HALF HOLLOW HILLS CENTRAL SCHOOL DISTRICT

PLEASE BE AWARE THAT IT IS A ***CRIME*** TO FRAUDULENTLY REGISTER A CHILD IN A SCHOOL DISTRICT OTHER THAN THE DISTRICT IN WHICH THE PARENTS OR LEGAL GUARDIANS RESIDE. THE HALF HOLLOW HILLS CENTRAL SCHOOL DISTRICT IS COMMITTED TO THE PREVENTION, TERMINATION AND PROSECUTION OF ANY SUCH ACTIVITY

WELCOME

We are pleased to welcome you to the Half Hollow Hills Central School District. Children age 5 on or before December 31st will be eligible for admission to kindergarten the preceding September. In order to safeguard the health of your youngster, to place him or her in the most appropriate program, and to conform with New York State Laws and district policy, we will need certain information and records. These include:

REQUIREMENTS FOR REGISTRATION
ABSOLUTELY NO EXCEPTIONS WILL BE MADE

Homeowners
Please provide any of the following:
House Deed
Suffolk County Tax Bill
Sales Contract w/ Attorney Letter
Mortgage Statement

Renters Must
Provide the following:
Current Lease
Landlord's Affidavit, and new change of address on license from the DMV

And both Homeowners and Renters MUST provide two of the following:

Telephone/Cell phone bill
Water bill/LIPA bill
Cablevision bill
Credit card statement
Bank statement/ Government issued notices

DOCUMENTS FOR CHILD

1. Birth Certificate
2. Proof of mandatory immunization (see attached form)
3. Parental guardianship – Copies of court papers
4. All Foster Parents must submit, at registration, a letter from the placement agency indicating the licensed foster parents and form DSS 2999 completed by the placement agency .
5. Transfer card or report card showing proof of grade level for transfer student.

Registration is not complete until all necessary information and documentation is provided to the school your child will attend

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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

STUDENT INFORMATION

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

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental
Asthma ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached ☐ Intermittent ☐ Persistent ☐ Other : ____________
Seizures ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached ☐ Type: ____________ Date of last seizure: ____________
Diabetes ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached ☐ Type 1 ☐ Type 2 ☐ HbA1c results: ____________ Date Drawn: ____________

Risk Factors for Diabetes or Pre-Diabetes:

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

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

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

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
Sickle Cell Screen/PRN	☐	☐		☐ Concussion – Last Occurrence: ____________
Lead Level Required Grades Pre- K & K			**Date**	☐ Mental Health: ____________
☐ Test Done ☐ Lead Elevated ≥10 μg/dL				☐ Other:

☐ **System Review and Exam Entirely Normal**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	____________	____________
	____________	____________
	____________	____________
☐ Additional Information Attached	____________	____________

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

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

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

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

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

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

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

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

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

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

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

Explain: ______________________________

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

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

HEALTH CARE PROVIDER

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

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

HALF HOLLOW HILLS CENTRAL SCHOOL DISTRICT

OF HUNTINGTON AND BABYLON

December 2018

Dear Parents/Guardians

We are writing to inform you about your rights as parents or guardians pursuant to Section 4402 of the Education Law. You have the right to refer you child for special education evaluations and services should you suspect that your child has a disability. Special educations includes specially designed instruction or special services or programs to meet the unique needs of students with disabilities. A parent or guardian who is concerned about his or her child's academic performance due to a disability may refer his or her child for a special education evaluation to determine whether he or she is in need of special education services. More specific information regarding referral and evaluation can be found in the New York State Education Department's handbook, "A Parent's Guide to Special Education," available in English at www.p12.nysed.gov/specialed/publications/policy /parentsguide.pdf and in Spanish at www.p12.nysed.gov/specialed/pujblications/policy/SpanishParentGuide.pdf.

You may also contact our district's Executive Director of Special Education, Allison Strand, at 631-592-3045 for any questions you may have. We look forward to partnering with you to ensure that your child has a successful experience with our school district.

Very truly yours,

Patrick Harrigan

Dr. Patrick Harrigan

Superintendent of Schools

525 HALF HOLLOW ROAD • DIX HILLS, NEW YORK 11746

NEW YORK STATE EDUCATION DEPARTMENT

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, national origin, sex, citizenship, handicapping condition, or immigration status.

Name of School:

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

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

DIRECTIONS TO PARENTS/GUARDIAN:

Please answer questions (1) and (2) please read them before you respond. [For Question (1) check (✓) the box that best describes your child] Check (✓) only One box.

1. Is the student Hispanic, Latino or of Spanish origin? Hispanic, Latino, or Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American or other Spanish culture or origin, regardless of race.

   ☐ **Yes** Hispanic ☐ **No**, not Hispanic

2. Select one or more races from the following five racial groups [For questions (2) Check (✓) all groups that apply to your child, check (✓) at least ONE box.]:

   ☐ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origin in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

   ☐ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

   ☐ **Native Hawaiian or other Pacific islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

   ☐ **Black or African American:** A person having origins in any of the Black racial groups of Africa.

   ☐ **White:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

______________________________ ______________________

Signature of Parent Date

Relationship to Student (please check one box below):

☐ Mother ☐ Father ☐ Guardian ☐ Other (specify)______________

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

DISTRICT OF RESIDENCE ADDENDUM

Date ___________________

Name of Student ______________________________________

Date of Birth ____

As of October 7, 2017 what was your district of residence?

____

____

Previous School District ________________________________

Name of School ____

Address of School District ______________________________

____

____

Office use only
School Code ___________
New York City students _______________

3/18/2013

Return form to your child's school or mail to:
Half Hollow Hills CSD
525 Half Hollow Road, Dix Hills, NY 11746
Attn: MIS Department

HOUSEHOLD INFORMATION FORM

For internal use

Household ID # ____________

☐ Check this box if you are a new registrant

☐ Check this box if you are requesting an activation key

☐ Check this box if you wish to change phone/email/contacts

School Year ____________

Primary Household Address ____________ Town ____________ Zip ______ Primary Household Phone: ____________

Children in the Household:

Name of Child	Date of Birth	School Attending (if any)	Grade

Parent/s or Guardian Information:

Name	Address if different than Primary Household Address	Home Phone if different than Primary Household Phone	Work Phone	Cell Phone	Email address (Important)
Mother First name: Last name:					
Father First name: Last name:					

Other Persons who live in this Household: (e.g. Step-parent, Grandparent)

Name	Relationship to children in the Household	Work Phone	Cell Phone	Comments

Emergency Contacts not living in the Household:

Name	Relationship to children in the Household	Home Phone	Work Phone	Cell Phone	Comments

For additional information or comments use the back of this form.

Parent/ Guardian (print name) ____________ Signature ____________ Date ____________