Susan Erdman
serdman@sachem.edu

Superintendent of Schools
Kenneth E. Graham, Ed.D.

51 School Street
Lake Ronkonkoma, NY 11779
631.471.7861
ext. 1145

#WeAreSachem

Sachem Central School District

Central Registration

December 15, 2019

IMPORTANT: PLEASE READ THOROUGHLY

You are receiving this letter because your child is currently enrolled in Sachem's Universal Pre-K Program. Kindergarten registration for the 2020-2021 school year begins February 3, 2020. Since your child has been registered with the Sachem Central School District for the UPK program, you have the option of completing the kindergarten registration process by mail avoiding the 'in person' office registration. The following criteria must be met in order to complete your registration by mail:

- The student must be currently attending the UPK program. If you have withdrawn your child from the program, you will need to come to our office to re-register.

- You must still be living in the same home that you lived in when you originally registered or have completed the necessary paperwork required by Central Registration to update your address. If you have moved since registering for the UPK program and have not yet updated this information with Central Registration, you will need to call the Central Registration Office to receive further information.

With the above requirements having been met, completion of the registration process by mail requires returning the following **FOUR** documents to Central Registration.

1. The enclosed ***UPK Kindergarten Registration Form***
2. A **current copy of a utility bill** for your address in your name. This bill must be dated within 30 days of your mailing. Acceptable proof would be electric, cable, water, gas, home or car insurance bills. Do not send mortgage bills, tax bills or residency affidavits. If you have questions about any other proof that might be accepted, please call the Central Registration Office for consideration before submitting it.
3. Although proof of immunizations were submitted when registering your child for the UPK Program, new proof is required. The child's immunization booklet is not acceptable. Proof must be on physician's letterhead and signed either by handwritten signature, electronic signature, or signature stamp. If after receiving your paperwork it is found that any of the immunizations required for kindergarten registration have not yet been administered, we will go forward with the registration, however, you will receive a letter informing you what vaccinations must be completed before the start of school. Current immunization requirements can be found at http://www.health.ny.gov/publications/2370.pdf or can be provided at the Central Registration Office.
4. The enclosed ***HEALTH HISTORY*** **form**

All FOUR of the above documents must be received together. Please do not submit any less than the four as partial documentation is not accepted and will be returned to you. Your child will not be considered registered for kindergarten until all documents are received. After the documents are verified, your child's folder will be forwarded to the appropriate school. The school will contact you with any pertinent information, such as the dates and times for the school's orientation and screening programs and your choice of bus stop. Orientations will be held between May 4th and May 8th and screenings will be held during the week of June 1st.

PLEASE NOTE: Children who have not been registered before the orientation and/or screening dates will miss the opportunity to attend the orientation and/or screening at the schools. With that in mind, please RETURN THE PROPER PAPERWORK TO US AS SOON AS POSSIBLE!

A *Physical Examination Form* and *Dental Health Certificate* are enclosed for your convenience. They are NOT needed to register. Each student must have a physical examination within the 12 month period prior to the first day of school. If the documentation is not included with your registration, it must be returned to the elementary school of attendance before school starts. The Dental Health Certificate is suggested but not required for registration.

UPK Kindergarten Registration Form

2020 – 2021

Student's Name _____
First Middle Last

Home Address _____

_____

Mailing Address (if different from home address) _____

Home Phone Number _____ Date of Birth _____

Elementary School that the child will attend in September 2020 _____

****

If the answer is **"YES"** to any of the following questions, please complete explanation portion provided.

	YES	NO
Have there been any changes regarding who the child resides with?	_____	_____
Have there been any changes regarding your residency?	_____	_____
Have there been any changes to the parents' marital status?	_____	_____
Does the child need ENL services?	_____	_____
Does the child receive Special Education or related services?	_____	_____
Are there any changes to cell or work numbers?	_____	_____

Explanation:

_____

_____

_____

_____

Parent/Guardian Signature _____ Date _____

STUDENT NAME _____

DATE OF BIRTH_____

HEALTH HISTORY – PAGE 1

If your child has had any of the following, please describe and include the dates:

Allergies:

Environmental _____

Food _____

Medication _____

Anemia _____

Sickle Cell _____

Sickle Cell Trait _____

Asthma/Medication Used _____

Cancer _____

Cystic Fibrosis _____

Diabetes/Medication Used _____

Insulin Dependent _____

Heart Disease _____

Heart Surgery _____

Hearing Loss _____

Loss_____r_____l _____

Has your child received services for this hearing problem? _____

Chronic Ear Problems _____

Hemophilia/Bleeding Disorders _____

Gastrointestinal Disease _____

Hospitalizations/Operations _____Reason _____

_____

Vision Problem _____

Loss_____r_____l _____

Has your child received services for this vision problem? _____

STUDENT NAME _____

DATE OF BIRTH_____

HEALTH HISTORY – PAGE 2

Scoliosis _____

Head Injury _____

Concussion _____Other _____

Serious Injuries _____

_____

Seizure Disorders

Grand Mal _____

Petit Mal _____

Focal _____

Other _____

Illnesses (please circle):

Chicken Pox – Doctor's verification is needed Measles Mumps German Measles

Rheumatic Fever Pertussis

Is there anything concerning your child's health that the school should know in order to provide special care?

Yes_____No _____

If yes, please explain: _____

_____

Please be advised that a yearly examination by your family physician is advisable. Physical examinations are *required* for all *new entrants* and must be dated within 12 months of the date your child enters school.

Physicals are also mandated for students entering Pre-K, Kindergarten, grades 1, 3, 5, 7, 9 and 11. Again, the physical must be dated within 12 months.

These examinations are performed for the purpose of detecting problems in their early stages with the hope of directing attention to them for proper medical treatment.

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.

Sachem Central School District

STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections
☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Conditions
☐ High Blood Pressure
☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
☐ Scoliosis
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition
☐ Speech Condition
☐ Urinary Condition

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education?
☐ No ☐ Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____
_____

Parent/Guardian Signature: _____ Date: _____

SACHEM CENTRAL SCHOOL DISTRICT

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

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

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment ? ☐ 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/ Dental Hygienist

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

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

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

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

Dentist's/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist's Signature

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

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

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

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

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

II. 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.