

**Auburn Enlarged City School District  
2017 3-YEAR-OLD  
UNIVERSAL PRE-KINDERGARTEN PROGRAM**

**IS YOUR CHILD . . .            A RESIDENT OF AUBURN?  
IS YOUR CHILD . . .            THREE YEARS OLD ON OR BEFORE DECEMBER 1, 2016?  
(This program is open to 3 year olds only)**

**No applications will be accepted without meeting the above requirements.  
NO EXCEPTIONS.**



**Items 1 - 5 below MUST be submitted with your application.**

**Items 6 - 8 below MUST be submitted prior to the first day of classes.  
(3-YEAR-OLD Universal Pre-Kindergarten is scheduled to begin  
January 23, 2017.**

1. Proof of Residence in the Auburn City School District (Must submit **one** of the following).

- \* Notarized Affidavit of Residency
- \* Mortgage statement
- \* Lease agreement showing address and parent/guardian name(s)
- \* Notarized letter from landlord
- \* Utility bill, tax bill for residence in parent/guardian name, landline phone bill  
(Cell phone bill is not acceptable)
- \* TV/cable receipt, paycheck 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 school start date)\*

7. Proof of Lead Screening

8. Proof of Dental Screening\*

*\*Our forms are attached. Present to your child's Physician/Dentist for him/her to complete!*

**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**  
**2017 3-YEAR-OLD**  
**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 3 YEAR OLDS ONLY)

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

**PARENT/LEGAL GUARDIAN**

Name (First, Middle, Last) \_\_\_\_\_  
 Relationship (to child) \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Work Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_

**PARENT/LEGAL GUARDIAN**

Name (First, Middle, Last) \_\_\_\_\_  
 Relationship (to child) \_\_\_\_\_  
 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:**

<u>Name</u>	<u>M/F</u>	<u>DOB</u>	<u>AGE</u>	<u>Relationship to Child</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**HOUSEHOLD TYPE** (Please circle 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:

<i>Location</i>	<i>Dates of Attendance</i>
_____	_____
_____	_____

**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 three years old (by 12/1/2016) 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 (1<sup>st</sup>) AND Second (2<sup>nd</sup>) CHOICE ONLY.** Also indicate if the site is also the site of your **child's daycare.**

- | <u>FULL-DAY OPTION</u>                              | <u>HALF-DAY OPTION</u>                           |
|---|--|
| _____ Cayuga Community College                      | _____ E. John Gavras Center                      |
| _____ Cayuga-Onondaga BOCES                         | _____ YMCA *                                     |
| _____ Cayuga Seneca Community Action Agency (CSCAA) | <i>*for this half-day option, please circle:</i> |
| _____ <b>E. John Gavras Center</b>                  | A.M.                                      P.M.   |
| _____ Montessori School of the Fingerlakes          |  |
| _____ YMCA  |  |

**CLASSES ARE SET TO BEGIN JANUARY 23, 2017!! APPLICATIONS ARE ACCEPTED ON A FIRST COME, FIRST SERVED BASIS – SLOTS ARE LIMITED!! No applications will be accepted without PROOF OF BIRTH AND COPY OF IMMUNIZATION RECORD. Should you have any questions, please feel free to contact Mary Cregg at 255-8825 or Kelly Garback at 255-8613.**  
**Please return completed form and supporting documents to:**  
**Auburn Enlarged City School District, 78 Thornton Avenue, Auburn, NY 13021, Attn.: Mary Cregg**

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 \_\_\_\_\_

**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 of 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 the school or 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.

Directions for Parent/Guardian: Please answer questions (1) and (2). Please read them before you respond. For question (1), check 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 or 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 Islander:** 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 (to registering child)

\_\_\_\_\_  
Date



*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 Pre-Kindergarten Program!*

*Before your child begins UPK, 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/guardian of any child entering a Pre-Kindergarten 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: _____ - _____ <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	Vision - without glasses/contact lenses	R	L	
	- with glasses/contact lenses	R	L	
	Hearing <input type="checkbox"/> 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

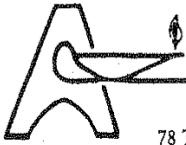
Restrictions: \_\_\_\_\_  Please monitor

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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 1/2 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.