Marlboro Central School District

Marlboro, New York

Name: _____ **Date:** _____

Address: _____

Phone: _____ **Grade Entering:** _____

REGISTRATION CHECKLIST

(for office use)

_____ **Housing Questionnaire**

_____ **Registration Form**

_____ **Health Office Questionnaire**

_____ **Home Language Questionnaire**

_____ **Release of Records** **Date Sent/Faxed:** _____

_____ **Transportation Form** **Date Sent/Faxed:** _____

_____ **Proofs of Residency: #1:** _____ **#2:** _____

_____ **Birth Certificate / Baptismal Certificate / Passport**

_____ **Immunizations**

_____ **Health Appraisal Form/Physical Exam Report**

_____ **Dental Health Certificate**

_____ **Photo ID**

_____ **Transcript/Report Card**

_____ **Parent Portal Form**

_____ **CPSE Parent Letter** _____ **Referral for Psych.**

Pick Up Restrictions/Custody? Yes _____ **No** _____

Special Education Needs/AIS Services? Yes _____ **No** _____ - _____

Foster Child Forms/Guardianship Papers? Yes _____ **No** _____

Marlboro Central School District

Michael M. Brooks
Superintendent of Schools

Central Registration for MCSD
Maggie Homonchuk, Central Registrar, Marlboro Middle School
Phone: 845-236-8000 x 1901
Email: maggie.homonchuk@marlboroschools.org

The Marlboro Central School District registers all students through **Mrs. Maggie Homonchuk**, Central Registrar, at the Marlboro Middle School, 1375 Route 9W, Marlboro, NY. **Please make an appointment to register your child or children.**

Only a Parent or legal Guardian can register a child in Marlboro Schools. Photo ID will be required at the time of registration.

Please bring the following items with you, as we cannot process your registration without these documents. In addition to the items below, you need to bring the registration packet. All documents in the packet are available online by clicking the **registration forms** link.

Student Documents Needed to Register

- Original Birth Certificate (Copies not acceptable) , or Original Baptismal Certificate, or Student Passport
- Immunization Record
- Report Card from Previous School
- Custody and/or guardianship papers, if applicable

PROOF OF RESIDENCY - (2) Required **that show the physical address.**

(1) one must be: Mortgage, Deed, or Signed and Notarized Landlord Statement

AND

(1) One of the following:
Current Driver's License
Pay Stub dated within 30 days with new address
Voter Registration Card
Social Services check or unemployment check with new address
Current Utility Bill with physical address
Property Tax Bill

Please be advised that the building principal or guidance Office will contact you about student placement once the registration process is complete.

Marlboro Central School District

Michael M. Brooks
Superintendent of Schools

Housing Questionnaire

Student Name	Grade	Date of Birth	Gender	School

Current/New Address: _____

Previous Address: _____

Previous School District: _____

Daytime Phone Number: _____ **Home Phone Number:** _____

The answer you give below will help the district determine what services you or your child(ren) 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 are you currently living? (Please check only one box.)

- ☐ In Permanent housing
- ☐ In a shelter
- ☐ With another family or other person because of housing or as a result of economic hardship (sometimes referred to as "doubled up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train or campsite
- ☐ Other temporary living situation (please describe): _____

_____

_____

_____ _____

Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

Date: _____

- ☐ Existing Family Change of Address
- ☐ New Family/Student
- ☐ Copy to MV Liaison

MARLBORO CENTRAL SCHOOL DISTRICT
Student Registration Form

This box for school use only.

Student ID: _____ Registration Date: _____ Grade: _____

STUDENT INFORMATION

_____ _____ _____
Last Name First Name Middle Name

_____ _____ _____
Gender DOB: mo/day/yr Place of Birth: City/State/Country

Ethnicity: Choose one: ☐ Yes, Hispanic/Latino ☐ No, Not Hispanic/Latino
(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.)

Race: Place an "x" in the box that describes your child. You must choose one or more:
☐ **American Indian/Alaska Native**: *A person having origins in North America and who maintains cultural identification through tribal affiliation or community recognition. e.g. Cherokee, Mohawk, Inuit.*
☐ **Asian**: *A person having origins in any of the origins of the Far East, Southeast Asia, or the Indian subcontinent.*
☐ **Native Hawaiian/Pacific Islander**: *A person having origins in Hawaii, Guam, Samoa, or other Pacific Islands.*
☐ **Black/African American**: *A person having origins in any of the Black racial groups of Africa.*
☐ **White**: *A person having origins in Europe, North Africa or the Middle East.*

Languages spoken at home: 1. _____ 2. _____

Student Lives with: ☐ Both Parents ☐ Mother only ☐ Father only ☐ Foster Parents (DSS 2999 required)
☐ Self ☐ Guardian: _____

If the student is living with one parent, are there custody papers? ☐ Yes ☐ No If yes, custody type: _____

Educational Background: Previous School Attended: _____

Last Grade: ____ Has your child been retained (repeated a grade)? ☐ Yes ☐ No If so, what grade? _____

Has your child received: ☐ Counseling ☐ Speech ☐ AIS Reading ☐ AIS Math ☐ ENL services

Does your child have a current IEP? ☐ Yes ☐ No Does your child have a current 504 Plan? ☐ Yes ☐ No

Other: _____

PARENT/GUARDIAN INFORMATION

Parent 1 Full Name

Residence Address

Mailing Address if different

Home Phone:

Cell Phone:

Work Phone:

Parent 2 Full Name

Residence Address if different

Mailing Address if different

Home Phone:

Cell Phone:

Work Phone:

Does either parent/guardian have any active military affiliation? _____

Student's Legal Guardian if different from above: _____

Address: _____

Phone Number(s): _____

Siblings Residing at Same Address

Name	Gender	DOB	Grade	Present School

EMERGENCY CONTACT INFORMATION

Local persons who have agreed to pick up your child in an emergency when parents/guardians cannot be reached.

Full Name	Relationship to Student	Phone # (indicate c/w/h)	Phone # (indicate c/w/h)

I declare under penalty of perjury, under the laws of the State of New York, that all statements contained in this application and any accompanying documents are true and correct, with full knowledge that all statements made in this application are subject to investigation.

Parent/Legal Guardian Signature: _____ **Date:** _____

MARLBORO CENTRAL SCHOOL DISTRICT

Health Office Information Questionnaire - Please be very specific

Student's Name: _____ Date of Birth: _____

Parent/Guardian Name(s): _____ Phone: _____

Family Doctor's Name: _____ Phone: _____

Hospital Preferred: _____

I give the school nurse permission to contact my child's physician in case of a medical emergency or for pertinent medical information.

Parent/Guardian Signature: _____ Date: _____

Has this student had any of the following sicknesses or conditions? If so, please include the dates of each.

Chickenpox: _____
Diabetes: _____
Measles: _____
Mumps: _____
TB or Contact: _____
Pneumonia: _____
Epilepsy: _____
Phobias: _____
Convulsions: _____
Orthopedic Problems: _____
Any Serious Injuries: _____
Surgeries: _____
Hospitalizations: _____

Frequent Colds/Sore Throats: _____
German Measles: _____
Scarlet Fever: _____
Rheumatic Fever: _____
High Blood Pressure: _____
Asthmatic Condition: _____
Whooping Cough: _____
Eye/Ear Condition: _____
Frequent Fevers: _____

1. Does the student have any vision problems? _____
2. Does the student wear eyeglasses or contact lenses? _____
3. Does the student have any type of hearing problems? _____
4. Does the student have any speech or language problems? _____
5. Does the student have any handicapping conditions? _____
6. Does the student have any emotional special needs? _____
7. Is the student receiving medical treatment of any kind? _____ If so, please explain: _____
8. Is the student receiving any kind of medication and/or herbs? _____ If so, please explain: _____
9. Does the student have any physical limitations or restrictions? _____ If so, please explain: _____
10. Has the student undergone any other screening or evaluation? _____ If so, please explain: _____
11. Are there any other special conditions/allergies or needs that you would like to bring to the School District's attention? _____

For the health and safety of your child this information will be shared with school personnel. Please sign and date this release.

Signature of Parent/Guardian: _____

Date Signed: _____

FOR SCHOOL NURSE USE ONLY BELOW THIS LINE

Are all immunizations complete? _____

If not, which ones are needed? _____ _____

_____ _____

_____ _____

List any special needs: _____ _____

_____ _____

Person taking information: _____

Date: _____

Reviewing Nurse's Initials: _____

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

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH: *Month* *Day* *Year*

GENDER: ❑ Male ❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

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

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

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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:

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

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Cuestionario de Idioma del Hogar ("HLQ" por sus siglas en inglés)

Estimados padres o tutores:
Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura, escritura y comprensión en el inglés, así como conocer su educación previa e historial personal. Por favor, llene con su información las secciones "Conocimientos de idiomas" e "Historial educativo". Apreciamos mucho su colaboración respondiendo a estas preguntas.
Gracias.

Por favor escriba con claridad al completar esta sección

NOMBRE DEL ESTUDIANTE:

Nombre *Segundo nombre* *Apellido*

FECHA DE NACIMIENTO:

Mes *Día* *Año*

GÉNERO:
☐ Masculino
☐ Femenino

INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL

Apellido *Primer Nombre* *Relación con el estudiante*

CÓDIGO DEL IDIOMA DEL HOGAR

Conocimientos de idiomas

(Por favor, marque todas las opciones que sean aplicables)

1. ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante?	☐ Inglés	☐ Otro *especifique*	
2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?	☐ Inglés	☐ Otro *especifique*	
3. ¿Cuál es el idioma primario de cada padre / tutor?	☐ Madre *especifique*	☐ Padre *especifique*	
	☐ Tutor(es) *especifique*		
4. ¿Qué idioma o idiomas entiende su hijo(a)?	☐ Inglés	☐ Otro *especifique*	
5. ¿Qué idioma o idiomas habla su hijo(a)?	☐ Inglés	☐ Otro *especifique*	☐ No sabe hablar
6. ¿Qué idioma o idiomas lee su hijo(a)?	☐ Inglés	☐ Otro *especifique*	☐ No sabe leer
7. ¿Qué idioma o idiomas escribe su hijo(a)?	☐ Inglés	☐ Otro *especifique*	☐ No sabe escribir

TO BE COMPLETED BY THE DISTRICT IN WHICH THE STUDENT IS REGISTERED

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

PARA LLENAR POR EL DISTRITO EN EL QUE EL ESTUDIANTE SE HA INSCRITO

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

8. Indique con un número el total de años que su hijo(a) lleva inscrito en una escuela: _____

9. ¿Cree usted que su hijo(a) pueda tener dificultades, interferencias o problemas educacionales que le afecten su capacidad para entender, hablar, leer o escribir en inglés o en cualquier otro idioma? En caso afirmativo, por favor describalos.

*Sí** *No* *No se sabe*
☐ ☐ ☐ * En caso afirmativo, por favor explique :_____

¿Qué gravedad considera usted que tienen estas dificultades educacionales? ☐ Poca gravedad ☐ Algo grave ☐ Muy grave

10a. ¿Alguna vez se ha recomendado a su hijo(a) a tener una evaluación de educación especial? ☐ No ☐ Sí* * *Por favor, llene 10b.*

10b. **Si se le ha recomendado alguna vez una evaluación,* ¿ha recibido su hijo(a) alguna vez alguna forma de educación especial?

☐ No ☐ Sí – Explique, que forma o formas de educación especial recibió:

Edad en la que recibió la intervención o forma de educación especial *(favor de marcar todas las opciones que sean aplicables):*

☐ De nacimiento a 3 años (Intervención Temprana) ☐ 3 a 5 años (Educación Especial) ☐ 6 años o mayor (Educación Especial)

10c. ¿Tiene su hijo(a) un Programa de Educación Individualizada ("IEP" por sus siglas en inglés)? ☐ No ☐ Sí

11. ¿Considera que hay alguna otra información importante que la escuela deba saber sobre su hijo(a)?
(Por ejemplo, talentos especiales, problemas de salud, etc.)

12. ¿En qué idioma(s) quiere usted recibir la información de la escuela? _____

_____ Mes: Día: Año:
Firma del padre/madre o de la persona en relación paternal *Date*
Relación con el estudiante: ☐ Madre ☐ Padre ☐ Otra:_____

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

Marlboro Central School District

Michael M. Brooks
Superintendent of Schools

To Whom It May Concern:

The student named below has requested admission into the Marlboro Central School District:

Student's Name: _____ DOB: _____

Name and mailing address of School Previously Attended:

_____ School Phone: _____

_____ School Fax #: _____

Parent/Guardian Signature: _____ Date: _____

Below for District Use Only

Please forward the following records for this student as soon as possible. **If appropriate, please forward this release to your Pupil Personnel/Special Education Office.**

( ) Attendance Records
( ) Birth Certificate
( ) Custody/Guardianship Papers
( ) Discipline Records
( ) Health Records (Immunizations/Physical)
( ) Report Card
( ) Science Labs (High School Level)
( ) Special Education Records (IEP/504)
( ) Standardized Test Scores
( ) Transcript
( ) Other _____

Is student currently expelled, suspended or under other disciplinary placement? _____? If yes, please forward details.

Please fax records to:

___Marlboro High School Guidance Office 50 Cross Road Marlboro, NY 12542 Tel: 845-236-5809 **Fax: 845-236-4088**	___ Marlboro Middle School Guidance Office 1375 Route 9W Marlboro, NY 12542 Tel: 845-236-5844 **Fax: 845-236-7202**	___ Marlboro Elementary Student Records 1380 Route 9W Marlboro, NY 12542 Tel: 845-236-1636 **Fax: 845-236-1639**
___ MCSD Student Services 21 Milton Tpke., Suite 100 Milton, NY12547 Tel: 845-236-8109 **Fax: 845-795-5907**	___ MCSD Registrar's Office 1375 Route 9W Marlboro, NY 12547 Tel: 845-236-8000 x1901 **Fax: 845-236-3634**	___ Other:

MARLBORO CENTRAL SCHOOL DISTRICT

Student Information Form

Date: _____/_____/_____

Student's Name: _____
(Last) (First) (MI)

Date of Birth: _____ Gender: _____ Primary Language: _____

Student's Residential Address (No PO Box):

Street: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Telephone: (_____) _____-_____

County of Residence: _____

Parent/Guardian Information:

Guardian Name: _____

Relationship: _____ Employer: _____

Email: _____ Cell: _____

Parent/Guardian Information:

Guardian Name: _____

Relationship: _____ Employer: _____

Email: _____ Cell: _____

Emergency Contact Information:

Emergency Contact: _____

Relationship: _____ Telephone: (___) ____-_____

Address: _____
(Street) (City) (State) (Zip)

MARLBORO CENTRAL SCHOOL DISTRICT

Bus Permission Form for Students

Note: This form is mandatory for kindergarten students. It is optional for all other students.

STUDENT'S NAME: _____

SCHOOL: _____

I give permission to the below named people to put my child on the bus and/or take my child off of the bus when I am not able to be at his/her bus stop:

NAME	RELATIONSHIP TO CHILD	TELEPHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

OFFICE USE ONLY:

BUS LETTER/ROUTE: A.M. _____ P.M. _____

STOP ASSIGNED: A.M. _____ P.M. _____

_____ COMPUTER _____ COPY TO DRIVER _____ STAFF INITIALS

Form Revised 07/12/18

MARLBORO CENTRAL SCHOOL DISTRICT

Babysitter Form

This form authorizes parental permission for students to be transported to and from an alternate location, other than the student's home address. This form must be completed and submitted to your child's school office or Quality Bus Service, LLC.

STUDENT'S NAME: _____

SCHOOL/GRADE 2015/2016: _____

HOME ADDRESS: _____
(Please give home location
- Example: white house, #1216
Route 9W, Marlboro,
New York, 12542

_____

_____

HOME PHONE: _____ **EMERGENCY PHONE:** _____

Marlboro Central School District allows an alternate transportation address on a ***FIVE DAY PER WEEK BASIS ONLY. PLEASE INDICATE YOUR BABYSITTER CHOICE BELOW:***

[ ] A.M. (Trip to School) **[ ] P.M. (Trip Home from School)** **[ ] Both Trips**

PLEASE FILL IN THE FOLLOWING PERTINENT BABYSITTER INFORMATION:

BABYSITTER NAME: _____

ADDRESS: _____

_____

TELEPHONE: _____

SIGNATURE PARENT/GUARDIAN: _____

DATE: _____

This form constitutes a public document. Individuals completing this form are advised that the information provided herein must be accurate and true in all respects since the Marlboro Central School District ("the District") will rely on the statements made herein. Any false statements made herein are punishable in accordance with the New York State Penal Law.

Marlboro Central School District

Rosanne Mele
Director of Student Services

Health and Dental Examination Requirements

Dear Parents/Guardians,

Date:

New York State law requires a health examination for all students **entering the school district for the first time and when entering Pre-K or K, 1st, 3rd , 5th, 7th , 9th and 11th grade**. The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time. The school will provide you with a list of dentists and registered dental hygienists who offer dental services on a free or reduced cost basis if you ask for it.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts Pre-K or K, 1st ,3rd , 5th, 7th , 9th & 11th grades. If a copy is not given to the school within 30 days, the school will contact you.
- If your child has an appointment for an exam during this school year that is after the first 30 days of school, please notify the Health Office with the date.
- For your convenience, a physical exam form and dental certificate for your health care providers is enclosed.
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the time of your child's appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office.

Anna Festa, Registered Nurse – Marlboro High School

Janine Beck, Registered Nurse – Marlboro Middle School

Lori Chalmers, Registered Nurse (3-5) – Marlboro Elementary School

Eileen Bowman, Registered Nurse (K-2) – Marlboro Elementary School

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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

STUDENT INFORMATION

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

HEALTH HISTORY

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

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

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

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

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

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

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

PHYSICAL EXAMINATION/ASSESSMENT

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

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

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

☐ **System Review and Exam Entirely Normal**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

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

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

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

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

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

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

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

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

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

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

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

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

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

HEALTH CARE PROVIDER

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

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

Dental Health Certificate

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.

MARLBORO CENTRAL SCHOOL DISTRICT

LANDLORD STATEMENT

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

This will verify that _____
(Tenant's Name)

Is a tenant residing at the following location: _____

_____

Landlord's Name: _____

Landlord's Address: _____

Landlord's Phone Number(s): _____

Landlord's Signature: _____ Date: _____

State of: _____

County of: _____

Sworn to before me this _____ day

of _____, 20____

_____
Notary Public

MARLBORO CENTRAL SCHOOL DISTRICT

Michael Brooks, Superintendent of Schools
845-236-5802

GENERAL INFORMATION

SCHOOL SCHEDULE

Grades K - 5	8:50 a.m. – 3:30 p.m.
Grades 6 – 8	7:38 a.m. – 2:22 p.m.
Grades 9 – 12	7:42 a.m. – 2:32 p.m.

If a child in the Elementary School walks to school, or is being transported in a manner other than a school bus, he/she should not arrive at school before 8:50 a.m. so that proper supervision can be provided.

ATTENDANCE

Daily school attendance promotes skills for lifelong training. The habit of good attendance tends to carry over into adult, business, and family life. The Marlboro Central School District believes that attendance is a key factor in student achievement. Absence represents an educational loss to the student. To assist you in understanding the New York State Law, the following is a summary from the State Education Department document: Legal Information Concerning School Attendance.

Written excuses are required for all absences. Students are marked illegally absent until a note from the Parent/Guardian is received by the school.

Legal absences include: sickness, family bereavement, religious observance, court appearance.

Illegal absences include: vacation, babysitting, shopping, visiting, oversleeping, truancy, suspension.

Your support is appreciated. Please refer attendance questions to your principal or School Health Office.

EARLY DISMISSAL

- The Superintendent or designee will determine the need for early dismissals. Building principals will notify staff and students.
- Parents/Guardians will be notified through the District's Blackboard Connect System, an automated system that calls home, cell phones, and other numbers designated by the parent/guardian.
- Radio and TV stations will be notified by the Superintendent or designee as follows:

FM:	101.5, 106.1, 106.2, 97.7, 92.7, 96.9, 94.3, 97.3, 92.1, 92.9, 93.3, 107.3, 96.1, 100.7, 104.7, 103.7, 97.3, 100.1
AM:	1340, 1390, 1450, 920, 1260, 1220, 1490
TV:	WRNN, FOX

SPECIAL EDUCATION

Parents/Guardians with questions pertaining to the referral and evaluation of their child for the purposes of special education may contact Rosanne Mele, Director of Student Services, at 845-236-8109 or via email: rosanne.mele@marlboroschools.org. A Parent's Guide to Special Education can be accessed at www.NYSED.gov (http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm) or on the Marlboro Central Schools webpage under the Student Services tab (www.marlboroschools.org)

Marlboro Central School District

CONNECT WITH US!

Stay informed about the things happening in the Marlboro Central School District by taking advantage of our new website features and following us on social media.

"Like" us on Facebook at www.facebook.com/marlborocentralschooldistrict

"Follow" us on Twitter @marlborosd

Sign up for the schoolTool Parent Portal to have access to valuable student management data:

- → **student grades**
- → **attendance**
- → **schedules**
- → **...and more!**

To log in or register, visit the Parents tab at marlboroschools.org and click "Parent Portal."

Get emergency notifications or general updates through our Marlboro Alerts auto-notification system. Sign in today to check that your contact information is current and manage your notification settings. Access to this, and other communication platforms, can be found at marlboroschools.org.

IF YOU HAVE ANY QUESTIONS, OR NEED MORE INFORMATION, PLEASE CALL US AT 845-236-8000, EXT. 1300.

MARLBORO CENTRAL SCHOOL DISTRICT
TECHNOLOGY SERVICES
50 CROSS RD
MARLBORO, NY 12542
parentportal@marlboroschools.org

Parent Portal Registration

Student's Name: _____

Building and Grade: _____

Parent Name: _____

Parent's Email: _____

Parent Home Phone: _____

Parent Cell Phone: _____

Voice ☐ Text ☐ Email ☐

Parent's Signature: _____

Identification Verified Yes_____ No_____