Sachem Central School District

Central Registration

Kevin Miller, Ed.D.
Kmiller3@sachem.edu

Patti Trombetta,
Superintendent of Schools

Documents Required to Register for a Pre-School Evaluation

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 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.

CPSE/CSE Registration Packet
Registration Packet provided on this web page or at the Central Registration office to be filled out in its entirety.

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 statement must be completed and signed by both the homeowner and the parent/guardian. 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 Statement 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.

Health Examination as mandated by the New York State Department of Health
All new entrants must have a Health Examination dated within one year of their child's first CSE/CPSE meeting which will take place approximately 60 days from registration. The physical examination form is not required for the registration, however, if your child had a physical examination within the time period required, it would be helpful to provide it at the time of registration. If your child has not had a physical within the last year, physical forms are 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. Please make arrangements to have the Physical Examination completed before your child's CSE/CPSE meeting.

Students with existing IEP's
If your preschool aged child has an IEP from their previous school district, please provide the IEP at the time of registration. If the IEP is not available to you, you will be required to sign a Release of Information form allowing Sachem CSD to obtain this information from your previous school district.

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

#WeAreSachem

Sachem Central School District

Office of Student Services

Patricia Trombetta, Superintendent of Schools

Elizabeth Caruana
Executive Director
for Special Education

Ashley Shepard
Administrator for Elementary
Special Education

Coleen Flanagan
Administrator for Secondary
Special Education

Jennifer Kropff
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for Special Education

The Sachem Central School District provides special education services and programs to students with disabilities pursuant to applicable federal and state laws. A parent or person in parental relation who suspects that his/her child has a disability may refer the child for an evaluation by the District's Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE), for eligibility for special education services and programs. More detailed information on this process is available in *A Parent's Guide to Special Education*, which is published on the New York State Education Department's website in English and Spanish.

Parents or persons in parental relation should contact the District's Executive Director of Special Education, Elizabeth Caruana at bcaruana@sachem.edu or 631-471-1890 extension 1230.

A Parent's Guide to Special Education (English)

A Parent's Guide to Special Education (Spanish)

*Copies of these documents will also be made available in the Central Registration Office.

Office Use Only

Registration Date: _____

Student ID#: _____

Residency Proof: _____

Age Verification: _____

Immunizations:_____

Records Requested: _____

School: _____

Grade: _____

OSS ☐ ☐ _____

NO YES

Other:

Sachem Central School District

Student Registration Form

STUDENT INFORMATION: LIST NAME AS APPEARS ON BIRTH CERTIFICATE

Last Name of Student **First Name of Student** **Middle Name (*not initial*)**

Address

Mailing Address if Different

IS THE STUDENT HISPANIC, LATINO, OR OF SPANISH ORIGIN?_____YES_____NO

Child's Ethnic Code (Circle all that apply) **Gender**: M or F

1. **American Indian/ Alaskan Native**
2. **Asian**
3. **Black**
4. **White**
5. **Native Hawiian/ Pacific Islander**

Date of Birth _____

Birth City and State_____

Household Language if not English_____

****

Parent/Guardian #1

Last Name **First Name** **Marital Status** **Relationship to Child**

Address (Write SAME if not different from child) **Email Address**

Home Phone 1 2 3 **Cell Phone 1 2 3** **Work Phone 1 2 3**

(Please circle the order of preference that you would like to be contacted in for each telephone number provided)

****

Parent/Guardian #2 (Please list all parents on the birth certificate even if address is unknown)

Last Name **First Name** **Marital Status** **Relationship to Child**

Address (Write SAME if not different from child) **Email Address**

Home Phone 1 2 3 **Cell Phone 1 2 3** **Work Phone 1 2 3**

(Please circle the order of preference that you would like to be contacted in for each telephone number provided)

****

*** Who does child live with?** Parents_____ Mom _____ Dad _____ Legal Guardian _____

*** Is either parent a member of the Armed Forces and on active duty? If yes, please indicate the date mother and/or father started active duty.**_____

*** Are there any special custody regulations regarding your child? (** Circle One) YES NO (if yes, please provide a copy of the court order**)**

* **Is enrollment related to homelessness?** (Circle One) YES NO

*** Name and Address of Current or Previous School**_____**Grade** _____

*** Has this child ever attended Sachem Schools, applied for transportation from Sachem or applied for services before including as a pre-schooler?**

(Circle One) YES NO *If yes, please list last date and school attended*_____

*** Does this child receive any Special Education services?** (Circle One) YES NO ***Has your child been declassified with support services?** YES NO

If yes, please check type of service(s) received. SPECIAL CLASS _____ RESOURCE ROOM _____ RELATED SERVICES_____

***Does this child receive any ESL/ENL Services?** (Cirlce One) YES NO ***Has your child ever received ESL Services?** YES NO

* **Please list all brothers and sisters that live in your home under the age of 21. If none, please write N/A.**

Name of Sibling	Date of Birth	Grade	School	Name of Sibling	Date of Birth	Grade	School

Parent/Guardian Signature_____ Date _____

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.

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

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:			GENDER:
			❑ Male ❑ Female
Month	*Day*	*Year*	

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:		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: ❑ 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:

COUNTY OF SUFFOLK

EDWARD P. ROMAINE
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES

GREGSON H. PIGOTT, MD, MPH
Commissioner

SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES
DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
SCHOOL DISTRICT HOME LANGUAGE SURVEY

Child's Name: _____ Child's DOB: _____
School District /Name of Person Completing Form: _____

SCHOOL DISTRICT INSTRUCTIONS:
If the answer for #2 is "No" then complete the rest of this side of the form and fax to evaluator along with consent and referral for a bilingual evaluation.
If the answer is yes then just fax to evaluator with consent to schedule a monolingual evaluation.

1. What is your Relationship to the Child [ ] Mother [ ] Father [ ] Guardian
2. English is the only language my child is exposed to: [ ] Yes [ ] No
3. Compared to other children his/her age do you think your child is speaking as well as they are? [ ] Yes [ ] No
4. What language did your child learn when he/she first began to talk? _____
5. What language(s) does your family speak in your home? _____
6. What language(s) does the mother speak to the child? _____
7. What language(s) does the father speak to the child? _____
8. What language does the caretaker speak to your child? _____
9. What language(s) does your child seem to respond to most readily? _____
10. What language does your child speak to his brothers/sisters/peers? _____
11. Has your child been exposed to English for at least 3 months? _____

School District Instructions: In cases where a child has been recently adopted from another country please suggest a three month waiting period.

12. Did your child spend time in a: [ ] Foster home [ ] Orphanage If so where? _____

PublicHealth
Prevent. Promote. Protect.

DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
3500 Sunrise Highway, PO Box 9006, Great River, NY 11739-9006
(631) 853-3130 | Fax (631) 853-2310

EVALUATOR SURVEY

Evaluator is to complete this side of form and send a copy to school district:

Name of evaluator completing this form: _____

Do you expect your child to or has your child been exposed to:

Wash Hands independently with soap and water? [ ]Yes [ ]No

Taking off and put on independently: Coat [ ]Yes [ ]No

Pants [ ]Yes [ ]No

Skirt [ ]Yes [ ]No

Shirt [ ]Yes [ ]No

Shoes [ ]Yes [ ]No

Toileting independently [ ]Yes [ ]No

Using a spoon/fork when eating [ ]Yes [ ]No

Walking up and down stairs independently [ ]Yes [ ]No

Peddling a tricycle [ ]Yes [ ]No

Playing (throwing/Catching) with a ball [ ]Yes [ ]No

Playing with other children at home or community [ ]Yes [ ]No

Using a Scissors [ ]Yes [ ]No

Using crayons, markers, pencils [ ]Yes [ ]No

Following directions [ ]Yes [ ]No

One Step [ ]Yes [ ]No

Two Step [ ]Yes [ ]No

How many words does your child have in his/her Vocabulary? _____

Do you have simple conversations [ ]Yes [ ]No

If yes such as_____

Imitate actual experiences from his/her life or from TV [ ]Yes [ ]No

Participate in pretend play (make believe) [ ]Yes [ ]No

Are books read to your child? [ ]Yes [ ]No

If yes by whom?_____ and in what language? _____

What kind of family activities does your child enjoy? _____

Do you think your child is doing the same things as other children his age? [ ]Yes [ ]No

If no what is your child not doing? _____

Do you have any concerns about how your child interacts with other children? [ ]Yes [ ]No

If yes what are your concerns? _____

Do you have any other concerns about your child? _____

_____

Public Health
Prevent. Promote. Protect.

DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
3500 Sunrise Highway, Great River, NY 11739-9006
(631) 853-3130 | Fax (631) 853-2310

*Student ID*_____ *Home School* _____

Referral/Authorization to Committee on Preschool Special Education (CPSE)

Child's Name/DOB: _____**Parent/Guardian:** _____

Address:_____ **Home /Cell:**_____

E-Mail _____

Dominant Lang. Child/Parent:_____

Nursery School Attending/Day/Time:_____

Is child currently receiving early intervention services: _____Yes _____ No
Name of Early Intervention Coordinator/Designee _____
Has this student received services/evaluation prior to this referral? _____ Yes _____No

---

Parent concerns checklist

CHECK IF YOUR CHILD HAS A HISTORY OF:

__seeming too quiet/withdrawn

__ear infections/fluid in ears

__not always knowing where sound/voice is coming from

__complaints about noises being too loud

__talking in a loud voice/hearing loss

__late speech development/not speaking clearly

__stuttering

__vision problems/amblyopia

__being clumsy, awkward

__poor adjustment to nursery school

__blood relative with delay/disability

__being very restless

__confusion if asked to do more than one task

__answering questions inappropriately

__saying "what" a lot

__poor eating habits

__difficulty with textures, choking, gagging

__poor sleeping habits

__poor social interaction

__difficulty tolerating touch

__not paying attention

__ other medical _____

REASON FOR REFERRAL: _____

****

OFFICE USE ONLY:

AGENCY:_____TENTATIVE CPSE DATE/TIME:_____

___*Social History* ___*Psychological* ___*Educational* ___*Speech/Language* ___*Physical Therapy*

___*Occupational Therapy* ___*Audiological* ___*Structured Observation* ___*Yearly Physical*

Date	# of Pages :
To	**From**
Co./Dept.	Co.
Phone #	Phone #
Fax#	Fax #

Sachem Central School District

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Jennifer Kropff
Assistant Director
for Special Education

AUTHORIZATION FOR RELEASE OF INFORMATION

Date:_____

I, _____, request that all psychological data, social
(Parent/Guardian)

history, information, speech and language reports and any other confidential information available from the records of my child, _____, date of birth, _____, be released to/by the Sachem Central School District Special Education Office.

_____
Signature

_____
Relationship

_____
Address

_____

_____

_____

Sachem Central School District
Committee on Special Education
Office of Student Services
51 School Street
Lake Ronkonkoma, NY 11779
(631) 471-1890

Written Notification Regarding Use of Public Benefits or Insurance to Pay for Certain Special Education and Related Services

INTRODUCTION: You are receiving this written notification to give you information about your rights and protections under the federal Individuals with Disabilities Education Act (IDEA), so that you can make an informed decision about whether you should give your written consent to allow your school district to use your or your child's public benefits or insurance to pay for special education and related services that your school district is required to provide at no cost to you and your child under IDEA. Funds from a public benefits or insurance program (for example, Medicaid funds) may be used by your school district to help pay for special education and related services, but only if you choose to provide your consent, as explained below.

Before your school district can ask you to provide your consent to access your/your child's public benefits or insurance for the first time, it must provide you with this notification of the rights and protections available to you under IDEA. This notification is intended to help you understand these rights and protections, including the type of consent your school district will ask you to provide. If you choose not to provide your consent, or later decide to withdraw your consent, your school district has a continuing responsibility to ensure that your child is provided all required special education and related services under IDEA at no charge to you or your child.

Parental Consent: Beginning on **July 3, 2013**, before your school district can use your or your child's public benefits or insurance for the first time to pay for special education and related services under IDEA, it must obtain your signed and dated written consent. Your school district is only required to obtain your consent one time. This consent requirement has two parts.

1. Consent to share records about your child: Your school district is required to obtain your written consent before disclosing [sharing] personally identifiable information about your child (such as your child's name, address, social security number, Individualized Education program (IEP), and evaluation results) from your child's education records. In asking for your consent, the district will (1) identify the records [or information] about your child that will need to be shared (for example, about the services that may be provided to your child); (2) tell you the purpose of sharing the records (for example, billing for special education and related services); and (3) identify the agency to which your school district may disclose the information (for example, the Medicaid agency).

2. Consent to bill your public insurance program (for example, Medicaid): Your consent must include a statement specifying that you understand and agree that your school district may use your or your child's public benefits or insurance (e.g., Medicaid) to pay for some of your child's special education services.

If your school district has on file your consent that you provided before July 3, 2013 to release your child's records and to use your or your child's public benefits or insurance to pay for special education and related services, your school district is required to request a new consent from you only when there is a change in any of the following: the type of services to be provided to your child (for example, physical therapy or speech therapy), the amount of services to be provided to your child (for example, hours per week lasting for the school year), or the cost of services (that is, the amount charged to the public benefits or insurance program).

If any of these changes occur, your school district must obtain from you a new one-time consent. Before you provide your school district the new, one-time consent, your school district must provide you with this notification. Once you provide this one-time consent, you will not be required to provide your school district with any additional consent in order for it to access your/your child's public benefits or insurance even if your child's services change in the future. However, your school district must continue to provide you with this notification annually.

You have the right to withdraw your consent at any time. If you withdraw your consent, the school district must still provide all of your child's IEP special education and related services at no cost to you. To withdraw your consent, you will need to submit your request in writing to your child's school district.

NO COST PROVISIONS: The IDEA "no cost" protections regarding the use of public benefits or insurance are as follows:

1. Your school district may not require you to sign up for, or enroll in, a public benefits or insurance program in order for your child to receive a free appropriate public education.

2. Your school district may not require you to pay any out-of-pocket expenses, such as the payment of a deductible or co-pay amount for filing a claim for services that your school district is otherwise required to provide your child without charge.

3. Your school district may not use your or your child's public benefits or insurance if using those benefits or insurance would:

- Decrease your available lifetime coverage or any other insured benefit, such as a decrease in your plan's allowable number of physical therapy sessions available to your child or a decrease in your plan's allowable number of sessions for mental health services;

- Cause you to pay for services that would otherwise be covered by your public benefits or insurance program because your child also requires those services outside of the time your child is in school;

- Increase your premium or lead to the cancellation of your public benefits or insurance; or

- Cause you to risk the loss of your child's eligibility for home and community-based waivers that are based on your total health-related expenditures.

We hope this information is helpful to you in making an informed decision regarding whether to allow your school district to use your or your child's public benefits or insurance to pay for special education and related services under IDEA. Contact information: For additional information and guidance on the requirements governing the use of public benefits or insurance to pay for special education and related services see: **http://www2.ed.gov/policy/speced/reg/idea/part-b/part-b-parental-consent.html. .gov/policy/speced/reg/idea/part-b/part-b-parental-consent.html.**

Suffolk County Department of Health
Office of Children with Special Needs
Preschool Special Education Program

Medicaid Consent Form

Dear Parent/Guardian of:_____Child's SS# /CTN#_____

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's Individualized Education Program ("IEP "). This consent allows the School District/Suffolk County to bill for covered health-related services and to release information to the School District's Medicaid billing agent for that purpose.

I have received with this Medicaid Consent Form separate written notification from the School District or IEP service provider that explains in detail my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the School District/Suffolk County may access Medicaid to pay for special education and related services provided to my child.

I understand that providing consent will not impact my or my child's Medicaid coverage. Upon request, I may review copies of records disclosed pursuant to this authorization. Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid. I have the right to withdraw consent at any time and the School District must give me annual written notification of my rights regarding this consent.

I also give my consent for the School District or Suffolk County or IEP service provider to release the following records and information about my child to the State's Medicaid Agency for the purpose of billing for special education and related services that are in my child's IEP:

-- **Records and service information that likely will be shared** --	
Prescriptions	Service Provider Attendance
Referrals	"Under the Direction of' Certification
Treatment Logs	"Under the Supervision of' Certification
Individualized Education Program - IEP	"Under the Direction of' Logs
Calendar and Attendance Records	"Under the Supervision of' Logs
Bus Logs	Other unnamed documents needed to support Medicaid claims

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless ofmy decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Print Parent/Guardian Name:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Parent/Guardian Signature:_____Date:_____

EJEMPLO DE FORMULARIO DE CONSENTIMIENTO PARA TENER ACCESO AL SEGURO DE MEDICAID DE UN PADRE O ESTUDIANTE PARA OBTENER EL PAGO DE ALGUNOS SERVICIOS DE EDUCACIÓN ESPECIAL EN EL PROGRAMA DE EDUCACIÓN PERSONALIZADA DEL ESTUDIANTE (IEP)

Estimado padre (madre)/tutor_____:

La presente es para solicitar su permiso (consentimiento) para facturarle a su Programa de Seguros Medicaid, o al de su hijo, por la educación especial y los servicios relacionados que forman parte del programa de educación personalizada de su hijo (IEP).

Este consentimiento permite que el distrito escolar facture los servicios cubiertos relacionados con la salud y que divulgue, con este propósito, información al Agente de facturación de Medicaid del distrito escolar.

Yo, _____ como padre (madre)/tutor de _____,
(Coloque el nombre de su hijo en letra de molde)
recibí una notificación escrita del distrito escolar que explica los derechos federales que están relacionados con el uso de beneficios públicos o de seguro para el pago de cierta educación especial y servicios relacionados.

Comprendo y acepto que el distrito escolar podría tener acceso a Medicaid para que pague por la educación especial y los servicios relacionados que se le prestan a mi hijo.

Comprendo que:

- el dar mi consentimiento no tendrá ninguna consecuencia para la cobertura de Medicaid de mi hijo o mía.
- a solicitud, puedo revisar las copias de los registros divulgados como resultado de esta autorización;
- los servicios enumerados en el IEP de mi hijo, deben prestarse sin costo alguno para mí, independiente de si doy o no mi consentimiento para que se le facture a Medicaid;
- tengo derecho de retirar mi consentimiento en cualquier momento; y
- el distrito escolar deberá entregarme una notificación escrita de los derechos relacionados con este consentimiento.

También doy mi consentimiento para que el distrito escolar divulgue la siguiente información, o los registros sobre mi hijo, a la Agencia estatal de Medicaid con propósitos de facturación de educación especial y servicios relacionados que forman parte del IEP de mi hijo. Se compartirán los siguientes registros.

Registros que se compartirán (tal como registros o información sobre los servicios que recibe su hijo)
IEP
Orden Escrito/Referido
Reportes de Evaluaciones
Notas de sesiones
Reporte de Administración de Medicamento
Registro de Transporte Especial
Otra Información Identificable Personalmente
Cualquier Otros Informes o Archivos Especifica Relativas a los Servicios del Estudiante o Programa

Doy mi consentimiento voluntario y comprendo que puedo retirar mi consentimiento en cualquier momento. También comprendo que el derecho de mi hijo de recibir educación especial y servicios relacionados no depende de que yo otorgue este consentimiento y que, independientemente de mi decisión de otorgar este consentimiento, a mi hijo se le prestarán todos los servicios requeridos en el IEP, sin costo alguno.

Nùmero de CIN _____

Nombre y firma del padre (madre)/tutor:

_____
Nombre en letra de molde

_____
Fecha

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: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	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: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

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

☐ **System Review Within Normal Limits**

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

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

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: 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	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

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

If Restrictions Apply – Complete the information below

☐ **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

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

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

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.