

R1-APPLICATION REGISTRATION
 NEW ENTRANT RE ENTRANT PRE-K ECC FR FU JA JM BO MA MS HS LEP SE

1-PUPIL/Alumno/a
 Last/APELLIDO _____ First/Primer Nombre _____ Middle/Segundo Nombre _____

1-1 HAS PUPIL EVER HAD ANOTHER NAME? No Yes/Sí _____
 ¿Ha tenido al alumno/a otro nombre?

2- GR./ Grado _____ 3-DOB/Fecha de nacimiento ___/___/___ 4-SEX M F
Month/Mes Day/Día Year/Año Sexo Masculino Femenino

5-Address: _____ 6-APT./FLOOR: _____ 7-Telephone: _____
 Dirección: _____ Teléfono _____

8-Displaced Yes/Sí No
 Desplazado

9- PUPIL NOW LIVING WITH: _____ DAY/WORK TELEPHONE: _____
 El alumno/a vive con Teléfono del Trabajo _____

10-1 Name _____ () _____ - Mother Guardian Foster
 Nombre Madre Apoderada Adoptiva

10-2 Name _____ () _____ - Father Guardian Foster
 Nombre Padre Apoderado Adoptivo

12-Birth Place (City/State/Country) _____ 13 DATE ENTERED USA ___/___/___
Lugar de nacimiento (Ciudad/Estado/Pais) Entrada a EEUU Mo Day Year

13-Is the student Hispanic, Latino, or of Spanish origin? ___ Yes ___ No
 Select one
 ___ American Indian or Alaska Native ___ Asian ___ Native Hawaiian/Pacific Islander ___ Black or African American ___ White

15 - Has pupil ever attended an HPS? Y N _____
 Ha estado registrado el estudiante en HPS? 15-1 School Gr. 15-2 From 15-3 To

16 - First entered school in the United States: Date ___/___/___ Grade _____
 Fecha que ingresó a una escuela en EEUU por primera vez: Fecha Grado

17 - First entered school in New York State: Date ___/___/___ Grade _____
 Fecha que ingresó a una escuela en NY por primera vez: Fecha Grado

18 - Has your child ever been enrolled in a school in the United States and subsequently returned to a country outside of the United States for more than one year? Yes No
 ¿Ha estado su hijo/a registrado en una escuela en los EEUU y posteriormente viajó a un país fuera de los EEUU por más de un año? Sí No

19 - Date left USA _____ Date returned to USA _____
 Fecha que viajó fuera de los EEUU Fecha que regresó a los EEUU

20 - The names, addresses, dates and grades of attendance & ESL/Bilingual Programs info for each school your child has attended in the United States
 Los nombres, direcciones, fechas y grados que cursó y los programas ESL / Bilingües que cursó en cada escuela que atendió en EEUU

School Name Nombre de Escuela	Address Dirección	State Estado	Dates of Attendance Fechas	Grades Grados	ESL Bilingual ESL BII
#1					
#2					
#3					

21 - Has student ever had any form of Special Education? Yes No
 ¿Ha tenido el estudiante algún tipo de Educación Especial? Sí No

Disability:....Speech Hearing Visual LD MR ED Other (specify) _____
 Incapacidad Habla Auditiva Visual LD MR ED Otra (especifique)

22-PARENT/GUARDIAN INFORMATION:

Información del Padre de Familia O Apoderado:

22-1 Mother Guardian 22-2 DOB _____ 22-3 Birthplace _____ 22-4 Deceased (Yr.) _____ 22-5 Marital Status _____
Madre Apoderado Fecha de Nacimiento Lugar de nacimiento Fallecido (año) Estado Civil

22-6 Father Guardian 22-7 DOB _____ 22-8 Birthplace _____ 22-9 Deceased (Yr.) _____ 22-10 Marital Status _____
Padre Apoderado Fecha de Nacimiento Lugar de nacimiento Fallecido (año) Estado Civil

23- Parent's Address: Mother Father (If Different from # 6) (dirección de los padres) si es diferente de #6

24- List ALL Other House Members:

List de todas las personas que viven en la casa:

	Last Name Apellido	First Name Primer Nombre	DOB FDN	Relationship Relación	School-Grade Escuela/Grado
24-1	_____	_____	____/____/____	_____	_____
24-2	_____	_____	____/____/____	_____	_____
24-3	_____	_____	____/____/____	_____	_____
24-4	_____	_____	____/____/____	_____	_____
24-5	_____	_____	____/____/____	_____	_____

25-Persons (other than parents) to be called in Emergencies:

Nombre de las personas a las que se pueden llamar en caso de emergencia (que no sean los padres)

25-1 Name/Nombre: _____ 25-2 Relationship/Relación _____
25-3 Address/Dirección: _____ 25-4 Telephone/Teléfono() _____

25-5 Name/Nombre: _____ 25-6 Relationship/Relación _____
25-7 Address/Dirección: _____ 25-8 Telephone/Teléfono() _____

26 Parent/Guardian's Signature _____ Immunization Documentation: OK ___/___/___
Firma del madre/apoderado _____ Inmunización Documentación

27-Approved by: _____ (Nurse's Signature)

28-Entered by: _____ Date: ___/___/___



Home Language Questionnaire (HLQ)

Dear Parent or Guardian:

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

Thank You

TO BE COMPLETED BY SCHOOL PERSONNEL			
DISTRICT <small>Please print or type clearly</small>			
SCHOOL		GRADE	
STUDENT NAME			
DATE OF BIRTH			
Month:		Day:	Year:
STUDENT IDENTIFICATION NUMBER			
COUNTRY OF BIRTH / ANCESTRY			
NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.			
NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION			
DETERMINATION:		<input type="checkbox"/> Possible LEP	
		<input type="checkbox"/> English Proficient	

(✓ boxes that apply)

- What language(s) is spoken in the student's home or residence? English Other _____ specify
- What language(s) are spoken most of the time to the student, in the home or residence? English Other _____ specify
- What language(s) does the student understand? English Other _____ specify
- What language(s) does the student speak? English Other _____ specify
- What language(s) does the student read? English Other _____ Does Not Read specify
- What language(s) does the student write? English Other _____ Does Not Write specify
- In your opinion, how well does the student understand, speak, read and write English?

	<i>Very well</i>	<i>Only a little</i>	<i>Not at all</i>
Understands English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reads English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Parent/Guardian/Other

Date

Month: Day: Year:



HEMPSTEAD PUBLIC SCHOOLS
HEMPSTEAD, NEW YORK 11550

PARENT QUESTIONNAIRE

Child's Name: _____ Birth date: ____/____/____ Sex: ____

Mother's Name: _____ Father's Name: _____

With whom does the child live? _____

Who is the legal guardian? _____

Allergies and Asthma

Please list and describe allergies or reactions to:

Medicines/Drugs: _____

Foods/Plants/Others: _____

Bee/Wasp stings: _____

Recommended treatment if allergy is severe: Allergy shots?

Does this child have asthma that has been diagnosed by a doctor? ____ Yes ____ No

If yes, what treatment has been prescribed?

Injuries, Illnesses, Surgeries

Please list any severe injuries, illnesses, or surgeries:

Injuries, Illnesses, Surgeries	Age of Child	If Hospitalized (check here)
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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Additional Information

What medications are give daily? _____

What medications are given frequently, but not daily? _____

This child is usually: ____ very active ____ normally active ____ rather inactive

Do you have any other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? Specify

Completed by: _____ Date: ____/____/____

Relationship to child: _____

I would like a conference with the school nurse: ____ Yes ____ No

**HEMPSTEAD PUBLIC SCHOOLS
185 PENINSULA BLVD
HEMPSTEAD, NY 11550**

HEALTH APPRAISAL

Student Name _____

Date of Birth _____

Address _____

Phone _____

IMMUNIZATIONS/SCREENING

Immunizations given since last Health Appraisal: None given today Immunization record attached

	1st	2nd	3rd	4th	5th
DTaP	*	*	*		
dT/Tdap	*	*	*		
OPV/IPV/ eIPV	*	*	*		
MMR	*	*			
Hep B	*	*	*		
Varicella	*	<input type="checkbox"/> Disease			

SICKLE CELL SCREEN		Date
Positive	Negative	
PPD		Date
Positive	Negative	
BLOOD LEAD TEST		Date
mcg/dL		

HIB		Vision—without glasses/contact lenses	R	L
Other		Vision—with glasses/contact lenses	R	L
Other		Vision---Near Point	R	L
		Hearing	R	L

PROVIDE MO/D/YR FOR ALL; * Required for entry to school in NYS

Significant Medical/Surgical History see attached

Allergies: None Food Insect Seasonal Medication LIFE THREATENING

PHYSICAL EXAM

Check here if entire exam normal Height _____ Weight _____ B.P. _____

	Normal	Abnormal	Comments
General Appearance			
Nutrition/Body Mass Index		BMI = / %	
Skin			
Head			
Eyes			
Ears			
Nose, Throat, Teeth			
Lymph Nodes/Thyroid			
Lungs			
Heart			
Abdomen			
Genitalia			Tanner - I. II. III. IV. V.
Musculoskeletal			Scoliosis Negative Positive
Neurological			

Medication (list all): None

Name _____ Dosage/Time _____
Name _____ Dosage/Time _____

IMPRESSIONS: _____

RECOMMENDATIONS: _____

PROVIDER'S SIGNATURE _____ Exam Date _____

PROVIDER'S NAME _____ Phone _____ FAX _____

OFFICE STAMP _____ Date _____

HEMPSTEAD PUBLIC SCHOOLS

Central Registration

436 Front St, Hempstead, NY 11550

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, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

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

Child's Name: Last

First

Middle

Birth Date: / /
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's Signature _____

Date _____

Section 2. To be completed by the Dentist

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

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

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

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

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

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

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

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

Yes No **Untreated Caries** - Does this child have an open cavity? [At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

Yes No **Dental Sealants Present**

Other problems (Specify): _____

III. Treatment Needs (check all that apply)

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

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

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