THE SCHOOL DISTRICT OF NEW ROCHELLE

Registration
Board of Education
515 North Avenue
New Rochelle, NY 10801
Tel. 576-4300, Ext. 39136
Email: CSDNRRegistration@nredlearn.org

Welcome to The City School District of New Rochelle

Parents/guardians wishing to register a new student must complete and return a registration packet. ***Please complete all school and health documents in Sections 1 & 2 below and provide all forms and information requested in Section 3.***

SPECIAL NOTE: Parents/guardians residing in the Lincoln Attendance Zone, who wish to register their child for school, need to contact the Superintendent's Office at (914) 576-4200 for assistance. **School placement is made on a space-available basis.**

Section 1
School Forms

- CSDNR School Registration Information
- NYS Home Language Questionnaire
- Student/Family Domicile Questionnaire
- Student Emergency Card
- Transportation Application
- Transportation - Childcare Application
- Dismissal and Contact Information
- Release of Student Records Authorization

Section 2
Health Forms

- NYS Health Examination Form: Completed by your doctor or medical provider, includes Physical Exam and Immunization Record. In special situations (Allergy, Diabetes, Seizure Management Plans, etc.), parents may wish to provide supplemental medical forms, which are available at https://www.nred.org/groups/17139/healthservicesdepartment/home.
- Student Health History Form: Completed by the parents/guardians.
- **Please note:** Public Health Law 2164 (7) states: "*A New York State school district may deny entry of a student whose parents/guardians have not submitted proof of their child's immunization.*"

Section 3
THERE ARE NO FORMS FOR SECTION 3.

Parents/Guardians must provide: Parent/guardian's photo ID, Student Proof of Age & Proof of Residency in the School District

- Parent/Guardian's Photo ID: The Parent/Guardian must present acceptable photo identification such as NYS Driver's License, NYS "Enhanced" Identification Card, a valid passport with photo, government or military ID, Residency-VISA Card, DSS ID, Office of Refugee Resettlement Card or another acceptable form of photo ID.

- Student Proof of Age: A student must be five (5) years of age before December 31, 2021 to register in Kindergarten. Proof of student's age may include birth or baptismal certificate with date of birth, guardianship or custodial documents issued by the court, or documents issued by federal, state, or local agencies with birth date. Documents must be "original" or "certified copy."

- Proof of Residency in the School District: Three (3) proofs of physical presence are required. Acceptable proofs may include: a current signed and dated lease, home mortgage statement, an income or property tax statement, a landlord affidavit, current pay stub with home address, utility bill, rental assistance voucher, insurance statement, or official documents issued by the federal, state or local government with name and property address.

  If you do not have proof of residency in your name, or are living with a host family, or are a custodial parent, you must complete a district affidavit, which can be found on the district homepage, www.nred.org.

NOTE: Registration forms are available on the District homepage, www.nred.org, in print form at any school (security desk), and at the following community locations: 95 Lincoln Avenue (WESTCOP), 345 Main Street (Bracey Houses), and Parkside Place (City Park). Additionally, registration center will operate at City Hall from 3:30 p.m. to 5:30 p.m., Monday through Wednesday. We welcome parents to call or make an appointment if they need assistance.

Once you complete your registration packet, place all documents in a sealed envelope, write your name, phone number, your child's name, and school your child will attend in September. Due to school construction this summer, registration packets may be dropped off at the Security Desk only at one of the following school: Trinity, Davis, Jefferson, Webster Elementary Schools, Isaac E. Young Middle School or the NR High School.

** ***Do Not Return Documents to City Hall or to a Community Location***

Need Help? Please email CSDNRRegistration@nredlearn.org, and be sure to leave your name and phone number . Kembly Vindas located at City Hall on the 3rd Floor is available Monday and Tuesday from 3:30 p.m. to 5:30 p.m. If you would like to make an appointment with Ms. Vindas at City Hall, please call (914) 576-4300 Ext. 39178, or contact your local school and make an appointment to speak to a registrar at any one of the following schools: Trinity 576-4440 Ext. 35604, Jefferson 576-4430/31, Davis 576-4420/21, Webster 576-4462/61, IEYMS 576-4360/61 and NRHS 576-4502/03.

Thank you

Registration Team

REGISTRATION PACKET

JONATHAN P. RAYMOND
SUPERINTENDENT OF SCHOOLS

CITY SCHOOL DISTRICT OF NEW ROCHELLE
515 North Avenue
New Rochelle, NY 10801

REGISTRATION INFORMATION

SCHOOL YEAR: ____________

Only students whose parents or legal guardians reside in New Rochelle may be registered in district schools. Students attend school according to their area of residence, except in the case of Magnet and Lincoln Attendance Zone students. Proof of residence must be provided in accordance with district policy. If the person registering the child is not listed as the parent, he/she must provide a copy of the following at time of registration: Court Order naming "*Parent by adoption*," "*Legal Guardian*," "*Order of Custody*," or "District Custodial Affidavit" and "Parent Affidavit."

PLEASE PRINT

Registration date: ____________

Student's name: ____________
Last Name First Name Middle Name

Date of birth: ____________ Male ☐ Female ☐

Student's first language: ____________

Did the child attend school outside the U.S.? ________ If yes, which grade(s): ____________

Language(s) spoken at home: ____________

Student's current grade: ________ Last grade attended. ________ When? ____________

Name and address of last school: ____________

Telephone number of last school: ____________ Name of contact person ____________

Has this child attended school in New Rochelle? When? ____________ Where? ____________

Home address: ____________
Street - Apt. # City State/zip-code

Home telephone number: ____________ Cellphone number: ____________

Parent 1/Custodian/Guardian Name: ____________

Home address: (If different) ____________
Street - Apt. # City State/zip-code

Email address: ____________

Home telephone number: ____________ Cellphone number: ____________

Marital status: Single: ☐ Married: ☐ Separated: ☐ Divorced: ☐ Widowed: ☐ Other: ☐

(Please continue to page 2)

JULY/2021

JONATHAN P. RAYMOND
SUPERINTENDENT OF SCHOOLS

CITY SCHOOL DISTRICT OF NEW ROCHELLE
515 North Avenue
New Rochelle, NY 10801

Parent 2/Custodian/Guardian Name: ____________________

Home address: (If different) ____________________
Street - Apt. # City State/Zip-code

Email address: ____________________

Home telephone number: ____________ Cellphone number: ____________

Marital status: Single: ☐ Married: ☐ Separated: ☐ Divorced: ☐ Widowed: ☐ Other: ☐

List below the FULL names of all other children in the family

Name	***Age***	***Date of Birth***	***School child is attends***	***Grade***

Previous home address: ____________________
Street – Apt. # City State/Zip-code

Does your child have an I.E.P. from Special Education? Yes: ☐ No: ☐

Does your child have a 504 plan? Yes: ☐ No: ☐

(Please continue to page 3)

JONATHAN P. RAYMOND
SUPERINTENDENT OF SCHOOLS

CITY SCHOOL DISTRICT OF NEW ROCHELLE
515 North Avenue
New Rochelle, NY 10801

Please list where and when your child has attended school:

GRADE:	***SCHOOL ATTENDED/LOCATION***	***DATE OF ATTENDANCE***
Preschool		
Kindergarten		
Grade 1		
Grade 2		
Grade 3		
Grade 4		
Grade 5		
Grade 6		
Grade 7		
Grade 8		
Grade 9		
Grade 10		
Grade 11		
Grade 12		

Has your child ever received the following services in any school?

SUPPORT SERVICES	***CHECK ALL THAT APPLY***	***GRADE(S) IN WHICH SERVICES WERE RECEIVED***
English as a Second Language	☐	
Bilingual Class	☐	
Reading Help/Lab	☐	
Resource Room	☐	
Speech/Language	☐	
Physical/Occupational Therapy PT/OT	☐	
Special Education	☐	
Counseling/Social Skills Group	☐	
Repeated a Grade	☐	
Recommended to Repeat Grade	☐	
Other (explain)	☐	

Please check ALL the appropriate boxes

Father		**Mother**
☐	American Indian	☐
☐	Asian/Pacific Islander	☐
☐	Hispanic or Latino	☐
☐	Black or African American	☐
☐	White	☐

(Please continue to page 4)

JONATHAN P. RAYMOND
SUPERINTENDENT OF SCHOOLS

CITY SCHOOL DISTRICT OF NEW ROCHELLE
515 North Avenue
New Rochelle, NY 10801

Student's name: ______________________________

Emergency contact name: ______________________________
Print Full Name

Relationship to the child: ______________________________

Home address: ______________________________
Street - Apt. # City State/Zip-code

Email address: ______________________________

Home telephone number: ______________ Cellphone number: ______________

Work telephone number: ______________ Another number: ______________

Emergency contact name: ______________________________
Print Full Name

Relationship to the child: ______________________________

Home address: ______________________________
Street - Apt. # City State/Zip-code

Email address: ______________________________

Home telephone number: ______________ Cellphone number: ______________

Work telephone number: ______________ Another number: ______________

____
Print Name of Parent/Custodian/Guardian completing the form

____
Signature of Parent/Custodian/Guardian completing the form

____
Date

OFFICE USE ONLY: Birth Cert ___ Res. ___ Medical Form ___ Lang. Survey ___ Transport. ___ M ___ F ___

ID# ______________________ Census # ______________

Magnet: Y ☐ N ☐ Lincoln Attendance Zone: Y ☐ N ☐ District-wide Special Education: Y ☐ N ☐

ESL. ☐ REG. ☐ Verified by: ______________

JULY/2021

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.)

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 ❑ Guardian(s) ________ specify	❑ Father ________ 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:

District Name (Number) & School Address

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school ___________

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** ☐ *No* ☐ *Not sure* ☐ ***If yes, please explain:** ___________________________

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ☐ **No** ☐ **Yes*** ***Please complete 10b below***

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
☐ **No** ☐ **Yes – Type of services received:** ___________________________

Age at which services received *(Please check all that apply):*
☐ **Birth to 3 years (Early Intervention)** ☐ **3 to 5 years (Special Education)** ☐ **6 years or older (Special Education)**

10c. Does your child have an Individualized Education Program (IEP)? ☐ **No** ☐ **Yes**

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

____

____

12. In what language(s) would you like to receive information from the school? ___________________________

___________________________ Month: Day: Year: ___________

Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ☐ **Mother** ☐ **Father** ☐ **Other:** ___________________

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: ___________________ POSITION: ___________________

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

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

NAME: ___________________ POSITION: ___________________

ORAL INTERVIEW NECESSARY: ☐ NO ☐ YES

**DATE OF INDIVIDUAL INTERVIEW: ___________ (MO DAY YR.)

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

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: ___________________ POSITION: ___________________

DATE OF NYSITELL ADMINISTRATION: ___________ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

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

JONATHAN P. RAYMOND
SUPERINTENDENT OF SCHOOLS

CITY SCHOOL DISTRICT OF NEW ROCHELLE
515 North Avenue
New Rochelle, NY 10801

STUDENT/FAMILY DOMICILE QUESTIONNAIRE: SCHOOL YEAR: ______________

Your child may be eligible for additional educational services through Title I, Part A; Title I, Part C – Migrant, and/or Federal McKinney-Vento Assistance. Eligibility can be determined by completing this questionnaire:

Presently, are you and/or your family in any of the following situations?

- ☐ In a shelter
- ☐ In a motel or hotel
- ☐ In a transitional housing program
- ☐ In a car, trailer, or campsite
- ☐ In a rented trailer/motor home on private property
- ☐ Awaiting foster placement
- ☐ In a rented garage due to loss of housing
- ☐ Temporarily with an adult that is not the parent/legal guardian of the child, due to loss of housing
- ☐ In a single room occupancy building
- ☐ Temporarily in another family's house or apartment due to loss of housing
- ☐ Another place unfit for human habitation
- ☐ **None of the above**

Is this temporary living arrangement due to: Loss of housing ☐ or economic hardship? ☐

Date family moved into temporary housing: ______________________

Address before moving into temporary housing: ______________________________________

Student's Name First	Last	Male	Female	Date of Birth	Grade	School Name
		☐	☐			
		☐	☐			
		☐	☐			
		☐	☐			

The undersigned certifies that the information provided above is accurate:

______________________________ ______________________________
Print Parent/Custodian/Guardian Name Parent/Custodian/Guardian Signature

Address: ____
Street - Apt. # City State/zip-code

Email address: ____

Cellphone number: ______________________ Date: ______________

SCHOOL USE ONLY

Note to school personnel: If any box above is checked, other than "none of the above," please refer the family to District Liaison and fax this form to Pupil Personnel Services, Ms. Millicent Lee, at (914) 576-4295.

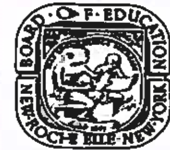
District McKinney-Vento Liaison: Base on the above information, I certify that the above-named student/family is eligible for benefits under the McKinney-Vento Act.

McKinney-Vento Liaison name and Signature: ______________________________ Date: ______________

JULY/2021

JONATHAN P. RAYMOND
SUPERINTENDENT OF SCHOOLS

CITY SCHOOL DISTRICT OF NEW ROCHELLE
515 North Avenue
New Rochelle, NY 10801



STUDENT EMERGENCY CARD

SCHOOL YEAR ______________

It is mandated by state law that we have the following information on file. This information will allow us to contact you or your designee in the event of an accident or illness to your child.

☐ Magnet: ______________ ☐ Lincoln attendance zone: ______________ ☐ Home zone school: ______________

Student name: ______________________________ **Teacher:** ______________
Last Name First Name

Student address: ____
Street - Apt. # City State/zip-code

Home phone: ______________________ Date of birth: ______________

Parent 1/Custodian/Guardian Full Name ______________________________

Email address: ______________________ Home phone: ______________

Work phone: ______________________ Cell phone: ______________

Home address: (if different from Student) ______________________________
Street - Apt. # City State/zip-code

Parent 2/Custodian/Guardian Full Name ______________________________

Email address: ______________________ Home phone: ______________

Work phone: ______________________ Cell phone: ______________

Home address: (if different from Student) ______________________________
Street - Apt. # City State/zip-code

Have phone numbers changed since last year? Yes ☐ No ☐
Has the above address changed since last year? Yes ☐ No ☐

(Please continue to page 2)

JONATHAN P. RAYMOND
SUPERINTENDENT OF SCHOOLS

CITY SCHOOL DISTRICT OF NEW ROCHELLE
515 North Avenue
New Rochelle, NY 10801

Family Physician: ______________________ Phone: ______________

Allergies: ____

Supplemental medical plan on file: Y ☐ N ☐ ______________________

If I cannot be contacted, I authorize the following people to pick up my child in an emergency:

1. Person name: ______________________ Relationship: ______________

   Address: ______________________ Home/cell #: ______________

2. Person name: ______________________ Relationship: ______________

   Address: ______________________ Home/cell #: ______________

3. Person name: ______________________ Relationship: ______________

   Address: ______________________ Home/cell #: ______________

ARE ANY ORDERS OF PROTECTION, CUSTODY VISITATION RIGHTS, OR RESTRAINING ORDERS IN EXISTENCE? IF SO, THE MAIN OFFICE MUST HAVE A COPY OF COURT PAPERS.

ILLNESS OR INJURY

If the student becomes ill in school or is injured, the nurse will make every effort to contact you. If she cannot reach you by phone, she will contact your family physician or send the child to the hospital unless you give other instructions. **The school in no way assumes financial responsibility**.

Parent/Custodian/Guardian Name ______________________________

______________________________ Date: ______________
Signature
Parent/Custodian/Guardian completing this card

JULY/2021

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CITY SCHOOL DISTRICT OF NEW ROCHELLE
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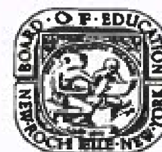


TRANSPORTATION APPLICATION SCHOOL YEAR ______________

OFFICE USE ONLY:	Magnet ☐	CILA ☐	Kaleidoscope ☐	Lincoln Attendance Zone ☐	Eligible for Transportation: Y ☐ N ☐
AM BUS: ________	TIME: ________	AM STOP: ________			
PM BUS: ________	TIME: ________	PM STOP: ________			
BUS COMPANY: ________			START DATE: ________		

Parent/Custodian/Guardian: Complete one application for each student being registered. **The Transportation Office staff will identify and notify students by mail. Only students who meet the 1.5 mileage requirement would be bussed.**

PLEASE PRINT CLEARLY, REPORT PHONE NUMBER CHANGES TO THE TRANSPORTATION OFFICE IMMEDIATELY

Please check ONE of the four choices: 1. New Student: ☐ 2. Address Change ☐

3. Moved out of District ☐ 4. School Change: ☐ ______________
Previous School

School ______________________ Grade: ________

Student ID: ____________ Date of birth: ____________ Male ☐ Female ☐

Student name: ______________________
Last Name First Name

Home address: ______________________
Street - Apt. # City State/Zip-code

Parent 1/Custodian/Guardian name: ______________________

Email address: ______________________

Primary phone number: ____________ Alternative phone: ____________

______________________ Relationship to student: ____________
Signature Parent/Custodian/Guardian

Parent 2/Custodian/Guardian name: ______________________

Email address: ______________________

Primary phone number: ____________ Alternative phone: ____________

______________________ Relationship to student: ____________
Signature Parent/Custodian/Guardian

Emergency contact name:
Other than Parent/Custodian/Guardian ______________________

Email address: ______________________

Primary Phone number: ____________ Alternative phone: ____________

JULY/2021

JONATHAN P. RAYMOND
SUPERINTENDENT OF SCHOOLS

CITY SCHOOL DISTRICT OF NEW ROCHELLE
515 North Avenue
New Rochelle, NY 10801

TRANSPORTATION – CHILD CARE APPLICATION K-5 SCHOOL YEAR ________

RETURN TO: City School District of New Rochelle
Office of Transportation
515 North Avenue
New Rochelle, NY 10801

Transportation@nredlearn.org

DEADLINE:
GRADE 1-5 APRIL 1st
KINDERGARTEN AUGUST 1st

Check ONE: Childcare: ☐ Religious Instruction: ☐

Student name: ____________________
Last Name First Name Middle Name

Student address: ____________________
Street Apt. # City State/zip-code

DISTRICT POLICY (ON BACK PAGE): **MUST READ, SIGN & DATE**. Your cooperation will **avoid delay** of bus assignment.

School: ____________________

Grade for **September 2021**: **(check one)** K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Parent/Custodian/Guardian Name ____________________

Email address: ____________________

Primary phone number: ____________ Alternative phone: ____________

____________________ Relationship to student: ____________
Signature Parent/Custodian/Guardian

Emergency contact name:
Other than Parent/Custodian/Guardian ____________________

Email address: ____________________

Primary Phone number: ____________ Alternative phone: ____________

Are you eligible for transportation from home to school? Yes ☐ No ☐

Requested start date: ____________ **(PLEASE ALLOW UP TO 10 DAYS FOR PROCESSING)**

(a) BEFORE SCHOOL ____________________
Name and address of childcare location or religious instruction program

Day(s) of the week – (circle) ALL WEEK OR MON TUES WED THURS FRI

Name of adult at childcare location ____________ Phone number: ____________

(b) AFTER SCHOOL ____________________
Name and address of childcare location or religious instruction program

Day(s) of the week – (circle) ALL WEEK OR MON TUES WED THURS FRI

Name of adult at childcare location ____________ Phone number: ____________

Start Date: ____________ Bus Company: ____________

Bus route: ____________ Bus stop: ____________

JULY/2021

TRANSPORTATION POLICY FOR CHILDCARE PROGRAMS

The New Rochelle City School District has a policy to comply with New York State Childcare Transportation Education Law (3635) as it pertains to elementary students in Grades K-5. The State law on childcare provider does *not* apply to after school religious instruction.

REQUIREMENTS

a) The childcare provider must be located within the City of New Rochelle.
Requests to childcare locations will be offered only to students who are New Rochelle residents and attend a public or non-public school located within the City of New Rochelle.

Note to parents of students who attend non-public schools within the City of New Rochelle: If you wish transportation to and/or from childcare, the Childcare Application must be submitted. *April 1st is the deadline*.

a. The days of the week requested must be on a regular basis every week

b. Applicants are limited to one pick up location and one drop off location. The bus stop assignment will be at the nearest corner to the childcare provider.

c. The childcare location must be 1.5 miles from the school and within the attendance zone of the school, your child attends.

d. If your childcare provider is **not** located within the attendance zone of your school, the childcare provider **must be licensed or registered** pursuant to Section 390 of the Social Services Law in order for your child to receive childcare transportation. The provider must meet the licensing requirement, be located in New Rochelle, and 1.5 miles from the school.

Childcare Transportation – Half-Day Sessions Transportation will be provided to an/or from the childcare provider.
You must notify the childcare provider of the 25-minute time difference. If you plan to make other arrangements, contact the school principal. **Please notify the Transportation Office if your childcare provider is closed.**

HOW TO APPLY

a) Written applications for transportation to childcare locations must be submitted by April 1st of each year for students in grades K-5. **Childcare is not available for Pre-K students.** Applications are available in main offices at elementary schools and the Board of Education Transportation Office at City hall.

b) Applications by families moving into New Rochelle must be received within 30 days after establishing residency. It will take ten school days after receipt of an application to start transportation.

c) Students enrolled in a magnet, and newly enrolled "district kaleidoscope" students must submit applications by August 1st.

d) Request to change or cancel your childcare location must be made in writing on a new application. **Ten school days are needed for processing before transportation will begin if approved.**

TRANSPORTATION TO AFTER SCHOOL RELIGIOUS INSTRUCTION

Request for transportation to after-school religious programs will be offered only for children attending public and non-public schools located within the City of New Rochelle.

Please review the following guidelines:

a) Students must be New Rochelle residents. Written applications must be submitted **annually** to the Transportation Office for such requests. Applications are available in the main office at the elementary schools and the Transportation Office at City Hall.

b) Transportation will only be provided on regular district buses to the regular bus stop nearest to the religious program. *Door to door service will not be provided.*

c) Students who do not meet mileage eligibility for daily transportation may apply.

d) Applications will be approved on a first-come, first-served basis for any seats available on the designated bus route.
Priority as follows:
   1. Eligible students assigned to designated bus route.
   2. Eligible students assigned to another bus route.
   3. Ineligible students
      For example: W6 is designated to go from Ward to Beth El. W6 riders have first preference, W5 riders second, ineligible riders third

e) The school district will not incur additional expense to provide transportation to an after-school religious program.

f) **Ten school days are needed for processing approved applications before transportations will begin.**

I have read all of the above information.

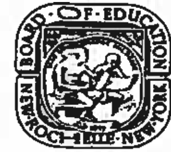
SIGNATURE PARENT/CUSTODIO/GUARDIAN ________________________ Date ____________

(Application will be processed only when signed here and on front)

JULY/2021

JONATHAN P. RAYMOND
SUPERINTENDENT OF SCHOOLS

CITY SCHOOL DISTRICT OF NEW ROCHELLE
515 North Avenue
New Rochelle, NY 10801



DISMISSAL AND CONTACT INFORMATION SCHOOL YEAR ________________

PLEASE PRINT CLEARLY.

Student name: ____ **Date of Birth:** ______________________
Last Name First Name

Student address: ____
Street - Apt. # City State/Zip-code

Emergency Early Dismissal

In the event of any early dismissal due to an emergency (weather, etc.), please indicate how your child should go home

Please check **ALL** boxes that apply:

- ☐ Contact by phone any of the adults listed below in case of emergency
- ☐ My child, who normally walks, has my permission to walk home
- ☐ My child, who normally is bussed, has my permission to be bussed home
- ☐ My child may be dismissed to any one of the adults listed below
- ☐ My child may not be dismissed to anyone

All students dismissed to an adult must be met and signed out at the Principal's office

	NAME	HOME NUMBER	WORK NUMBER	CELL NUMBER
Parent/Custodian/ Guardian #1				
Parent/Custodian/ Guardian #2				
Adult #1				
Adult #2				

Regular Dismissal

At regular dismissal, my child will: ☐ Walk Home ☐ Be picked-up

Persons Authorized to pick-up my child:

1. ____
2. ____
3. ____
4. ____

Date: ______________

JULY/2021

JONATHAN P. RAYMOND
SUPERINTENDENT OF SCHOOLS

CITY SCHOOL DISTRICT OF NEW ROCHELLE
515 North Avenue
New Rochelle, NY 10801

RELEASE OF STUDENT RECORDS AUTHORIZATION SCHOOL YEAR ____________

Supreme Court decisions require schools to have written consent from a parent, custodian, or legal guardian before they can release student records. If the student is eighteen-years-old, permission from the student must be obtained.

The form provided below will authorize your last school to provide us with transcripts and records. Please complete the required information and sign this form.

Last school attended: ______________________________

Address: ______________________________
Street/Avenue City State/Zip-Code

Phone # ______________ Last date attended: ______________

Guidance counselor: ______________

Parent/Custodian/Guardian name (please print): ______________________________

Student name: ______________________________

Age: ________ Date of birth: ______________

Date of Enrollment at CSDNR: ______________ Grade level: ________

Parent/Custodian/Guardian signature: ______________________________

Dear Principal or Registrar:

In accordance with the Family Education Rights and Private Act of 1974 (PL 93-390), I do hereby authorize you to release the following information to the City School District of New Rochelle for the student named above: health and testing records, an official transcript, and the most recent report card.

To:

School name: ______________________________

School Address: ______________________________
Street/Avenue City State/Zip-Code

Phone # ______________ Fax # ______________

Registrar email: ______________________________

JULY/2021

HEALTH FORMS

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

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

HEALTH HISTORY

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
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI________kg/m2

Percentile (Weight Status Category): ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ 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*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:				**DOB:**
SCREENINGS				
Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <u>**ONLY**</u> **required** for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V   Age of First Menses (if applicable) : ___________

☐ **Other Accommodations***: (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached   ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:	
Provider Name: ***(please print)***	
Provider Address:	
Phone:	**Fax:**

Please Return This Form To Your Child's School When Completed.

JONATHAN P. RAYMOND
SUPERINTENDENT OF SCHOOLS

CITY SCHOOL DISTRICT OF NEW ROCHELLE
515 North Avenue
New Rochelle, NY 10801

STUDENT HEALTH HISTORY

SCHOOL YEAR ______________

Name: ______________________________ DOB: __________ Age: ____ Male: ☐ Female: ☐

Parent/Custodian/Guardian name: ______________________________ Home phone: ______________

Email: ______________________________ Cellphone: ______________

Your child's medical History:	Yes	No	If Yes, please explain and include date
Born premature or had complications after birth	☐	☐	
Has an ongoing medical or developmental condition	☐	☐	
Has severe allergies or anaphylaxis	☐	☐	☐ Food ☐ Environmental ☐ Insect ☐ Medication ☐ Other Specify:
Has been hospitalized	☐	☐	
Has an operation/required surgery	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion, has a seizure disorder, or epilepsy	☐	☐	
Has a vision problem or condition	☐	☐	☐ Food ☐ Environmental
Has a hearing problem or condition	☐	☐	☐ Food ☐ Environmental
Wears a dental bridge, braces or mouthpiece	☐	☐	

Have any family members under the age of 50 ever:	Yes	No	If yes, please specify:
Has a heart attack	☐	☐	
Had other serious health problems	☐	☐	

Check all that apply to your child

- ☐ ADHD
- ☐ Allergies
- ☐ Asthma
- ☐ Autism
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/Migraines
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Mental Health Condition (Depression, Eating Disorder, Anxiety, OCD, ODD, etc)
- ☐ Scoliosis/Orthopedic Impairment
- ☐ Single Organ (☐ Kidney ☐ testicle)
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Urinary Condition
- ☐ EI/CPSE/CSE services
- ☐ Supplemental Plan (☐ Allergy, ☐ Seizure, ☐ Diabetes ☐ Asthma)
- ☐ Sees a medical specialist

Current Medications	Yes	No	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	

Assistive Equipment	Yes	No	Please check all that apply
During or outside of school	☐	☐	☐ crutches ☐ walker ☐ Wheelchair ☐ other:

Treatments	Yes	No	Please check all that apply
During or outside of school	☐	☐	☐ insulin/blood glucose monitoring ☐ Inhaler/nebulizer/peak flow monitoring ☐ Special diet

Is there any condition that would prevent your child form participating in physical education or sports? Yes ☐ No ☐

Specify: ______________________________

Please list any additional concerns: ______________________________

Parent/Custodian/Guardian signature ______________________________ Date: ______________

PARENT REQUIREMENTS

1. *PHOTO ID*
2. *STUDENT PROOF OF AGE (Birth Certificate preferable)*
3. *PROOFS OF RESIDENCY (Three)*