Early Childhood in Niagara Falls

Beyond the Universal Pre-K Program

- **Early Head Start Program** - Serving infants and toddlers at the District's Community Education Center-6040 Lindbergh Avenue
- **Head Start Program** - Serving 3 and 4-year-old children at the Di Franceso Center - 901 24th Street
- **Universal Pre-K 3 and Pre-K 4** - Classes will continue to be offered at all District elementary schools except, Abate Intermediate School
- **LaSalle Early Childhood Center** – Pre-K 4 only located at 8477 Buffalo Avenue

General Facts

• All programs are full-day.	• Free to families residing in the city of Niagara Falls.
• Students must be the age of the program they are registering for on or before December 1" of the enrolling year.	• Translation support is available upon request.
• Guidance from the Committee on Pre-School Special Education is available upon request.	• Transportation is NOT provided.
• Complete registration packets must be completed to confirm enrollment. • **Full registration packets are due by June 2, 2023.**	• Breakfast, lunch and a fresh fruit snack are served daily. • Curriculum is aligned to the NYS Early Learning Standards.

Applications for the 2023-2024 school-year are available by hovering over the QR Code on the next page.

Pre-K Registration Packet - Step 1

NIAGARA FALLS CITY SCHOOL DISTRICT

630 66TH STREET

NIAGARA FALLS, NY 14304

CENTRAL STUDENT REGISTRATION

716-286-4263 (PHONE) ~ 716-286-4240 (FAX)

jdavidson@nfschools.net

Document Required ______________________________ **Date Received** ____

Completed Registration Packet______________________________

Birth Certificate (can be requested from previous school)______________________________

Parent/Guardian Valid Photo I.D.______________________________

Proof of Residency

(utility bill, lease, notarized statement of address from landlord, or social services verification of address)____________

Legal Custody Papers or Petition (if pertaining)______________________________

Info for Previous School

(grades 1-6)______________________________

Last Report Card

(checkout/withdrawal grades)______________________________

Transcript

(grades 9, 10, 11, 12)______________________________

Immunization Records (can be requested from previous school)______________________________

Physical______________________________

Current IEP or 504 Plan______________________________

Please note:

Children in Pre-K WILL NOT BE REGISTERED without a current physical and immunizations.

Children in grades K-12 can be registered without a current physical, but may be removed from school if one in not received within 20 days of starting school.

Children in grades 9-12 WILL NOT BE REGISTRED until their transcripts are received from their previous school.

Your home school is______________________________

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*	

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
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(518) 474-8775 / Fax: (518) 474-7948

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:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School *Address*	

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

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

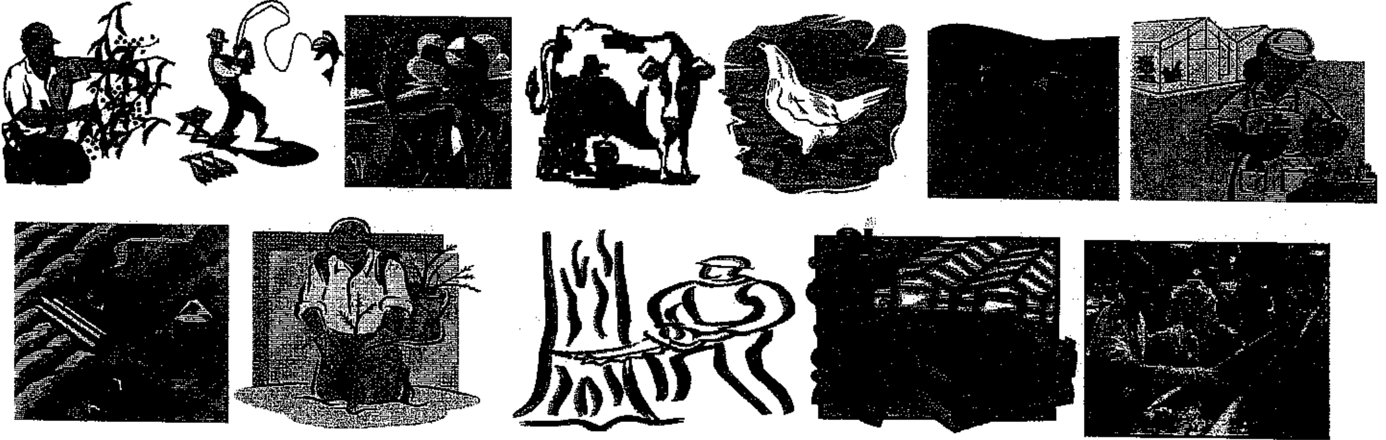
IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

- ☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- ☐ Work related to logging, harvesting, or initial processing of trees.
- ☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



If you answered YES, please provide your contact information below:

Parent/Guardian Name: ______________________________

Home address: ______________________________

Telephone number: (____)-______-______ Best time to be reached: ______ AM/PM

Previous Address: ______________________________

Student name: ______________________ Age __________ Grade________

Student name: ______________________ Age __________ Grade________

To submit this referral please fax to 607-436-3606, or by mail to NYS Migrant Education Program-Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.

For Parent/Guardians:

Definitions:
Indian means an individual who is (1) A member of an Indian Tribe or Band, as membership is defined by the Indian Tribe or Band, including any Tribe or Band terminated since 1940, and any Tribe or Band recognized by the State in which the Tribe or Band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, Aleut, or other Alaska Native; or (5) A member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect on October 19, 1994.

Student Information: Write the name of the child, date of birth, grade level, name of school and school district. Only name one child per form.

Tribal Membership: Write the name of the individual with the tribal membership, if it is not the child listed. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one identifier: the child, child's parent or grandparent, for whom you can provide membership information.

Write the name and address of the organization that maintains updated and accurate membership data for such Tribe or Band of Indians. The name does not need to be the official name as it appears exactly on the Department of Interior's list of federally recognized Tribes, but the name must be recognizable and be of sufficient detail to permit verification of the eligibility of the Tribe. Check only one box indicated whether it is a Federally Recognized, State Recognized, Terminated Tribe or Organized Indian Group. Write the enrollment number establishing the membership for the child, parent or grandparent, if readily available, or other evidence of membership.

Attestation Statement: Provide the printed name of parent/guardian and signature, address, phone number and email of the parent or guardian of the child. The signature of the parent or guardian of the child verifies the accuracy of the information supplied.

Paperwork Burden Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3W238, Washington, D.C. 20202-6335

OMB Control No. 1810-0021 (Exp. 01/31/2024)

ED 506 Form

Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

Student Information

Name of the Child ________________________ Date of Birth __________ Grade level __________

Name of School ________________________ School District ________________________

Tribal Membership

The individual with Tribal membership is the (select only one): ○ child ○ child's parent ○ child's grandparent

If the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: ________________________

Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name ________________________ Address ________________________

City ________________ State ______ Zip Code __________

The Tribe or Band is (select only one):

- ○ Federally Recognized Tribe
- ○ State Recognized Tribe
- ○ Terminated Tribe
- ○ Alaska Native
- ○ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

- ○ Membership or enrollment number establishing membership (if readily available) or
- ○ Other evidence establishing membership in the Tribe listed above (describe and attach)

Membership or enrollment number establishing membership (if readily available) or other evidence establishing membership in the Tribe listed above (describe and attach). ________________________

Attestation Statement

I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian ________________________ Signature ________________________

Address ________________________ City ________________________ State ______ Zip Code __________

Phone Number ________________________ Email ________________________ Date ______________

School Selection Process

Please select the school(s) that you would like your child to attend in your order of preference. REMEMBER, transportation is not provided, therefore it is critical that you consider how your child will get to and from school each day. In the event that your first choice is filled, the application will be moved to your second choice and so on until an opening becomes available.

_____ Bloneva Bond Elementary School, 2513 Niagara Street (Formerly Niagara Street School)

_____ Cataract Elementary School, 6431 Girard Avenue

_____ Geraldine Mann Elementary School, 1330 95th Street

_____ Hyde Park Elementary School, 1620 Hyde Park Blvd.

_____ Kalfas Early Childhood School, 1800 Beech Avenue

_____ Maple Avenue Elementary School, 952 Maple Avenue

_____ 79th Street Elementary School, 551 79th Street

_____LaSalle Early Childhood Program, 8477 Buffalo Avenue

Early Head Start

_____Community Education Center, 6040 Lindbergh Avenue

Head Start

_____DiFrancesco Center, 901 24th Street

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,
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.

☐ ☐
Yes **No**

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**

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.

SCHOOL DISTRICT OF THE CITY OF NIAGARA FALLS
HEALTH SERVICES

Pre-Kindergarten & 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** - 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 by November 2022 the District Medical Director/Nurse Practitioner will complete the physical exam.**

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 1, 3, 5, 7, 9 & 11. This law became effective September 1, 2008.

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.

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

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

______________________	______________________	______________________
School	School Nurse	Telephone

Sincerely,
Dr. Jo Silvaroli FNP

Niagara Falls City School District
Health Services

PRE-K & K SOCIAL HISTORY

Child's Name____________________ Date of Birth____________
School Entering____________________ Today's Date____________
Brothers/Sisters____________________ Date of Birth____________
____________________ Date of Birth____________
(USE BACK IF NECESSARY)

PLEASE ANSWER **YES OR NO** TO ALL QUESTIONS. THIS WILL HELP US BETTER UNDERSTAND THE HEALTH NEEDS OF YOUR CHILD.

Birth Information

Did you have:

	Yes	No
Premature birth	___	___
Cesarean delivery	___	___
Any newborn problems	___	___
Any problems the First year	___	___
Normal pregnancy	___	___
Full term pregnancy	___	___
Normal delivery	___	___
Birth Weight	______________	
Breast fed	___	___

How long?________________
Comments:________________
____
____

Growth and Development/Skills

Any problems with:

Feeding	___	___
Crawling	___	___
Walking	___	___
Talking	___	___
Hopping	___	___
Counting numbers	___	___
Naming colors	___	___
Dressing self	___	___
Eating	___	___
Muscle coordination	___	___
Speech	___	___

Did your child attend

Preschool	___	___
Head start	___	___
Day Care	___	___

Name________________
Comments________________
____

Behavior Development

Would you say your child:

	Yes	No
is friendly	___	___
is secure	___	___
is talkative	___	___
is shy	___	___
is helpful	___	___
is cooperative	___	___
listens well	___	___
follows directions well	___	___
adjusts well to new situations	___	___
has stayed overnight away from mother	___	___
is eager to start school	___	___
separates easily from family	___	___
plays well with other children	___	___
plays well alone	___	___
relates well to other adults	___	___
has temper tantrums	___	___
is disobedient	___	___
talks back	___	___
is destructive	___	___
has nightmares	___	___
has fears	___	___
is jealous	___	___
sucks thumb	___	___
has uncontrolled bowel movements	___	___
constipation	___	___
wetting	___	___
wets the bed	___	___
has had any unusual or unexpected stresses	___	___
does your child have any habits that concern you	___	___

Do you have any concerns as a Parent
____
Comments____
____

Parent/Guardian Signature________________________ Date ____________

F-12a 1/00

Niagara Falls City School District
Health Services
Parent Notification/Request for Mandated Health Appraisal

Dear Parent(s) or Guardian(s):

New York State law requires that each child in a school district have a health examination including body mass index before entering school for the first time, and again in grades 1, 3, 5, 7, 9, 11. Students wishing to play interscholastic sports or requesting work permits must have an annual health exam. A dental exam form is also requested, but not required at these same times.

Your child's health care provider is always the best choice for these exams especially for Pre-K and Kindergarten. We encourage you to call early as it may take several weeks to schedule exams during the busy summer and fall months.

We have included a form for your health provider to complete. We can accept any exam form dated before September 7, 2021. Your child's health care provider can fax a copy of the exam to 286-0758, or you can bring a copy into your child's school nurse.

If you do not provide an exam form by November 2022, an exam will be scheduled with our school medical director. While most parents choose not to attend, you may do so if you wish. Please let your child know they will be examined at school. In order that the physical examinations by the District Medical Director/Nurse Practitioner be thorough and of real value to the student, it will be necessary for the schdent to remove some clothing. Modesty will be maintained at all times.

Upon completion of in-school exam, you will be informed of any important findings and need to follow up with your health care provider.

Please Complete And Return The Bottom Portion To Your Building Health Office Today

....✂..

Student's Name ______________________ **Grade** __________

Student's School ______________________

☐ My child had a health exam on ________. I will return the completed form by the date above.

☐ My child has an appointment to have a physical with his/her health care provider on _________.
My child's MD/NP/PA will fax a copy to 286-0758, or I will return the form after the date above. **NOTE: Only Physical Exams completed by the district medical director will be accepted for sports for students in grades 7-12.**

☐ I need information on obtaining health insurance or finding a health care provider.

☐ Schedule the district Medical Director to complete the exam for my child. **So that the physical examinations completed by the district medical director be thorough and of real value to the student, it will be necessary for the student to remove some clothing. Modesty will be maintained.**

- ☐ I would like to attend my child's school physical exam
- ☐ I will **NOT** be attending my child's school physical exam

Parent Name ______________________ Date __________

Parent's Signature ______________________

Parent Phone Contact (   ) ______________

This document is adopted from the NYS Center for School Health Website www.schoolhealthny.com (1/10/20)

SCHOOL DISTRICT OF THE CITY OF NIAGARA FALLS
DEPARTMENT OF HEALTH SERVICES

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:

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	___	___	___
Testicles: injury/surgery	___	___	___
Menstruation	___	___	___
date began______________			
Problems______________			
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

HEALTH SERVICES

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER

NYSED REQUIRES A PHYSICAL EXAM FOR NEW ENTRANTS AND STUDENTS IN GRADES Pre-K or K, 1, 3, 5, 7, 9 & 11, AND AS REQUIRED FOR THE COMMITTEE ON SPECIAL EDUCATION

STUDENT INFORMATION

Name:	**Sex:** ☐ M ☐ F	**DOB:**
School:	**Grade:**	**Exam Date:**

***PROVIDER IF AN AREA IS NOT ASSESSED INDICATE NOT DONE * PLEASE COMPLETE THE FORM TO ITS ENTIRETY**

HX OF POSITIVE COVID 19 DIAGNOSIS ☐NO ☐YES DATE OF DX ________

Allergies ☐ No ☐ Yes, indicate type	**Type:** ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizure ☐ No ☐ YES	**Type:** ____________ **Date of last seizure** ____________ ☐ MEDICATION/TREATMENT ORDER ATTATCHED
Diabetes ☐ No ☐ Yes, indicate type	**Type:** ☐ 1 ☐ 2 ☐ Diabetes Medical Mgmt. Plan Attached ☐ MEDICATION/TREATMENT ORDER ATTATCHED

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, Hx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2 Percentile: ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL				

☐ **System Review and Abnormal Findings Listed Below**

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
	*Only for students with an IEP and receiving Medicaid

NIAGARA FALLS CITY SCHOOL DISTRICT

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

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

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: Name

Grade

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

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature ______________________________ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of ______________________________ on__________ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

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

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

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

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

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

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

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

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

☐ Yes ☐ No Dental Sealants Present

Other problems (Specify):______________________________

II. Treatment Needs (check all that apply)

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

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

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

Additional Required Information for Head Start Application

If you are interested in applying for our Head Start program, please submit copies of the required documents below and answer the following questions. Please be advised that additional enrollment paperwork will need to be completed with a family advocate before your child can start.

Required Documents for Head Start (office staff please check off when documentation is submitted)

☐ **Child's proof of birth** *(e.g. birth certificate, Acknowledgement of Paternity, passport)*

☐ **Proof of income** *(e.g. foster care stipend, TANF budget, SNAP budget, SSI letter, W2, 1040 tax form, paystubs (must be a month's worth and be consecutive), unemployment, social security)*

☐ **Insurance card**

☐ **Current physical and immunization record**

☐ **Current dental exam**

☐ **Any custody/restraining orders? N/A ☐**

Parental Status

I am the child's:

☐ **biological parent**

☐ **foster parent**

☐ **guardian/non-relative**

☐ **guardian/kinship**

The child lives in a: ☐ one parent home (mother) ☐ one parent home (father) ☐ two parent home

Please check the assistances your family receives below:

☐ **TANF**

☐ **SNAP**

☐ **SSI**

☐ **WIC**

The Registration packet is NOT complete until we have ALL of the following:

Birth Certificate

Parent or Guardian I.D.

Proof of Residency

Custody or Guardianship documents (if pertaining)

Immunizations/Physical

You may submit any documents via email or fax:

jdavidson@nfschools.net or

716-286-4240