Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
914.934.7900

www.portchesterschools.org

Superintendent's Office
914.934.7901

Deputy Superintendent's Office
914.934.2442

Dear Parents/Guardians:

Thank you for your interest for the Port Chester-Rye Union Free School District Universal Pre-Kindergarten program. Attached you will find the registration packet for the 2021-22 school year.

Please have the following forms completed and any copies of required documents for your child's enrollment:

- Birth Certificate or other proof of birth **(copy)**
- Proof of Residency **(copy)**
- Photo ID of Parents/Guardians **(copy)**
- Health Certificate Appraisal Form Completed by Physician
- Most recent immunizations record(s) **(required)**
- Housing Questionnaire Form
- Photography/Video OPT-OUT Form
- Emergent Multilingual Learners Language Profile
- School Based Health Center Form *(optional)*
- Open door Dental Services Form *(optional)*

Please place your completed registration including all required documentation in the black box located at **113 Bowman Avenue** or deliver it to **18 Central Avenue**. If you have any questions, please contact me at **914-934-8041**.

Sincerely,

Elsy Gonzalez

Elsy Gonzalez

Port Chester-Rye UFSD

Port Chester-Rye Union Free School District

2020-2021 Prekindergarten Campus Selection

PLEASE PRINT CLEARLY AND COMPLETE ALL AREAS.

Mail or hand-deliver your registration to: Elsy Gonzalez, Pre K administrator
113 Bowman Avenue, Rye Brook, NY 10573
or
Jennifer Coggio and/or Gloria Guerra
18 Central Avenue, Port Chester, NY 10573

Child's name_____
First Last

Parent/Guardian Name_____
First Last

Does the child speak English? ☐ Yes ☐ No If no, please indicate primary language_____

Do you have an interest in a dual language program? ☐ Yes ☐ No (only offered at Laura Vicuña Campus)

Does the child receive ANY special education services? ☐ Yes ☐ No

If yes, please list services received:

_____

_____

_____

(Placement of students into integrated classrooms will be determined by the Committee on Preschool Special Education.)

Will you enter more than one child in the Pre-K for 2021-2022? Yes☐ No☐

Do you currently have another child/children enrolled in Corpus Christi-Holy Rosary (Fr. Rinaldi) Campus?

☐ Yes ☐ No If yes, please indicate grade for 2021-2022 _____

Please choose campus preferred for your child to attend UPK:

☐ Corpus Christi-Holy Rosary (Fr. Rinaldi) Campus
135 S. Regent Street

☐ Corpus Christi-Holy Rosary (Laura Vicuña) Campus
18 Central Avenue

I affirm that the information included in this application is true and complete to the best of my knowledge. I understand that completing this form does not guarantee my child admission to my preferred campus. Upon acceptance into the universal prekindergarten program, I, as parent or guardian, agree to attend any meetings or orientations that may be required by the school.

Parent/Guardian Signature_____ Date_____

Port Chester – Rye Union Free School District

Student Information

<table>
<tr><td colspan="3">Name: First Middle Last</td></tr>
<tr><td>Birthdate:

_____ / ____ /_____
month day year</td><td colspan="2">Street City</td></tr>
<tr><td>____Male _____Female</td><td colspan="2">Place of Birth: City State Country</td></tr>
<tr><td colspan="2">Main Telephone:</td><td>Other (Cell):</td></tr>
<tr><td>Entering
Grade: UPK</td><td colspan="2">Parent/Guardian Name:</td></tr>
<tr><td>Is the student Hispanic or Latino?</td><td colspan="2">☐ Yes, Hispanic or Latino ☐ No, not Hispanic or Latino</td></tr>
<tr><td>Select one of more races from the following 5 racial groups.</td><td>☐ White: A person having origins in any of the original peoples of Europe, Spain, North Africa, or the Middle East.</td><td>☐ Black: A person having origins in any of the black racial groups of Africa.

☐ Native Hawaiian or other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</td></tr>
<tr><td></td><td>☐ Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Vietnam.</td><td>☐ Native American Indian or Native Alaskan: A person having origins in any of the original peoples of North America and South America (including Central America) and WHO DERIVES TRIBAL AFFILIATION OR ATTACHMENT IDENTIFICATION THROUGH TRIBAL e.g. CHEROKEE, MOHAWK, INUIT, MAYAN,INCA,(but not limited to those listed).</td></tr>
<tr><td>Child’s Physician:</td><td colspan="2">Name Phone

Address</td></tr>
<tr><td rowspan="2">Emergency Contact:
(if parent not available)</td><td>Name Phone Relationship</td><td></td></tr>
<tr><td>Name Phone Relationship</td><td></td></tr>
<tr><td></td><td>Name Phone Relationship</td><td></td></tr>
</table>

Parent/Guardian Information:	Mother/Guardian #1	Father/Guardian #2
Relationship to Student		
Last Name		
First Name		
Middle Name		
Street Address		
City		
State		
Zip		
Main Telephone		
Cell Phone		
E-mail address		

	Name	Relationship to UPK Student	Gender	Birthdate (mm/dd/yy)	School
Siblings of UPK student living at home:					

Note: All requested documentation must be received before registration is considered complete

I certify that all of the information above is true and accurate as of this date.

I understand and consent to permitting my directory and contact information to be used by the school to keep me informed of school related matters.

Parent/Guardian Signature _____ Date _____

Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
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SEE ATTACHED
2021-2022 School Year
New York State Immunization Requirements
for School Entrance/Attendance

Students presenting without documentation of receiving any, or an insufficient number of, immunizations or proof of immunity may be permitted a grace period to attend school for not more than 14 calendar days; which may be extended to not more than 30 calendar days for an individual student who is transferring from out of state or from another country and can show a good faith effort to get the necessary evidence of immunization. (10NYCRR 66-4)

Students wishing to enroll in the Open Door Family Medical Center School Based Health Center for the purposes of obtaining immunizations can enroll with the site provider. Enrollment forms are available upon request.

Please send proof of immunization to the school nurse where your child will be attending school.

Proof of immunization must be any 1 of the 3 items listed below.

- An immunization certificate signed by your health care provider
- Immunization Registry report (NYSIIS or CIR from NYC) from your health care provider or your county health department
- A blood test (titer) lab report that proves your child is immune to the diseases
    - For varicella (chickenpox), a note from your health care provider (MD, NP, PA) which says your child had the disease is also acceptable.

If you have any questions or concerns about immunizations, please contact the school health office. Thank you.

Sincerely,

School Nurse

New York State Immunization Requirements for School Entrance/Attendance[1]

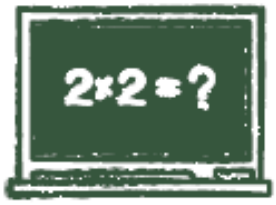
NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades pre-k through 11, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grade 12 except for interval between measles vaccine doses. See footnotes for specific information for **each** vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule.

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)[3]	**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**3 doses**
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses**	**3 doses or 2 doses** of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years	
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		**1 dose**
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9 and 10: 1 dose**	**2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

NEW YORK STATE | Department of Health

PARENTS: NYS School Vaccination Requirements Have Changed



Nonmedical exemptions to school vaccination requirements have ended for children attending day care and pre-K through 12th grade in New York State. This includes all public, private, and religious schools. Religious exemptions are no longer allowed.

Children with nonmedical exemptions must now be vaccinated to attend or remain in school.

Students who already have all required school vaccinations, and students with a valid medical exemption from a physician, are not affected by this change.

IMPORTANT VACCINATION DEADLINES:

- **Within 14 days of the first day of school or day care** – children must receive the first age-appropriate dose in each immunization series to attend or remain in school or day care.
- **Within 30 days after the first day of school or day care** – parents or guardians must show that they have appointments for the next required follow-up doses for their child. Deadlines for follow-up doses depend on the vaccine.

What vaccines does my child need?

Talk to your health care provider. Requirements will differ based on your child's age and any previous vaccinations.

Is it safe for my child to have more than one shot at a time?

Scientific data show that getting multiple vaccines at the same time is safe. It also means fewer doctor's office visits which can be less stressful for your child. Visit **health.ny.gov/vaccinesafety** to learn more.

Tips to help your child relax at their next shot visit:

www.cdc.gov/vaccines/parents/visit/less-stressful.html
www.cdc.gov/vaccines/parents/tools/tips-factsheet.pdf

NEW YORK STATE | Department of Health

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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 **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** — **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** — **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

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

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

HOUSING QUESTIONNAIRE

Name of LEA: Port Chester-Rye Union Free School District

Name of School: Universal Pre-Kindergarten

Name of Student: _____
First Middle Last

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

Address: _____ Phone: _____

The answer you give below 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.

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

☐ 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):
_____
☐ In permanent housing

Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____

Date _____

Please send a copy to Kathy Sutherland at the Central Office.
Fax: 914-934-2429

Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
914.934.7925
www.portchesterschools.org

PHOTOGRAPHY/VIDEO OPT-OUT FORM

(Complete and return this form **ONLY IF YOU DO NOT GIVE PERMISSION** for your student to appear in school publicity images, yearbooks or videos, including postings on the school or district websites and social media.)

There are many activities and accomplishments that take place in our schools which the Port Chester-Rye Union Free School District feels are positive, newsworthy and of interest to the community. District representatives and program partners will, from time to time, use still photography or videography for the purpose of highlighting student achievements or chronicling classroom/school activities. Those images may be used in informational newsletters, school brochures, class pictures, yearbooks and other printed material published by the Port Chester-Rye Union Free School District and those acting under its permission. It is possible that those images might be used on school and/or district websites, social media accounts affiliated with the district and may also be submitted to the news media for possible publication.

If, for any reason, **you do not want** your child's likeness to be used by the Port Chester-Rye Union Free School District or by the news media for the purpose of positive publicity about school activities or student achievement, please fill out this form and return to your school office. A separate form is required for each child.

This form only applies to the current school year and to classroom activities or school events that are not already open to the public.

☐ I do NOT wish to have my child photographed/videotaped for news media or school publicity purposes.

Student's full name (please print)_____

School _____ Grade Universal Prekindergarten

Parent or guardian's name_____

Parents or guardian's signature_____ date_____

Please return the signed form to your school office.

NEW YORK STATE EDUCATION DEPARTMENT
Emergent Multilingual Learners Language Profile for Prekindergarten Students[i]

Dear Parent or Guardian,
Thank you for completing the Emergent Multilingual Learners Language Profile. This survey will assist your new school with valuable information about your child's experience with languages. Information gathered will assist Prekindergarten educators in delivering academically and linguistically relevant instruction that strengthens the language and literacy of all students.

THIS SECTION TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY AND MAINTAINED ON FILE
Date Profile Completed:
Student Name:
Gender:
Date of Birth:
District or Community Based Organization Name: Port Chester-Rye UFSD
Name of Person Administering Profile: Elsy Gonzalez
Title: Pre K Administrator

Parent or Person in Parental Relation Information

Name of parent or person in parental relation: _____

Relationship (to student) of person providing information for this profile: ☐ mother ☐ father

☐ other _____

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

☐ English ☐ other home language: _____

Language in the Home

1. In what language(s) do you (parents or guardians) speak to your child at home?

2. What is/are the primary language(s) of each parent/guardian in your home? (List all that apply.)

3. What language(s) does your child understand?

4. In what language(s) does your child speak with other people?

5. Does your child have siblings? ☐ yes ☐ no

If yes, in what language(s) do the children speak with each other most of the time?

6. How has your child learned English so far (home, television shows, siblings, childcare, etc.)?

Language Outside the Home/Family

7. Has your child attended any nursery, Head Start or childcare program? ☐ yes ☐ no

If yes, in what language was the program conducted?

Language Goals

8. Would you like your child to learn another language? ☐ yes ☐ no

9. Would you be interested in participating in a Dual Language program? ☐ yes ☐ no

Emergent Literacy

10. Does your child have access to books whether at home or from the library? ☐ yes ☐ no

In what language(s) are these books read to him or her?

11. Does your child pretend to read? ☐ yes ☐ no ☐ unsure

If yes, in what language(s)?

12. Is your child able to retell stories about his/her personal experiences? ☐ yes ☐ no

If yes, in what language(s)?

13. *(optional)* Does or has your child received Early Intervention Services? ☐ yes ☐ no

[i] For more information contact: the New York State Education Department Office of Early Learning at (518) 474-5807 or email OEL@nysed.gov or the New York State Education Department Office of Bilingual Education and World Languages at (518) 474-8775 or (718) 722-2445 or email OBEWL@nysed.gov.