Dr. Alex Marrero
Interim Superintendent of Schools

City School District of New Rochelle
515 North Avenue
New Rochelle, NY 10801

City School District of New Rochelle Registration Information Sheet

Only students whose parents or legal guardians reside in New Rochelle may be registered in our district schools. Students attend school according to their area of residence, except in the case of Magnet students. Proofs 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 child attend school outside of U.S.: _____ If yes, which grades? _____

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# ZIP CODE

Home telephone number: _____

Parent/Guardian Name: _____ Birthplace: _____

Home address (if different) _____

STREET CITY STATE/ZIP CODE

EMAIL address: _____

Telephone Numbers Home: _____ Work: _____ Cell: _____

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Occupation: _____ Employer: _____

Marital Status (please check one) **Single** □ **Married** □ **Separated** □ **Divorced** □ **Widowed** □

Parent/Guardian Name: _____ Birthplace: _____

Home address (if different) _____

STREET **CITY** **STATE/ZIP CODE**

EMAIL address: _____

Telephone Numbers Home: _____ Work: _____ Cell: _____

Occupation: _____ Employer: _____

Marital Status (please check one) **Single** □ **Married** □ **Separated** □ **Divorced** □ **Widowed** □

List below the **FULL** names of all other children in the family				
Name	**Age**	**Date of Birth**	**School Child attends**	**Grade**

Previous Home Address: _____

STREET **CITY** **STATE/ZIP CODE**

Previous Home Telephone Number: _____

Does your child have an I.E.P. from Special Education? **YES** □ **NO** □

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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		

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		
PT/OT		
Special Education		
Counseling/Social Skills Group		
Repeated Grade		
Recommended to Repeat Grade		
Other (explain)		

Optional – Please check the appropriate box (es)		
Father		Mother
	American Indian	
	Asian/Pacific Islander	
	Hispanic or Latino	
	Black	
	White	

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Child's Name: _____

Emergency Contact: _____

Relationship to Child: _____

Telephone Number(s) Home: _____ Work: _____

Cell: _____

Email: _____

_____

Print Name of Parent or Guardian Completing Form

_____

Signature of Parent or Guardian Completing Form

_____

Date

FOR OFFICE USE ONLY: Birth Cert. _____ Res. _____ Medical Forms _____ Lang. Survey _____ Transportation _____

ID# _____ CENSUS #_____

Magnet YES □ NO □ **Special Education** YES □ NO □ **ENL** □ Verified by: _____

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:			GENDER:
Month	*Day*	*Year*	❑ 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*	❑ Father _____ *specify*	❑ Guardian(s) _____ *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:		STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School	*Address*	

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:

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Questionnaire: Student/Family Domicile

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
- ☐ Asiting foster placement
- ☐ In a rented garage due to loss of housing
- ☐ Temporarily with an adult that is not the parent/legal guardian of 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
- ☐ Other 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 prior to moving into temporary housing: _____

Student's Name First	Last	*M/F*	*Date Of Birth*	*Grade*	*School Name*

The undersigned certifies that the information provided above is accurate.

Print Parent/Guardian Name _____ Signature _____ Date _____

Phone Number _____ Street Address _____ City _____ State _____ Zip _____

SCHOOL USE ONLY

***Note to school personnel:** If any box above is checked, other than "none of the above" please refer family to District Liaison and fax this form to: Pupil Personnel Services, Dr. Rhonda Jones ay (914) 576-

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

McKinney-Vento Liaison _____ Signature _____ Date _____

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STUDENT EMERGENCY CARD

SCHOOL YEAR: 20_____

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 ☐ Home Zone School: _____

Student Name: _____ Teacher: _____

Address: _____

Home Phone: _____ Date of Birth: _____

Mother/Guardian Full Name: _____ Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email address: _____

Home Address (if different from student) _____

Father/Guardian Full Name: _____ Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email address: _____

Home address (if different from student) _____

Have phone numbers changed since last year? ☐ YES ☐ NO

Has the above address changed since last year? ☐ YES ☐ NO

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SCHOOL YEAR: 20_____

Family Physician: _____ Phone: _____

Allergies: _____

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

1. Person: _____ Relationship: _____
   Address: _____ Home/Cell #:_____

2. Person: _____ Relationship: _____
   Address: _____ Home/Cell #:_____

3. Person: _____ Relationship: _____
   Address: _____ Home/Cell #:_____

ARE ANY ORDERS OF PROTECTION, CUSTODY VISITIATION 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.

_____
Signature of parent/guardian completing this card

_____ _____
Print name Date

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TRANSPORATION APPLICATION

SCHOOL YEAR: 20_____

OFFICE USE ONLY _____Magnet _____CILA _____Kaleidoscope

AM BUS: _____TIME:_____AM STOP:_____

PM BUS: _____TIME:_____PM STOP:_____

BUS COMPANY: _____START DATE:_____

Parent:/Guardian*: Complete one application for each student being registered. The transportation office staff will identify and notify those students who meet the 1.5 mileage requirement necessary to receive bussing, by mail at the end of August.*

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

Please check ONE: ☐ **New Student** ☐ **Address Change** ☐ **School Change**

School: _____ Grade: _____

Student ID#: _____ Date of Birth: _____ ☐ M ☐ F

Student Name: _____
LAST FIRST

Home Address: _____
STREET APT.

_____
CITY STATE ZIP CODE

Parent/Legal Guardian

Mother: _____ Father: _____

Mother Cell: _____ Father Cell: _____

Email:_____

Parent/Legal Guardian Signature: _____

Relationship to student: _____

EMERGENCY CONTACT

Contact Name: _____

Relationship to student: _____ Contact # _____

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TRANSPORTATION – CHILD CARE APPLICATION SCHOOL YEAR: 20_____

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

Check ONE: ☐ Childcare ☐ Religious Instruction

Student Name: _____

Student Address: _____

City: _____ State:_____ Zip:_____

School: _____Sex: _____ Date of Birth: _____

Grade for **September 2020** (Circle one): K 1 2 3 4 5

Parent or Legal/Custodial Guardian Information

Mother_____Father_____

Primary Phone_____Alt.Phone ._____

E-Mail. _____

Signature of Mother or Father
or Legal/Custodial Guardian _____Relationship to Student:_____

Emergency Contact (other than parent or legal/custodial guardian)

Contact Name:_____ Phone: (_____)_____

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

Requested Start Date: _____ (PLEASE ALLOW UP TO 10 DAYS FOR PROCESSING)

OFFICE USE ONLY

Start Date: _____ Bus Company: _____

Bus Route:_____ Bus Stop: _____

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A. BEFORE SCHOOL _____

Name and address of childcare location or religious instruction program

DAYS OF THE WEEK (CIRCLE) MON TUE WED THU FRI

NAME OF ADULT AT CHILDCARE CENTER: _____ PHONE NUMBER: _____

B. AFTER SCHOOL _____

Name and address of childcare location or religious instruction program

DAYS OF THE WEEK (CIRCLE) MON TUE WED THU FRI

NAME OF ADULT AT CHILDCARE CENTER: _____ PHONE NUMBER: _____

OFFICE USE ONLY

Start Date: _____ Bus Company: _____

Bus Route:_____ Bus Stop: _____

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DISMISSAL AND CONTACT FORM Date: _____

Please Print

_____ _____

STUDENT'S NAME **DATE OF BIRTH**

_____ _____

HOME ADDRESS **CITY/ST/ZIPCODE**

Emergency Early Dismissal

In the event of an 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 bused has my permission to be bused 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/Guardian #1				
Parent/Guardian #2				
Adult #1				
Adult #2				

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Regular Dismissal

At regular dismissal, my child will:

☐ Walk Home ☐ Be picked-up

Persons Authorized to pick-up my child

1. _____
2. _____
3. _____
4. _____

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Authorization for Release of Student Records

Supreme Court decisions require schools to have written consent from a parent or legal guardian before they can release student records. In the case of eighteen-year-old students, permission of 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:	
Phone #:	Last Date Attended:
Guidance Counselor:	

Dear Principal or Registrar:

In accordance with the Family Education Rights and Private Ace 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 below: health and testing records, an official transcript, and the most recent report card.

Parent/Guardian Name (please print):	
Student Name:	
Age:	Date of Birth:
Date of Enrollment at CSDNR:	Grade Level:
Parent/Guardian Signature:	

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.

CITY SCHOOL DISTRICT OF NEW ROCHELLE
HEALTH SERVICES DEPARTMENT

STUDENT HEALTH HISTORY

Name:	**DOB:** **Age:** **Grade:**	**Gender:**
Parent/Guardian Name:	**Home Phone:** **Cell:** **Email:**	**Date:**

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	☐	☐	
Sees a medical specialist	☐	☐	
Has severe **allergies** or **anaphylaxis**	☐	☐	☐Food ☐Environmental ☐Insect ☐Medication ☐Other Specify:
Has been hospitalized	☐	☐	
Had 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	☐	☐	☐ glasses ☐ contacts
Has a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Wears a dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had 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_____

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**	
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 from participating in physical education or sports?
☐ No ☐ Yes: _____
Please list any additional concerns:

Parent/Guardian Signature: _____ Date: _____