HUDSON FALLS CENTRAL SCHOOL DISTRICT

PART 1: ENROLLMENT/REGISTRATION REQUIREMENTS Pre-K & Kindergarten

Student Name: _____

____ **SIGNED RESIDENCY QUESTIONNAIRE**

____ **COMPLETED AND SIGNED REGISTRATION FORM**

____ **PROOF OF RESIDENCY**

- LEASE AGREEMENT OR NOTORIZED STATEMENT FROM LANDLORD THAT INCLUDES THE FULL ADDRESS OF YOUR RESIDENCE
- COPY OF PURCHASE CONTRACT FOR THE RESIDENCE YOU WILL BE LIVING IN, WITH LETTER FROM ATTORNEY THAT INCLUDES DATE/TIME OF CLOSING
- NOTORIZED STATEMENT FROM A THIRD PARTY ESTABLISHING THE PHYSICAL PRESENCE OF THE PARENT/GUARDIAN IN THEIR HOUSEHOLD IN THE SCHOOL DISTRICT
- COPY OF DEED

ACCEPTED ALTERNATE FORMS OF RESIDENCY IF THE ABOVE ARE UNAVAILABLE

- PAY STUB
- INCOME TAX FORM
- UTILITY BILL
- OFFICIAL DRIVER'S LICENSE, LEARNER'S PERMIT, OR NON DRIVER ID
- STATE OR OTHER GOVERNMENT ISSUED ID
- DOCUMENTS ISSUED BY FEDERAL, STATE OR OTHER LOCAL AGENCIES

____ **BIRTH CERTIFICATE BAPTISMAL RECORD PASSPORT**

ACCEPTED ALTERNATE FORMS IF THE ABOVE ARE NOT AVAILABLE

- OFFICIAL DRIVERS LICENSE OF STUDENT (if applicable)
- SCHOOL PHOTO ID WITH DATE OF BIRTH
- CONSULATE ID CARD WITH DATE OF BIRTH
- MILITARY DEPENDENT ID WITH DATE OF BIRTH
- NATIVE AMERICAN TRIBAL DOCUMENTS WITH DATE OF BIRTH

____ **COURT CUSTODY PAPERS or CUSTODIAL AFFADAVITS (if applicable)**

____ **REQUEST FOR RELEASE OF RECORDS COMPLETED AND SIGNED**

Hudson Falls Central School District

ENROLLMENT FORM – RESIDENCY QUESTIONNAIRE

Name of School/LEA: _____

Legal Name of Student : _____
Last First Middle

Gender: Male / Female Date of Birth: _____ / _____ / _____ Grade: _____ Student ID # _____
Month Day Year PreK - 12

Current Address: _____ Phone: ____ - ____ - ____
House # Street Apt/Lot # City

Previous Address: _____
House # Street Apt/Lot # City

The answer you give below will help the district determine what services you or your child may be able to Receive under the McKinney-Vento Act. Students that are protected under the McKinney-Vento Act are Entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

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

_____ In permanent housing (*your own apartment or house*)

_____ In a shelter

_____ With another family because of loss of housing or economic hardship (referred to as "doubled up")

_____ In a hotel/motel

_____ In a car, park, bus, train or campsite

_____ Other temporary living situation (please describe): _____

_____ _____

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

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

Date: _____

Office Use Only: Signature _____ Date: _____ Time: _____

NOTE TO SCHOOL/LEAS: if the student is **NOT** living in permanent housing, please ensure that a Designation/STAC Form is completed.

Revised 10/19/2016

HUDSON FALLS CENTRAL SCHOOL DISTRICT

PO Box 710
Hudson Falls, NY 12839
(518) 747-2121

REQUEST FOR RELEASE OF STUDENT RECORDS

To:_____ _____
Previous School Name Student Name

_____ _____ _____
Street Address of Previous School Grade Date of Birth

_____ _____ _____
City, State, Zip Code School Fax # School Phone #

The above student has registered for grade _____ at our school district. Please forward, at your earliest convenience, the following school records:

- Academic Record
- Attendance Record
- Health/Immunization Record
- Standardized Test Data
- Approx. grades for the current marking period
- CSE Records (IEP, Social History, Psycho-educational Evaluation, Speech Evaluation, OT/PT Scripts, Medical Records, Medicaid Consent Form)

*It is understood that the privilege and confidential nature of such records will be preserved.

These records should be sent to the following indicated address:

Margaret Murphy Kindergarten Center
2 Clark Street
Hudson Falls, NY 12839
Fax: (518) 747-3853
Phone: (518) 681-4512

Hudson Falls Intermediate School
139 Maple Street
Hudson Falls, NY 12839
Fax: (518) 747-2774
Phone: (518) 681-4400

Hudson Falls Middle School
131 Notre Dame Street
Hudson Falls, NY 12839
Fax: (518) 746-2790
Phone: (518) 681-4319

Hudson Falls Primary School
47 Vaughn Road
Hudson Falls, NY 12839
Fax: (518) 747-3502
Phone: (518) 681-4462

Hudson Falls Senior High School
Guidance Dept.
80 East LaBarge Street
Hudson Falls, NY 12839
Fax: (518) 746-9033
Phone: (518) 681-4214

Hudson Falls District Office
80 East LaBarge St.
Hudson Falls, NY 12839
Fax: (518) 681-4136
Phone: (518) 747-2121

I hereby request and direct the above school to release and/or exchange all information pertaining to the above student.

_____ _____
Date Signature of Parent/Guardian

_____
Relationship

Updated 10/19/16

HUDSON FALLS CENTRAL SCHOOL DISTRICT
Student Registration Form

Office Personnel Please Sign & Enter - DATE OF REGISTRATION:

Complete all information carefully. Please print. **GRADE ENTERING:** _____

STUDENT'S LEGAL NAME: _____
(First) (Middle) (Last)

DATE OF BIRTH: _____ **PLACE OF BIRTH:** _____ **GENDER:** ☐Male ☐Female

STREET ADDRESS: _____ **HOME PHONE:** ____-____-____
(Address where Student resides) (No P.O. Boxes) (APT. OR LOT #)

_____, NY _____
City Zip

MAILING ADDRESS: _____
(If different from Street Address)

_____, NY _____
City Zip

FAMILY INFORMATION - Student lives with: ☐Both Parents ☐Mother Only ☐Father Only ☐Mother/Stepfather
☐ Father/Stepmother ☐Grandparents ☐Self ☐Guardian(s)_____(First & Last Name)
☐ Other _____ ☐Foster Parent(s) _____ (First & Last Name)
* Court documents or Custodial /Non-Custodial affidavits stating current custody arrangements must be provided to the school district if student is not living with both parents. ** If a foster placement, a copy of **DSS 2999** form must be submitted.

FATHER: _____ **Home Phone Number** ____-____-____

Cell Number ____-____-____ **Employer:** _____ **Work Number** ____-____-____

Step Parent_____ **Cell Number** ____-____-____ **Work Number** ____-____-____

**Only complete if different than Student*
Street Address _____ **Mailing Address**_____
(if different)

_____ _____

MOTHER: _____ **Home Phone Number** ____-____-____

Cell Number ____-____-____ **Employer:** _____ **Work Number** ____-____-____

Step Parent_____ **Cell Number** ____-____-____ **Work Number** ____-____-____

**Only complete if different than Student*
Street Address _____ **Mailing Address** _____
(if different)

_____ _____

BROTHERS AND SISTERS: (living in same household that are expected to attend one of the schools in our district)

Name: _____ D.O.B.____/____/____ Grade _____ ☐Male ☐Female
Name: _____ D.O.B.____/____/____ Grade _____ ☐Male ☐Female
Name: _____ D.O.B.____/____/____ Grade _____ ☐Male ☐Female
Name: _____ D.O.B.____/____/____ Grade _____ ☐Male ☐Female

OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

Student ID#: _____ Date Entering: _____ Homeroom: _____ Birth Certificate: Yes / No Custody Papers Rec'd: Yes / No

HAS YOUR STUDENT EVER BEEN REGISTERED IN THE HUDSON FALLS SCHOOL DISTRICT : YES / NO (circle one)

PREVIOUS SCHOOL INFORMATION: *Name of School Last Attended*_____

*School Phone Number*_____-_____-_____ *School Fax Number*_____-_____-_____

* Has your child ever repeated a grade? Yes No (Circle One) If yes, which grade: _____

For High School Students, what date did they enter into 9th grade? _____

*** SPECIAL NEEDS OF THE STUDENT**

Does your child currently receive free or reduced lunch? No Free Reduced (Please Circle One)

Does the student receive AIS? Yes No (Please Circle One) If Yes, what subject? _____

* Does the student receive Special Education services? Yes No (Circle One)

If Yes, does he/she currently participate in any of the following: (circle any that apply) IEP - Self Contained Classroom - Consultant Teacher - Resource Room - Speech/Language Therapy - Occupational Therapy - Physical Therapy - 504 Plan - BOCES Placement. Other special needs _____

*** EMERGENCY CONTACT PERSON(s):** When injury, illness or non-emergency situations occur involving your child, we want to be able to quickly reach families and other responsible adults. In the event that we cannot reach a parent/guardian, please list a person you trust who is available during the day to provide care for your child. (Must be a local contact)

Full Name_____ Relationship:_____ Phone Number: _____-_____-_____

Full Name_____ Relationship:_____ Phone Number: _____-_____-_____

Full Name_____ Relationship:_____ Phone Number: _____-_____-_____

Full Name_____ Relationship:_____ Phone Number: _____-_____-_____

Parent/Guardian or Eligible Student Statement: I certify that the above information is true and correct. Any misinformation regarding residency or custody may result in being billed to cover the cost of instruction and/or exclusion from attending the Hudson Falls Central School District. I further understand that it is my responsibility as the Parent/Guardian or Eligible Student to immediately inform the school district of any changes in the information provided.

Parent/Guardian: _____ Date: _____

HUDSON FALLS CENTRAL SCHOOL DISTRICT

PART 2: ENROLLMENT/REGISTRATION REQUIREMENTS **Pre-K & Kindergarten**

PLEASE BE PREPARED TO SUBMIT THE FOLLOWING ADDITIONAL REQUIREMENTS AFTER STUDENT IS ENROLLED

Student Name: _____

____ **HQL: HOME LANGUAGE QUESTIONNAIRE**

____ **STUDENT RACIAL / ETHNIC IDENTIFICATION FORM**

____ **TRANSPORTATION / SITTER FORM**

____ **PESTICIDE APPLICATION**

____ **STUDENT QUESTIONNAIRE**

____ **KINDERGARTEN PARENT INTERVIEW PACKET (Kindergarten Only)**

____ **IMMUNIZATION RECORDS**

____ **RECENT HEALTH APPRAISAL / PHYSICAL**

____ **COMPLETED CUMULATIVE HEALTH RECORD**

____ **DENTAL HEALTH CERTIFICATE (UPK – 5TH grade)**

____ **LEAD SCREENING REPORT (UPK Only)**

HUDSON FALLS CENTRAL SCHOOL DISTRICT
Home Language Questionnaire (HLQ)

Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes English. Your assistance in answering these questions is greatly appreciated.

Thank You

To Be Completed By School Personnel

District: Hudson Falls Central School District School: _____

Student: _____

Date of Birth: _____ ID# _____

Country of Birth: _____

Number of years enrolled in school outside the US: _____

Name/Position of School Personnel Completing This Section:

_____

Determination: _____ Possible LEP _____ English Proficient

(Circle all that apply)

1. What language(s) is spoken in the student's home or residence? English Spanish Other_____ Specify
2. What language(s) are spoken most of the time to the student, in the home or residence? English Spanish Other_____ Specify
3. What language(s) does the student understand? English Spanish Other_____ Specify
4. What language(s) does the student speak? English Spanish Other_____ Specify
5. What language(s) does the student read? English Spanish Other_____ Specify
6. What language(s) does the student write? English Spanish Other_____ Specify
7. In your opinion, how well does the student understand, speak, read and write English? (Please circle one)

Understands English:	Very Well	Only a little	Not at all
Speaks English:	Very Well	Only a little	Not at all
Reads English:	Very Well	Only a little	Not at all
Writes English:	Very Well	Only a little	Not at all

_____ _____

Signature of Parent/Guardian/Other Date

Revised 2016

Hudson Falls Central School District

Student Racial and Ethnic Identification

Student Name: _____ Date of Birth _____
Last First Middle mm/dd/yyyy

Directions to Parent/Guardian: PLEASE ANSWER BOTH QUESTIONS BELOW. PLEASE READ THEM BEFORE YOU RESPOND.

FOR QUESTION (1) **CHECK ONLY ONE** RESPONSE THAT BEST DESCRIBES YOUR CHILD.

FOR QUESTION (2) CHECK ALL GROUPS THAT APPLY TO YOUR CHILD. **Check at least ONE choice.**

1. **Is the student Hispanic, Latino, or of Spanish origin?** Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

_____ **YES**, Hispanic _____ **NO**, Not Hispanic

2. Select one or more races from the following five racial groups.

____ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition. (For example: Cherokee, Mohawk, Inuit, etc.)

____ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

____ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

____ **BLACK:** A person having origins in any of the black racial groups of Africa.

____ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

_____ _____
Signature of Parent/Guardian/Other Date

Relationship to Student (Please circle one): Mother Father Guardian Other (Specify)_____

This form will become part of your child's permanent record. The information you provide on this form is confidential and it is protected by the Confidentiality Regulations cited here: "The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number."

*All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed, or national origin, sex, citizenship, handicapping condition, or immigration status.

Hudson Falls Central School
Transportation Information Form
Hudson Falls School District Policy

1. **Students who are in Pre-K or Kindergarten MUST be met by an Adult, if nobody is there to meet the student, they will be taken back to school.**
2. Transportation Information Form **must be filled out for each school year,** even if the information is the same as the previous year.
3. Transportation Information Forms are available at each school and/or the Transportation Department.

NOTE: REQUEST FORM MUST BE FILLED OUT PRIOR TO CHANGE AND PLEASE PLAN FOR CHANGES TO TAKE A MINIMUM OF ONE WEEK TO PROCESS!

Today's Date _____ Effective Date: _____

Student's Name: _____ Grade: _____

Parent/Guardian Name: _____

Primary Home Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

AM Sitter/Child Care Provider : _____

Address: _____

Sitter Home Phone: _____ Sitter Cell Phone: _____

Please *circle* which days your child will be PICKED UP at daycare:

MON TUES WED THURS FRI

PM Sitter/Child Care Provider : _____

Address: _____

Sitter Home Phone: _____ Sitter Cell Phone: _____

Please *circle* which days your child will be DROPPED OFF to daycare:

MON TUES WED THURS FRI

Parent/Guardian Signature_____

Please mail to: Hudson Falls Central School
Transportation Department
3663 Burgoyne Avenue
Hudson Falls, NY 12839
FAX 518-747-9179

rev 3/30/16

Dear Parent, Guardian, and School Staff:

New York State Education Law Section 409-H, effective July 1, 2001, requires all public and nonpublic elementary and secondary schools to provide written notification to all persons in parental relation, faculty, and staff regarding the potential use of pesticides periodically throughout the school year.

The Hudson Falls Central School District is required to maintain a list of persons in parental relation, faculty, and staff who wish to receive 48-hour prior written notification of certain pesticide applications. We will use Integrated Pest Management (IPM) practices. IPM practices are designed to have minimal effects on non-target species and on human health. Certain methods of pest control may not be preceded by a notification.

In the event of an emergency application necessary to protect against an imminent threat to human health, a good faith effort will be made to supply written notification to those on the 48-hour prior notification list.

If you would like to receive 48-hour prior notification of pesticide applications that are scheduled to occur in your school, please complete the form below and return it to David McKeighan, the Hudson Falls Central School District pesticide representative at 3665 Burgoyne Avenue, Hudson Falls, NY 12839. Tel 681-4570. Fax no. 747-8554. E-mail dmckeighan@hfcsd.org .

<table>
<tr><td colspan="3">Hudson Falls Central School District
Request for Pesticide Application Notification
(please print)</td></tr>
<tr><td colspan="3">_____School Building</td></tr>
<tr><td colspan="2">Please Print Parent/Guardian Name:</td><td>Address:</td></tr>
<tr><td>Date:</td><td>Phone:</td><td>Town:</td></tr>
</table>

Please feel free to contact David McKeighan the Hudson Falls Central School District pesticide representative at 3665 Burgoyne Avenue, Hudson Falls, NY 12839. Tel 681-4570. Fax no. 747-8554.
E-mail dmckeighan@hfcsd.org for further information on these requirements.

HUDSON FALLS CENTRAL SCHOOL DISTRICT – STUDENT QUESTIONNAIRE

STUDENT NAME: _____ Date of Birth: _____

Grade: _____ Reason for student's transfer: _____

Are you the legal parent? YES NO (Please Circle One)

If No, please state relationship to child: _____

ELEMENTARY LEVEL: K-5 Please check all that apply

___ Enjoys School

___ Makes friends easily

___ Is happy and outgoing

___ Follows school rules

___ Gets along well with classmates

___ Works independently

___ Almost always completes homework

___ Has difficulty completing homework

___ Has trouble following school rules

___ Is nervous about a new school

___ Has trouble making friends

___ Is shy and withdrawn

What does your child like the most about school? _____

Is there anything you would like to share that will help us get to know your child? _____

_____

_____

_____

EDUCATIONAL HISTORY: Please list all prior school districts your child has attended, by grade level.

UPK/Pre-K _____

K _____

2nd _____

4th _____

6th _____

8th _____

10th _____

1st _____

3rd _____

5th _____

7th _____

9th _____

11th _____

Has your child ever been suspended from school? YES NO (Please Circle)

If yes, what grade level and describe the reason(s) for suspension _____

_____

Has your child ever received a psycho educational evaluation? YES NO If yes, at what grade level? _____

Has your child ever been diagnosed with ADD/ADHD? YES NO (Please circle one)
If yes, please note the year/age and physician _____

Has your child ever exhibited violent or threatening behaviors? YES NO (Please circle one)
If yes, please explain _____

_____

Is your child/family currently working with any outside service providers such as social service workers, counselors/therapists, drug/alcohol counselors, probation, PINS Diversion, etc.? YES NO (please circle one)
If yes, please list names and agencies of service providers below:

_____

_____

_____

Do we have your permission to share information regarding your child with the above service providers?
YES NO (please circle one)

Do you need information about outside services for your family? YES NO (please circle one)
If yes, please note concerns _____

_____

Please note here any specific behavioral/social/emotional concerns that you have about your child: _____

_____

_____

_____

_____

Please note here any comments/suggestions you may have regarding your child's educational program: _____

_____

_____

_____

==========

BAND / ORCHESTRA / CHOIR

If your child participates in a music program, please circle which program listed below.

Band 5 6 7 8 9 10 11 12 What instrument? _____ Own or Rent

Orchestra 4 5 6 7 8 9 10 11 12 What instrument? _____ Own or Rent

Choir 7 8 9 10 11 12

==========

Parent/Guardian Name (Please Print) _____

Parent/Guardian Signature _____ Date _____

PARENT INTERVIEW FORM

Child's last name _____ First name _____ Middle _____

Child prefers to be called _____ D.O.B.: _____

Please check (✓) Yes or No or fill in answers as needed.

	Yes	No
Language Development		
Has your child ever had a speech/language evaluation?	___	___
Has your child ever received speech/language therapy?	*___	___
*If YES, please list **where?** _____ **How long?** _____		
Does your child express his/her needs and wants?	___	___
Does your child speak clearly?	___	___
Self-Help/Small Muscle Skills		
Does your child:		
write his/her name	___	___
hold a pencil comfortably	___	___
color	___	___
cut with scissors	___	___
(Circle all that apply) take care of own clothing (dressing: snap, button, ties shoes, zip)	___	___
need to be reminded to go to the bathroom	___	___
have soiling accidents	___	___
Has your child ever had other screenings for hearing and vision?	___	___
Other		
Does your child have any strong fears? (storms, dark, heights, nightmares, fire alarms, loud and noisy rooms)? **(circle all that apply)**	*___	___
*If YES, please explain:		
How would you describe your child?		

Form completed by _____ **Date** _____

Relation to child _____

PARENT INTERVIEW FORM

ABOUT MY CHILD:

Favorite toy_____

Other favorites: _____

My child needs help with: _____

_____

My child is good at: _____

_____

My child likes to:
___Listen to stories ___Draw and color ___Play alone
___Play outside ___Play with other children
___Play quiet games inside ___Go to a friend's house
___Play sports/dance class

My child doesn't like to: _____

_____

I would like you to observe my child because I am concerned about the following:

_____

_____

_____

How does your child play/share with others? _____

_____

How does your child handle frustration or things that don't go his/her way? _____

_____

_____

Requirements for Students Entering Pre-Kindergarten

1. Physical Examination completed and signed. These physicals must be dated on or after September 5, 2019.
2. Blood Lead Level Results
3. Dental Health Certificate
4. Proof of Current Immunizations (see below)

Per NY State Law, all students entering Pre-Kindergarten MUST have the required immunizations (per chart below) on or before September 17, 2020 or the student will be excluded from school starting on September 18, 2020.
Proof of the immunizations must be on file in the Health Office.

Immunizations	Number of Doses for Pre-Kindergarten
Polio	3
Hepatitis B	3
Diptheria/Tetanus/Pertussis	4
Measles/Mumps/Rubella	1
Varicella (Chickenpox)	1
Hemophilus Influenzae	1 to 4
Pneumococcal Conjugate	1 to 4

If you have any questions or concerns regarding Health Requirements for Pre-Kindergarten, please contact the nurse at 518-681-4501.

Kindergarten Center Health Office Fax# 518-681-4530

Requirements for Students Entering Kindergarten

1. Physical Examination completed and signed. These physicals must be dated on or after September 5, 2019.
2. Blood Lead Level Results
3. Dental Health Certificate
4. Proof of Current Immunizations (see below)

Per NY State Law, all students entering Kindergarten MUST have the required immunizations (per chart below) on or before September 17, 2020 or the student will be excluded from school starting on September 18, 2020.

Proof of the immunizations must be on file in the Health Office.

Immunizations	Number of Doses for Kindergarten
Polio	4-5
Hepatitis B	3
Diptheria/Tetanus/Pertussis	4-5
Measles/Mumps/Rubella	2
Varicella (Chickenpox)	2

If you have any questions or concerns regarding Health Requirements for Kindergarten, please contact the nurse at 518-681-4501.

Kindergarten Center Health Office Fax# 518-681-4530

2020-21 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for **each** vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]	**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses or 2 doses** of **adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9, 10 and 11: 1 dose**	**2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.

   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.

   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grade 6: 10 years; minimum age for grades 7 through 12: 7 years)

   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.

   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2020-2021, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grade 6; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 7 through 12.

   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)

   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.

   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

   d. Only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)

   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine

   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).

   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)

   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grade 7: 10 years; minimum age for grades 8 through 12: 6 weeks).

   a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7, 8, 9, 10 and 11.

   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.

   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.

   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.

   d. If dose 1 was received at 15 months or older, only 1 dose is required.

   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)

   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.

   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.

   d. If one dose of vaccine was received at 24 months or older, no further doses are required.

   e. PCV is not required for children 5 years or older.

   f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

Hudson Falls and NYSED Health History–Two Page Form
Both pages must be completed.

Student Name:	DOB:
School Name:	Age:
Date of last health exam:	Date form completed:
List Medications:	
	Physician's Name

Health History To Be Completed By Parent/Guardian, Provide Details To Any Yes Answers On Back.
Any medications to be taken at practice and/or athletic event will require the proper paperwork, contact school with questions.

Has/Does your child:	Yes	No
General Health Concerns		
1. Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason?		
2. Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait or disease ☐ Other		
3. Ever had surgery?		
4. Ever spent the night in a hospital?		
5. Been diagnosed with Mononucleosis within the last month?		
6. Have only one functioning kidney?		
7. Have a bleeding disorder?		
8. Have any problems with his/her hearing or wears hearing aid(s)?		
9. Have any problems with his/her vision or has vision in only one eye?		
10. Wear glasses or contacts?		
Allergies	**Yes**	**No**
11. Have a life threatening allergy? Check any that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other		
12. Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health	**Yes**	**No**
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?		
14. Wheeze or cough frequently during or after exercise?		
15. Ever been told by their health care provider they have asthma?		
16. Use or carry an inhaler or nebulizer?		

Has/Does your child:	Yes	No
Concussion/ Head Injury History		
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?		
18. Have you ever had a head injury or concussion?		
19. Ever had headaches with exercise?		
20. Ever had any unexplained seizures?		
21. Currently receive treatment for a seizure disorder or epilepsy?		
Devices/Accommodations	**Yes**	**No**
22. Use a brace, orthotic, or other device?		
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes there may be need for another required form to be filled out.		
24. Wear protective eyewear, such as goggles or a face shield?		
Family History	**Yes**	**No**
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Females Only	**Yes**	**No**
26. Begun having her period?		
27. Age periods began:		
28. Have regular periods?		
29. Date of last menstrual period:		
Males Only	**Yes**	**No**
30. Have only one testicle?		
31. Have groin pain or a bulge or hernia in the groin?		

Sample Recommended NYSED Interval Health History for Athletics – Page 2

Student Name:

School Name: DOB:

Has/Does your child:		
Heart Health	**Yes**	**No**
32. Ever passed out during or after exercise?		
33. Ever complained of light headedness or dizziness during or after exercise?		
34. Ever complained of chest pain, tightness or pressure during or after exercise?		
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?		
36. Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)?		
37. Ever been told they have a heart condition or problem by a physician? If so, check all that apply: ☐Heart infection ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐Other:		
Injury History	**Yes**	**No**
38. Ever been diagnosed with a stress fracture?		

Has/Does your child:		
Injury History *continued*	**Yes**	**No**
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
41. Have a bone, muscle, or joint injury that bothers him/her?		
42. Have joints become painful, swollen, warm, or red with use?		
Skin Health	**Yes**	**No**
43. Currently have any rashes, pressure sores, or other skin problems?		
44. Have had a herpes or MRSA skin infections?		
Stomach Health	**Yes**	**No**
45. Ever become ill while exercising in hot weather?		
46. Have a special diet or have to avoid certain foods?		
47. Have to worry about his/her weight?		
48. Have stomach problems?		
49. Have you ever had an eating disorder?		

Please explain fully any question you answered yes to in the space below. (Please print clearly and provide dates if known.

Parent/Guardian Signature:_____ Date: _____

HUDSON FALLS CENTRAL SCHOOL

DENTAL HEALTH CERTIFICATE

Name _____ Date of Birth _____

School _____ Grade _____

Date of Comprehensive Dental Examination _____

Describe Dental Health Condition at time of Dental Exam:

_____

_____

_____

The student is in fit condition of dental health to permit his/her attendance in school: (please check)

Yes No

Dental Provider's Signature:_____ Phone: _____

Provider's Name/Address: _____

If you have questions or concerns regarding this request, please contact the nurse at (518) 681-4501

Kindergarten Center Health Office Fax # 518-681-4530

HUDSON FALLS CENTRAL SCHOOL

LEAD SCREENING REPORT

Name _____ **Date of Birth** _____

School _____ **Grade** _____

Date of LEAD SCREENING/Test _____

Lead Level Results _____

_____

Provider's Signature: _____ **Phone:** _____

Provider's Name/Address: _____

(stamp) _____

New York State Public Health Law requires students entering pre-kindergarten to have a blood test for lead screening completed since the age of one. A copy of this result needs to be provided to the Health Office. This report brought to the Health Office or may be faxed by your doctor's office to the school. Our fax number is 518-681-4530.

Students without insurance that need a lead screening blood test may contact Public Health at 518-746-2400.

If you have questions or concerns regarding this request, please feel free to contact the nurse at (518) 681-4501.

Kindergarten Center Health Office Fax # 518-681-4530