Niagara Falls City School District
Universal Prekindergarten Application
2021 – 2022

IF YOUR CHILD CURRENTLY ATTENDS THE DISTRICT'S PRE K-3 PROGRAM, YOU DO NOT NEED TO COMPLETE THIS APPLICATION.

Child's Name: ______________________________

Program Level (circle one) Pre-K 3 – All Students Pre-K 4 New to District Students Only

Parent's Name: ______________________________

Address: ______________________ Niagara Falls, NY Zip ____________

Cell Phone Mother: ________________ Cell Phone Father: ________________

Child's Date of Birth: ________________ Child's Gender: Male / Female (Circle One)

Language Spoken at Home: ________________

Ethic Origin (circle one): Hispanic/Latino NOT Hispanic/Latino

Race (circle all that apply): Asian Black or African-American White American Indian or Alaskan Native Hawaiian or Other Pacific Islander

Does Child receive Special Education services? ______________________

NEW SCHOOL SELECTION PROCESS FOR 2021-2022

As of September 2020, all families wishing to enroll their child in the District's Pre-K program will be required to participate in the District's Pre-K lottery when all seats have been filled at their desired school.. The lottery process is as follows:

1. Complete and return the full Pre-K Registration Packet no later than **June 11, 2021**.
2. Select your school(s) of choice in order of preference using "1" as the first choice. **Remember**, transportation is not provided for Pre-K students, it is imperative that you consider how your child will get to and from school, and where your other children currently attend school.
3. If all seats are filled at the 1st school of choice, the application will be moved to the 2nd choice etc.

TRANSPORTATION IS NOT PROVIDED

Please select your school(s) of choice in order of preference using "1" as your first choice:

_____ Cataract Elementary School, 6040 Lindbergh Avenue
_____ Hyde Park Elementary School, 1620 Hyde Park Blvd.
_____ Henry J. Kalfas Elementary School, 1800 Beech Avenue
_____ Geraldine J. Mann Elementary School, 1330 – 95th Street
_____ Maple Avenue Elementary School, 952 Maple Avenue
_____ Niagara Street Elementary School, 2513 Niagara Street
_____ 79th Street Elementary School, 551 – 79th Street

*****For Office Use Only*****

Received by ________________ *Dated Received* ________________

Niagara Falls City School District
Niagara Falls, New York

Prekindergarten Program Information and Overview

The Niagara Falls City School District will offer a free program for all 3 and 4 year old children living in the City of Niagara Falls in September 2021. Classes will be offered at; Cataract Elementary, Hyde Park Elementary, Kalfas Magnet, Maple Avenue Elementary, G.J. Mann Elementary, Niagara Street Elementary, and 79th Street Schools.

Important Facts About the Pre-K Program

TRANSPORTATION IS NOT PROVIDED

- Children who have turned **3 or 4 years of age, on or before December 1, 2021** are strongly encouraged to attend.
- A lottery will be conducted when there are more applications than seats at a particular school.
- Children will receive breakfast, lunch, and a fruit snack daily.
- Classes meet Monday, Wednesday, Thursday and Friday 8:45 a.m. to 3:00 p.m. Tuesday's schedule is 8:45 a.m. – 2:00 p.m.
- The program will include family events and informational parent workshops.

Application Process

- Parents wishing to have their child attend this valuable program must complete and return the full registration packet to:

  Niagara Falls Board of Education
  Pre-K Program
  630 66th Street
  Niagara Falls, New York 14304

- Applications must be received by **June 11, 2021**.
- Placement letters are mailed in **July 2021.**

SCHOOL DISTRICT OF THE CITY OF NIAGARA FALLS
HEALTH SERVICES

Pre-Kindergarten Packet

Dear Parent or Guardians:

You have filled out an application for your child to attend a pre-kindergarten in September. We would like your child to have a positive, successful and exciting school experience. In order for this to happen without difficulty for your child, certain regulations of New York State Education Laws and Public Health Laws must be fulfilled. **You must supply us with the following information when you register your child for school.**

1. **Immunization Record** for your child – attached is a copy of the Immunization Requirements for School Entrance/ Attendance (I-1a). **Failure to satisfy these requirements may result in exclusion from school.**

2. **Physical Examination (F-16A) -** this must be completed and signed by a licensed health care provider, submitted within 30 days of admission. Any physical completed within the last 12 months will be valid. **Failure to satisfy these requirements may result in exclusion from school.**

3. **Pre-Kindergarten Social History** (F-12a) and **Health History Form for Students** (F-8) – completed and signed by parents/guardians in order to help us understand your child and provide the safest education plan.

4. **Dental Health Certificates** – a report of a comprehensive dental examination, signed by a licensed dentist, will be requested for all public school students entering for the first time and students in grades 2, 4, 7 & 10. This law became effective September 1, 2008.

*******PLEASE RETURN ALL FORMS TO THE SCHOOL NURSE*******

IMPORTANT THINGS TO REMEMBER

1. The Niagara County Health Department provides immunizations by appointment only. Call **278-1903** for an appointment.

2. In order for your child to attend a pre-kindergarten program in New York State he or she must be four years old on or before December 1.

If you have any questions, please contact your school nurse.

____________________	____________________	____________________
School	School Nurse	Telephone

Sincerely,
School Health Services

NIAGARA FALLS CITY SCHOOL DISTRICT
HEALTH HISTORY FORM FOR STUDENTS

Student's name________________________ School ________________ Grade__________

Address____ Home Phone________________

Date of Birth____________________ Place of Birth____________________ Sex M____ F_____

Mothers Name____________________ Address____________________ Phone__________
Mothers Place of Employment______________________________ Work Phone__________
Fathers Name____________________ Address____________________ Phone__________
Fathers Place of Employment______________________________ Work Phone__________
Physician__________________________ Dentist__________________________

Emergency: 1. Name______________________ Phone______________________
2 .Name______________________ Phone______________________

Describe your child's current state of health (circle one) Excellent Good Fair Poor

Please check YES or NO for questions below so that our School Health Service may best serve your child.
Explain any yes answers in the space provided on the back of the form.

HAS YOUR CHILD EVER HAD:

SKIN	**yes**	**no**	**date**
Lesions	___	___	___
Rashes	___	___	___
EYE PROBLEMS			
Vision loss-Rt eye_____ Lt eye_____			
Amblyopia- Rt eye_____ Lt eye_____			
Glasses	___	___	___
Contact lenses	___	___	___
Hearing loss – Rt ear____ Lt ear____			
Ear tubes - Rt ear____ Lt ear____			
Infections	___	___	___
Frequent nose bleeds	___	___	___
Nose fracture/surgery	___	___	___
SORE THROAT			
Tonsillitis	___	___	___
Strep throat	___	___	___
Scarlet fever	___	___	___
Tonsils/adenoids removed	___	___	___
DENTAL PROBLEMS			
Braces	___	___	___
Capped teeth	___	___	___
Bridge/loss of teeth	___	___	___
CARDIOVASCULAR			
High Blood Pressure	___	___	___
Rheumatic fever	___	___	___
Heart Murmur	___	___	___
Heart Surgery	___	___	___
Cardiac Workup	___	___	___
LUNGS/RESPIRATORY			
Asthma	___	___	___
Allergies	___	___	___
Hives	___	___	___
Hayfever	___	___	___
Pneumonia	___	___	___
Bronchitis	___	___	___
Tuberculosis	___	___	___

GASTROINTESTINAL	**yes**	**no**	**date**
Jaundice	___	___	___
Stomach Disorders	___	___	___
Frequent Abdominal pain	___	___	___
Ulcers	___	___	___
MUSCULOSKELETAL	___	___	___
Arthritis	___	___	___
Joint pains	___	___	___
Limb or back deformities	___	___	___
Fracture (broken bone)	___	___	___
Dislocation	___	___	___
Scoliosis	___	___	___
Chronic sprains	___	___	___
Recurrent injuries	___	___	___
GENITOURINARY			
Hernia	___	___	___
Bladder or kidney disorder	___	___	___
Infections	___	___	___
MALES: Testicles: injury/surgery	___	___	___
FEMALES: Menstruation	___	___	___
Date first began______________			
Last menstrual period______________			
NEUROLOGICAL			
Headaches	___	___	___
Head injuries	___	___	___
Concussions	___	___	___
Convulsions	___	___	___
Seizure Disorder	___	___	___
Fainting/blackouts	___	___	___
Paralysis/numbness	___	___	___
Hyperactivity	___	___	___
ENDOCRINE			
Diabetes	___	___	___
Hypoglycemia	___	___	___
Thyroid Condition	___	___	___
COMMUNICABLE DISEASES			
Measles	___	___	___
Chicken Pox	___	___	___
Mononucleosis	___	___	___

HEMATOLOGY

Hepatitis A yes___ no___ date___ **Hepatitis B** yes___ no___ date___ **Hepatitis C** yes___ no___ date____
Anemia yes___ no___ date____ Bleeding disorders yes___ no___ date____ Transfusions yes___ no___ date____
Sickle Cell Anemia yes___ no___ date____

PLEASE CONTINUE ON OTHER SIDE

Niagara Falls City School District
Department of Health Services
PHYSICAL EXAMINATION

RETURN TO REGISTRATION OFFICE

Name________________________ D O B______________ School______________ Grade ____________

*I hereby grant permission for the medical staff of the Niagara Falls City School District to obtain medical information from my child's health care provider pertaining to the information indicated in this physical.

______________________________ ______________________________
Parent/Guardian Signature Parent/guardian printed name

IMMUNIZATIONS/HEALTH HISTORY

- ◻ Immunization record attached
- ◻ No Immunization given today
- ◻ Immunizations given since last appraisal

Sickle Cell Screen: ◻ Positive ◻ Negative ◻ Not done Date: ______
PPD: ◻ Positive ◻ Negative ◻ Not done Date______
Elevated Lead ◻ Yes ◻ No ◻ Note done Date______
Dental Referral ◻ Yes ◻ No ◻ Not done Date______

Significant Medical/Surgical History: ___SEE ATTACHED

Allergies: ___Life Threatening ___Food:______________ __Insect:____________ __ Other:____________
___ Seasonal ____ Medication: ________________

PHYSICAL EXAM

Date of exam: _________Height:_________ Weight_________ Vision R_________ L_________ B.P._______ Pulse_____
Body Mass Index_______ BMI Percentile: __< 5 % __5% - 49% __50% - 84% __85% - 94% __95%-98% __99% and higher

☐ **EXAM ENTIRELY NORMAL** specify any abnormality (use reverse of form if needed):______________

Scoliosis: ___Negative ___Positive

Menarche___________ LMP___________ Testes ___________ Tanner Stage I II III IV V

*****PLEASE SPECIFY CURRENT DISEASES:*** ___Asthma ___ Diabetes: ___Type 1 ___Type 2
___Hyperlipidemia ___Hypertension

MEDICATIONS

Medication: ☐ **None** ☐ **Medication at home only** ☐ **Medication to be given at school**
Name: ____
Dosage/Time: ______________________________________
(List additional medications on reverse of form)
If AM dose is missed at home: _________________________
Self-Administer attestation:
I attest that this student has demonstrated to me that they can self-administer the medication(s) listed above safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications listed above or on reverse of this form if needed: Yes ☐ No ☐

PHYSICAL EDUCATION/ SPORTS/ PLAYGROUND /WORK QUALIFICATION /CSE CONSIDERATION

____ **Free from contagions & physically qualified for all physical education, sports, and playground, work and school activities OR only as checked below:**

____ Limited contact: baseball, basketball, softball, volleyball, diving
____ Strenuous/non-contact: cross country, track & field, swimming, tennis, indoor track
____ Non strenuous/non-contact: bowling, golf, cheerleading

____ **Specify medical accommodations needed for school:** ______________________ ___**None**

____ **Known or suspected disability:** ______________________ ___**Please monitor**

____ **Restrictions:** ______________________ ___**Please monitor**

____ **Protective equipment required:** ___ **Athletic Cup** ___ **Sport goggles/impact resistant eyewear** ___ **Other**______________

Provider"s Signature:______________________ Phone:______________ (stamp below)

Provider's Name/Address:______________________ Fax: ______________

NYSED requires an annual exam for new entrants, students in grades K,2,4,7,& 10, sports, working permits and triennially for the Committee on Special Education (CSE).

F 16a rev. 3/16

Niagara Falls City School District
Department of Health Services

RETURN TO REGISTRATION OFFICE

DENTAL HEALTH CERTIFICATE

Parent/guardian: New York State Law (chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7,& 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school year, ask your dentist to fill out Section 2. Return the completed form to the school nurse as soon as possible.

SECTION 1. TO BE COMPLETED BY PARENT/GUARDIAN (Please Print)

Child's Name: Last First Middle

____

Birth Date: ________/________/__________ (Month Day Year)

Sex: __ Male __Female

Will this be your child's first visit to a dentist? ___Yes ___No

School: ______________________________ **Grade**__________

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities:
_________Yes _________No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.
I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent Signature______________________________ Date__________

SECTION 2. TO BE COMPLETED BY THE DENTIST

1. The Dental Health condition of ______________________ **on** ___________ **(date of exam). The date of 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 school.**

____**No, the student listed above is not in a fit condition of dental health to permit his/her attendance at school.**

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. This may include pain, swelling or infection related to clinical evidence of open cavities. **The designation of "not in fit condition" 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, 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 1/2mm 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 cavitated lesion is also present.)

___Yes ___No **Dental Sealants Present**

Other Problems______________________________

III Treatment Needs: ___No obvious problem. Routine dental care recommended. Visit your dentist regularly.
___ May need dental care. Please schedule an appointment with your dentist as soon as possible
___ Immediate dental care required. Please schedule an appointment with your dentist

F-16d

4455 Porter Road, Niagara Falls, NY 14305

SCHOOL DISTRICT OF THE CITY OF NIAGARA FALLS
HEALTH SERVICES

Pre-Kindergarten Packet

Dear Parent or Guardians:

You have filled out an application for your child to attend a pre-kindergarten in September. We would like your child to have a positive, successful and exciting school experience. In order for this to happen without difficulty for your child, certain regulations of New York State Education Laws and Public Health Laws must be fulfilled. **You must supply us with the following information when you register your child for school.**

1. **Immunization Record** for your child – attached is a copy of the Immunization Requirements for School Entrance/ Attendance (I-1a). **Failure to satisfy these requirements may result in exclusion from school.**

2. **Physical Examination (F-16A) -** this must be completed and signed by a licensed health care provider, submitted within 30 days of admission. Any physical completed within the last 12 months will be valid. **Failure to satisfy these requirements may result in exclusion from school.**

3. **Pre-Kindergarten Social History** (F-12a) and **Health History Form for Students** (F-8) – completed and signed by parents/guardians in order to help us understand your child and provide the safest education plan.

4. **Dental Health Certificates** – a report of a comprehensive dental examination, signed by a licensed dentist, will be requested for all public school students entering for the first time and students in grades 2, 4, 7 & 10. This law became effective September 1, 2008.

*******PLEASE RETURN ALL FORMS TO THE SCHOOL NURSE*******

IMPORTANT THINGS TO REMEMBER

1. The Niagara County Health Department provides immunizations by appointment only. Call **278-1903** for an appointment.

2. In order for your child to attend a pre-kindergarten program in New York State he or she must be four years old on or before December 1.

If you have any questions, please contact your school nurse.

School	School Nurse	Telephone

Sincerely,
School Health Services

NIAGARA FALLS CITY SCHOOL DISTRICT
HEALTH HISTORY FORM FOR STUDENTS

Student's name______________________ School ______________ Grade________
Address______________________________ Home Phone______________
Date of Birth________________ Place of Birth________________ Sex M____ F____
Mothers Name________________ Address________________ Phone__________
Mothers Place of Employment______________________ Work Phone__________
Fathers Name________________ Address________________ Phone__________
Fathers Place of Employment______________________ Work Phone__________
Physician______________________ Dentist______________________
Emergency: 1. Name______________________ Phone________________
2. Name______________________ Phone________________

Please check YES or NO for questions below so that our School Health Service may best serve your child.
Explain any yes answers in the space provided on the back of the form.
HAS YOUR CHILD EVER HAD:

	yes	no	date
SKIN			
Lesions	___	___	___
Rashes	___	___	___
EYE PROBLEMS			
Vision loss-Rt eye_____ Lt eye_____			
Amblyopia- Rt eye_____ Lt eye_____			
Glasses	___	___	___
Contact lenses	___	___	___
Hearing loss – Rt ear____ Lt ear____			
Ear tubes - Rt ear____ Lt ear____			
Infections	___	___	___
Frequent nose bleeds	___	___	___
Nose fracture/surgery	___	___	___
SORE THROAT			
Tonsillitis	___	___	___
Strep throat	___	___	___
Scarlet fever	___	___	___
Tonsils/adenoids removed	___	___	___
DENTAL PROBLEMS			
Braces	___	___	___
Capped teeth	___	___	___
Bridge/loss of teeth	___	___	___
CARDIOVASCULAR			
High Blood Pressure	___	___	___
Rheumatic fever	___	___	___
Heart Murmur	___	___	___
Heart Surgery	___	___	___
Cardiac Workup	___	___	___
LUNGS/RESPIRATORY			
Asthma	___	___	___
Allergies	___	___	___
Hives	___	___	___
Hayfever	___	___	___
Pneumonia	___	___	___
Bronchitis	___	___	___
Tuberculosis	___	___	___

	yes	no	date
GASTROINTESTINAL			
Jaundice	___	___	___
Stomach Disorders	___	___	___
Frequent Abdominal pain	___	___	___
Ulcers	___	___	___
MUSCULOSKELETAL			
Arthritis	___	___	___
Joint pains	___	___	___
Limb or back deformities	___	___	___
Fracture (broken bone)	___	___	___
Dislocation	___	___	___
Scoliosis	___	___	___
Chronic sprains	___	___	___
Recurrent injuries	___	___	___
GENITOURINARY			
Hernia	___	___	___
Bladder or kidney disorder	___	___	___
Infections	___	___	___
MALES: Testicles: injury/surgery	___	___	___
FEMALES: Menstruation	___	___	___
Date first began______________			
Last menstrual period______________			
NEUROLOGICAL			
Headaches	___	___	___
Head injuries	___	___	___
Concussions	___	___	___
Convulsions	___	___	___
Seizure Disorder	___	___	___
Fainting/blackouts	___	___	___
Paralysis/numbness	___	___	___
Hyperactivity	___	___	___
ENDOCRINE			
Diabetes	___	___	___
Hypoglycemia	___	___	___
Thyroid Condition	___	___	___
COMMUNICABLE DISEASES			
Measles	___	___	___
Chicken Pox	___	___	___
Mononucleosis	___	___	___

HEMATOLOGY

Hepatitis A yes___ no___ date___ **Hepatitis B** yes___ no___ date___ **Hepatitis C** yes___ no___ date___
Anemia yes___ no___ date___ Bleeding disorders yes___ no___ date___ Transfusions yes___ no___ date___
Sickle Cell Anemia yes___ no___ date___

PLEASE CONTINUE ON OTHER SIDE

School District of the City of Niagara Falls
Department of Health Services
PHYSICAL EXAMINATION

Name______________________________ D O B______________ School______________

***I hereby grant permission for the medical staff of the Niagara Falls City School District to obtain medical information from my child's health care provider pertaining to the information indicated in this physical.** ______________________________

____
Parent/guardian Signature **Parent/guardian printed name**

IMMUNIZATIONS/HEALTH HISTORY

- ☐ Immunization record attached
- ☐ No Immunization given today
- ☐ Immunizations given since last appraisal

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date:________
PPD: ☐ Positive ☐ Negative ☐ Not done Date________
Elevated Lead ☐ Yes ☐ No ☐ Note done Date________
Dental Referral ☐ Yes ☐ No ☐ Not done Date________

Significant Medical/Surgical History: ___**SEE ATTACHED**

____

Allergies: ___**Life Threatening** ___Food:______________ ___Insect:____________ ___ Other:______________

___ Seasonal ____ Medication: ______________________

PHYSICAL EXAM

Date of exam: __________Height:________ Weight________ Vision R________ L________ B.P.________ Pulse_____

Body Mass Index___ ___.__ BMI Percentile: __ < 5 % __5% - 49% ___50% - 84% __85% - 94% ___95%-98% ___99% and higher

☐

☐ **EXAM ENTIRELY NORMAL specify any abnormality (use reverse of form if needed):**

____

Scoliosis: ___Negative ___Positive

Menarche__________ LMP__________ Testes ____________ Tanner Stage I II III IV V

*****PLEASE SPECIFY CURRENT DISEASES:*** ___Asthma___ Diabetes: ___Type 1 ___Type 2

___Hyperlipidemia ___Hypertension

MEDICATIONS

Medication: ☐ **None** ☐ **Medication at home only** ☐ **Medication to be given at school**
Name:______________________________
Dosage/Time:______________________________
(list additional medications on reverse of form)
If AM dose is missed at home:______________________________
I assess this student to be self- directed and may self-carry medication ☐ Yes No ☐

PHYSICAL EDUCATION/ SPORTS/ PLAYGROUND /WORK QUALIFICATION /CSE CONSIDERATION
(Interscholastic sports participants must be seen by the District Nurse Practitioners)

___ **Free from contagions & physically qualified for all physical education, sports, playground, work and school activities OR only as checked below:**
____ Limited contact: baseball, basketball, softball, volleyball, diving
____ Strenuous/non-contact: cross country, track & field, swimming, tennis, indoor track
____ Non strenuous/non-contact: bowling, golf, cheerleading

____ **Specify medical accommodations needed for school:** ______________________ ___**None**

____ **Known or suspected disability:**______________________ ___**Please monitor**

____ **Restrictions:** ______________________ ___**Please monitor**

____ **Protective equipment required:** __ Athletic Cup __ Sport goggles/impact resistant eyewear

___ Other______________________

Provider"s Signature:______________________ Phone:______________ (stamp below)

Provider's Name/Address:______________________ Fax: ______________

NYSED requires an annual exam for new entrants, students in grades Pre-K or K,2,4,7,& 10, sports, working permits and triennially for the Committee on Special Education (CSE).

F 16a rev. 2/11

NIAGARA FALLS CITY SCHOOL DISTRICT
Health Services

DENTAL HEALTH CERTIFICATE

Parent/guardian: New York State Law (chapter 281) permits schools to **request** a dental examination in the following grades: school entry, K,2,4,7,& 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school year, ask your dentist to fill out Section 2. Return the completed form to the school nurse as soon as possible.

SECTION 1. TO BE COMPLETED BY PARENT/GUARDIAN (Please Print)

Child's Name: **Last** **First** **Middle**

____

Birth Date: ________/________/__________ **Sex:** __ **Male** __**Female** **Will this be your child's first visit to a dentist?** ___**Yes** ___**No**

Month **Day** **Year**

School: ____ **Grade**________________

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities: ________**Yes** ________**No**

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.
I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent Signature____Date________________

SECTION 2. TO BE COMPLETED BY THE DENTIST

1. The Dental Health condition of ______________________________ **on** ____________**(date of exam). The date of 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 school.**

____**No, The student listed above is not in a fit condition of dental health to permit his/her attendance at school.**

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. This may include pain, swelling or infection related to clinical evidence of open cavities. **The designation of "not in fit condition" 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, 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 1/2mm 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 cavitated lesion is also present.)

___Yes ___No **Dental Sealants Present**

Other Problems____

III Treatment Needs: ___No obvious problem. Routine dental care recommended. Visit your dentist regularly.
___ May need dental care. Please schedule an appointment with your dentist as soon as possible
___ Immediate dental care required. Please schedule an appointment with your dentist

F-16d

NIAGARA FALLS CITY SCHOOL DISTRICT
STUDENT REGISTRATION FORM

Rev. 9/29/10

FOR OFFICE USE ONLY Roll Call/Homeroom # ________

Date of Entry ____________ Student ID Number ____________ Teacher ____________

Child's
Legal Name ____

Last Name *First Name* *Middle Name*

Home Address ______________________________ Apt. # ________ Zip ________

☐ Female ☐ Male Date of Birth ____________________ Grade ____________

Year started 9th grade ____________________

Special Education ________ Yes ________ No 504 Plan ________ Yes ________ No
(If Yes, refer to PSA)

U.S. Citizen ________ Yes ________ No (If no, citizen of what country?) ____________

ESL: ______ Yes ______ No (If yes, what is Native Language: ____________________)

Parent E-Mail address for school contact ______________________________

Ethnicity (Check One)	Race (Check one or more, regardless of Ethnicity)
☐ Hispanic/Latino	☐ American Indian or Alaska Native ☐ White
☐ Non-Hispanic/Latino	☐ Black or African American ☐ Asian
	☐ Native Hawaiian or Other Pacific Islander

Previously registered in the Niagara Falls School System? ☐ Yes ☐ No

Last School Attended ____________________ Date Left ________ Grade(s) Repeated ______

Address of Last School ____
(If NOT in Niagara Falls) Street City/State Zip

Phone Number of Last School ____________________ Fax Number ____________

Student resides with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other Legal/Custody Papers? Yes___ No___

If Other: Name and Relationship ____

Mother's Name (if applicable) ____________________ Home Phone ____________

Address (if different from student) ____________________ Cell Phone ____________

Place of employment ____________________ Work Phone ____________

Father's Name (if applicable) ____________________ Home Phone ____________

Address (if different from student) ____________________ Cell Phone ____________

Place of employment ____________________ Work Phone ____________

Student's Guardian's Name ____________________ Home Phone ____________

Guardian's Address ____________________ Cell Phone ____________

Place of Employment ____________________ Work Phone ____________

(OVER)

Niagara Falls City School District Student Residency Questionnaire

Name of LEA: School District of the City of Niagara Falls, New York

Name of School: ______________________________

Name of Student: ______________________________
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ______ / ______ / ______ (*Month* *Day* *Year*) Grade: _____ (*preschool-12*) ID#: ____________ (*optional*)

Address: ______________________________ Phone: ____________________

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

☐ In permanent housing
☐ In a shelter
☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes 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

NOTE: The answer you give will 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, 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. After the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

NOTE TO SCHOOLS/LEAS: If the student is NOT living in permanent housing, please ensure that a Designation Form is completed.

Please send a copy of this form to Eileen Burkett at Central Office (Fax Number 286-4123)

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

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 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.

Please write clearly when completing this section.

STUDENT NAME:

First	Middle	Last

DATE OF BIRTH:

Month	Day	Year

GENDER: ☐ Male ☐ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name	First Name	Relation to Student

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

Question			
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*	

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Cuestionario de Idioma del Hogar ("HLQ" por sus siglas en inglés)

Estimados padres o tutores:
Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura, escritura y comprensión en el inglés, así como conocer su educación previa e historial personal. Por favor, llene con su información las secciones "Conocimientos de idiomas" e "Historial educativo". Apreciamos mucho su colaboración respondiendo a estas preguntas.
Gracias.

Por favor escriba con claridad al completar esta sección.

NOMBRE DEL ESTUDIANTE:

Nombre *Segundo nombre* *Apellido*

FECHA DE NACIMIENTO:

Mes *Día* *Año*

GÉNERO:
❑ Masculino
❑ Femenino

INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL

Apellido *Primer Nombre* *Relación con el estudiante*

CÓDIGO DEL IDIOMA DEL HOGAR

Conocimientos de idiomas
(Por favor, marque todas las opciones que sean aplicables)

Pregunta			
1. ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante?	❑ Inglés	❑ Otro ______ *especifique*	
2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?	❑ Inglés	❑ Otro ______ *especifique*	
3. ¿Cuál es el idioma primario de cada padre / tutor?	❑ Madre ______ *especifique*	❑ Padre ______ *especifique*	❑ Tutor(es) ______ *especifique*
4. ¿Qué idioma o idiomas entiende su hijo(a)?	❑ Inglés	❑ Otro ______ *especifique*	
5. ¿Qué idioma o idiomas habla su hijo(a)?	❑ Inglés	❑ Otro ______ *especifique*	❑ No sabe hablar
6. ¿Qué idioma o idiomas lee su hijo(a)?	❑ Inglés	❑ Otro ______ *especifique*	❑ No sabe leer
7. ¿Qué idioma o idiomas escribe su hijo(a)?	❑ Inglés	❑ Otro ______ *especifique*	❑ No sabe escribir

TO BE COMPLETED BY THE DISTRICT IN WHICH THE STUDENT IS REGISTERED

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

PARA LLENAR POR EL DISTRITO EN EL QUE EL ESTUDIANTE SE HA INSCRITO

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

Angelica Infante-Green, Assistant Commissioner
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Home Language Questionnaire (HLQ) گھریلو زبان کے بارے میں سوالنامہ (ایچ ایل کیو)

عزیزی والدین یا سرپرست
آپ کے لڑکے/ لڑکی کو ممکنہ بہترین تعلیم دینے کے لیے ہمیں یہ تعین کرنے کی ضرورت ہے کہ وہ کتنی اچھی طرح سے انگلش سمجھتا / سمجھتی ، بولتا/ بولتی اور لکھتا /لکھتی ہے اور پہلی سکول ہسٹری کیا ہے۔ مہربانی کر کے نیچے کی سیکشن زبان کا پس منظر اورتعلیمی ہسٹری کو مکمل کریں۔ ان سوالات کے جوابات دینے میں آپ کی مدد قابلِ ستائش ہے۔
آپ کا شکریہ

آپ جب یہ حصہ مکمل کررہے ہوں تو مہربانی فرما کر صاف صاف لکھیں

طالب علم کا نام

نام کا آخری حصہ | نام کا درمیان والا حصہ | نام کا پہلا حصہ

جنس	تاریخ پیدائش
☐ مرد ☐ عورت	سال / دن / ماہ

والدین / والدین جیسے رشتہ دار کے بارے میں معلومات

نام کا آخری حصہ | نام کا پہلا حصہ | طالب علم کے ساتھ تعلق

گھریلو زبان کا کوڈ ____________

زبان کا پس منظر
(مہربانی کرکے ہر متعلقہ سوال کا جواب دیں)

1. طالب علم کے گھر / رہائش میں کون سی زبان / زبانیں بولی جاتی ہیں؟ ☐ انگلش ☐ دوسری ____________ وضاحت کریں

2. وہ پہلی زبان کونسی تھی جو آپ کے بچے نے سیکھی تھی؟ ☐ دوسری ☐ دوسری ____________ وضاحت کریں

3. دونوں والد اور والدہ کی گھریلو زبان کون سی ہے؟ ☐ باپ ____________ وضاحت کریں ☐ ماں ____________ وضاحت کریں ☐ سرپرست ____________ وضاحت کریں

4. آپ کا بچہ کونسی زبان / زبانیں سمجھتا ہے؟ ☐ دوسری ☐ دوسری ____________ وضاحت کریں

5. آپ کو بچہ کون سی زبان / زبانیں بولتا ہے؟ ☐ دوسری ☐ دوسری ____________ وضاحت کریں ☐ نہیں بولتا

6. آپ کا بچہ کون سی زبان / زبانیں پڑہتا ہے ؟ ☐ دوسری ☐ دوسری ____________ وضاحت کریں ☐ نہیں پڑہتا

7. آپ کا بچہ کون سی زبان / زبانیں لکھتا ہے؟ ☐ دوسری ☐ دوسری ____________ وضاحت کریں ☐ نہیں لکھتا

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*	

School Year 2020 - 2021

City School District Of the City Of Niagara Falls
Consolidated Permission Form for Releasing Information to the US Military,
Using District Computer Systems, Online Art Gallery and Media Release and Publication on-line.

Please complete this form and return it to your child's school on or before September 30, 2020.
Put your **initials** in the appropriate box, **Yes** I give my permission or No I do not give my permission.

Student Name _________________________________ Student ID Number___________

School _________________________ Class/Homeroom Teacher ___________________

☐ ☐
Yes **No**

Release of information to the US Military (Grades 11 and 12 only)
The No Child Left Behind Law of 2002 requires high schools to release the name, address, and phone number of any 11th or 12th grade student to the United States Military. In order to receive federal funding, the City School District Of the City Of Niagara Falls must comply with this mandate unless parents provide written notification via this form that they do not want this information released.

☐ ☐
Yes **No**

Computer Acceptable Use (all grades)
Parents and guardians can obtain a copy of the District's Acceptable Use Policy by visiting any school or www.nfschools.net. All student computer use must comply with this policy. Internet Safety is part of the State curriculum and learning to use technology responsibly is an important part of education. Unless a parent provides written notification via this form, students will have access to the District's computer system in accordance with the Districts AUP.

Online Art Gallery (all grades)
I give permission to the City School District Of the City Of Niagara Falls to share my child's artwork along with his/her **first name** on the Online Art Gallery on the School District's Website, www.nfschools.net

☐ ☐
Yes **No**

☐ ☐
Yes **No**

Photographs ,Videos, Interviews District Website Release (all grades)
I give my permission to City School District Of the City Of Niagara Falls that photographs, and/or video tapes and/or interviews of my child may be taken and used by the District only for public relations, educational, or other purposes consistent with the purposes and mission of the District, including use of any photograph and/or image and/or interview on the District Website or other District electronic resources such as social media. I understand that my permission allows the District to use my child's first and last name for public relations and educational purposes. I further agree that said materials will become the property of the District and I hereby release and discharge the District and it representatives from any
and all claims that may result by reason of taking of such photographs and/or videotapes and/or interviews.

☐ ☐

Yes **No**

Media Release (all grades)

I give permission to the City School District Of the City Of Niagara Falls to use my child's photograph, likeness and/or work and/or interviews in any compilations to be distributed within the community. Specifically photographs of students may be used in the District newsletter(s), in pamphlets or brochures, or on flyers. Such images may also be distributed to local media, either print or video, or may be used on the OSC-TV Channel 21, or be used or distributed in like manner.

If in the future you wish to reverse any permission, you may do so by notifying your child's principal in writing.

Parent/ Guardian Name: (Please Print) ____
Date__________

Parent/ Guardian Signature: ____