Dear Parent/Guardian(s):

Welcome to the Mahopac Central School District. Listed below and enclosed are the required registration documents for eligible non-resident students to be evaluated for Special Ed Services Only. If you have any questions or need to set up a registration appointment, please contact the Office of Central Registration at 845-621-0656, Ext. 13905 or 13902.

Registration Requirements **NON RESIDENT CSE EVALUATION REQUESTS ONLY**
REGISTRATION FORMS
Student Registration Form with Emergency Information
Registration Contact List
Country and Home Language Survey ESOL
Health Appraisal Form (to be completed by Physician) **
NYS Immunization Requirements for School Entry
Health History (to be completed by Parent/Guardian)
Developmental History from Parent/Guardian
Parent Request for Evaluation
** The physical must be within the twelve months prior to registration and accompanied by a record of your child's immunizations.
ADDITIONAL DOCUMENTATION TO BE PROVIDED
Proof of Birth – **Original Birth Certificate Only** Proof of Enrollment in Non Public School located within the MCSD *(Letter from the Non Public School of attendance)*

MAHOPAC CENTRAL SCHOOL DISTRICT
REGISTRAR

Student Registration Form

Please print legibly with blue or black ink

STUDENT LAST NAME _____ FIRST NAME _____ MI _____

Birth City _____ Birth State _____ Birth Country if not the U.S. _____ Male / Female

Birth Date _____ Date of Entry in U.S. _____ Date of Entry in U.S. Schools _____

HOME ADDRESS _____ _____ NEAREST CROSSROAD _____
City

MAILING ADDRESS (if different) _____ CUSTODY ISSUES [1]: Yes / No

ARE SPECIAL SERVICES REQUIRED: English Language Lerner / ESOL: Yes / No Special Education / IEP: Yes / No

ETHNICITY

Is the child Hispanic, Latino, or of Spanish Origin? (*Hispanic, Latino, or Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.*) _____***Yes, Hispanic*** _____***No, Not Hispanic***

Select one or more races from the following five racial groups *(Check all groups that apply to your child; check at least one box):*

___ **American Indian or Alaskan Native** — *A person having origins in any of the original peoples of North and South America, and who maintains cultural identification through tribal affiliation or community recognition.*

___ **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, Philippine Islands, Thailand and Vietnam*

___**Black or African American** — *A person having origins in any of the Black racial groups of Africa*

___**Native Hawaiian/Other Pacific Islander** — *A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands*

___**White** — *A person having origins in any of the original peoples of Europe, North Africa or the Middle East*

RESIDENT PARENT/GUARDIAN INFORMATION

If student resides with Foster Parents or Legal Guardian, supporting documentation will be required.

Name _____ ___Parent ___Step Parent ___Legal Guardian _____Other Male / Female

Employer/Occupation _____ E-Mail Address: _____

Home Phone ( )_____ Business Phone ( )_____ Cell ( )_____

Work Location: City & State _____ Hours: _____ to _____ Work Days: __Mon __Tues __Wed __Thurs __Fri

Name _____ ___Parent ___Step Parent ___Legal Guardian _____Other Male / Female

Employer/Occupation _____ E-Mail Address: _____

Home Phone ( )_____ Business Phone ( )_____ Cell ( )_____

Work Location: City & State _____ Hours: _____ to _____ Work Days: __Mon __Tues __Wed __Thurs __Fri

IF APPLICABLE, NON-RESIDENT PARENT/GUARDIAN INFORMATION

Name _____ ___Parent ___Step Parent ___Legal Guardian _____Other Male / Female

Employer/Occupation _____ E-Mail Address: _____

Parent Mailing Address (if different from Student): _____

_____ Parent requests extra mailings: ___Yes ___ No

Home Phone ( )_____ Business Phone ( )_____ Cell ( )_____

Work Location: City & State _____ Hours: _____ to _____ Work Days: __Mon __Tues __Wed __Thurs __Fri

HAS YOUR CHILD EVER ATTENDED THE MAHOPAC CSD: Yes / No IF YES PLEASE GIVE DATES: _____

TRANSFER FROM: School Name _____ City & State _____

FOR GRADE K REGISTRATION, PRE-SCHOOL ATTENDED _____

TO BE COMPLETED BY SCHOOL PERSONNEL ENTER DATE _____ SCHOOL CODE _____

STUDENT ID NO. _____ MAP CODE _____ GRADE _____

PROOF OF BIRTH: ___ Original Birth Certificate ONLY RECORD OF IMMUNIZATIONS: Yes / No

BUS NO. TO _____ BUS NO. FROM _____

Revised 12/23/10

Mahopac Central School District – Student Registration Form

Is your child presently under an order of suspension/expulsion from another school district Yes _____ No _____
Is your child presently under consideration of suspension or expulsion from another school district Yes _____ No _____
Is your child currently involved in the Juvenile Justice System Yes _____ No _____

BROTHERS & SISTERS (Include All Children Living With Family):

NAME (First & last)	DATE OF BIRTH	CURRENT SCHOOL	GRADE	GENDER	EXPECTED TO ATTEND MCSD IF YES – START DATE	FOR MCSD USE	

ARE THERE ANY SIBLINGS UNDER THE AGE OF FIVE WITH SPECIAL NEEDS? ____ Yes ____ No

EMERGENCY CONTACT INFORMATION: *In case of an emergency, the parent/guardians listed on page one of this form are the first to be contacted. In the event you cannot be reached, please list below three additional contacts. Please include their city and state in order to assist us in determining the contact in closest proximity to the school. The individuals below have the authorization to pick up your child in the event you cannot be reached.*

		RELATIONHIP TO STUDENT (i.e., grandparent, neighbor, childcare provider)	TELEPHONE NUMBER	CIRCLE ONE
CONTACT(1):	_____	_____	( ) _____	Home Cell Work
CONTACT(2):	_____	_____	( ) _____	Home Cell Work
CONTACT(3):	_____	_____	( ) _____	Home Cell Work

PHYSICIAN: _____ **TEL:** ( ) _____

DENTIST: _____ **TEL:** ( ) _____

IF I WISH TO CHANGE THE DOCTOR INDICATED ABOVE, IT IS MY RESPONSIBILITY TO NOTIFY THE SCHOOL NURSE OF THIS CHANGE.

EMERGENCY MEDICAL CARE CONSENT

In the event of an accident, sudden illness, or other cause which, in the judgment of the school nurse or other person in charge, requires advice or treatment beyond general aid, I give permission for an ambulance to be called to transport my child to the nearest hospital. Furthermore, I give permission to the hospital to treat my child. I understand that every effort will be made to contact me if the above circumstances should occur. I recognize that when the school calls for assistance in this way, it is acting on my behalf, and that any medical care that my youngster receives is the financial obligation of myself and not the school.

_____ _____
Parent/Guardian Signature **Date**

Note: As a procedure the school will ask parents to keep their child(ren) home from school if they show any sign of significant infection. If your child has had a fever (100 F. or above) he/she should not return to school until his/her temperature has been normal for at least 24 hours. Please have any body rash or eye inflammation checked by your doctor to determine whether or not it is contagious.

If a child requires any medication during school hours, the medication should be brought to the School Nurse by the parent or a responsible adult. It must be in the original prescription bottle with a permission form completed by the parent and doctor and signed by the parent/guardian. Students are not to bring medication (including over the counter medications such as Tylenol) with them.

_____ _____
Parent/Guardian Signature **Date**

I (We) affirm that the information provided on this form is true and correct. I (We) understand that the District may investigate any allegation contained in this form and may ask for written proof of any statement. In order to verify the information or statements provided on this form (including any supporting documents and affidavits), I (we) give consent for the release of this form (including any supporting documents and affidavits) or any information contained in this form to Mahopac Central School District, the landlord, or any other third party in furtherance of the School District's investigation. I (We) understand that if the allegations contained in this form (including supporting documents and affidavits) are determined not to be true and accurate, I (we) will be held responsible for the payment of tuition to the District.

_____ _____
Parent/Guardian Signature **Date**

[1] See Registration procedures for Custody Issues.

Registration Contact Sheet

Mahopac Central School District Office
179 East Lake Boulevard, Mahopac, NY 10541
Phone: 845-628-3415 Fax: 845-628-0261
District Website: www.mahopac.k12.ny.us

Office of Central Registration
100 Myrtle Avenue, Mahopac, NY 10541

Registration for Grades K – 12 and Transportation: Elfriede Schober
Phone: 845-621-0656 x13902 Fax: 845-628-3034
Registration for Pre School Evaluations: Marie Micol
Phone: 845-621-0656 x13905 Fax: 845-628-3034

Parent Portal – Marie Micol
Phone: 845-621-0656, ext. 13905 - Email: pcxp@mahopac.k12.ny.us

Mahopac High School
421 Baldwin Place Road, Mahopac, NY 10541-4631
Phone: 845-628-3256 Fax: 845-628-4380
Registrar: Elfriede Schober (The Office of Central Registration – 845-621-0656, x13902)
Nurse: Lynn Karst – 845-628-3256, Ext. 11700

Mahopac Middle School
425 Baldwin Place Road, Mahopac, NY 10541-4631
Phone: 845-621-1330 Guidance Fax: 845-628-2012
Registrar: Lynne Mongon, Ext. 12600
Nurse: Alice Foley, Ext. 12700

Austin Road Elementary School
390 Austin Road, Mahopac, NY 10541-2777
Phone: 845-628-1346 Fax: 845-628-5521
Registrar: Donna Tritremmel, Ext. 15502
Nurse: Teresa Sedran – 845-628-4574

Fulmar Road Elementary School
55 Fulmar Road, Mahopac, NY 10541-4521
Phone: 845-628-0440 Fax: 845-628-5714
Registrar: Jane Garbo, Ext. 14503
Nurse: Noreen Beichert – 845-628-3457

Lakeview Elementary School
112 Lakeview Drive, Mahopac, NY 10541-2316
Phone: 845-628-3331 Fax: 845-628-5849
Registrar: Lisa Cancel, 16503
Nurse: Mary Brunetti – 845-628-3777

Transportation - Bus Garage – Falls District Office
100 Myrtle Avenue, Mahopac, NY 10541 - Phone: 845-628-7447

Building and Grounds – Facilities –
23 Secor Road, Mahopac, NY 10541 - Phone: 845-628-3331 x16901

MAHOPAC CENTRAL SCHOOL DISTRICT

179 East Lake Blvd., Mahopac, NY 10541-1666 (845) 628-3415 Fax (845) 628-0261

Dr. Greg Stowell
Assistant Superintendent
Pupil Personnel and Educational Services

Dennis W. Creedon, Ed.D.
Superintendent of Schools

Dear Parents/Guardians:

Welcome to the Mahopac Central School District. Parents/Guardians and the school district enter into an important partnership to ensure that every student in our schools acquire the skills, knowledge, attitudes and interpersonal skills that will permit him or her to operate effectively in the broader community and lead a successful productive life in a changing world. This is critically important when a child has an educational disability. Therefore, please know the Pupil Personnel Department is here to support you if your child has or is suspected of having an educational disability.

Below is the contact information for the special education administrators at each level and a link to the New York State Education Department's *"A Parent's Guide to Special Education"* in both English and Spanish. The parent guide provides an overview of a parent's rights regarding referral and evaluation of their child for the purposes of special education services or programs upon a student's enrollment in public school.

- Elizabeth Blessing
  Special Education Administrator, OOD Placements
  blessinge@mahopac.k12.ny.us
  (845) 621-0656 x13704

- Christine Shea-Coelho
  Preschool & Elementary Special Education Administrator
  sheacoelhoc@mahopac.k12.ny.us
  (845) 621-0656 x13703

- Dr. Catherine Sweeney
  Secondary Special Education Administrator (MS/HS)
  sweeneyc@mahopac.k12.ny.us
  (845) 628-3256 x11640

A Parent's Guide to Special Education

English
http://www.p12.nysed.gov/specialed/publications/policy/parentsguide.pdf

Spanish
http://www.p12.nysed.gov/specialed/publications/policy/spanishparentguide.htm

Sincerely,

Greg Stowell

Greg Stowell, D.P.S.
Assistant Superintendent for PPS
(845) 628-3415 x10710

COUNTRY AND HOME LANGUAGE SURVEY
To Be Completed By Parent/Guardian

Student Name _____ Date of Birth _____

School _____ Grade/Class _____

Parent/Guardian Name _____
Person completing survey ☐ Mother ☐ Father ☐ Guardian

COUNTRY

Name of Country where child was born (Birth Country) _____

If country of birth is *not the* US or it's surrounding territories, please complete the following:
Was child born overseas to American parents traveling, working or stationed in the military?
_____ Yes _____ No
Was your child adopted abroad? _____ Yes _____ No

Name of Country child last resided before entering US (Country of Origin)_____

When did your child first enter the US Date: _____

When did your child first enter school in the US Date: _____

HOME LANGUAGE

Did your child receive ESOL (English as a Second Language) in his/her previous school? ☐ Yes ☐ No

Original Start Date of ESOL Services _____

Name of Previous School _____

Previous School Address _____ Phone _____

Directions: Circle the correct response for each of the following questions concerning your child:

1. What language did the child learn when s/he first began to talk?	English	Other _____
2. What language does the family speak in the home most of the time?	English	Other _____
3. What language does the mother speak to her child most of the time?	English	Other _____
4. What language does the father speak to his child most of the time?	English	Other _____
5. What language does the child speak to his/her mother most of the time?	English	Other _____
6. What language does the child speak to his/her father most of the time?	English	Other _____
7. What language does your child speak to his/her brothers and sisters most of the time?	English	Other _____
8. What language does your child speak to his/her friends most of the time?	English	Other _____

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and Triennially for the Committee on Special Education (CSE).

Mahopac Central School District

HEALTH APPRAISAL FORM

This form MUST be filled out in its entirety

THIS FORM AND ALL ATTACHMENTS MUST BE SIGNED AND STAMPED TO BE VALID

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

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

IMMUNIZATIONS / HEALTH HISTORY

❑ Immunization record attached/on reverse side of this form
❑ No immunizations given today

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 _____

Specify current diseases: ❑ Asthma Diabetes: ❑ Type 1 ❑ Type 2 ❑ Pre hypertensive ❑ Hypertension
❑ Other: _____

Allergies: ❑ **LIFE THREATENING** ❑ Food: _____ ❑ Insect: _____ ❑ Other: _____
❑ Seasonal ❑ Medication: _____ _____

If any medications are needed, a current medications slip MUST be on file in the health office for the current school year

PHYSICAL EXAM: ALL sections MUST be filled out

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

Body Mass Index: _____ _____ . _____

Weight Status Category (BMI Percentile):

❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
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 _____

MEDICATIONS

Medications ❑ None

List medications taken at home: _____

_____

(OVER)

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider. *Rev. 11/09*

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and Triennially for the Committee on Special Education (CSE).

IMMUNIZATIONS: Please give type and full date (Month/Day/Year)

DPT/DTaP #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

Tdap _____

HIB #1 _____ #2 _____ #3 _____ #4 _____

OPV #1 _____ #2 _____ #3 _____ #4 _____

IPV #1 _____ #2 _____ #3 _____ #4 _____

Live Measles, Mumps, Rubella (MMR) _____ MMR Booster _____

If given separately, Measles #1_____ Measles #2_____ Rubella _____ Mumps _____

Hepatitis A Vaccine #1 _____ #2 _____ #3 _____

Hepatitis B Vaccine #1 _____ #2 _____ #3 _____

GARDASIL/HPV #1 _____ #2 _____ #3 _____

Varicella Vaccine #1 _____ #2 _____ Varicella Disease_____

PPD_____ results _____

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION

❒ **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.

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

THIS FORM AND ALL ATTACHMENTS MUST BE STAMPED AND SIGNED BY PROVIDER:

Parent Signature: _____ Date: _____

DENTAL HEALTH

REQUESTED BY NEW YORK STATE EDUCATION LAW

Student_____ Grade _____

Please have your child checked by your family dentist.

Under treatment _____ Completed _____

No Treatment Needed _____ Date _____

THIS FORM MUST BE STAMPED BY PROVIDER: Dentist's Signature _____

THIS PHYSICAL EXAMINATION/DENTAL HEALTH FORM MUST BE COMPLETED AND RETURNED TO THE SCHOOL NURSE WITHIN 30 DAYS OF BEGINNING SCHOOL. IF YOUR CHILD HAS A SCHEDULED APPOINTMENT PLEASE MAKE THE SCHOOL NURSE AWARE OF THE APPOINTMENT DATE. The school physician will examine all students in the above mentioned grades for whom we do not have a record of exam by the family physician.

(OVER)

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider. *Rev. 11/09*

The N.Y.S. Education Law requires physical examinations for every student upon entrance to the district, kindergarten, and in the second, fourth, seventh, and tenth grades. This requirement can be best met by your family physician since he/she is the one most informed about your child's health. Such examination shall be acceptable if it is administered not more than twelve months prior to the start of the school year in which the examination is required. If your child has had a routine examination by your family physician, please ask the physician to complete this form.

The dental health part of the form may be detached and returned to the school nurse after completion by your family dentist.

THE PHYSICAL EXAMINATION FORM MUST BE COMPLETED AND RETURNED TO THE SCHOOL NURSE AS SOON AS POSSIBLE. IF YOUR CHILD HAS A SCHEDULED APPOINTMENT PLEASE MAKE THE SCHOOL NURSE AWARE OF THE APPOINTMENT DATE. The school physician will examine all pupils in the above mentioned grades for whom we do not have a record of exam by the family physician.

NOTE: As a procedure the school will ask parents to keep their child home from school if the child shows any sign of significant infection. If your child has had a fever (100F or above) he/she should not return to school until the temperature has been normal for 24 hours.

Please have any body rash or eye inflammation checked by your doctor to determine whether or not it is contagious.

If a child requires any medication during school hours, the medication should be **brought to the school nurse in the original prescription bottle with a permission form completed by the parent and doctor.** Students are not to carry any medication (including Tylenol) with them.

The Nurse will administer a hearing screening to all new school entrants and to all K, 1, 3, 5, 7 and 10th graders. A near vision screening and color perception vision screening is administered to all Kindergarten students. A distance vision screening is administered to all new school entrants, K, 1, 2, 3, 5, 7, and 10th graders. Scoliosis screening is mandated for students in grades 5, 6, 7, 8 and 9 who have not been checked by their private physician.

2015-16 School Year

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 for Immunization Practices (ACIP).

For grades Pre-k through 7, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: intervals between doses of polio vaccine need to be reviewed only for grades kindergarten, 1, 6 and 7.) 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 grades 8 through 12. 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 through Grade 1	Grades 2 through 5	Grades 6 through 7	Grades 8 through 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years of age or older or **3 doses** if the series is started at 7 years of age 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 of age or older	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years of age or older	**3 doses**
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**			
Hepatitis B vaccine[6]	**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 of age			
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**	**1 dose**	**2 doses**	**1 dose**
Haemophilus influenzae type b conjugate vaccine (Hib)[8]	**1 to 4 doses**	Not applicable			
Pneumococcal Conjugate vaccine (PCV)[9]	**1 to 4 doses**	Not applicable			

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15 through 18 months, and 4 years of age or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at age 4 years or older, the fifth (booster) dose of DTaP vaccine is not necessary.
   c. For children born prior to 1/1/2005, doses of DT and Td meet the immunization requirement for diphtheria toxoid-containing vaccine.
   d. Children ages 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. A Tdap vaccine (or incorrectly administered DTaP vaccine) received at 7 years or age or older will meet the 6th grade Tdap requirement.
   e. For previously unvaccinated children 7 years of age and older, the immunization requirement is 3 doses. Tdap should be given for the first dose, followed by two doses of Td in accordance with the ACIP recommended immunization schedule for persons 0-18 years of age: an initial Tdap followed 4 weeks later by a Td, and 6 months later by another Td.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
   a. Students 11 years of age or older entering grades 6 through 12 are required to have one dose of Tdap. A dose received at 7 years of age or older will meet this requirement.
   b. Students who are 10 years old in grade 6 are in compliance until they turn 11 years of age.

4. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at ages 2, 4, 6 through 18 months, and 4 years of age or older. The final dose in the series should be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at age 4 years or older, the fourth dose of polio vaccine is not necessary.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Students in grades kindergarten through 12 must have received 2 doses of measles-containing vaccine, 2 doses of mumps-containing vaccine and at least 1 dose of rubella-containing vaccine.
   c. One dose of MMR is required for prekindergarten.

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be received at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than 24 weeks of age.
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Two doses of varicella vaccine are required for students in grades kindergarten, 1, 6 and 7.
   c. One dose of varicella vaccine is required for prekindergarten and grades 2 through 5 and 8 through 12.

8. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and 12 through 59 months of age.
   b. If 2 doses of vaccine were received before 12 months of age, only 3 doses are required with dose 3 at 12 through 15 months of age and at least 8 weeks after dose 2.
   c. If dose 1 was received at ages 12 through 14 months of age, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months of age or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years of age or older.

9. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at ages 2 months, 4 months, 6 months and 12 through 59 months of age. The final dose must be received at 12 through 59 months of age.
   b. Unvaccinated children 7 through 11 months of age are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at age 12 through 15 months.
   c. Unvaccinated children 12 through 23 months of age are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months of age or older, no further doses are required.
   e. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

MAHOPAC CENTRAL SCHOOL DISTRICT
HEALTH OFFICE

HEALTH HISTORY FORM
TO BE COMPLETED BY PARENT

STUDENT _____ DOB _____ GRADE _____

DISEASES: (*Give Dates*)

History	Date	Date	Date
Chicken Pox	Epilepsy	Asthma	
Whooping Cough	Heart Disease	Bronchitis	
Tuberculosis	Kidney Disease	Pneumonia	
Tbc. Contact	Lyme Disease	Freq. Ear Conditions	
Anemia	Rheumatic Fever	Strep Throat	
Diabetes	Fifth's Disease	Scarlet Fever	

Allergies: Foods: _____ Medications: _____
Insects: _____ Environmental (grass, dust, etc.): _____

OTHER PERTINENT HEALTH DATA

Vision Difficulties _____ Glasses: Yes _____ No _____
Any family history of Color Perception Abnormalities Yes _____ No _____
Hearing Difficulties _____ Hearing Aid: Yes _____ No _____
Physical Handicaps _____
High Fevers _____ With Convulsions: Yes _____ No _____
Operations: Tonsils _____ Appendectomy _____ Hernia _____
Tubes in Ears _____ Other _____
Fractures _____ Sutures or Serious Injuries _____
Hospitalization: Reason _____
_____ Date: _____
Medications: Taken at home Yes _____ No _____ How Often? _____
Taken at school Yes _____ No _____ How Often? _____
Name of medication _____
Name of physician _____
Address & Phone Number _____
Menstruation: Age began: _____
Regular: Yes _____ No _____ Painful: Yes _____ No _____

Is child capable of carrying a full program of school work? Yes _____ No _____
Is child able to participate in all physical education activities? Yes _____ No _____
If no, give reason _____
Does child have irremedial defects? Yes _____ No _____
Is there any need to alter child's school program? Yes _____ No _____
If yes, give reason _____

Note: As a procedure the school will ask parents to keep their child home from school if they show any sign of significant infection. If your child has had a fever (100F or above) he/she should not return to school until his/her temperature has been normal for at least 24 hours.

Please have any body rash or eye inflammation checked by your doctor to determine whether or not it is contagious.

If a child requires any medication during school hours, the medication should be brought to the school nurse in the original prescription bottle with a permission form completed by the parent and doctor. Students are not to carry any medication (including Tylenol) with them.

I give permission for health information to be shared with school personnel.

Date _____ Parent Signature _____

MAHOPAC CENTRAL SCHOOL DISTRICT
HEALTH OFFICE

Developmental History Form
(GRADE K-5 ONLY)

Dear Parents:

We request that this be completed to offer the staff more insight to your child's development. This will remain part of your child's health folder.

Child's Name_____Birthdate_____

1. Developmental history:

   Pregnancy: Full Term _____ If no, how many weeks? _____
   Delivery: Normal _____ If no, what difficulties? _____
   Birth Weight: Pounds_____ Ounces_____
   Age of child when: Walking _____ Talking _____
   Age of child when: Toilet training: day _____ night _____

2. Did your child attend nursery/preschool? ☐ Yes ☐ No

   If yes, which one? _____

   How long? _____
   (years) (half days) (full days)

3. Has your child had any previous physical, developmental or educational difficulties or delays?
   ☐ Yes ☐ No Please specify _____

4. Has your child received any special services through the district, such as:

   ☐ Speech ☐ Occupational Therapy ☐ Physical Therapy

   ☐ Special Education ☐ Resource Room

   Does your child have any problems with their speech at this time?
   ☐ Yes ☐ No Please specify _____

5. What is the main language spoken in the home? _____

   Second language spoken in the home? _____

_____ _____
Parent Signature *Date*

MAHOPAC CENTRAL SCHOOOL DISTRICT

Request for CSE Evaluation

Date: _____

Child's Name: _____

Child's DOB: _____

Address: _____

_____

To The Committee on Special Education:

I am the Parent/Guardian of _____. I would like to have my child evaluated for _____.

Thank you for your time and consideration of my request.

_____ _____

Parent/Guardian Name Parent/Guardian Signature