HASTINGS-ON-HUDSON
UNION FREE SCHOOL DISTRICT
27 Farragut Avenue
Hastings-on-Hudson, NY 10706
phone: 914-478-6207
fax: 914-478-6259

REGISTRATION CHECK LIST

Items needed to complete the Registration Process
for Each Student Entering Hastings-on-Hudson UFSD

- **Student Registration Form**

  Proper documentation must be provided for each child entering the school district. (This includes an original Birth Certificate, Health Forms, and all other necessary documents) Please make sure that the Registration Form is filled out completely.

- **Proof of Residency** (Needed per family entering Hastings-on-Hudson UFSD)
  - Utility Bills **(2 needed)**
    - Telephone (NOT cell phone)
    - Cable Bill
    - Utility Bill (Con Ed, Gas/Electric)
    - Water Bill
    - Homeowners or Renters Insurance
  - And **(At least 1 needed)**
    - Deed to House
    - Tax Bill
    - Lease
    - Notarized letter from owner of house and copy of tax bill or deed
- **Proof of Age**
- **School Physical form**. Physical must be completed and the form must be signed and stamped by physician.
- **Immunization Records**, form must be signed and stamped by physician.
- **School Records/Release of Records Form**
  - Report Cards (Final report card from past 2 grades.)
  - Transcript (If available)
  - Standardized Test Scores
  - Medical Records
  - I.E.P.
- **Proof of Guardianship**
  This applies to parents who are separated or divorced and for those children not living with biological/adoptive parents.
  - Court Order Agreement re: Guardianship/Custody
  - Other document(s) establishing Guardianship/Custody

ALL ITEMS MUST BE SUBMITTED PRIOR TO ADMITTANCE INTO SCHOOL.

If your child has previously received Special Education Services or has a Section 504 Accommodation Plan, please call our Director of Special Education, Deborah Augarten, at 914-478-6261

STUDENT NAME: _____

STUDENT NAME: _____

Registration Information

Kindergarten through Grade 12

Student's First Name	Student's Middle Name	Student's Last Name

Student Gender: ☐ **Male** ☐ **Female**

Student's Nickname	Student's Code

Students Date of Birth: _____ **Grade Level** _____ **School Year** _____

Place of Birth _____

Date child entered the U.S. _____

How many years has the child been enrolled in U.S. schools? _____ **Pre-school?** _____

What Language did your child first learn? _____

What language does your child respond to in the home? _____

Hispanic, Latino or of Spanish origin: ☐ **Yes** ☐ **No**

Ethnicity/Race: (Please check one)

☐ **White** ☐ **Black** ☐ **Asian** ☐ **Native Hawaiian/Pacific Islander** ☐ **American Indian/ Native Alaskan**

Student's Address:

Street #	Street Name	P.O. Box	Apt.

City	State	Zip Code

Home Telephone: _____ **Unlisted?** ☐ **Yes** ☐ **No**

Parent Email address: _____

Previous Address

Street #	Street Name	Apt. #

City	State	Zip Code

This question is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1) Is your current address a temporary living arrangement? ☐ Yes ☐ No

2) Is this temporary living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No If yes, please answer:

Where is the student currently living:)*check one box)*

☐ In a motel ☐ In a shelter ☐ With more than one family in a house or apartment

☐ Moving from place to place ☐ In a place not designed for ordinary sleeping accommodations such as a car, park or campsite

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition and other costs TEC Sec. 25.002(3)(d).

STUDENT NAME: _____

Names and Dates of Birth of brothers and Sisters *(living in household)*

Names	Date of Birth

Student resides with *(check all that apply):* ☐ Father ☐ Mother ☐ Stepmother ☐ Stepfather ☐ Other
If other, specify relationship:

_____

Parent/Guardian Salutation: ☐ Mr. & Mrs. ☐ Mr. & Ms. ☐ Mrs. ☐ Mr. ☐ Ms. ☐ Miss ☐ Dr.
If parents prefer not to be addressed as Mr. & Mrs., please write out both names:

_____

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower ☐ Single

Is there anything about your family arrangement that we should be aware of: *(split/joint custody, guardianship, live-in au pair, grandparent, etc.)?* Please explain:

_____

If parents are not living together, indicate name and address of non-custodial parent:

We must have copies of legal papers or other acceptable documents to confirm any custody or guardianship arrangements. Copies received? ☐ Yes ☐ No

Name: _____ _____
Last Name First Name

Relationship to student: _____

Address *(if known)*: _____

Employer: _____

Home Phone: (____) _____ Work Phone: (____) _____ ext: _____

Cell Phone: (____) _____ Beeper: (____) _____

Please list the names and addresses of any Step-parents:

Name: _____

Address: _____

Information Updated Annually

Mother/Guardian: _____ _____
First Name Last Name
Relationship to Student: _____ Same address as Student: ☐ Yes ☐ No

If no, please specify: _____

Employer: _____

Home Phone: (____) _____ Work Phone: (____) _____ ext: _____

Cell Phone: (____) _____ Beeper: (____) _____

Home Email: _____ Work Email: _____

Father/Guardian: _____ _____
First Name Last Name
Relationship to Student: _____ Same address as Student: ☐ Yes ☐ No

If no, please specify: _____

Employer: _____

Home Phone: (____) _____ Work Phone: (____) _____ ext: _____

Cell Phone: (____) _____ Beeper: (____) _____

Home Email: _____ Work Email: _____

Do the people listed above have the authority in all school and medical matters? ☐ Yes ☐ No
If no, a copy of the court order or other acceptable documentation must be provided.

In the case of an emergency, when the parent/guardian is unavailable, please list two people who would be available to come for your child:

Name: _____ **Phone:** (____) _____ ☐ Home ☐ Cell ☐ Work

Address: _____ **Relationship to Student:** _____

Name: _____ **Phone:** (____) _____ ☐ Home ☐ Cell ☐ Work

Address: _____ **Relationship to Student:** _____

Are there any medical issues that the school should be made aware of? ☐ Yes ☐ No

If yes, please explain: _____

_____

Daycare Arrangements (if applicable):

Name of person or facility: _____ Phone #: _____

Days applicable, check all that apply: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

By signing here, you are attesting to the information you have provided is accurate. If it is determined that the information is false, the Hastings-on-Hudson UFSD may seek legal recourse, including, but not limited to, seeking judgment for non-resident tuition.

Signatures of:

_____ _____
Mother/Father/Guardian (circle one) Date

STUDENT NAME: _____

HASTINGS PUBLIC SCHOOLS

HASTINGS-ON-HUDSON, N.Y. 10706

RELEASE FORM FOR STUDENT INFORMATION

(In compliance with Federal General Education Provision Act, Part C, the Protection of the Rights and Privacy of Parents and Students, Public Law 93-380.)

To: _____ (School, Organization, Agency)

Address: _____

_____

_____

We are in need of information for _____(birthdate) _____ who is enrolled in our school/program. We have received student/parent signature as indicated below for you to release or impart this information to us. All information will be treated as confidential.

Please provide information to:

Registrar's Office
27 Farragut Avenue
Hastings-on-Hudson, N.Y. 10706

Types of Information needed:

_____ Transcript/Grade Reports
_____ Health/Medical Records/Information
_____ Test Scores/Appraisal Reports
_____ Withdrawal Grades
_____ Other _____

Thank you for your prompt consideration of this request.

_____ _____ _____
(Signature) (Title) (Date)

==========

I understand the need for information being transferred and hereby grant my permission for you to release or impart any information you may have concerning the above named student to the person or organization requesting as above.

_____ _____
(Student signature - if 18 or older) (Parent Signature)

_____
(date)

STUDENT NAME: _____

Hastings-on-Hudson UFSD
Parent/Guardian Home Language Survey

New York State requires that parents fill out a Home Language Questionnaire for each child they register in a public school. Please take a few moments to answer the following questions. Thank you.

NAME OF CHILD: _____ GRADE: _____

NAME OF PERSON COMPLETING THIS SURVEY: _____

1. Is any other language besides English spoken in your home?

If the answer to question #1 is NO, stop here. If the answer is YES, please answer the remaining questions.

2. What other language is spoken in your home?
3. Who speaks the other language?
4. What language did your child learn when he/she first began to talk?
5. At what age did your child begin to speak? _____
6. At what age did your child begin to speak English? _____
7. What language does your family speak at home most of the time?
8. What language does the mother speak to her child most of the time?
9. What language does the father speak to his child most of the time?
10. What language does the child speak to his/her mother most of the time?
11. What language does the child speak to his/her father most of the time?
12. What language does the child speak to other adults at home most of the time?
13. What language does your child speak to his/her brothers and sisters most of the time?
14. What language does your child speak to his/her friends most of the time?
15. How well does your child communicate in the other language?

Thank you. Please sign below.

_____ _____

STUDENT NAME: _____

Hastings-on-Hudson UFSD

Student

Network Access Form

Please read the included policy packet with your parents. Your network and eChalk access will be activated once this form has been returned.

Name: _____

Grade Level: _____

ACCEPTABLE USE POLICY

I have read and understood the district Technology Acceptable User Policy for students. By signing this form I agree to abide by the rules, policies, and regulations set forth in this agreement.

Student Signature: _____

Date: _____

Parent Signature:_____

Date:_____

FOR OFFICE USE ONLY

Create the appropriate information in the following locations for:

_____ Network; _____ EChalk

STUDENT NAME: _____

HASTINGS-ON-HUDSON
UNION FREE SCHOOL DISTRICT
27 Farragut Avenue
Hastings-on-Hudson, New York 10706
Tel: (914) 478-2900
www.hohschools.org

Farragut Health Complex-914-478-6224
Fax 914-478-6340

Hillside Health Complex-914-478-6280
Fax 914-478-3795

Dear Parent/Guardian:

The last few pages of this packet includes an Emergency Contact form, a Health History a Health Appraisal/Physical, Medication Authorization, Tuberculin Screening and Dental form. Please note that the Appraisal/Physical must be accompanied with the students Immunization history. These forms should be returned directly to the Health Office.

Immunizations:

New York State Law Section 2164 requires certain immunizations (shots) to enter kindergarten and certain immunizations to enter grades 1-5, and to enter grade 6. Please check with your health care provider as soon as possible to make sure your child has all the needed immunizations.

Health Appraisal/Physical:

You may use the form in the packet, or one that your health care provider uses. Please note, the state mandated years for submitting a Health Appraisal/ Physical are as follows: all new entrances, and grades K, 2, 4, 7, and 10. In addition, if your child (children) is playing a sport an Annual Health Appraisal/Physical is required. It is a good habit to send in a copy of the Health Appraisal/physical whenever your child receives it.

Please feel free to discuss anything about your child's health history with the school nurse.

Sincerely,

Health Office Staff

STUDENT NAME: _____

STUDENT HEALTH HISTORY FORM
EMERGENCY INFORMATION

HEALTH PROVIDER INFORMATION

Physician Name: _____ **Telephone #:** (___) _____

Address: _____
Street Address *City* *State* *Zip Code*

Dentist Name: _____ **Telephone #:** (___) _____

Address: _____

STUDENT HEALTH INFORMATION

Please check "Yes" or "No" for each question. Explain all "Yes" answers in space provided and include age and/or year where appropriate.

1. Do you have any concerns about your child's general health? ☐No ☐Yes _____

2. Does your child have any specific illness or problem? ☐No ☐Yes _____

3. Does your child have any allergies (food, medication, insects, etc.)? ☐No ☐Yes _____

4. Does your child have asthma? ☐No ☐Yes _____

5. Does your child take any medication (daily or occasionally)? ☐No ☐Yes _____

6. Does your child have any problems with vision, hearing or speech (glasses, ear tubes, hearing aids, contacts)?
☐No ☐Yes _____

7. Has your child had any hospitalization, operation, or major illness (specify)? ☐No ☐Yes _____

8. Has your child had any significant injury or illness (specify)? ☐No ☐Yes _____

9. Has your child ever had Chicken Pox, Scarlet Fever or Fifth Disease? ☐No ☐Yes _____

10. Would you liked to discuss anything about your child's health and/or family medical history with the school nurse?
☐No ☐Yes _____

STUDENT NAME: _____

SIGNIFICANT MEDICAL HISTORY

Please include any allergies, medical conditions and medications: _____

_____

_____

_____

_____

HEALTH/EMERGENCY DECLARATION

IN CASE OF AN ACCIDENT OR SERIOUS ILLNESS, I REQUEST THAT THE SCHOOL NURSE, ADMINISTRATOR (OR HIS/HER DESIGNEE) SEEK MEDICAL CARE FOR MY CHILD AND MAKE ANY NECESSARY MEDICAL DECISIONS UNTIL I CAN BE REACHED.

I UNDERSTAND AND ACCEPT THAT THE INFORMATION PROVIDED TO THE HEALTH OFFICE REGARDIN MY CHILD MAY BE PROVIDED TO OTHER HASTINGS-ON-HUDSON SCHOOL PERSONNEL ON AN "AS NEEDED" BASIS IN ORDER TO ENSURE THE SAFETY AND WELL BEING OF MY CHILD.

Printed Name of Parent or Guardian: _____

Signature (Applies to this Health/Emergency Declaration): _____

Date: _____

Printed Name of Parent or Guardian Filling Out Registration Form: _____

Signature: _____ Date: _____

STAFF USE ONLY

Printed Name of Staff Processing Health Packet: _____

EMERGENCY INFORMATION SHEET
HASTINGS ON HUDSON UFSD

Hillside Main Office: 478.6270 - Nurse's Office: 478.6280
Farragut Middle School Main Office: 478.6230 - Nurse's Office: 478.6226
High School Main Office: 478.6250 - Nurse's Office: 478.6226

Please fill in the following information regarding emergency contacts. If this information should change at any time, please notify the office as soon as possible.

Child's Name: _____

Grade: _____

Home Address: _____

Home Telephone #: _____

PARENT/GUARDIAN INFORMATION:

Mother/Guardian Name: _____

Does mother/guardian live with child? Yes ____ *No* _____ **If no, supply address& telephone on back.*

Mother/Guardian cell #: _____ *Pager #:* _____

Mother/Guardian Work #: _____

Father/Guardian Name: _____

Does father/guardian live with child? Yes ____ *No* _____ **If no, supply address& telephone on back.*

Father/Guardian cell #: _____ *Pager #:* _____

Father/Guardian Work #: _____

EMERGENCY CONTACT:

#1 Name: _____ *Relationship:* _____

Phone: _____ *Cell:* _____ *Work:* _____

#2 Name: _____ *Relationship:* _____

Phone: _____ *Cell:* _____ *Work:* _____

#3 Name: _____ *Relationship:* _____

Phone: _____ *Cell:* _____ *Work:* _____

STUDENT NAME: _____

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** ❑ **M** ❑ **F** **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

❒ Immunization record attached
❒ No immunizations given today
❒ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ❒ Positive ❒Negative ❒ Not done Date: _____
PPD: ❒ Positive ❒Negative ❒ Not done Date: _____
Elevated Lead: ❒ Yes ❒ No ❒ Not 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

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

			Referral
Body Mass Index: _____ _____ . _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th	Vision - Near Point	R	L	
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	Hearing ❑ Pass 20 db sc both ears or:	R	L	

❒ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❒ Negative ❒ Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): ❒ None ❒ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ❒ Yes ❒ No Student may self carry and self administer medication ❒ Yes ❒ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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

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

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

❒ **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: _____

OPTIONAL INFORMATION, if known

Specify current diseases: ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2 ❒ Hyperlipidemia ❒ Hypertension
❒ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

STUDENT NAME: _____

Hastings Public Schools

Health Offices

High School-Middle School
(914) 478-6340
Fax (914) 478-6340
27 Farragut Avenue

Hillside School
(914) 478-6280
Fax (914) 478-6279
120 Lefurgy Avenue

Hastings on Hudson, New York 10706

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATIONS IN SCHOOL

A. To be completed by parent/guardian:
I request that my child _____grade_____ receive the medication as prescribed below by our licensed health care prescriber.
The medication is to be furnished by me in a properly labeled original container from the pharmacy.
Signature: (Parent/Guardian) _____
Address: _____
Telephone: Home _____ Work_____

B. To be completed by the licensed health care prescriber:
I request that my patient, as listed below, receive the following medication:

Student Name: _____DOB:_____

Diagnosis: _____

Medication: _____Dosage: _____ Frequency/Route___
Medication: _____ Dosage: _____ Frequency/Route___
Medication: _____ Dosage: _____ Frequency/Route___

Possible side effects/adverse reaction: _____

PLEASE CHECK ONE:

C. ____ I deem this child to be self directed. He/she has been instructed in the proper use of the above medication. He/she understands the purpose, appropriate method of its administration and frequency of use.
____ I do not deem this child to be self directed in the above medication

Licensed Prescriber: Name and Title (print please) _____
Signature: _____
Address: _____
Phone: _____

For Office Use Only

Proof of Residency:

Lease: _____ **Expiration Date:** _____ **Notarized letter from Landlord** _____ **End Date:** _____

Or

Deed to house: _____ **or tax bill** _____

Utility Bill 1: _____ **Name of Utility:** _____ **Date:** _____

Utility Bill 2: _____ **Name of Utility:** _____ **Date:** _____

Original Proof of Age: _____

Does a home language survey need to be completed? ☐ **Yes** ☐ **No**

Health Records:

Physical form completed: _____ **Date of physical:** _____

Date Immunization records received: _____

Date Health History Form Received: _____ **Verified by:** _____

Previous Records:

Requested from: _____ **Date:** _____

Address: _____ **Phone #** _____

_____ **Fax #** _____

Received:

Report Cards: _____

Standardized Test Scores: _____

Medical Records: _____

Special Education files: _____

Section 504 files: _____

Other: _____