

Comsewogue Central Registration
Melinda Ornstein | Registrar
mornstein@comsewogue.k12.ny.us
Phone: 631-474-8225 | Fax: 631-474-3639

Welcome to Comsewogue School District!

Documents Required to Register for 1st-12th Grade Currently Receiving Special Education Services or With An Existing IEP

1. **Copy of Student's Birth Certificate (preferred) Passport or Baptismal Certificate**
2. **Registration Packet**
Registration packet provided on this webpage or at the central registration office must be filled out in its entirety.
3. **Health Examination as Mandated by the New York State Department of Health**
The physical examination must be dated no more than twelve months prior to the student's first day of attendance. If this documentation cannot be presented at the time of registration, proof of an upcoming appointment must be provided. The student may receive a physical examination from the school physician if the documentation is not received.
4. **Immunizations 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
5. **TWO proofs of residency from Parent/Guardian**
Registration cannot take place prior to move in date.

Homeowners First Proof

- a. Current Mortgage statement or
- b. Current yearly property tax bill
- c. Deed

Renters/other:

A notarized (may be sworn or unsworn) statement of Landlord or Owner from whom the parent or guardian leases or shares property with and a copy of the lease agreement.

Second Proof for Homeowners AND renters

Any of the following forms of documentation are accepted for your second proof. A copy of your pay stub, income tax return, utility bill, voter registration documents, official driver's license, learner's permit or non-drive identification, state or other governmental issued identification, documents issued by federal, state or local agencies.

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.

Once all of the necessary paperwork is received, it will be processed and sent to the school that they will be attending. The school will contact you with your child's start date, teacher assignments and bussing information.

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Comsewogue School District Ethnicity Policy

The Comsewogue School District has adopted a policy which requires the collection and recording of the ethnic identity of students in the Comsewogue School District in accordance with the federal categories and definitions. The information will be used to:

- **Report information to the State and Federal Education Departments.**
- **Plan educational programs and make sure they are readily available to all students.**
- **Analyze differences in academic performance, attendance, and completion of school.**

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions listed below before completing the question on the first page of this packet.

Hispanic: Hispanic Latino or of a Spanish origin- A person of Cuban, Mexican, Puerto Rican, Central/South American or other Spanish culture or origin regardless of race.

White: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East

Black or African American: A person having origins in any of the Black racial groups of Africa

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including 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.

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

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, national origin, sex, citizenship, handicapping condition or immigration status,

The Comsewogue School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and federal student privacy laws and regulations. If the information requested is not provided on the form on behalf of your child. A student records officer from the school or the district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

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.

Comsewogue School District
Office of Pupil Personnel Services
290 Norwood Avenue
Port Jefferson Station, NY 11776
Phone (631) 474-8127 Fax (631) 474-8112

RELEASE OF INFORMATION FORM

Date: _____

I, _____

(PARENT/GUARDIAN NAME)

HERBY REQUEST THAT PSYCHOLOGICAL, SOCIAL, EDUCATIONAL,
MEDICAL AND ANY OTHER PERTINENT INFORMATION
REGARDING MY CHILD _____,

(STUDENT'S NAME)

A STUDENT AT COMSEWOGUE SCHOOL DISTRICT BE RELEASED
TO:

**OFFICE OF PUPIL PERSONNEL SERVICES
COMSEWOGUE SCHOOL DISTRICT
290 NORWOOD AVENUE
PORT JEFFERSON STATION, NY 11776**

**I understand this information shall be kept confidential and shall be used only for
the purpose of planning and coordinating educational programming and services.**

(SIGNATURE)

(RELATIONSHIP)

Comsewogue School District
Office of Pupil Personnel Services
290 Norwood Avenue
Port Jefferson Station, NY 11776
Phone (631) 474-8127 Fax (631) 474-8112

PARENTAL CONSENT FOR EVALUATION

STUDENT NAME: _____

DATE OF BIRTH: _____

_____ I hereby give my consent to the Comsewogue School District to have appropriately certified personnel evaluate my child for the purpose of determining if he/she is in need of special education services. The individual evaluations will consist of those indicated on the attached letter.

_____ I do not give my consent to have my child evaluated.

I understand this consent is only for evaluation and not for special education placement. I am aware I will be invited to a meeting of the District Committee on Special Education, at which determination regarding my child's educational placement will be made.

NO FINAL DETERMINATION OF STUDENT PLACEMENT WILL BE MADE WITHOUT THE COMPLETION OF AN UPDATED MEDICAL EXAMINATION. THE CSE MEETING WILL BE HELD BUT THE FINAL DETERMINATION WILL BE DEFERRED UNTIL THE EXAMINATION IS COMPLETED.

PARENT SIGNATURE: _____ DATE: _____

**Parental Consent for the Use of Public Benefits or Insurance Pursuant to the
Individuals with Disabilities Education Act (IDEA)**

I, _____ the parent/guardian of _____, have received a written notification from the Comsewogue School District that explains 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/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or access Medicaid to pay for special education and related services provided to my child. I understand that:

- Providing consent will not impact my child's/my 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 and/or provide my child's CIN;
- I have the right to withdraw consent at any time; and
- The school district, county must give me annual written notification of my rights regarding this content.

I also give my consent for the school district/county to release the following records/information about my child to the State's Medicaid Agency for the purpose of checking Medicaid eligibility and/or billing for special education and related services that are in my child's IEP. The following records may be shared:

- Student demographic information (name, age, address, SSN, etc.)
- Student services information (special education services provided to student)

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 of my 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.

Student's CIN (if known) _____

Date: _____

Print Name: _____

Parent/Guardian Signature _____

COMSEWOGUE SCHOOL DISTRICT

OFFICE OF PUPIL PERSONNEL SERVICES

290 Norwood Avenue, Port Jefferson Station, NY 11776 | Phone 631.474.8100 | Fax 631.474.8112

Timothy Dornick
District Administrator for Pupil Personnel Services
tdornick@comsewogue.k12.ny.us | 631.474.8127

Jennifer Quinn, Ed.D.
Superintendent of Schools

Dear Parent/Guardian,

The District provides special education services and programs to students with disabilities pursuant to applicable federal and state laws. Any parent or guardian who suspects that their child has a disability may refer their child for an evaluation by the District's Committee on Special Education (CSE) or the District's Committee on Preschool Special Education (CPSE) for eligibility determination 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:

<https://www.nysed.gov/special-education/parents-guide-special-education>

Parents or guardians should contact the District's Pupil Personnel Offices at 631-474-8127.

Sincerely,

Timothy Dornick
District Administrator for Pupil Personnel Services



NEW ENTRANT FORM

For Office Use Only
Registration Date: _____
Student ID# _____
Immunizations Y/N
Physical Y/N
Custody Flag Y/N
Existing IEP Y/N
ESL/ENL Y/N

_____	_____	_____
Last name of student (As appears on birth certificate)	First name of student	M.I.
_____	_____	_____
Male/Female/Non-Binary	Date of birth	Grade registering for

Address		

Child's Ethnic Code (Circle all that apply)
Hispanic
American Indian/Alaskan Native
Asian
Black
White
Native Hawaiian/Pacific Islander

Parent/Guardian #1 (primary contact)

_____	_____	_____	_____
Last name	First name	Marital Status	Relationship to child

Address(write SAME if not different from child) _____

Please list phone numbers in the order you would like to receive calls.
1. _____ (Home Work Cell) 2. _____ (Home Work Cell)
3. _____ (Home Work Cell) **Email:** _____

Parent/Guardian #2

_____	_____	_____	_____
Last name	First name	Marital Status	Relationship to child

Address (if different from student, will this parent be receiving mail from the school? **YES** ___ **NO** ___)

Please list phone numbers in the order you would like to receive calls.
1. _____ (Home Work Cell) 2. _____ (Home Work Cell)
3. _____ (Home Work Cell) **Email:** _____

Who does this child live with? Parents ___ **Parent/Guardian 1** ___ **Parent/Guardian 2** ___ **Legal Guardian** ___

Is your child currently receiving special education services? Yes ___ **No** ___
Does your child have an existing IEP? Yes ___ **No** ___

Are there any special custody regulations or court orders regarding your child? Yes ___ **No** ___
If yes, please provide a copy of court order

Does this child receive any ESL/ENL services? Yes ___ **No** ___

Is either parent a member of the Armed Forces on Active Duty? Yes ___ **No** ___

Parent/Guardian Signature _____ Date _____

Comsewogue School District Request for Student Records

Student's Name _____ Date of Birth _____

Name of Previous School _____

Address of Previous School _____

Prior School Phone # _____ Prior School Fax # _____

The above listed student has registered to attend Comsewogue School District.
Please send all applicable records pertaining to this student to the school indicated below.

- Immunization records/current physical/health records
- Grade evaluation/testing/academic performance
- Psychological evaluations and any other pertinent information

<p>Boyle Road Elementary School 424 Boyle Road Port Jefferson Station NY, 11776 Phone (631) 474-8140 Fax (631) 474-8498 cbrodersen@comsewogue.k12.ny.us</p>	<p>Terryville Road Elementary School 401 Terryville Road Port Jefferson Station NY, 11776 Phone (631) 474-2834 Fax (631) 474-2846 gdigiovanna@comsewogue.k12.ny.us</p>	<p>Clinton Avenue Elementary School 140 Clinton Avenue Port Jefferson Station NY, 11776 Phone (631) 474-8150 Fax (631) 474-8499 kdawson@comsewogue.k12.ny.us</p>
<p>Norwood Avenue Elementary School 290 Norwood Avenue Port Jefferson Station NY, 11776 Phone (631) 474-8130 Fax (631) 474-8385 amatonti@comsewogue.k12.ny.us</p>	<p>John F. Kennedy Middle School Attn: Guidance Office 200 Jayne Boulevard Port Jefferson Station NY, 11776 Phone (631) 474-8166 Fax (631) 642-4322 smcgeeney@comsewogue.k12.ny.us</p>	<p>Comsewogue High School Attn: Guidance Office 565 Bicycle Path Port Jefferson Station NY, 11776 Phone (631) 474-8185 Fax (631) 474-2196 ldirusso@comsewogue.k12.ny.us</p>

Parent/Guardian Signature _____ Date _____

HOUSING QUESTIONNAIRE

Name of LEA: **Brookhaven-Comsewogue School District**

Name of School: _____

Name of Student _____

Last

First

MI

Gender: _____ DOB ____/____/____

Grade: _____

Student ID# _____

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 are entitled to immediate enrollment in school even if they don't have the documents normally needed. 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 a loss of housing or as a result of economic hardship

____ In a hotel/motel

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

____ Other temporary living situation (please describe) _____

____ Foster Care Placement. Start date: _____

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

Print Name of Parent, Guardian
(or student if Unaccompanied Youth)

Parent/Guardian Signature _____ Date _____



Elisa Alvarez, Associate Commissioner Office of
Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Person in Parental Relation:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
Month	Day	Year
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	_____	<input type="checkbox"/> Parent 2
		<i>specify</i>	_____
	<input type="checkbox"/> Guardian(s)	_____	<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not write
			<i>specify</i>

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: Parent Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: No Yes

**DATE OF INDIVIDUAL INTERVIEW: _____
 MO. DAY YR.

OUTCOME OF INDIVIDUAL INTERVIEW:
 ADMINISTER NYSITELL
 ENGLISH PROFICIENT
 REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ PROFICIENCY LEVEL ACHIEVED ON NYSITELL:
 MO. DAY YR. ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

**Comsewogue School District
First Notification of State Mandated Physical Exam**

New York State Educational Law and the Regulations of the commissioner of Education requires and BMI calculation of children when they:

- Enter or reenter the school district
- Enter grades PK, K, 1, 3, 5, 7 and 9

In accordance to the law, this physical examination shall not be performed more than once a year prior to the first day of attendance of the required year. It is recommended that a dental exam be completed in the same interval.

By checking the space next to the appropriate statement, please indicate whether you intend to have your family physician or the school district physician examine your child.

___ “I will have my child examined by _____ on _____.
(Physician's Name) (Date)

___ “I will have my child examined by the school district physician in the school nurses’ office at my child’s school.”

Parent Signature: _____

COMSEWOGUE SCHOOL DISTRICT

STUDENT HEALTH HISTORY UPDATE

Name:	DOB:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)	Grade:	Home Phone:	Date:
	Cell Phone:		

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"/>	
Have any family members under the age of 50 ever:	YES	NO	If Yes, please specify:
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
<input type="checkbox"/> Asthma/trouble breathing
<input type="checkbox"/> Autism/Asperger
<input type="checkbox"/> Dental Injuries
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Ear Infections | <input type="checkbox"/> GI Conditions (ulcer, reflux, IBS)
<input type="checkbox"/> Headaches/migraines
<input type="checkbox"/> Heart Conditions
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Mental Health Condition
(depression, eating disorder, anxiety, OCD, ODD, etc.) | <input type="checkbox"/> Scoliosis
<input type="checkbox"/> Single Organ (<input type="checkbox"/> kidney, <input type="checkbox"/> testicle)
<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Speech Condition
<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

Is there any condition that would prevent your child from participating in physical education or sports?

No Yes: _____

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

Parent/Guardian Signature: _____ Date: _____

EMERGENCY CONTACT CARD

Student's Name _____ Date of Birth _____

Address _____ Phone _____

Parent/Guardian #1

Name _____ Work _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Parent/Guardian #2

Name _____ Work _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

If the school cannot get in touch with either of the above, please name two local relatives/friends who may be called upon to assume responsibility if your child is ill.

Name _____ Name _____

Address _____ Address _____

Phone _____ Phone _____

Child's Physician _____ Phone _____

Transportation of a sick child is to be arranged by parent/guardian or a person named above.
It is the parent's/guardian's responsibility to notify the school nurse of changes in the above information.

Siblings

Name	Grade	Teacher	School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional Contacts

Name _____ Name _____

Address _____ Address _____

Phone _____ Phone _____

**Comsewogue School District
Transportation Office
290 Norwood Avenue
Port Jefferson Station, NY 11776
Phone 631-474-8124 | Fax 631-474-3639**

The Comsewogue School District procedure for Kindergarten through 5th Grade is that a Parent/Guardian or Authorized Adult meet the child at the bus stop.

My child, _____, has permission in my absence at the bus stop to be released to any person named below.

Please return this completed form to the Comsewogue Transportation Office only, **NOT BUILDING LEVEL.**
Photo I.D. is required for the release of your child.

Please print clearly:

	Name	Relationship	Telephone Number
1.	_____	Mother	_____
2.	_____	Father	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Do NOT release child to:

1. _____
2. _____

Parent / Guardian Signature _____

Contact # _____ Date _____

Bus Stop _____

School _____ Route # _____ Grade _____

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"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<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"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	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/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
TB-PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 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

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done	
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						
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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>	
Notes						
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK						
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act						
<input type="checkbox"/> Student may participate in all activities without restrictions.						
If Restrictions Apply – Complete the information below						
<input type="checkbox"/> Student is restricted from participation in:						
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.						
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.						
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.						
<input type="checkbox"/> Other Restrictions:						
Developmental Stage for Athletic Placement Process <u>ONLY</u> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V						
<input type="checkbox"/> 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						
<input type="checkbox"/> Order Form for medication(s) needed at school attached						
COMMUNICABLE DISEASE			IMMUNIZATIONS			
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS			
HEALTHCARE PROVIDER						
Healthcare Provider Signature:						
Provider Name: <i>(please print)</i>						
Provider Address:						
Phone:			Fax:			
Please Return This Form to Your Child's School Health Office When Completed.						

2023-24 School Year

New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:
All children must be age-appropriately immunized to attend school in NYS. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the [“ACIP-Recommended Child and Adolescent Immunization Schedule.”](#) 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 must 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	Pre-Kindergarten (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		

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. 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 grades 6 through 9: 10 years; minimum age for grades 10, 11, and 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 2023-2024, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 9; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 10, 11, and 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. For children with a record of OPV, 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, must 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 grades 7 through 10: 10 years; minimum age for grades 11 and 12: 6 weeks)
 - a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) 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.
 - f. [For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.](#)
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 CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.](#)

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**

New York State Department of Health/Bureau of Immunization
health.ny.gov/immunization

Comsewogue Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, pre-K, K, 1, 3, 7,9 & 11. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

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

Child's Name:			Last	First	Middle
Birth Date: / /	Sex: <input type="checkbox"/> Male	Will this be your child's first visit to a dentist? <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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Parent's Signature _____					Date _____

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

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

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

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

Dentist's name and address (please print or stamp)	Dentist's Signature

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

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

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

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

Yes No **Dental Sealants Present**

Other problems (Specify): _____

III. Treatment Needs (check all that apply)

No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.