Mount Sinai School District
Mount Sinai, New York

CHECKLIST FOR INCOMING STUDENTS

All forms must be completed, signed and returned at registration.

√	Check the appropriate box after completing each form
☐	1. Registration Form
☐	2. Parent Questionnaire
☐	3. Health History
☐	4. Home Language Questionnaire
☐	5. Proper Use of Information Resources
☐	6. Physical Examination Form (*to be completed by your child's Physician*)
☐	7. Dental Health Certificate (*to be completed by your child's Physician*)

In addition to the above forms, you will also need the following items:

√	Check the appropriate box after obtaining each item
☐	1. Proof of Residency
	Owners:
	☐ Original Town of Brookhaven tax bill or deed
	Renters:
	☐ Notarized Lease
	☐ Copy of Lessor's tax bill or deed
	☐ Current Utility Bill or Current Driver's License
☐	2. Original birth certificate with raised seal
☐	3. Immunizations Record

Registration Date: _____

MOUNT SINAI SCHOOL DISTRICT
118 North Country Road
Mount Sinai, NY 11766
(631) 870-2500

STUDENT INFORMATION

Last Name	First Name	MI	Suffix (Jr, III, IV)

Gender (Circle) Male Female Non-Binary	Date of Birth ____/____/_____	Age: _____ Entering Grade: _____

Ethnic Identification:
Is the student Hispanic, Latino or Spanish origin (Circle One)

YES or NO

AND
Race: (check all that apply)

- o American Indian Or Alaska Native
- o Asian
- o Black/African American
- o Native Hawaiian or Other Pacific Islander
- o White

Place of Birth (City, State or Country):

Date entered U.S.:
____/____/_____

Language Spoken in the Home:

HOUSEHOLD INFORMATION

Residence Street Address

Home Phone Number	Mailing Address (if different)

PARENT/GUARDIAN INFORMATION

Marital Status of Parents/Guardian:

___Married ___ Separated ___Divorced ___Widowed ___Single ___Official Custody Papers

Parent/Guardian Name	Employer	Work Phone	Cell Phone

Email Address	Custodial Parent? Yes No	Does the child reside with this parent/Guardian? Yes No

Address (if different than child's address)

Parent/Guardian Name	Employer	Work Phone	Cell Phone

Email Address	Custodial Parent? Yes No	Does the child reside with this parent/Guardian? Yes No

Address (if different that child's address)

Is either parent a member of the Armed Forces and on active duty? _____ Yes _____ No
If Yes, indicate date active duty began: _____/_____/____

SIBLINGS/OTHERS IN HOUSEHOLD

Name	Gender	Date of Birth	Age	Grade
Name	Gender	Date of Birth	Age	Grade
Name	Gender	Date of Birth	Age	Grade
Name	Gender	Date of Birth	Age	Grade

PREVIOUS EDUCATION INFORMATION (If Applicable)

Previous School District Name	Name of Building	Phone #
School Address		Date of Entry into Grade 9

HOUSING INFORMATION

Is the family experiencing Homelessness? _____Yes _____No
Is the student an unaccompanied youth? _____Yes _____No
If Yes, where is the student currently living?

_____ In a shelter
_____ Temporarily living with another family/person due to loss of housing
_____ In a Motel/Hotel
_____ In a car, park or campsite
_____ Other temporary situation (Please Describe) _____

FOSTER CARE INFORMATION

Is the student in Foster Care? _____Yes _____No

Name and Address of Foster Agency:

Name of Case Worker	Phone #

SPECIAL EDUCATION SERVICES

Is the student receiving Special Education Services? _____Yes _____No

If Yes, please complete (a) and (b)

(a) Does the student have a current Individualized Education Plan (IEP)? _____Yes _____No
(b) Does the student have a current 504 Accommodation Plan in place _____Yes _____No

Name of District issuing the current IEP: _____

ENGLISH AS A NEW LANGUAGE (ENL) SERVICES

Is the student receiving ENL services? _____Yes _____ No

OTHER INFORMATION

Has your child ever been retained? _____Yes _____No | If yes, what Grade? _____ Year _____

Does your child have any unique abilities &/or limitations? _____Yes _____No
If yes, please explain: _____

Does your child have vision issues? _____Yes _____No | hearing issues? _____Yes _____No

Are there any special circumstances the school should be aware of regarding your child? _____Yes _____No
If yes please explain: _____

Parent/Guardian Signature: _____ Date: _____

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

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.

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*

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?	❑ Parent 1 *specify*	❑ Parent 2 *specify*		
	❑ Guardian(s) *specify*			
4. What language(s) does your child understand?	❑ English	❑ Other	*specify*	
5. What language(s) does your child speak?	❑ English	❑ Other *specify*	❑ Does not speak	
6. What language(s) does your child read?	❑ English	❑ Other *specify*	❑ Does not read	
7. What language(s) does your child write?	❑ English	❑ Other *specify*	❑ Does not write	

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

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School: *Address:*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes ***No*** ***Not sure***
❑ ❑ ❑ ***If yes,** please explain:* _____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ **No** ❑ **Yes*** **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
❑ **No** ❑ **Yes – Type of services received:** _____

Age at which services received *(Please check all that apply):*
❑ **Birth to 3 years (Early Intervention)** ❑ **3 to 5 years (Special Education)** ❑ **6 years or older (Special Education)**

10c. Does your child have an Individualized Education Program (IEP)? ❑ **No** ❑ **Yes**

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ **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: ❑ **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:

PROPER USE OF INFORMATION RESOURCES

It is the policy of the Mt. Sinai School District to maintain access for its staff and student's local, national and international sources of information and to provide an atmosphere that encourages access to knowledge and sharing of information. The Mt. Sinai UFSD works to create an intellectual environment in which students. staff and faculty may feel free to create and to collaborate with colleagues at any institution, without fear that the products of their intellectual efforts will be violated by misrepresentation. tampering, destruction and/or theft.

It is the policy of the Mt. Sinai UFSD that information resources will be used by members of its community with respect for the public trust through which they have been provided and in accordance with policy and regulations established from time to time by the State of New York, the State Board of Regents, the State Board of Education and the Mt. Sinai UFSD Board of Education and Administration.

For purposes of this policy, information resources are meant to include any information in electronic or audio-visual format or any hardware or software that make possible the storage and use of such information. As example, included in this definition are electronic mail, local databases, externally accessed databases, CD-ROM, On-Line services, the Internet, motion picture film, recorded magnetic media, photographs, and digitized information such as may be made available on the network or in the district.

Access to the information resource infrastructure within Mount Sinai UFSD, sharing of information and security of the intellectual products of the community, all require that each and every user accept responsibility to protect the rights of the community. Any member of the Mt. Sinai UFSD community who, without authorization, accesses. uses, destroys, alters, dismantles or disfigures any institution information technologies, properties or facilities, including those owned by third parties, thereby threatens the atmosphere of increased access and sharing of information , and threatens the security within which members of the community may create intellectual products and maintain records. That person(s) has engaged in unethical and unacceptable conduct and moreover, may be guilty of violating the New York State law. Access to the networks and to the information technology environment within Mt. Sinai UFSD is a privilege and must be treated as such by all users of the network and its associated systems.

To ensure the existence of this information resource environment, members of the Mt. Sinai UFSD community will take actions to identify and to set up technical and procedural mechanisms to make the information technology environment on the network resistant to disruption.

The Mt. Sinai UFSD characterizes as unethical and unacceptable, and just cause for taking disciplinary action. removal of networking privileges, and/or legal action, any activity through which an individual:

(a) violates such matters as institutional or third party copyright, license agreements and other contracts,

(b) interferes with the intended use of the information resources,

(c) seeks to gain or gains unauthorized access to information resources,

(d) uses or knowingly allows another to use any computer, computer network, computer system, program, or software to devise or execute any artifice or scheme to defraud or to

obtain money, property, services, or other things of value by false pretenses, promises, or representations.

This policy is applicable to any member of the Mt. Sinai UFSD community, whether at educational institutions or elsewhere, and refers to all information resources whether individually controlled, or shared, stand alone or networked. The individual buildings may define "conditions of use" for facilities under their control. Such statements should be consistent with this overall policy but may provide additional detail, guidelines and/or restrictions. Where such "conditions of use" exist, enforcement mechanisms defined therein shall apply. Disciplinary action, if any, for students, faculty and staff shall be consistent with the district' standard policies and practices. Where use of external networks is involved, policies governing such use also are applicable and must be adhered to.

FORMS

Student Name _____ Grade _____

I have read the Acceptable Use Policy and Student Guidelines, and agree to abide by the provisions. I understand that violation of the use provisions stated in the policy may constitute suspension or revocation of network privileges, as well as other actions noted in the policy.

Student Signature _____ Date _____

SPONSORING PARENT OR GUARDIAN (Required)

I have read the Acceptable Use Policy and I understand that administrators of the network have taken reasonable precautions to ensure that controversial material is eliminated. I hereby give my permission for my child to use the network and certify that the information contained on this form is correct.

Parent Signature _____ Date _____

Address _____ Phone _____

MOUNT SINAI SCHOOL DISTRICT
MOUNT SINAI, NEW YORK

HEALTH HISTORY

Name of Child _____ Grade _____ Teacher _____

Sex _____ Date of Birth _____ Place of Birth _____

Home Address _____ Phone _____

Parent/Guardian _____

Place of Employment _____ Phone _____

Parent/Guardian _____

Place of Employment _____ Phone _____

Physician to be notified in emergency _____ Phone _____

Two local relatives/friends to notify in case of emergency:

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

Does your child wear glasses? _____ Doctor _____ Date of last exam _____

Does your child have a hearing problem? _____ Doctor & number _____

Child's Dentist _____ Date of last exam _____

Does your child have any allergies? _____ Type of allergy? _____

_____

Does your child have asthma? _____

Does your child take medication regularly? _____ If so, what medication and why? _____

Serious injuries (type/year) _____

Operations (type/year _____

Is there anything else concerning your child which the school should know (Speech, IEP, 504, Health Concern) in order to provide special care? _____

_____

_____

Parent/Guardian Signature _____ Date _____

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.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE 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	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	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: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

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

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **System Review and Abnormal Findings Listed Below**

☐ 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*

*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing 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 ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

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

☐ **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 Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

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

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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

MOUNT SINAI ELEMENTARY SCHOOL
MT. SINAI, NEW YORK 11766

Request for Education Records

TO: SENDING/PREVIOUS SCHOOL	
School:	
Address:	
City, State, Zip:	
Telephone:	Fax:
The student(s) listed below have enrolled in the Mt. Sinai School District and request their complete transcript including all scholastic records, immunizations, attestation form indicating any completion of required NYS Science investigations and special education records (including psychological evaluations and Individualized Education Plan).	

STUDENT INFORMATION		
Name	Date of Birth	Entering Grade

FROM: REQUESTING SCHOOL	
School: Mt. Sinai Elementary School	
Address: North Country Road	
City, State, Zip: Mt. Sinai, New York 11766	
Telephone: (631)870-2600	Fax: (631)928-3860
School Official:	Date:
Parent signature:	Date:

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