NORTH COLLINS
CENTRAL SCHOOL DISTRICT
P.O. Box 740, North Collins, NY 14111

Dear Parent/Guardian:

Welcome to the North Collins Central School District! We are incredibly proud of our school community and pleased that you have chosen to register your child(ren) with us. Once you have completed the attached registration forms, they can be dropped off at the Elementary School Office. We will also need the following documents:

- Student's Birth or Baptismal certificate-NYS requirement
- Proof of Identity for Parent/Guardian – Valid NYS Driver's license preferred
- **Two** acceptable proofs of residency:
  - Signed contract for home purchase
  - Current mortgage statement, deed, or signed lease agreement
  - current rent receipt with landlord signature
  - current utility bill specific to the new address
  - unaltered, valid NYS driver's license or vehicle registration
  - bank statement
  - US Post Office form documenting change of address
- Court documentation (if applicable):
  - guardianship/divorce decree/custody papers
- Foster Child DSS-2999 (if applicable)
- Completed Health Appraisal (completed by Health Care Provider)including updated immunization record

Please feel free to contact Mrs. Buell, Elementary School Principal, at 716-337-0166 with any questions. We look forward to meeting you.

Sincerely,

Kerry Buell

Kerry Buell
Principal

NORTH COLLINS
CENTRAL SCHOOL DISTRICT

P.O. Box 740, North Collins, NY 14111

TO: (Current School Name) _____

(School's Fax #) _____

Student's Name: _____

Student's DOB: _____

****

The student above has recently enrolled at North Collins Elementary School. I give permission for the following transcripts to be forwarded to NCES:

- ☐ **Scholastic records**
- ☐ **Health records**
- ☐ **Birth certificate**
- ☐ **Psychological reports**
- ☐ **Special Education Information**
- ☐ **Free/reduced lunch information**

TRANSCRIPTS CAN BE SENT VIA

- **Fax #:** 716-337-0598
- **Mail:** North Collins Elementary School
  10469 Bantle Road
  PO Box 740
  North Collins, NY 14111

_____
Parent/Guardian signature

_____
Date

NORTH COLLINS ELEMENTARY SCHOOL

10469 Bantle Road North Collins, NY 14111
Phone: 716-337-0166 Fax: 716-337-0598

Cumulative Questionnaire

FOR OFFICE USE ONLY (4/12)

Date Entered: _____ ☐ Nw Entry ☐ Birth Verification (Type and #): ☐ Re-Entry

Student #: _____

Grade Level: _____ Hmrm: _____

☐ Immunizations ☐ Proof of Residency ☐ Release Sent ☐ Records Received

STUDENT REGISTRANT INFORMATION (complete all questions.)

Student Name _____ **Gender** male / female ☐ ☐
Last First Middle

Home Phone/Cell # _____

Birth Date _____ **Age** _____ **Grade Entering** _____

Street Address _____
Street Number PO Box # Town State Zip Code

ETHNICITY ***New York State requires the following information*:**

Is the student Hispanic, Latino or of Spanish origin? You must select one: ☐ Yes ☐ No

Also, check ALL of the following that apply. You must check at least one:

American Indian or Alaskan Native ___ Asian _____

Native Hawaiian or Pacific Islander _____ Black _____ White _____

Has your child been receiving Special Education services? ☐ Yes (please specify) ☐ No

☐ IEP ☐ 504 Plan ☐ Adaptive Physical Education

☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy

Is your child receiving remedial or AIS help in: ☐ Reading ☐ Math

Other Schools Attended 1. _____ When _____

2. _____ When _____

Has your child attended North Collins Central School before? ☐ Yes ☐ No

If yes, what grade(s)? _____

FAMILY INFORMATION

Resides with ☐ Both Parents ☐ Mother Only ☐ Father only ☐ Step-Parent ☐ Guardian ☐ Foster Parent DSS Form ____

(A court order must be present in the file before a parent can be denied access to his/her child.)

Note: List mother and father as separate contacts

Parent/Guardian #1 (Person the student resides with): Relationship to student _____

Mailing Salutation (example Mr. and Mrs.) _____

First Name _____ Last Name _____

Primary Contact Phone _____ Secondary Phone _____

E-Mail _____ Occupation _____

Parent/Guardian #2: Relationship to student _____

Mailing Salutation (example Mr. and Mrs.) _____

First Name _____ Last Name _____

Primary Contact Phone _____ Work Phone _____

E-Mail _____ Occupation _____

Resides with Student? Yes No (If No, complete Mailing Address below)

Mailing Address _____

Street Number PO Box # Town State Zip Code

List all children ages 0 to 18 years (up to 21 years if disabled) living in your household. *Do NOT list the child you are registering.*

CHILD'S NAME	M/F	DOB	GRADE LEVEL

HOUSING INFORMATION

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the Student currently living? (*Please check one box.* Your response helps the District determine if the student is eligible to receive additional services.)

- ☐ In permanent housing (Own/Rent)
- ☐ Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason
- ☐ Living in a motel, hotel, trailer park, or camping ground
- ☐ Living in an emergency or transitional shelter awaiting DSS placement
- ☐ Living in a car, park, bus or train station
- ☐ Living in an abandoned building or similar substandard housing
- ☐ Other, please specify: _____

PARENT/GUARDIAN: Please read the next page and verify the information on this form.

EMERGENCY CONTACT INFORMATION

In the event of an emergency or illness, I give my permission to release my child to any of the contacts listed below.

Name _____ Name _____

Relationship to Child _____ Relationship to Child _____

Phone _____ Cell/Work _____ Phone _____ Cell/Work _____

Address_____ Address_____

_____ _____

Town, State Zip Code Town, State Zip Code

NOTICE

Please be advised that any false information on this registration form could constitute a crime. In addition, the District reserves its right to recover from parents, legal guardian or other responsible parties the entire actual cost of educating a student, plus related costs, for the entire period that any non-resident student is enrolled in the District's schools without authorization and/or under false pretenses.

CHANGE OF ADDRESS

Please be advised that if there is ANY residential change, which exceeds 48 hours, the school district must be informed immediately of any and all changes. Non-compliance may jeopardize continued enrollment.

CERTIFICATION

I hereby certify that the student listed on this registration form actually resides at the address specified on page 1, within the North Collins Central School District boundaries. I further certify that all the information I provided on this registration form is true and correct. I understand that I must immediately notify the District if the residency of the student changes from the address listed on this registration form.

AUTHORIZATION

I authorize the request of student records from previous schools and give permission to the North Collins Central School District to verify telephone numbers, addresses and employment. I understand that if the District believes that the information on this form is no longer correct or that the child being registered no longer lives at the address provided by you, the North Collins Central School District has the right under New York State Law to investigate and to withdraw the child from the North Collins Central School District.

APPLICATION SIGNATURE

I have read and understand all of the information contained in this form.

Person completing this form (Please print) _____

Signature _____ **Date** _____

Relationship to Registrant Child _____

NORTH COLLINS
CENTRAL SCHOOL DISTRICT
P.O. Box 740, North Collins, NY 14111

Photograph, Video and/or Audio Tape Release

I am advised that from time to time the North Collins Central School District, its agents, or employees may take still or moving pictures and make recordings of the voices (all hereinafter called "video or audio records") of its students and staff members, and that the "Family Educational Rights and Privacy Act" requires parental consent before said video or audio records may be released.

☐ I hereby give permission to the North Collins Central School District, its agents, or its employees to photograph, video tape and/or audio tape my child _____.
Student's Name (Please Print)

And I hereby consent that such video, photograph or audio tape of my child may be made or used by the North Collins Central School District, its agents, employees, or representatives in school or school-related activities, school publications, school website, or other education purposes consistent with the purpose and mission of the North Collins Central School District.

I further agree that the above shall be made or used without compensation or payment and that the said photograph, video, or audio records are the property of the North Collins Central School District. I hereby release and discharge the North Collins Central School District and its agents, employees or representatives from any claims that may arise by reason of the making of said photograph, video, or audio records or the use or publication of same for the above purposes.

I reserve the right to preview any photograph, video tape and/or audio tape prior to its use.

Permission given for: (Check all that apply) ☐ **Photo** ☐ **Audio** ☐ **Video**

☐ I hereby **DO NOT** give permission to the North Collins Central School District, its agents, or its employees to photograph, video tape and/or audio tape my child _____.
Student's Name (Please Print)

Parent/Guardian's Signature _____ Date _____

Parent/Guardian's Name (Please Print) _____

Off-Campus Trip Permission Form

There will be times during the year when your child's class will be taking walks off the school campus to areas surrounding the Elementary School. Please sign below to allow your child to take walks off the school campus. By signing below, you will also give medical consent to treat your child if necessary. This permission form will be kept on file for your child's Elementary School career.

_____ has permission to take walks off the school campus and/or
Student's Full Name (Please Print) to attend the walking field trips while at school.

Parent/Guardian's Signature _____

Parent/Guardian's Name Printed _____

Date _____

NORTH COLLINS
CENTRAL SCHOOL DISTRICT
P.O. Box 740, North Collins, NY 14111

Dear Parent/Guardian:

As we welcome your child to North Collins Elementary School, please note that NYS Education Law requires each student to have current health information on file. Enclosed are the necessary Health Information Forms that must be submitted for student enrollment. Please review them carefully and bring the completed forms to the Main Office to finalize registration.

- Student Health Information Form – completed by person in parental relation
- Dental Health Certificate (optional)
- Health Certificate/Appraisal Form – completed by Health Care Provider
- NYS Immunization Requirements

If your child's previous school has this information on file or your child has been seen by your healthcare provider since the beginning of the school year, please contact them and request that your child's health records be forwarded to North Collins Elementary via fax or email (whabermehl@northcollins.wnyric.org). **We MUST receive these documents within 30 days of your child starting school.**

If you have any questions or concerns, please do not hesitate to contact me in the health clinic at 716-337-0166 ext. 2101. We look forward to meeting you.

Sincerely,

Wendy Habermehl

Wendy Habermehl
RN-School Nurse

NORTH COLLINS ELEMENTARY SCHOOL

10469 Bantle Road North Collins, NY 14111
Phone: 716-337-0166 Fax: 716-337-0598

Student Health Information

STUDENT INFORMATION (TO BE COMPLETED BY THE PARENT/GUARDIAN):

Student Name _____ **Gender** male / female ☐ ☐
Last First Middle

Home Phone/Cell # _____

Date of Entry _____ **Grade Entering** _____ **Date of Birth** _____

Street Address _____
Street Number PO Box # Town State Zip Code

Father's Name _____ **Mother's Name** _____

Student's Primary Doctor _____ **Phone #** _____

MEDICAL UPDATE (TO BE COMPLETED BY THE PARENT/GUARDIAN):

Student's Medical Providers (include specialists)

	DOCTOR/CLINIC	DOCTOR/CLINIC
Name		
Street		
City/Town/Zip		
Phone #		

Please record the date your child has had any of the following diseases:

	Date		Date		Date		Date
Anemia		Heart Disease		Rheumatic Fever		*Asthma	
Chicken Pox		Measles/Rubella		Scarlet Fever		Ear Conditions	
Diabetes		Mumps		Tuberculosis		*Operations	
Epilepsy/Seizures		Nephritis		Contact w/ TBC		*Serious Injuries	
Frequent Colds & Sore Throats		Pneumonia		Whooping Cough		*Serious Illness	

*Explanation: _____

_____

_____

Does your child have allergies? Y / N If yes, what is the child allergic to, how do the allergies react and how are they treated? _____

_____

_____

If there is anything concerning the eyes, ears, or health of this child which the school should know in order to provide special care, please specify below.

_____

_____

Does your child require any medication at school? Y / N

If yes, please contact the school nurse.

Additional Comments

_____

_____

_____

CONSENT TO SHARE INFORMATION (TO BE COMPLETED BY THE PARENT/GUARDIAN):

The school nurse has my permission to share medical information concerning my child with appropriate members of the educational team for use in meeting the health and educational needs of my child. This will be done on a 'need to know' basis, in a confidential manner per FERPA (Family Educational Rights & Privacy Act). This includes information for communication between the health provider, medical staff and school nurse, including copying relevant healthcare records to facilitate this process. This will be valid for the duration of the child's enrollment in the North Collins Elementary School and may be rescinded by any party at any time.

Yes _____ No _____ Student's Name: _____

Parent/Guardian Signature: _____

Date: _____

SAMPLE

Dental Health Certificate- Optional

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

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

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

Grade

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

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

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

Parent's Signature_____ Date

Section 2. To be completed by the Dentist

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

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

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

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

Dentist's name and address (please print or stamp) Dentist's Signature

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

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

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ 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/m2

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

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

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: 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.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

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

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

2023-24 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
All children must be age-appropriately immunized to attend school in NYS. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the "ACIP-Recommended Child and Adolescent Immunization Schedule." Doses received before the minimum age or intervals 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 must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

<table>
<tr><th>Vaccines</th><th>Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)</th><th>Kindergarten and Grades 1, 2, 3, 4 and 5</th><th>Grades 6, 7, 8, 9, 10 and 11</th><th>Grade 12</th></tr>
<tr><td>Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]</td><td>4 doses</td><td colspan="2">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</td><td>3 doses</td></tr>
<tr><td>Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]</td><td colspan="2">Not applicable</td><td>1 dose</td><td></td></tr>
<tr><td>Polio vaccine (IPV/OPV)[4]</td><td>3 doses</td><td colspan="3">4 doses
or 3 doses
if the 3rd dose was received at 4 years or older</td></tr>
<tr><td>Measles, Mumps and Rubella vaccine (MMR)[5]</td><td>1 dose</td><td colspan="3">2 doses</td></tr>
<tr><td>Hepatitis B vaccine[6]</td><td>3 doses</td><td colspan="3">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</td></tr>
<tr><td>Varicella (Chickenpox) vaccine[7]</td><td>1 dose</td><td colspan="3">2 doses</td></tr>
<tr><td>Meningococcal conjugate vaccine (MenACWY)[8]</td><td colspan="2">Not applicable</td><td>Grades 7, 8, 9, 10 and 11:
1 dose</td><td>2 doses
or 1 dose
if the dose was received at 16 years or older</td></tr>
<tr><td>Haemophilus influenzae type b conjugate vaccine (Hib)[9]</td><td>1 to 4 doses</td><td colspan="3">Not applicable</td></tr>
<tr><td>Pneumococcal Conjugate vaccine (PCV)[10]</td><td>1 to 4 doses</td><td colspan="3">Not applicable</td></tr>
</table>

NEW YORK STATE | Department of Health

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. 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 grades 6 through 9: 10 years; minimum age for grades 10, 11, and 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 2023-2024, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 9; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 10, 11, and 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. For children with a record of OPV, 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, must 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 grades 7 through 10: 10 years; minimum age for grades 11 and 12: 6 weeks).
   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.
   f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. PCV is not required for children 5 years or older.
   f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

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

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.

First	*Middle*	*Last*
DATE OF BIRTH:		**GENDER:** ☐ Male ☐ Female
Month	*Day*	*Year*

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*	

ENGLISH

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: