**Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid	



Name:		Affirmed Name (if applicable):		DOB:	
<b>SCREENINGS</b>					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
<b>Vision</b>	<b>With Correction</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
Notes					
<b>Hearing</b> Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					<b>Not Done</b>
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
<b>FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>*Family cardiac history reviewed</b> – required for Dominic Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b>					
<b>If Restrictions Apply</b> – Complete the information below					
<input type="checkbox"/> <b>Student is restricted from participation in:</b>					
<input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> <b>Other Restrictions:</b>					
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level.					
<b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> <b>Other Accommodations*:</b> (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
<b>MEDICATIONS</b>					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
<b>COMMUNICABLE DISEASE</b>			<b>IMMUNIZATIONS</b>		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
<b>HEALTHCARE PROVIDER</b>					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form to Your Child's School Health Office When Completed.</b>					

# VOORHEESVILLE CENTRAL SCHOOL DISTRICT

## Dental Health Certificate

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

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

Child's Name: Last First Middle

Birth Date:     /     /                      Sex:  Male  
Month    Day    Year                       Female

Will this be your child's first oral health assessment?     Yes     No

School: \_\_\_\_\_ Grade \_\_\_\_\_

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

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

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

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

### Section 2. To be completed by the Dentist/ Dental Hygienist

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

- Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.
- No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means, that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

**Dentist's/ Dental Hygienist's name and address**

(please print or stamp)

**Dentist's/Dental Hygienist's Signature**

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

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

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

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

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

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

VOORHEESVILLE ELEMENTARY SCHOOL  
EMERGENCY HEALTH INFORMATION

Name of Student \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_  
(Last) (First)

Home Address \_\_\_\_\_  
\_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_ Home Phone \_\_\_\_\_

\*Parent/Guardian \_\_\_\_\_ Located at \_\_\_\_\_  
(During school hours) (Phone number)

\*Parent/Guardian \_\_\_\_\_ Located at \_\_\_\_\_  
(During school hours) (Phone number)

\*Step-Parent \_\_\_\_\_ Located \_\_\_\_\_  
or Guardian (During school hours) (Phone number)

\*Please put a priority as to who you would like called first.

In the event of early dismissal, illness or injury, if parents/guardians cannot be reached, contact the following for care/transportation:

**NOTE: PLEASE ADVISE THESE INDIVIDUALS YOU ARE LISTING THEM FOR EMERGENCY CARE IN CASE THE SCHOOL IS UNABLE TO REACH YOU.**

1. \_\_\_\_\_ at \_\_\_\_\_  
(Phone Number)

Or \_\_\_\_\_ at \_\_\_\_\_  
(Phone Number)

1. Child's Physician \_\_\_\_\_ at \_\_\_\_\_

2. Family Dentist \_\_\_\_\_ at \_\_\_\_\_

3. Hospital \_\_\_\_\_ (in event of serious injury)

4. Has your child had medical, dental or surgical treatment, or any other serious illness or injury?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*OVER\***

Has your child ever had any of the following? Please give dates

Anemia	Pneumonia	Chicken Pox
Rheumatic Fever	Diabetes	Rheumatic Fever
Tuberculosis	Mumps	Epilepsy
Nephritis	Contact with TB	Heart Disease
Bladder Infection	Whooping Cough	Orthopedic Injuries

1. Does your child have asthma and if so what makes him/her wheeze or get short of breath? \_\_\_\_\_  
\_\_\_\_\_
2. Please list any medication your child takes \_\_\_\_\_  
\_\_\_\_\_
3. Please list any allergies your child has and the medication (if any) they are taking  
\_\_\_\_\_  
\_\_\_\_\_
4. Does your child have or has had a history of chest pain with exertion? Please explain \_\_\_\_\_  
\_\_\_\_\_
5. Does your child have a history of fainting with exertion? Please explain  
\_\_\_\_\_  
\_\_\_\_\_
6. Does your child have a history of shortness of breath with exertion? Please explain \_\_\_\_\_  
\_\_\_\_\_
7. Does your child have a family history related to cardiac cause? Please explain  
\_\_\_\_\_  
\_\_\_\_\_
8. Does your child have chronic/frequent ear infections? \_\_\_\_
  - a. If so, does your child have tubes in their ears? \_\_\_\_\_
9. Any problems with toilet training for bladder or bowels? \_\_\_\_\_
10. Does your child wear glasses? If so, all the time or for classwork? \_\_\_\_\_
11. Is there anything concerning the health of your child which the school should know so that we may better understand your child's health needs?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## VOORHEESVILLE CENTRAL SCHOOL DISTRICT

New York State Education Law requires that every child have a physical examination upon entering the school district for the first time, as well as in grades 2 and 4. The school offers school physicals for students in grades 2, 4, 7 and 10. However, if you wish to have your child examined by your own physician (or pediatrician), who may know your child best, you are free to do so. If you choose an exam by your private physician he/she must fill out the attached form to be returned to school. A recent medical exam, completed within the past 12 months, is acceptable. In this case, you may mail the form to your doctor requesting them to complete it and return it to school.

The school physician does not diagnosis medical problems. These will be reported to you immediately and you will be advised to bring them to the attention of your family doctor. We will request a report of your physician's findings and treatments.

Please check the appropriate statement below and return this form to school as soon as possible. If we do not receive a response from you, we will make arrangements to have your child examined by the school physician.

## VOORHEESVILLE CENTRAL SCHOOL DISTRICT

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

I prefer to have my child examined by the school physician, Dr. Silverman.

I prefer to have my child examined by our private physician. Private physician's appointment date is \_\_\_\_\_. (Bring the attached form to this appointment and have the physician fill it out and return it to school.)

My child was examined by Dr. \_\_\_\_\_ on \_\_\_\_\_.  
I will have the physician fill out the form and return it to school.

\_\_\_\_\_  
Parent's Signature