



# Sachem Central School District

## Central Registration

**Kevin Miller, Ed.D.**  
KMiller3@sachem.edu

**Patti Trombetta,**  
Superintendent of  
Schools

### Documents Required at the Time of Registration

#### Original Birth Certificate with a raised seal

Parental names on the birth certificate must match the parent's photo ID and supporting documents, if they do not, please supply a marriage certificate or court documentation showing the name change.

#### Parent or Guardian's photo identification

The residential parent or guardian of the child must be in attendance at the time of registration. If you are a step-parent, please bring your marriage certificate with you. It is not necessary for your child to be with you at the time of registration.

#### Proof of Residency from Parent/Guardian (all must provide first and second proof):

##### First Proof

1. **Homeowners, Proof of Ownership**
  - a. Current mortgage statement or
  - b. Current yearly property tax bill or
  - c. Indenture documents if registering within 90 days of closing
2. **Renters in an Apartment Complex**
  - a. Original lease must be signed by both the parent/guardian and complex management. The lease must be current. Registration cannot take place prior to the move in date.
3. **Renting or Living in a Private Home that you do not own**
  - a. Residents living in a privately owned home that he/she does not own must submit a Statement of Residence. The affidavit must have both the homeowner's and the parent/guardian's signatures. The homeowner must also provide the current month's mortgage statement or current year's tax bill. Registration cannot take place prior to the move in date. The Affidavit of Residence form is available on the Sachem website as well as at the Central Registration Office.

##### Second Proof- Must be in the parent/guardian's name

1. Utility bill (electric, gas, cable, house telephone or water) or car insurance document dated within 30 days of registration.
2. If the above is not possible, three separate documents addressed to the residence are required. They must be dated within 30 days of registration. Examples of such are payroll stub, health insurance statement, cell phone bill, governmental agency letter, bank statement, medical bill, etc.

#### Immunization as mandated by the New York State Department of Health.

Proof of required **immunizations** for school entry is mandated by the New York State Department of Health and must be presented at the time of registration. Current immunization requirements can be provided at the Central Registration Office or found at <http://www.health.ny.gov/publications/2370.pdf>. The child's immunization booklet is not acceptable. Proof must be on physician's letterhead and signed by either actual signature, electronic signature, or signature stamp.

#### Health Examination as mandated by the New York State Department of Health

All new entrants must have a **Health Examination**. The physical examination form will be accepted if it is dated not more than twelve months prior to the student's first day of attendance. If this documentation cannot be presented at the time of registration, it must be provided to the school within 30 days of the student's first day of attendance. The student may receive a physical examination from the school physician if the documentation is not received. A Dental Health Certificate is suggested but not required for registration. Both dental and physical forms can be provided at the Central Registration Office or on the Sachem website,

[https://sachem.edu/Assets/Health\\_Services\\_Documents/040423\\_NYS\\_Health\\_Examination\\_Form-All.pdf?t=638161947161300000](https://sachem.edu/Assets/Health_Services_Documents/040423_NYS_Health_Examination_Form-All.pdf?t=638161947161300000)

**If your child receives Special Ed or Related Services, you must supply the IEP at the time of registration.**

**Custody Issues** (if applicable) – Please supply any court documents regarding custody

51 School Street  
Lake Ronkonkoma,  
NY 11779  
631-471-7861  
ext.1145



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www.sachem.edu



# Sachem Central School District

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Schools

### Documentos requeridos al momento de registro

#### Acta de Nacimiento original con sello en relieve

Los nombres de los padres en el certificado de nacimiento deben coincidir con la identificación de los padres y los documentos de respaldo; si no es así, proporcione un certificado de matrimonio o documentación judicial que muestre el cambio de nombre.

#### Identificación con fotografía de los padres o tutores

El padre o tutor residencial del niño debe estar presente en el momento de la inscripción. Si es padrastro o madrastra, traiga su certificado de matrimonio. No es necesario que su hijo esté con usted en el momento de la inscripción.

### Prueba de residencia del padre/tutor (todos deben proporcionar primera y segunda prueba):

#### Primera prueba

1. **Propietarios, Prueba de propiedad**
  - a. Estado de cuenta actual de la hipoteca o
  - b. Factura anual actual de impuestos a la propiedad o
  - c. Documentos de contrato si se registra dentro de los 90 días posteriores al cierre
2. **Renters in an Apartment Complex**
  - a. El contrato de arrendamiento original debe estar firmado por el padre/tutor y la administración del complejo. El contrato de arrendamiento debe estar al día. El registro no puede realizarse antes de la fecha de mudanza.
3. **Alquilar o vivir en una casa privada que no es de su propiedad**
  - a. Los residentes que vivan en una casa privada que no sea de su propiedad deben presentar una Declaración de residencia. La declaración jurada debe tener la firma del propietario y del padre/tutor. El propietario también debe proporcionar el estado de cuenta de la hipoteca del mes actual o la factura de impuestos del año en curso. El formulario de declaración jurada de residencia está disponible en el sitio web de Sachem, así como en la oficina central de registro.

#### Segunda prueba- Debe estar a nombre del padre/tutor

1. Factura de servicios públicos (electricidad, gas, cable, teléfono de la casa o agua) o documento de seguro de automóvil con fecha dentro de los 30 días posteriores al registro.
2. Si lo anterior no es posible, se requieren tres documentos separados dirigidos a la residencia. Deben estar fechados dentro de los 30 días posteriores al registro. Ejemplos de tales son talón de nómina, declaración de seguro médico, factura de teléfono celular, carta de agencia gubernamental, extracto bancario, factura médica, etc.

### Vacunación según lo dispuesto por el Departamento de Salud del Estado de Nueva York.

El Departamento de Salud del Estado de Nueva York exige la prueba de las vacunas requeridas para ingresar a la escuela y se debe presentar en el momento de la inscripción. Los requisitos de vacunación actuales se pueden proporcionar en la oficina de registro central o se pueden encontrar en

<http://www.health.ny.gov/publications/2370.pdf>. El folleto de vacunación del niño no es aceptable. La prueba debe estar en papel con membrete de médico y estar firmada con una firma real, una firma electrónica o un sello de firma.

### Examen de salud según lo dispuesto por el Departamento de Salud del Estado de Nueva York

Todos los nuevos ingresantes deben tener un examen de salud. Se aceptará el formulario de examen físico si tiene una fecha de no más de doce meses antes del primer día de asistencia del estudiante. Si esta documentación no se puede presentar en el momento de inscripción, se debe proporcionar a la escuela dentro de los 30 días posteriores al primer día de asistencia del estudiante. El estudiante puede recibir un examen físico del médico de la escuela si no se recibe la documentación. Se sugiere un certificado de salud dental, pero no se requiere para el registro. Tanto los formularios dentales como los físicos se pueden proporcionar en la oficina central de registro o en el sitio web de Sachem, [https://sachem.edu/Assets/Health\\_Services\\_Documents/040423\\_NYS\\_Health\\_Examination\\_Form-All.pdf?t=638161947161300000](https://sachem.edu/Assets/Health_Services_Documents/040423_NYS_Health_Examination_Form-All.pdf?t=638161947161300000)

**Si su hijo recibe educación especial o servicios relacionados, debe proporcionar el IEP en el momento de la inscripción.**

**Cuestiones de custodia** (si es aplicable) – Proporcione todos los documentos judiciales relacionados con la custodia.

51 School Street  
Lake Ronkonkoma,  
NY 11779  
631-471-7861  
ext.1145



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# SACHEM CENTRAL SCHOOL DISTRICT

Patti Trombetta  
Superintendent of Schools

Kevin Miller  
Attendance Teacher

Central Registration  
51 School Street  
Lake Ronkonkoma, NY 11779  
(631) 471-7861  
Request for Student Records

Date: \_\_\_\_\_ Student's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Current/Entering Grade \_\_\_\_\_

The above listed student has enrolled in the Sachem Central School District on \_\_\_\_\_.  
Please send all applicable records pertaining to this student to the school indicated below.  
Thank you.

- Immunization Records/Current Physical/Health Records
- Standardized Test Data/NYS Assessments
- Attendance Record
- Withdrawal Grades
- Most Recent Report Card
- Science Labs
- Transcript
- NYSESLAT Scores
- IEP(Individualized Education Plan); if applicable
- Most Recent Special Education Evaluations; if applicable

<b>Cayuga Elementary School</b> 865 Hawkins Avenue Lake Grove, NY 11755 (631)471-1800	<b>Chippewa Elementary School</b> 31 Morris Avenue Holtsville, NY 11742 (631)696-8640	<b>Grundy Elementary School</b> 950 Grundy Avenue Holbrook, NY 11741 (631)471-1820	<b>Hiawatha Elementary School</b> 97 Patchogue-Holbrook Road Lake Ronkonkoma, NY 11779 (631)471-1830
<b>Lynwood Elementary School</b> 50 Lynwood Avenue Farmingville, NY 11738 (631)696-8650	<b>Merrimac Elementary School</b> 1090 Broadway Avenue Holbrook, NY 11741 (631)244-5670	<b>Nokomis Elementary School</b> 151 Holbrook Road Holbrook, NY 11741 (631)471-1840	<b>Tamarac Elementary School</b> 50 Spence Avenue Holtsville, NY 11742 (631)244-5680
<b>Waverly Avenue Elementary</b> 1111 Waverly Avenue Holtsville, NY 11742 (631)654-8690	<b>Wenonah Elementary School</b> 251 Hudson Avenue Lake Grove, NY 11755 (631)471-1880	<b>Sagamore</b> 57 Division Street Holtsville, NY 11742 (631)696-8600	<b>Samoset</b> 51 School Street Lake Ronkonkoma, NY 11779 (631)471-1700
<b>Seneca</b> 850 Main Street Holbrook, NY 11741 (631)471-1850	<b>Sachem High School East</b> 177 Granny Road Farmingville, NY 11738 (631)716-8200	<b>Sachem High School North</b> 212 Smith Road Lake Ronkonkoma, NY 11779 (631)471-1400	<b>Sachem CSD-OISA Home Schooling</b> 51 School Street, Rm. 203 Lake Ronkonkoma, NY 11779 (631)471-1348

\_\_\_\_\_  
Parent or Guardian Signature      Date

\_\_\_\_\_  
School Personnel Signature

**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.



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

Lisette 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

TO BE COMPLETED BY SCHOOL PERSONNEL

Country of birth: \_\_\_\_\_

Date of student's initial entry to US:  
Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Country from which student emigrated: \_\_\_\_\_

Number of years attended school outside of the U.S.: \_\_\_\_\_

Schools attended outside of the U.S.: \_\_\_\_\_

Number of years attended school within the U.S.  
(including pre-school): \_\_\_\_\_

Date the student entered U.S. schools:  
Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

English speaking contact: \_\_\_\_\_  
Phone # \_\_\_\_\_

If translator needed, preferred language: \_\_\_\_\_

**Home Language Questionnaire (HLQ)**

**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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	_____
	<input type="checkbox"/> Guardian(s)		_____
			specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak
			specify
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
			specify
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write
			specify

**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? \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or of Person in Parental Relation

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_  
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:

# HOUSING QUESTIONNAIRE

Name of School: \_\_\_\_\_

Name of Student: \_\_\_\_\_  
Last First Middle

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_

**The answer you give below may 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 may also be entitled to transportation and other services.**

Where is the student currently living? (Please check **one**)

\_\_\_\_\_ In Permanent Housing (house, apartment, trailer)

\_\_\_\_\_ In a Shelter

\_\_\_\_\_ With Another Family because of loss of housing or as a result of economic hardship

\_\_\_\_\_ In a Hotel/Motel

\_\_\_\_\_ In a Car, Park, Bus, Train or Campsite

\_\_\_\_\_ Other (please describe) \_\_\_\_\_

\_\_\_\_\_  
**Print** Name of Parent, Guardian  
(or Student if Unaccompanied Youth)

\_\_\_\_\_  
**Signature** of Parent, Guardian  
(or Student if Unaccompanied Youth)

\_\_\_\_\_  
Date

If the student is NOT living in permanent housing, please ensure that a Designation Form is completed.



# 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: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

### HEALTH HISTORY

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

<input type="checkbox"/> <b>Allergies</b>	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> <b>Asthma</b>	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> <b>Seizures</b>	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> <b>Diabetes</b>	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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/m<sup>2</sup>

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

**Hyperlipidemia:** ☐ Yes ☐ Not Done

**Hypertension:** ☐ Yes ☐ Not Done

### PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Lead Level</b> Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

☐ **System Review Within Normal Limits**

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> 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:	
<b>SCREENINGS</b>					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
<b>Vision Screening</b>	<b>With Correction</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
Notes					
<b>Hearing Screening:</b> 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.					<b>Not Done</b>
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
<b>Scoliosis Screening:</b> Boys grade 9, Girls grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
<b>FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>*Family cardiac history reviewed</b> – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b>					
<b>If Restrictions Apply</b> – Complete the information below					
<input type="checkbox"/> <b>Student is restricted from participation in:</b>					
<input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> <b>Other Restrictions:</b>					
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level.					
<b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> <b>Other Accommodations*:</b> Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):					
<small>*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.</small>					
<b>MEDICATIONS</b>					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
<b>COMMUNICABLE DISEASE</b>			<b>IMMUNIZATIONS</b>		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
<b>HEALTHCARE PROVIDER</b>					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form to Your Child's School Health Office When Completed.</b>					

Sachem Central School District  
**STUDENT HEALTH HISTORY UPDATE**

Name:	DOB: Grade:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	
Seen a medical specialist	<input type="checkbox"/>	<input type="checkbox"/>	
Had allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other
Been hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	
Had an operation	<input type="checkbox"/>	<input type="checkbox"/>	
Had an injury requiring an Emergency Room visit	<input type="checkbox"/>	<input type="checkbox"/>	
Missed 5 days of school in a row due to illness/injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a bone/muscle injury	<input type="checkbox"/>	<input type="checkbox"/>	
Passed out, had a concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a convulsion/seizure	<input type="checkbox"/>	<input type="checkbox"/>	
Had a vision problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> glasses <input type="checkbox"/> contacts
Had a hearing problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant
Worn dental bridge, braces or mouthpiece	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Have any family members under the age of 50 ever:</b>	<b>YES</b>	<b>NO</b>	<b>If Yes, please specify:</b>
Had a heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
Had other serious health problems	<input type="checkbox"/>	<input type="checkbox"/>	

**CHECK ALL THAT APPLY TO YOUR CHILD:**

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

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

**FAMILY HEART HEALTH HISTORY**

A relative has/had any of the following:

Check all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy<br><input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy?<br><input type="checkbox"/> Heart rhythm problems, long or short QT interval? | <input type="checkbox"/> Brugada Syndrome?<br><input type="checkbox"/> Catecholaminergic Ventricular Tachycardia?<br><input type="checkbox"/> Marfan Syndrome (aortic rupture)?<br><input type="checkbox"/> Heart attack at age 50 or younger?<br><input type="checkbox"/> Pacemaker or implanted cardiac defibrillator (ICD)? |
|---|--|

A family history of:

- ☐ Known heart abnormalities or sudden death before age 50?  
 ☐ Structural heart abnormality, repaired or unrepaired?  
☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

Name:	Affirmed Name (if applicable):	DOB:
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If you answered <b>YES</b> to any questions give details. Sign and date below.	
Parent/Guardian Signature:	Date:

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:	/	/	Sex: <input type="checkbox"/> Male	Will this be your child's first oral health assessment ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Month	Day	Year	<input type="checkbox"/> Female	
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.**

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#### 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.