January 2020

Dear Parent/Guardian(s):

Attached is the Universal Prekindergarten information packet for the 2020-2021 school year. Please read it carefully, complete all of the information, and call for an appointment to register at the Universal Prekindergarten office (with the required documents) or the UPK agency (site).

The Universal Prekindergarten Program is a free program only for children who will be four years old by December 1, 2020, and are residents of the Utica City School District. The program provides children with 2½ hours of instruction, 5 days a week for the entire school year. Prekindergarten is also available for children at First Nursery - Kernan, Columbus, Conkling and Head Start – Hughes & Martin Luther King sites. If more applications are received than seats are available a lottery will be held on August 7, 2020. There are NO FEES for eligible children to participate in Universal Prekindergarten.

All Universal Prekindergarten classes are offered in partnership with community agencies in Utica. Attached is a list of agencies that offer the UPK program. You may choose to send your child to any of these agencies. Your first choice will be honored if space allows. Please register early since slots will be filled at each site as registrations are received. Applications for UPK at Head Start will be completed at Head Start (Mohawk Valley Community Action Agency), contact 315-624-9930 to make an appointment.

Childcare services beyond the Universal Prekindergarten program hours are available at many of the UPK sites. Parents/guardians are responsible for any childcare costs.
If you need help or have any questions, please call the Utica Universal Prekindergarten Office at 315-792-2216.

Complete the attached registration packet and submit it with the required documents listed below:

- Universal Prekindergarten Registration Form (attached)
- Home Language Questionnaire (attached)
- Student Racial and Ethnic Identification Form (SREI attached)
- Physical History Form (attached)
- Current Report of Physical History Exam, signed by a doctor
- Birth Certificate
- Immunization Records with required shots
- Current Proof of Residency - (National Grid, water, cable, telephone landline bill, TANF Budget Sheet or SSI Award Letter), lease/deed, Utica tax bill, paystub and etc. (*Please call the UPK office regarding any questions).

Sincerely,

Alicia M. Mroz

Alicia M. Mroz
Administrator for Pre-K & Student Programs
2020-2021 Utica Universal Pre-Kindergarten
Partner Agencies

There are no fees for participation in the UPK program. Agencies operate independently of the Utica City School District and may provide other services, such as child care, for a fee. Placement at a particular agency is on a first come, first served basis. *UPK sites may vary each year.

<table>
<thead>
<tr>
<th>Agency Information</th>
<th>UPK Hours</th>
<th>Child Care Available</th>
<th>Busing Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Nursery School</td>
<td>AM: 9:00-11:30 and PM: 12:30-3:00</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Director: Nadean Gleitsmann</td>
<td></td>
<td></td>
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<tr>
<td>315-797-6523</td>
<td></td>
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</tr>
<tr>
<td>Columbus Elementary School</td>
<td>AM: 8:30-11:00 and PM: 12:00-2:30</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>934 Armory Dr.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Conkling Elementary School</td>
<td>AM: 8:45-11:15 and PM: 12:15-2:45</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>1115 Mohawk St.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Kernan Elementary School</td>
<td>AM: 8:45-11:15 and PM: 12:15-2:45</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>929 York St.</td>
<td></td>
<td></td>
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<tr>
<td>Head Start</td>
<td>AM: 8:30-11:00</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mohawk Valley Community</td>
<td></td>
<td>At no cost. (6 hrs. per day).</td>
<td></td>
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<tr>
<td>Action Agency</td>
<td></td>
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<tr>
<td>315-624-9930 X2830</td>
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<tr>
<td>Assistant Director of Child Development:</td>
<td></td>
<td></td>
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<tr>
<td>Michelle Kelley</td>
<td></td>
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<tr>
<td>Neighborhood Center</td>
<td>AM: 8:30-11:00 and PM: 12:30-3:00</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Directors: Patrice VanNortwick</td>
<td></td>
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<tr>
<td>Receptionist: 315-272-2760</td>
<td></td>
<td></td>
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<tr>
<td>Sabrina Lamie</td>
<td></td>
<td></td>
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<tr>
<td>New Discoveries</td>
<td>AM only: 9:00-11:30</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Upstate Cerebral Palsy</td>
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<tr>
<td>Director: Jennifer Hummel</td>
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<tr>
<td>Judy Locash: 315-927-2430</td>
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<tr>
<td>North Utica</td>
<td>AM: 8:30-11:00 and PM: 12:30-3:00</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Senior &amp; Pre-K Center</td>
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<tr>
<td>Acting Executive Director:</td>
<td></td>
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<tr>
<td>Yvonne McClusky 315-724-2430</td>
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<tr>
<td>Notre Dame Elementary</td>
<td>AM: 8:00-10:30 and PM: 12:00-2:30</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Director: Carol Polito</td>
<td></td>
<td></td>
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<tr>
<td>315-732-4374</td>
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<tr>
<td>Thea Bowman House</td>
<td>AM: 9:30-12:00 and PM: 12:45-3:15</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Director: Jane Domingue</td>
<td></td>
<td></td>
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<tr>
<td>Site Supervisor: Sandra Wright</td>
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<tr>
<td>315-735-6995, Parent Advocates:</td>
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<td></td>
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<tr>
<td>Diane Greene 315-724-6388</td>
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<tr>
<td>Saman Salem (Arabic)</td>
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<tr>
<td>TBA, Coordinator of Services</td>
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<tr>
<td>315-797-0748</td>
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</tbody>
</table>
Child's Name ________________________________________________ AM or PM

Please read, check & number your 3 PreK site choices. 1 being the first site preferred.  
(See attached list of eligible agencies for program details).

**PLEASE BE ADVISED THAT PRE-K SITES MAY VARY EACH YEAR.

1/2 DAY Pre-K AM &/ PM Classes

☐ First Nursery @ Genesee Street  ☐ Neighborhood Center

☐ First Nursery @ Columbus  ☐ New Discoveries - UCP

☐ First Nursery @ Conkling  ☐ North Utica Senior & Pre-K Center

☐ First Nursery @ Kernan  ☐ Notre Dame Elementary

☐ Head Start (income eligibility applies) Hughes & MLK  *Please contact 624-9930 for more information.

☐ Thea Bowman House

RESIDENCY

* I affirm that my child is currently a resident of the Utica City School District. If I move to  
another address within Utica during the school year, I will provide an updated proof of address  
within 30 days. I understand that if I move out of the school district my child/children are no  
longer eligible to attend Utica Universal Prekindergarten.

ATTENDANCE

** I understand that my child must attend all Universal Prekindergarten classes unless I provide  
a valid legal written excuse.

Print Parent's Name __________________________________________

Parent's Signature __________________________________________
* Please complete application & print clearly.

Child’s Name ____________________________________________

Last First Middle

Date of Birth __________________________ Gender:  □ Male  □ Female

Address of Child’s Residence ________________________________ Apt# ______ Zip Code ______

Is this your permanent address? □ Yes  □ No  If you answered NO, please complete a Student Residency Affidavit

Language(s): □ English  □ Other(s) __________________________

Home Language: _____________________________________________ Parent(s) Preferred Language

Student resides with: □ Both Parents  □ Mother  □ Father  □ Other

**Is there a CURRENT ORDER OF PROTECTION or NO CONTACT ORDER which concerns this child?**

□ No  □ Yes (If, yes please provide a current copy of the documentation and directions for school staff).

** Has your child been identified as a preschool student with a disability as determined by the Committee for Preschool Education? □ No  □ Yes

CONTACT #1 Adult lives with child (PRIMARY UTICA RESIDENCE)

_________________________________________ Relationship to child

Last Name ____________________________________________

First Name ___________________________________________

Home Phone # __________________________ □ UNLISTED  Cell phone # __________________________

Work Phone # __________________________ E-Mail Address _______________________________________

* Please provide updated phone contact numbers if there are any changes for emergency purposes.

CONTACT #2

_________________________________________ Relationship to child

Last Name ____________________________________________

First Name ___________________________________________

CHECK BOX IF ADDRESS IS THE SAME AS ABOVE. IF NO please list

Home Phone # __________________________ □ UNLISTED  Cell phone # __________________________

Work Phone # __________________________ E-Mail Address _______________________________________

If you have other children living with you, please provide the names, birthdates, and school they attend.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
<th>School Name</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>
All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenshiphip, handicapping condition, or immigration status.

Name of Student: ___________________________ Date of Birth (Month/Day/Year): __/__/__

School Student will be Attending: ___________________________

DIRECTIONS TO PARENTS/GUARDIANS
PLEASE ANSWER BOTH QUESTIONS (1) AND (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) Check (√) the box that best describes your child.] Check (√) only ONE box.

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; You must check (√) at least ONE box regardless of your answer to question 1.]
   □ AMERICAN INDIAN OR ALASKA NATIVE: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains 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.

_________________________________________  ________________________________
Signature of Parent/Guardian/Other                    Date

Relationship to Student (please check one box below):

□ Mother     □ Father     □ Guardian     □ Other (Specify) ___________________________
To the Parent/Guardian: The Utica City School District has adopted a policy which requires the collection and recording of the ethnic identity of students in the Utica City School 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 on the back of this page. Put a (√) in the box for the category or categories which best describe your child. The Utica City School District understands the sensitive nature of this information and wishes 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.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff: This form will be filed in the student’s permanent record as confidential information.

To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

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.

Please complete the form attached to this page.
STUDENT RESIDENCY QUESTIONNAIRE

NOTE TO SCHOOLS: Please assist students and families fill out this form. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the student is not required to submit proof of residency and other required documents that may be part of the registration packet.

Name of School: ________________________________

Name of Student: __________________________________________

Last                      First                      Middle

Gender:  □ Male  Date of Birth: __/__/____  Grade: ___________

□ Female  Month  Day  Year  (preschool-12)

Current Address: __________________________________________  Phone: ______________

The answer you give below 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.

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

□ In a shelter (one night at a time)
□ In transitional housing (shelter for longer periods of time)
□ “Doubled-Up” – living with relatives, another family, or other people because of loss of housing or as a result of economic hardship
□ In a hotel/motel
□ In a car, park, bus, train, or campsite
□ Other temporary living situation (Please describe):

□ Permanently housed (not eligible for McKinney Vento services)

Is the student an “unaccompanied youth” (not living with a parent or guardian)? ________

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

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

Date ______________

If the student is NOT living in permanent housing, proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. The district’s LEA liaison is required to assist the student in obtaining any necessary documents, including immunization or school records after the student has been enrolled.

NOTE TO SCHOOL: if the student is NOT living in permanent housing, please ensure that a STAC-202 form is completed and sent to Pre-K & Student Programs. Safe Schools coordinators are available to assist with this procedure. Send all documentation related to the student’s temporary housing situation to Pre-K & Student Programs. Do NOT retain copies of these forms in the student’s permanent file.

9/1/18
UPK - Utica City School District
Physical History

<table>
<thead>
<tr>
<th>Child's Last Name, First Name</th>
<th>Date of Birth</th>
<th>Place of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents' Names</td>
<td>Place of Employment</td>
<td>Tel. No. Home/Work</td>
</tr>
</tbody>
</table>

**PHYSICAL HISTORY:** What diseases or conditions has your child had? (Give dates.)

- Chickenpox
- Scarlet Fever
- Pneumonia
- Other
- Rheumatic Fever
- Diabetes
- Ear Infection
- Throat Infection
- Heart Disease
- Epilepsy

Does your child have allergies, asthma?  
If yes, what is your child allergic to?  

Does your child take medication?  
If yes, give name of medication, dosage and for what condition:

Has your child ever had an accident, operation or x-rays?  
Explain:

Does your child have any limitation that the school should know of?  
Explain:

Is your child toilet trained?  

Is there anything about the eyes, ears, teeth or general health of your child that the school should know of?  
Explain:

---

**EMERGENCY CARE:** In case of an emergency, we will contact you immediately at the phone number provided above. If it is not possible to reach you, please state below what action you wish the school to take and the name of your preferred hospital.

**NAME & TELEPHONE OF CHILD'S DOCTOR:**  
**NAME & TELEPHONE OF EMERGENCY CONTACT:**  
**NAME OF HOSPITAL EMERGENCY ROOM:**

---

DATE

SIGNATURE OF PARENT/GUARDIAN
2020-2021 UTICA CITY SCHOOL DISTRICT
PHOTO/VIDEO RELEASE FORM

Dear Parent/Guardian:
Many times we document and present student work in the building which highlights the Universal Pre-K Program and other exemplary programs on Time Warner Channel 3 and other district media. (i.e.: website, newsletters, calendars, etc.)

We, therefore, request that you sign the permission slip below. We will keep it on file in the office as a record that you are aware of our need to share student lessons and presentations through public broadcasting, broadcasting in school, videotaping and still photo collections. It also may include pictures/films of students for the news media (television/newspaper).

☐ I hereby give my permission for the Utica City School District to use the image and representations of my child in school related activities including filming, photography and presentation purposes.

Child's UPK Agency ____________________________

Parent/Guardian (PRINT) ________________________ Parent/Guardian (SIGNATURE) ______________________

Student's Name (PRINT) ________________________ Grade _______  Homeroom Teacher _______ Date _______

☐ I DO NOT GIVE PERMISSION to have my child shown on a video, film, or TV program.

Please sign below and return to your teacher.

Parent/Guardian (PRINT) ________________________ Parent/Guardian (SIGNATURE) ______________________

Student's Name (PRINT) ________________________ Grade _______  Homeroom Teacher _______ Date _______

We are an Equal Opportunity Employer which fully and actively supports equal access for all regardless of Race, Color, Weight, National Origin, Ethnic Group, Religion, Religious Practice, Disability, Sexual Orientation, Gender, Age, Veteran Status, or Genetic Information.
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.

---

**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?

---

**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:
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
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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</thead>
<tbody>
<tr>
<td>If yes, in what language(s)?</td>
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<tr>
<td>17a. Does your child pretend to read?</td>
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<tr>
<td>If yes, in what language(s)?</td>
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<tr>
<td>17b. Does your child pretend to write?</td>
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<tr>
<td>If yes, in what language(s)?</td>
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<tr>
<td>18. Does your child tell the stories from his/her favorite books or videos?</td>
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<tr>
<td>If yes, in what language(s)?</td>
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<tr>
<td>19. Does your child’s childcare or nursery program describe goals for his or her learning?</td>
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<tr>
<td>If so, what goals do they describe?</td>
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<tr>
<td>20. Please describe anything special you did to prepare your child to begin Prekindergarten.</td>
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</table>

1 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 OB EWL@nysed.gov.
NAME: ____________________________  DATE OF BIRTH: ____________

SCHOOL: ____________________________  GENDER: □ M  □ F  GRADE: ____________

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached  ☐ Sickle Cell Screen: □ Positive  □ Negative  □ Not done  Date: ____________
☐ No immunizations given today  ☐ PPD: □ Positive  □ Negative  □ Not done  Date: ____________
☐ Immunizations given since last health appraisal:
  ☐ Elevated Lead: □ Yes  □ No  □ Not done  Date: ____________
  ☐ Dental Referral: □ Yes  □ No  □ Not done  Date: ____________

SIGNIFICANT MEDICAL/SURGICAL HISTORY:  ☐ See attached

ALLERGIES:
  ☐ LIFE THREATENING  ☐ Food: ____________________________  ☐ Insect: ____________________________  ☐ Other: ____________________________
  ☐ Seasonal  ☐ Medication: ____________________________

PHYSICAL EXAM

HEIGHT: ________  WEIGHT: ________  BLOOD PRESSURE: ________  DATE OF EXAM: ____________

☐ 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 contagious & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
  □ Limited contact: cheerleader, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
  □ Non-contact: badminton, bowling, 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: ____________________________

OPTIONAL INFORMATION, IF KNOWN

Specify current diseases:
  ☐ Asthma  ☐ Other: ____________________________  ☐ Diabetes: □ Type 1  □ Type 2  ☐ Hyperlipidemia  ☐ Hypertension

Provider's Signature: ____________________________  Phone: ____________________________  (Stamp below)

Provider's Name/Address: ____________________________

Parent Signature: ____________________________  Date: ____________________________

Fax: ____________________________
<table>
<thead>
<tr>
<th>AREA OR SYSTEM</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td></td>
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<tr>
<td>Ears, Nose, Throat</td>
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</tr>
<tr>
<td>Mouth, Teeth</td>
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<tr>
<td>Thyroid</td>
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<tr>
<td>Lymph Nodes</td>
<td></td>
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<tr>
<td>Skin</td>
<td></td>
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<tr>
<td>Chest, Lungs</td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
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<tr>
<td>Genitalia (Tanner)</td>
<td></td>
</tr>
<tr>
<td>□ Refuse</td>
<td></td>
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<tr>
<td>□ Student states both testicles down, no masses</td>
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<tr>
<td>Musculoskeletal</td>
<td></td>
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<tr>
<td>Neck, Spine, Posture</td>
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<tr>
<td>Shoulders</td>
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<tr>
<td>Arms, Elbows, Hands</td>
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<tr>
<td>Hips, Thighs</td>
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<tr>
<td>Ankles, Feet</td>
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<tr>
<td>ROM, Strength</td>
<td></td>
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<tr>
<td>Knees</td>
<td></td>
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</tbody>
</table>

Smoke: ___________________ ETOH: ___________________ Drug: ___________________

CP, SOB or dizzy with ex: ___________________

Concussion: ___________________ Mono: ___________________

Family History Early Cardiac: ___________________

Joint or Muscle Problem: ___________________

Referrals/Recommendation: ___________________