City School District of the City of Niagara Falls

Universal PreK

and Head Start

2025-2026

Registration

Packet

NIAGARA FALLS CITY SCHOOL DISTRICT

UNIVERSAL PRE K AND HEAD START PROGRAMS

2025 - 2026

FREQUENTLY ASKED QUESTIONS

1. **Is there a cost to attend Universal PreK or Head Start?** No. NFCSD is proud to offer these programs free to the residents of Niagara Falls. Included in both programs are a nutritious breakfast, lunch and snack every day.

2. **Can my child take a school bus?** Unfortunately, transportation is not available for our Universal PreK or Head Start students. Transportation is the responsibility of the Parent/Guardian.

3. **What schedule do PreK students follow?** Universal PreK students and Head Start students follow the Niagara Falls City School District school year calendar and daily bell schedule. Arrival is 8:45am and dismissal is 3:25pm. We are a full day program. Before or after school child care is not available at this time.

4. **How old does my child need to be to attend?** Four years old on or before December 1st for the UPK 4 program and three years old on or before December 1 for the UPK 3 program.

5. **Will there be an Open House at my child's school before school starts?** Each school schedules an Open House; you will receive a letter with the date and time from your child's school. Join us at the PreK Jamboree held in August at Niagara Falls High School! Meet PreK teachers, other PreK families, have some fun and gather information about our program and from our local partners.

6. **Who will help my child start the school year on a good note?** Along with parents and guardians' support, highly qualified teachers together with certified nurses, school social workers and school counselors work as a team to ensure each child is learning and growing in a positive way.

Thank you for joining our program!

We proudly offer the following early childhood education programs in the Niagara Falls City School District:

1. Universal PreK for 3 year olds

Locations: All NFCSD Elementary Schools (except H.F. Abate Elementary School)

2. Universal PreK for 4 year olds

Locations: All NFCSD Elementary Schools (except H.F. Abate Elementary School)

3. Early Head Start

Serving children from 6 weeks to 3 years of age.

Location: NFCSD Community Education Center, 6040 Lindbergh Avenue, Niagara Falls, NY 14304

4. Head Start

Serving 3 and 4 year old children.

Location: The DiFrancesco Center, 901 24th Street, Niagara Falls, NY 14301

Registration Process

1. Obtain a registration packet from any NFCSD Elementary School, Central Administration Office at 630 66th Street or print a copy from our website: www.nfschools.net.
2. Complete all sections of the packet and gather the required document listed on the following page.
3. Submit the completed packet to the Registration Office at 630 66th Street between 9:00am and 2:00pm OR drop it off at the Main Office of any NFCSD Elementary School.
4. Families will receive a Welcome letter in July with the confirmation of your child's enrollment.

Completed registration packets are due on or before June 20, 2025.

Niagara Falls City School District
Registration Document Requirements

The Registration packet is incomplete until ALL of the following have been submitted:

1. Birth Certificate for student(s)
2. Parent or Guardian I.D.
3. Proof of Residency
4. Custody or Guardianship documents (if child's guardian is/was determined by a Court)
5. Immunization record & most recent Physical exam paperwork

Additional documents needed for Head Start registration:

1. Health Insurance card
2. Proof of income (e.g. Foster car stipend, TANF budget, SNAP budget, SSI letter, W2, 1040 tax form or Pay Stubs)

For your convenience, documents may be submitted three separate ways:

1. **E-mail:** jdavidson@nfschools.net
2. **Fax:** 716-286-4240
3. **Mailed or dropped off** (9:00am – 2:00pm) at Central Registration located at:

630 66th Street
Niagara Falls, NY 14304

School Selection Process

Please select the school(s) that you would like your child to attend in your order of preference. REMEMBER, transportation is not provided, therefore it is critical that you consider how your child will get to and from school each day. In the event that your first choice is filled, the application will be moved to your second choice and so on until an opening becomes available.

_____ Bloneva Bond Elementary School, 2513 Niagara Street (Formerly Niagara Street School)

_____ Cataract Elementary School, 6431 Girard Avenue

_____ Geraldine Mann Elementary School, 1330 95th Street

_____ Hyde Park Elementary School, 1620 Hyde Park Blvd.

_____ Kalfas Early Childhood School, 1800 Beech Avenue

_____ Maple Avenue Elementary School, 952 Maple Avenue

_____ 79th Street Elementary School, 551 79th Street

_____LaSalle Early Childhood Program, 8477 Buffalo Avenue

Early Head Start

_____Community Education Center, 6040 Lindbergh Avenue

Head Start

_____DiFrancesco Center, 901 24th Street

NIAGARA FALLS CITY SCHOOL DISTRICT
STUDENT REGISTRATION FORM

Rev. 9/29/10

FOR OFFICE USE ONLY Roll Call/Homeroom # _____

Date of Entry _____ Student ID Number _____ Teacher _____

Child's
Legal Name _____
Last Name *First Name* *Middle Name*

Home Address _____ Apt. # _____ Zip _____

☐ Female ☐ Male Date of Birth _____ Grade _____

Year started 9th grade _____
Special Education _____ Yes _____ No 504 Plan _____ Yes _____ No
(If Yes, refer to PSA)
U.S. Citizen _____ Yes _____ No (If no, citizen of what country?) _____

ESL: _____ Yes _____ No (If yes, what is Native Language: _____)

Parent E-Mail address for school contact _____

Ethnicity (Check One)	Race (Check one or more, regardless of Ethnicity)
☐ Hispanic/Latino	☐ American Indian or Alaska Native ☐ White
☐ Non-Hispanic/Latino	☐ Black or African American ☐ Asian
	☐ Native Hawaiian or Other Pacific Islander

Previously registered in the Niagara Falls School System? ☐ Yes ☐ No

Last School Attended _____ Date Left _____ Grade(s) Repeated _____

Address of Last School _____
(If NOT in Niagara Falls) Street City/State Zip

Phone Number of Last School _____ Fax Number _____

Student resides with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other Legal/Custody Papers? Yes ___ No ___

If Other: Name and Relationship _____

Mother's Name (if applicable) _____ Home Phone _____

Address (if different from student) _____ Cell Phone _____

Place of employment _____ Work Phone _____

Father's Name (if applicable) _____ Home Phone _____

Address (if different from student) _____ Cell Phone _____

Place of employment _____ Work Phone _____

Student's Guardian's Name _____ Home Phone _____

Guardian's Address _____ Cell Phone _____

Place of Employment _____ Work Phone _____

(OVER)

PERSON (S) TO BE CONTACTED IN CASE PARENT CANNOT BE REACHED (Please list 2)

(1)Name_____ **Relationship**_____

Address_____

Phone Number _____ **Cell Phone** _____

(2)Name_____ **Relationship**_____

Address_____

Phone Number _____ **Cell Phone** _____

Student's Brothers / Sisters (PreK – Grade 12):

Name	**Age**

FOR OFFICE USE ONLY

Registration Checklist (Check, NA, or initial)

☐ **Proof of Residency**	☐ **Birth Certificate**	☐ **Special Needs - PSA**
☐ **Health History Form**	☐ **Immunizations**	☐ **Home Language Questionnaire**
☐ **Mc-Kinney-Vento Questionnaire**	☐ **Student Media Form**	☐ **Computer Usage Form**
☐ **Charter School Sign Off**	☐ **Release of Information Form**	☐ **Schedule**
☐ **Alternate Transportation**	☐ **Lunch Application**	

Registrar _____ **Date** _____

Computer Input _____ **Date** _____

Administrator Approval _____ **Date** _____

Niagara Falls City School District Student Residency Questionnaire

Name of LEA: School District of the City of Niagara Falls, New York

Name of School: _____

Name of Student: _____
Last First Middle

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

Address: _____ Phone: _____

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

- ☐ In permanent housing
- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____

_____ _____

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

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

_____

Date

NOTE: The answer you give will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services. After the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

ATENCIÓN ESCUELAS Y DISTRITOS: Ofrezca asistencia a los estudiantes y familias para completar este formulario. No incluya este formulario en el paquete de inscripción sin advertencias apropiadas. Por ejemplo, tendrá que cambiar partes del paquete de inscripción que requieren que se entreguen prueba de inscripción antes de matricular. Estudiantes elegibles según el Acto de McKinney-Vento, no necesitan entregar prueba de residencia y otros documentos normalmente requeridos antes de matricular.

FORMULARIO DE INSCRIPCIÓN – CUESTIONARIO DE RESIDENCIA

Nombre del Distrito Escolar: _____

Nombre de la Escuela: _____

Nombre del Estudiante: _____
Apellido Primer Nombre Segundo Nombre

Género: ☐ Hombre ☐ Mujer Fecha de Nacimiento: ____ / ____ / ____ Grado: _____ ID#: _____
Mes Día Año (jardín de infantes – 12) (opciónal)

Dirección: _____ Teléfono: _____

Su respuesta abajo permitirá al distrito escolar definir los servicios que puede aprovechar su hijo/hija según el Acto de McKinney-Vento. Los estudiantes elegibles tienen derecho a la inscripción inmediata en la escuela, aun si ellos no tienen los documentos necesarios tales como: prueba de residencia, documentos escolares, documentos de inmunización, o partida de nacimiento. Los estudiantes elegibles según el Acto de McKinney-Vento tienen además derecho al transporte gratuito y otros servicios que ofrece el distrito escolar. Si el estudiante **NO** vive en un hogar permanente, **no se requieren prueba de domicilio** u otros documentos normalmente requeridos para inscripción **y el estudiante debe ser matriculado inmediatamente**. Después de que el estudiante sea matriculado, el distrito o la escuela debe pedir los documentos escolares, incluyendo los documentos de inmunización, al distrito o la escuela anterior. El enlace del distrito debe ayudar al estudiante conseguir cualquier otro documento necesario o inmunización.

¿Donde está el estudiante viviendo actualmente? (*Por favor marque **una** caja.*)

- ☐ En un hogar permanente
- ☐ En un refugio
- ☐ Con otra familia o otra persona debido a la pérdida del hogar o a dificultades económicas
- ☐ En un hotel/motel
- ☐ En un carro, parque, autobús, tren, o camping
- ☐ Otra vivienda temporal (Por favor describa):

_____

_____ _____

Nombre de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

Firma de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

_____

Fecha

October 2017

NYSED.gov

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

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

THIS SECTION TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY AND MAINTAINED ON FILE
Date Profile Completed:
Student Name:
Gender:
Date of Birth:
District or Community Based Organization Name:
Student ID (if applicable):
Name of Person Administering Profile:
Title:

Parent or Person in Parental Relation Information

Name of parent or person in parental relation:

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

In what language(s) would you like to receive information from the school? ☐ English ☐ other home language:

Language in the Home

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

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

3. Is there a caretaker in the home? ☐ yes ☐ no

If yes, what language(s) does the caretaker speak most frequently?

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

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

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

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

7a. At what age did your child begin to speak in short sentences?

In what language?

7b. At what age did your child begin to speak in full sentences?

In what language?

8. In what language does your child pretend play?

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

Language Outside the Home/Family

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

If yes, in what language was the program conducted?

In what language does your child interact with other people in the nursery or childcare setting?

11. How would you describe your child's language use with friends?

Language Goals

12. What are your language goals for your child? For example, do you want child to become proficient in more than one language?

13. Have you exposed your child to more than one language to ensure that he or she is bilingual or multilingual? ☐ yes ☐ no

14. Does your child need to speak a language other than English in order to communicate with your relatives or extended family?
☐ yes ☐ no

If yes, in what language(s)?

Emergent Literacy

15. Does your child have books at home or does he or she read books from the library?

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

16a. Can your child name any letters or sounds in English? ☐ yes ☐ no

16b. Can your child recognize letters or symbols in another language? ☐ yes ☐ no

If yes, in what language(s)?

17a. Does your child pretend to read? ☐ yes ☐ no ☐ unsure

If yes, in what language(s)?

17b. Does your child pretend to write? ☐ yes ☐ no ☐ unsure

If yes, in what language(s)?

18. Does your child tell the stories from his/her favorite books or videos? ☐ yes ☐ no

If yes, in what language(s)?

19. Does your child's childcare or nursery program describe goals for his or her learning? ☐ yes ☐ no

If so, what goals do they describe?

20. Please describe anything special you did to prepare your child to begin Prekindergarten.

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

City School District Of the City Of Niagara Falls
Consolidated Permission Form for Releasing Information to the US Military,
Using District Computer Systems, Online Art Gallery and Media Release and Publication on-line.

Put your **initials** in the appropriate box, **Yes** I give my permission or No I do not give my permission.

Student Name _____ Student ID Number_____

School _____ **Class/Homeroom Teacher** _____

☐ **Yes** ☐ **No**

Release of information to the US Military (Grades 11 and 12 only)
The No Child Left Behind Law of 2002 requires high schools to release the name, address, and phone number of any 11th or 12th grade student to the United States Military. In order to receive federal funding, the City School District Of the City Of Niagara Falls must comply with this mandate unless parents provide written notification via this form that they do not want this information released.

☐ **Yes** ☐ **No**

Computer Acceptable Use (all grades)
Parents and guardians can obtain a copy of the District's Acceptable Use Policy by visiting any school or www.nfschools.net. All student computer use must comply with this policy. Internet Safety is part of the State curriculum and learning to use technology responsibly is an important part of education. Unless a parent provides written notification via this form, students will have access to the District's computer system in accordance with the Districts AUP.

☐ **Yes** ☐ **No**

Online Art Gallery (all grades)
I give permission to the City School District Of the City Of Niagara Falls to share my child's artwork along with his/her **first name** on the Online Art Gallery on the School District's Website, www.nfschools.net

☐ **Yes** ☐ **No**

Photographs ,Videos, Interviews District Website Release (all grades)
I give my permission to City School District Of the City Of Niagara Falls that photographs, and/or video tapes and/or interviews of my child may be taken and used by the District only for public relations, educational, or other purposes consistent with the purposes and mission of the District, including use of any photograph and/or image and/or interview on the District Website or other District electronic resources such as social media. I understand that my permission allows the District to use my child's first and last name for public relations and educational purposes. I further agree that said materials will become the property of the District and I hereby release and discharge the District and it representatives from any
and all claims that may result by reason of taking of such photographs and/or videotapes and/or interviews.

☐ ☐

Yes No

Media Release (all grades)

I give permission to the City School District Of the City Of Niagara Falls to use my child's photograph, likeness and/or work and/or interviews in any compilations to be distributed within the community. Specifically photographs of students may be used in the District newsletter(s), in pamphlets or brochures, or on flyers. Such images may also be distributed to local media, either print or video, or may be used on the OSC-TV Channel 21, or be used or distributed in like manner.

If in the future you wish to reverse any permission, you may do so by notifying your child's principal in writing.

Parent/ Guardian Name: (Please Print) _____

Date_____

Parent/ Guardian Signature: _____

SCHOOL DISTRICT OF THE CITY OF NIAGARA FALLS
DEPARTMENT OF HEALTH SERVICES

HEALTH HISTORY FORM FOR STUDENTS

Student's name_____ School _____ Grade_____

Address_____ Home Phone_____

Date of Birth_____ Place of Birth_____ Sex M____ F____

Mothers Name_____ Address_____ Phone_____
Mothers Place of Employment_____ Work Phone_____
Fathers Name_____ Address_____ Phone_____
Fathers Place of Employment_____ Work Phone_____
Physician_____ Dentist_____

Emergency: 1. Name_____ Phone_____
2. Name_____ Phone _____

Please check YES or NO for questions below so that our School Health Service may best serve your child.
Explain any yes answers in the space provided on the back of the form.

HAS YOUR CHILD EVER HAD:

SKIN	**yes**	**no**	**date**
Lesions	___	___	___
Rashes	___	___	___
EYE PROBLEMS			
Vision loss-Rt eye____ Lt eye_____			
Amblyopia- Rt eye_____ Lt eye_____			
Glasses	___	___	___
Contact lenses	___	___	___
Hearing loss – Rt ear____ Lt ear____			
Ear tubes - Rt ear____ Lt ear____			
Infections	___	___	___
Frequent nose bleeds	___	___	___
Nose fracture/surgery	___	___	___
SORE THROAT			
Tonsillitis	___	___	___
Strep throat	___	___	___
Scarlet fever	___	___	___
Tonsils/adenoids removed	___	___	___
DENTAL PROBLEMS			
Braces	___	___	___
Capped teeth	___	___	___
Bridge/loss of teeth	___	___	___
CARDIOVASCULAR			
High Blood Pressure	___	___	___
Rheumatic fever	___	___	___
Heart Murmur	___	___	___
Heart Surgery	___	___	___
Cardiac Workup	___	___	___
LUNGS/RESPIRATORY			
Asthma	___	___	___
Allergies	___	___	___
Hives	___	___	___
Hayfever	___	___	___
Pneumonia	___	___	___
Bronchitis	___	___	___
Tuberculosis	___	___	___

GASTROINTESTINAL	**yes**	**no**	**date**
Jaundice	___	___	_____
Stomach Disorders	___	___	_____
Frequent Abdominal pain	___	___	_____
Ulcers	___	___	_____
MUSCULOSKELETAL	___	___	_____
Arthritis	___	___	_____
Joint pains	___	___	_____
Limb or back deformities	___	___	_____
Fracture (broken bone)	___	___	_____
Dislocation	___	___	_____
Scoliosis	___	___	____
Chronic sprains	___	___	_____
Recurrent injuries	___	___	_____
GENITOURINARY			
Hernia	___	___	_____
Bladder or kidney disorder	___	___	_____
Infections	___	___	_____
Testicles: injury/surgery	___	___	_____
Menstruation	___	___	_____
date began_____			
Problems_____			
NEUROLOGICAL			
Headaches	___	___	_____
Head injuries	___	___	_____
Concussions	___	___	_____
Convulsions	___	___	_____
Seizure Disorder	___	___	_____
Fainting/blackouts	___	___	_____
Paralysis/numbness	___	___	_____
Hyperactivity	___	___	_____
ENDOCRINE			
Diabetes	___	___	_____
Hypoglycemia	___	___	_____
Thyroid Condition	___	___	____
COMMUNICABLE DISEASES			
Measles	___	___	_____
Chicken Pox	___	___	_____
Mononucleosis	___	___	_____

HEMATOLOGY

Hepatitis A yes___ no___ date____ **Hepatitis B** yes___ no___ date___ **Hepatitis C** yes____ no____date____
Anemia yes___ no___ date____ Bleeding disorders yes___no___ date____ Transfusions yes___ no___date____
Sickle Cell Anemia yes___ no___ date____

PLEASE CONTINUE ON OTHER SIDE

PLEASE LIST ALL MEDICATIONS YOUR CHILD IS TAKING AT HOME OR SCHOOL:
All medications have side effects and for your child's safety it is important for the School Nurse to have this information.

MEDICATION	DOSE	TIMES

HAS YOUR SON/ DAUGHTER:

Ever been a patient in a hospital?

Explain_____

_____

Had any operations? Explain_____

Had any accidents? Explain_____

Is your son/daughter under a physicians care now? _____

Is he/she allergic to any medication?_____

Has he/she had any psychological testing?_____

EXPLAIN YES ANSWERS HERE:

_____

_____

_____

_____

_____

COMMENTS:_____

_____

_____

PARENT OR GUARDIAN SIGNATURE

_____

DATE

Please contact the Health Office if you have any questions or if we may be of any service to you and your family.

_____	_____	_____
SCHOOL NURSE	SCHOOL	TELEPHONE

Niagara Falls City School District
Health Services

HEALTH HISTORY

Student's Name _____ **Date of Birth**_____ **Gender at birth M**____ **F**____
Mothers Name_____ **Address**_____ **Phone**_____
Mothers Place of Employment_____ **Work Phone**_____
Fathers Name_____ **Address**_____ **Phone**_____
Fathers Place of Employment_____ **Work Phone**_____
Emergency: 1. Name_____ **Phone**_____
2. Name_____ **Phone** _____

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalized	☐	☐	
Had an operation	☐	☐	
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/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn 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
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Dental Injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
- ☐ Scoliosis
- ☐ Single Organ (☐kidney, ☐testicle)
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Urinary Condition

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: (use back of sheet if necessary) _____

_____

Parent/Guardian Signature: _____ Date: _____

Niagara Falls City School District
Health Services

PRE-K & K SOCIAL HISTORY

Child's Name_____ Date of Birth_____
School Entering_____ Today's Date_____
Brothers/Sisters_____ Date of Birth_____
_____ Date of Birth_____
(USE BACK IF NECESSARY)

PLEASE ANSWER **YES OR NO** TO ALL QUESTIONS. THIS WILL HELP US BETTER UNDERSTAND THE HEALTH NEEDS OF YOUR CHILD.

Birth Information	Yes	No
Did you have:		
Premature birth	___	___
Cesarean delivery	___	___
Any newborn problems	___	___
Any problems the First year	___	___
Normal pregnancy	___	___
Full term pregnancy	___	___
Normal delivery	___	___
Birth Weight _____		
Breast fed	___	___
How long?_____		
Comments:_____		
_____		
_____		

Growth and Development/Skills		
Any problems with:		
Feeding	___	___
Crawling	___	___
Walking	___	___
Talking	___	___
Hopping	___	___
Counting numbers	___	___
Naming colors	___	___
Dressing self	___	___
Eating	___	___
Muscle coordination	___	___
Speech	___	___
Did your child attend		
Preschool	___	___
Head start	___	___
Day Care	___	___
Name_____		
Comments_____		
_____		

Behavior Development	Yes	No
Would you say your child:		
is friendly	___	___
is secure	___	___
is talkative	___	___
is shy	___	___
is helpful	___	___
is cooperative	___	___
listens well	___	___
follows directions well	___	___
adjusts well to new situations	___	___
has stayed overnight away from mother	___	___
is eager to start school	___	___
separates easily from family	___	___
plays well with other children	___	___
plays well alone	___	___
relates well to other adults	___	___
has temper tantrums	___	___
is disobedient	___	___
talks back	___	___
is destructive	___	___
has nightmares	___	___
has fears	___	___
is jealous	___	___
sucks thumb	___	___
has uncontrolled		
bowel movements	___	___
constipation	___	___
wetting	___	___
wets the bed	___	___
has had any unusual or unexpected stresses	___	___
does your child have any habits that concern you	___	___

Do you have any concerns as a Parent
_____
Comments_____
_____

Parent/Guardian Signature_____ Date _____

F-12a 1/00

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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 ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥5 µg/dL				

☐ **System Review and Abnormal Findings Listed Below**

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:				DOB:
Vision & Hearing SCREENINGS - Required for PreK or K, 1, 3, 5, 7, & 11				
Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school Interscholastic sports level **OR** Grades 9-12 who wish to play at the modified Interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

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

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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

Niagara Falls City School District
Health Services

DENTAL HEALTH CERTIFICATE (To Be Completed by Child's Dental Office)

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 year, ask your dentist to fill out Section 2. Return the completed form to the school nurse as soon as possible.

SECTION 1. TO BE COMPLETED BY PARENT/GUARDIAN (Please Print)

Child's Name: Last_____ **First** _____ **Middle**_____

Birth Date: ____/____/____ **Sex:** __ **Male** __ **Female**

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

School: _____ **Grade**_____

Have you noticed any problem 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 Signature_____ Date_____

SECTION 2. TO BE COMPLETED BY THE DENTIST

1. **The Dental Health condition of** _____ **on** _____ **(date of exam). The date of 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 school.**

____**No, the student listed above is not in a fit condition of dental health to permit his/her attendance at school.**

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. This may include pain, swelling or infection related to clinical evidence of open cavities. **The designation of "not in fit condition" 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, 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 1/2mm 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 cavitated lesion is also present.)
___Yes ___No **Dental Sealants Present**

Other Problems_____

III Treatment Needs:
___No obvious problem. Routine dental care recommended. Visit your dentist regularly.
___May need dental care. Please schedule an appointment with your dentist as soon as possible
___Immediate dental care required. Please schedule an appointment with your dentist

NEW YORK STATE MIGRANT EDUCATION PROGRAM

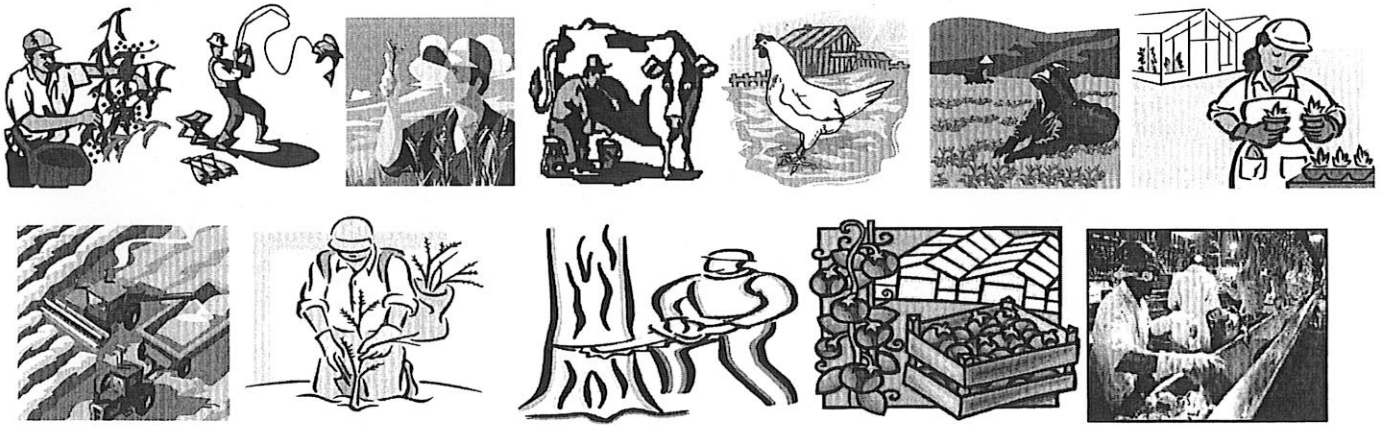
IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

- ☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- ☐ Work related to logging, harvesting, or initial processing of trees.
- ☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



If you answered YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____

Telephone number: (____)-_____-_____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____Grade_____

Student name: _____ Age _____Grade_____

To submit this referral please fax to 607-436-3606, or by mail to NYS Migrant Education Program-Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.

ADDITIONAL INFORMATION FOR HEAD START

If you are interested in applying for our Head Start program, please submit copies of the required documents below and *completely* fill out this form. Please be advised that additional enrollment paperwork will need to be completed with a family advocate before your child can start.

REGISTRATION STAFF ONLY COMPLETE THIS BOX!

Required Documents for Head Start:

(office staff please check off when documentation is submitted)

☐ **Child's proof of birth** *(e.g. birth certificate, Acknowledgement of Paternity, passport)*

☐ **Proof of income** *(e.g. foster care stipend, TANF budget, SNAP budget, SSI letter, W2, 1040 tax form, paystubs* ***(must be a month's worth and be consecutive)****, unemployment, social security)*

☐ **Insurance card**

☐ **Current physical and immunization record**

☐ **Dental**

☐ **Any custody/restraining orders? N/A ☐**

☐ **IFSP/IEP**

Parental Status

I am the child's:

☐ **biological parent**

☐ **foster parent**

☐ **guardian/non-relative**

☐ **guardian/kinship**

The child lives in a:

☐ **one parent home (mother)**

☐ **one parent home (father)**

☐ **two parent home**

Please check any assistance your family receives below:

☐ **TANF** ☐ **SSI**

☐ **SNAP** ☐ **WIC**

Please check your highest level of education completed:

☐ **Master's degree**

☐ **Bachelor's degree**

☐ **Associate's degree**

☐ **College training certificate**

☐ **General Education Diploma (GED)**

☐ **High school graduate**

☐ **12th grade**

☐ **11th grade**

☐ **10th grade**

☐ **9th grade or less**

Please list the date of birth for each parent and child living in the household below.

Person in household	**Date of birth**

Eligibility Selection Criteria Questions: (Please check yes or no only)

Does your child have a diagnosed disability? Yes ☐ No ☐ Disability: _____

Is there a suspected disability in process? Yes ☐ No ☐

Is your child transitioning from Early Head Start? Yes ☐ No ☐

Are your family immigrants/refugees to the City of Niagara Falls? Yes ☐ No ☐

Is there a parent in the household in the military? Yes ☐ No ☐

Does your child suffer from chronic health problems? Yes ☐ No ☐

Is there a family member in the household with a diagnosed mental illness? Yes ☐ No ☐

Are there substance abuses in the home? Yes ☐ No ☐

Does parent suffer from chronic health problems? Yes ☐ No ☐

Is there a sibling already enrolled in Head Start or Early Head Start? Yes ☐ No ☐

Was the family referred by a professional agency to Head Start? Yes ☐ No ☐

Does the child have an incarcerated parent? Yes ☐ No ☐

Was the child previously enrolled in another Head Start program? Yes ☐ No ☐

Is the mother pregnant at the time of registration? Yes ☐ No ☐

Is/was mother a teen parent? Yes ☐ No ☐

Has there been a death in the household in the last six (6) months? Yes ☐ No ☐

Is parent employed or attending school/training? Yes ☐ No ☐

Is parent employed full time or part time? Full time ☐ Part time ☐ Unemployed ☐

Does the family have three (3) or more children under the age of twelve (12) years? Yes ☐ No ☐

Is there a large age gap (4 or more years) between eligible child and closest sibling? Yes ☐ No ☐

Does the family receive Medicaid/CHIPS? Yes ☐ No ☐

Parent/Guardian Signature: _____ Date: _____

Thank you for your interest in our Head Start program. There may be additional paperwork necessary for your child's enrollment into our program. Head Start must meet all required Head Start Program Performance Standards set forth by the federal government. The Office of Children and Family Services (OCFS) also requires Head Start to retain certain documents. If we deem that additional paperwork is necessary (e.g. medical, financial, educational) you will be informed by a family advocate from the center your child may be attending. After your child's application is screened they will automatically be placed on our waitlist. There is no time frame as to how long this may be. Head Start fills open slots as they are available and we must serve the neediest families first. Please keep Head Start up to date with any changes in phone numbers and addresses.