IS YOUR CHILD:

- **A RESIDENT OF AUBURN?**
- **FOUR YEARS OLD ON OR BEFORE DECEMBER 1, 2016? (PROGRAM IS OPEN TO 4 YEAR OLDS ONLY)**

No application will be accepted without meeting the above requirements – NO EXCEPTIONS.

Items 1 – 5 MUST be submitted with your Application.

Items 6-8 need to be submitted By August 31st, 2016.

1. Proof of Residence in the Auburn City School District (Must have **one** of the following)
   - Notarized Affidavit of Residency
   - mortgage statement
   - lease agreement showing address and your name(s)
   - notarized letter from landlord
   - utility bill, tax bill for residence in your name, landline phone bill (cell phone bill is not acceptable)
   - TV/cable receipt, pay check within the last two weeks showing address
   - auto insurance ID with address, furniture rental receipt
   - Social Security statements, DSS documentation
2. Copy of child's Birth Certificate
3. Immunization Record (signed by a physician or clinical staff)
4. Custody papers, if applicable
5. Special education records, if applicable
6. Physical Exam (dated within one year of scheduled start date)
7. Proof of Lead Screening
8. Proof of Dental Screening

PROOF OF IMMUNIZATION: No application will be accepted unless a photocopy of the immunization record is attached. (Baby books are not acceptable proof of vaccinations) Required immunizations are:

- 4 doses diphtheria (DTP, Dtap)
- 3 doses Polio (3 OPV or 4 IPV)
- 1 dose Measles, Mumps, Rubella (MMR)
- 3 doses Hepatitis B
- 1-4 doses (depending on administration times) Haemophilus Influenzae Type b (Hib)
- 1 dose Varicella (chicken pox)
- 1-4 doses (depending on administration times) Pneumococcal Conjugate
- Lead Screening

NYS requests that students enrolling in a pre-kindergarten public elementary school in this State present a dental health certificate; such dental health certificate must contain a report of a comprehensive dental examination performed on such child. Universal Pre-Kindergarten students must also have a physical exam.

Auburn Enlarged City School District
2016-17
UNIVERSAL PRE-KINDERGARTEN PROGRAM
CHILD ENROLLMENT APPLICATION

Last Name _____ First _____ Middle _____
Address (must be street address) _____ Sex: ☐ M ☐ F
City, State, Zip Code _____ Date of Birth _____
Phone _____

In which elementary school attendance area does this child live?
☐ **Casey Park** ☐ **Genesee** ☐ **Herman**
☐ **Owasco** ☐ **Seward**

Child's Race/Ethnicity:

It is a requirement for the parent/guardian to fill out and sign the attached Student Racial and Ethnic form.

Child's age on December 1, 2016 _____ (PROGRAM IS OPEN TO 4 YEAR OLDS ONLY)

CHILD MUST BE A PERMANENT RESIDENT OF THE AUBURN ENLARGED CITY SCHOOL DISTRICT

PARENT/LEGAL GUARDIAN
Name (First, Middle, Last)_____
Relationship _____
Address _____
City _____ Zip Code _____
Home Phone_____ Cell Phone _____
Employer _____
Work Phone: _____
Email: _____

PARENT/LEGAL GUARDIAN
Name (First, Middle, Last)_____
Relationship _____
Address _____
City _____ Zip Code _____
Home Phone _____ Cell Phone _____
Employer _____
Work Phone: _____
Email: _____

Emergency Contact (Name, Relationship, Address, Phone): _____
_____

The answer you give below will help the district determine what services 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 certificates. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

☐ 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 car, park, bus, train, or campsite
☐ In a motel/hotel
☐ In permanent housing
☐ Temporary living situation (please describe):_____
_____

LIST ALL FAMILY MEMBERS LIVING IN THE CHILD'S HOME:

Name	M/F	DOB	AGE	Relationship to Child

(OVER)

(**UNIVERSAL PRE-K CHILD ENROLLMENT APPLICATION** continued)

HOUSEHOLD TYPE (Please mark the one that best describes household situation):

(F)	Single Parent/Female	(M)	Single Parent/Male
(T)	Two Parent Household	(E)	Foster Parent
(TP)	Teen Parent (17 years or younger)	(O)	Other, please specify _____

Previous pre-school experience: Please list all childcare and preschool programs this child has attended:

Location	*Dates of Attendance*
_____	_____
_____	_____

Is your child enrolled in the Dolly Parton Imagination Library? Yes _____No_____
If yes, please circle years enrolled 1, 2, 3, 4

Special Needs:

Do you suspect your child has an educational disability or learning problem? Yes _____ No _____
If yes, please explain _____
Is your child's primary language other than English? Yes _____ No _____
If yes, what language? _____

INELIGIBILITY: A child is ineligible for this program if the child is enrolled in another pre-kindergarten program that is supported by public funds such as a preschool special education program. Students who are unable to attend pre-kindergarten 5 days per week, 2 ½ hours per day (half-day program) or 5 hours per day (full-day program), for the entire school year also are ineligible.

Selection Criteria: This program is open to all children who turn four years old (by 12/1/2015) who live in the Auburn School District. If we receive more applications than we have slots prior to the application cutoff date, children will be randomly selected. Site placement will be determined on the basis of daycare, financial income, and parental choice.

PLEASE MAKE SURE TO VISIT THE SITES BEFORE MAKING YOUR SELECTION.
ALL PLACEMENTS ARE FINAL.

PREFERENCE FOR PROGRAM LOCATION: The pre-kindergarten program will be held at the following nine locations: Due to limited space at some locations, the District CANNOT GUARANTEE your choice. **PLEASE INDICATE YOUR First (1st) AND Second (2nd) CHOICE ONLY.** Also indicate if the site is also the site of your **child's daycare**.

FULL-DAY OPTIONS

_____Cayuga Community College
_____Cayuga Seneca Community Action Agency (CSCAA)
_____Cayuga-Onondaga BOCES
_____Early Childhood Center
_____Montessori School of the Fingerlakes
_____Neighborhood House
_____YMCA

HALF-DAY OPTIONS

_____E. John Gavras Center
_____Westminster

I attest that the information completed by me on this form is current, true, and accurate.
Signature of Parent/Guardian _____ **Date** _____

My child may be pictured in the school newsletter, school brochures, newspaper articles, videos, web, etc.
Signature of Parent/Guardian _____ **Date** _____

DEADLINE FOR APPLICATIONS: JULY 6, 2016 – No applications will be accepted without PROOF OF BIRTH AND COPY OF IMMUNIZATION RECORD. Please return form to: Auburn Enlarged City School District, 78 Thornton Avenue, Auburn, NY 13021, Attn: Kim Dygert.

Should you have any questions, please feel free to contact Kim Dygert at 255-8814 or Kelly Garback at 255-8613.

AUBURN ENLARGED CITY SCHOOL DISTRICT
STUDENT RACIAL AND ETHNIC IDENTIFICATION

Dear Parent/Guardian:

The Auburn Enlarged City School District has adopted a procedure which requires the collection and recording the ethnic identity of students in the district in accordance with the Federal categories and definitions the information will be used to:

Report information to the State and Federal Education Departments.
Plan educational programs and make sure that they are readily available to all students.
Analyze differences in academic performance, attendance, and completion of school.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions listed below. Put a check in the box for the category or categories which best describe your child. We understand the sensitive nature of this information and wish to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from thee school or the district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

Student Name:_____ Date of Birth: _____
School: _____ Grade Level: _____

Directions to Parent/Guardian: Please answer questions (1) and (2). Please read them before you respond. For Question 1 cheek the box that best describes your child.

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of 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

2. Select one or more races from the following five racial groups. For Question 2 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 (including Central America), and who maintain tribal affiliation or community attachment.

☐ **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, and Vietnam.

☐ **Native Hawaiian or other Pacific !slander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **Black or African American:** A person having origins in any of the black racial groups of Africa.

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

_____ _____ _____
Parent/Guardian Signature Relationship Date

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

Auburn Enlarged City School District

NURSING SUPERVISOR
HEALTH SERVICES

Harriet Tubman
Administration Building
78 Thornton Avenue
Auburn, New York 13021-4698
Telephone: (315) 255-8829
Fax: (315) 255-8855

Dear Parent/Guardian,

Welcome to the Universal Preschool Program!

Before your child begins New York State Public Health Law 2164 requires that all children entering school in New York State must be immunized against certain communicable diseases. Immunization records must be received prior to the start of the UPK program. The submitted proof of immunizations may be obtained from the child's pediatrician. Baby books, unless physician signed are no longer acceptable as proof of vaccination.

In addition to vaccinations, New York State Law also requires the parent or guardian of any child entering Pre-K program to provide the school district with a report of a medical examination, signed by a licensed health care provider. This exam must be current and not done more than twelve months prior to the commencement of the school year. Proof of lead testing and a dental health certificate containing a report of a comprehensive dental examination are also required.

Thank you

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).

AUBURN ENLARGED CITY SCHOOL DISTRICT HEALTH APPRAISAL FORM

Name: _____ Date of Birth: _____

School: _____ Gender: ☐ M ☐ F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

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 or use reverse of form if needed _____

Specify current diseases: ☐ Respiratory ☐ Endocrine ☐ Cardiac ☐ Neurological
☐ Other: _____
See attached or use reverse of form if needed

Allergies: ☐ **LIFE THREATENING** ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____
☐ Seasonal ☐ Medication: _____
☐ NKDA

PHYSICAL EXAM

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

				Referral
Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	
	- with glasses/contact lenses	R	L	
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher	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 (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ☐ Yes ☐ No Student may self carry and self administer medication ☐ Yes ☐ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **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.

☐ **Specify medical accommodations needed for school:** _____ ☐ None

☐ Known or suspected disability: _____ ☐ Please monitor

☐ Restrictions: _____ ☐ Please monitor

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

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 and the school medical director.

Auburn Enlarged City School District

ADMINISTRATIVE OFFICES
78 Thornton Avenue, Auburn, N.Y. 13021-4698

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

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

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature _____ Date

Section 2. To be completed by the Dentist

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

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

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

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

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

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

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

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

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

III. Treatment Needs (check all that apply)

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

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

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