MOBOCES
Lead•Partner•Innovate•Excel

2024-2025 School Year
3 and 4 Year-old Program

Dear Parent/Guardian:

We are pleased that you are interested in the Madison-Oneida BOCES Pre-Kindergarten Program. **In order for your child to be considered for the program you will need to complete and submit items 1 through 7.** Your child ***cannot*** be considered for the program until these forms/documents are completed and received by our office.

1. **Application** (yellow)
2. **School Lunch Form** (pink)
3. **Copy of your child's Birth Certificate**
4. **Copy of your child's Immunization Record**
5. **Proof of Residency**
6. **Information /Health** (ivory)
7. **Transportation** (green)
8. **Dental Form (optional)** (white)

A Parent Checklist (White) is enclosed to assist you in keeping track of what documents you still need to submit.

All information obtained in this application process is needed for placement consideration and will be kept confidential. Please note **all documentation is required** and submission does not guarantee placement.

Your child's eligibility for the **3-year-old** or **4-year-old** Pre-Kindergarten is determined by the following:

- Your child needs to be three years old on or before December 1, 2024 for the 3 year-old program and four years old on or before December 1, 2024 for the 4-year-old program
- Your child resides within **Morrisville School District**
- The majority of students meet economic guidelines set by the New York State Education Department for programming.

The educational program is designed to meet the needs of 3- and 4-year-old children. Class size is limited and staffed with a certified teacher and a teacher aide. Our program is based on the New York State Pre-Kindergarten Next Generation Learning Standards. Classroom learning opportunities include experience with dramatic play, language/literacy, outdoor play, art projects, creative manipulatives, and sand/water table play.

Parent participation is highly encouraged and an essential aspect of the Pre-K program. Creative opportunities are provided for working and non-working parents to become involved in a variety of activities. These include volunteering in the classroom, parent meetings, family functions, parent conferences, "at home" activities, and home visits.

Please refer to the enclosed Frequently Asked Questions sheet, as it may answer many of your questions. If you have any further questions, please call us at 315-361-5903. If in the future there are any changes in the information you provide today, please contact us as soon as possible.

Thank you for your interest in the Pre-Kindergarten program.

Sincerely,

Lindsey Kurak
Early Childhood Coordinator
LK/mu

Dr. Amanda Hopkins
Director of Elementary Programs

Madison-Oneida BOCES 2024-2025
Pre-Kindergarten Registration
Frequently Asked Questions

1. Are all children accepted into Pre-K?
Age restrictions limit acceptance to only those children who turn 3 or 4 years old on or before December 1, 2024 and are not eligible for Kindergarten. A birth certificate is necessary as proof of eligibility for Pre-K. The state has given us strict guidelines to determine eligibility. Class size is limited with an average of 18 students per class, therefore, only a select number of slots may be available dependent upon the year. A certain percentage of slots must meet income eligibility guidelines.

2. Do I have to fill out the Application for Free & Reduced Price School Meals?
Yes. Completing the federal free and reduced school meal application informs us of your family's size and household income. It is important to include everyone who legally resides in your home whether or not they have an income. Since most slots are income-based **we request the form to be completed even if you do not qualify for the school lunch program**. This form will only be used for Pre-K eligibility purposes. Once your child is accepted and enrolled a new form will be distributed by the district your child is enrolled in for the school lunch program. Please note that this information is strictly confidential.

3. If I hand in my application right away, does that improve my child's chances of being selected?
No. All completed, eligible applications will be included in the selection process; handing your application in on the registration date versus handing it in later in the year does not affect your child's chances of being selected one way or the other.

4. When will I know if my child is accepted into Pre-K?
If you have completed all the forms needed to be considered for enrollment, you will be notified of your child's acceptance or non-acceptance into the program during the summer of 2024.

5. Will my child attend school every day?
Yes, we follow each school district's 180-day attendance calendar. Students attend programming Monday-Friday according to this calendar. Some districts have scheduled half days or early dismissal days. When this occurs we adjust our program accordingly. The Program is half-day (2 ½ hours.)

6. Where will my child attend Pre-K?
E.R. Andrews Elementary - 55 Eaton Street, Morrisville.

7. How will my child be transported to/from school?
Your child will be bussed to and from school by the Morrisville School district.

8. **Does the program provide meal/snack time?** Yes

*** * * VERY IMPORTANT HEALTH INFORMATION ON BACK OF PAGE * * ***

>>>>> >>>>> >>>>> >>>>>>

9. How will I be informed of my child's progress in Pre-k?

Each classroom teacher has a home - school communication system in place. Students entering Pre-K in the fall will receive a Pre-K screening to determine where they are in their development. Assessment results, based on performance rubrics, will be shared with you quarterly. At Fall parent conferences, you will discuss the results of the first couple of learning units. The learning units and assessment rubrics are aligned with the New York State Pre-Kindergarten Next Generation Learning Standards. Staff members are always available for conferencing with you as needed.

10. What is the Pre-K Dental Health Certificate?

A law was passed in New York State requesting that all parents with a Pre-K student entering school provide a dental certificate signed by a licensed dentist. You will be provided with a sample certificate to take to your child's dentist. The certificate would be returned to the school nurse.

New York State Law requires your child to have a physical exam upon entering school.

- The physical report must be submitted by the first day of school.
- The physical must have been done within 12 months prior to entering school and performed by a NYS licensed physician.
- The physical report should contain an indication of lead screening results.

A reminder, too, that New York State Law requires the following immunizations for entrance into school:

- **3 Polio**
- **1 MMR**
- **3 DTaP**
- **4 Pneumococcal**
- **3 Hep B**
- **3 HiB**
- **1 Varivax**

Official proof of these immunizations must be submitted at the time of registration.
Immunizations are available by calling the following health departments:

Oneida County at 315-798-5748 or Madison County at 315- 366-2361.

Please call the Early Childhood Office at 315-361-5903 if you have any questions.

Revised 1/3/24

Madison-Oneida BOCES
2024-25 Pre-Kindergarten Program Application

District: _____ County: _____

Child's Name: _____
Last First Middle

Date of Birth: ___/___/____ Male ☐ Female ☐

Student Ethnicity (optional): ___White (non-Hispanic) ___American Indian/Alaskan Native

___Hispanic ___Black (non-Hispanic) ___Asian Pacific Islander ____Other

Language Spoken in Home: English Other _____

Mailing Address: _____
Street Address/P.O. Box City Zip

911 Residential Address
(if different from mailing address): _____

Home phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____

If no phone, how can we reach you? _____ Relationship to child: _____

Babysitter/Child Care (Name/Address/Phone): _____

_____

Name	Workplace & Phone #	Educational Level (Diploma,GED,Grade level) (optional)
Father:		
Mother:		

Legal Guardian: _____
(If Foster Parent – the school **must have** DSS-2999 form prior to the child starting school)

PLEASE COMPLETE BOTH SIDES OF FORM **(OVER) ➔**

Student is currently living with:

- ❒ Both parents
- ❒ His/her mother
- ❒ His/her father
- ❒ His/her mother & step-father
- ❒ His/her father & step-mother
- ❒ His/her grandparents
- ❒ His/her foster parents
- ❒ Legal Guardian

Custody Comment(s) _____
_____
_____
_____
_____
_____
_____
_____
_____

*****<u>If separated or divorced – custody papers must be on file in the classroom & school office before the beginning of school to monitor who is allowed to pick up the child</u>.*****

*** Please list other children in the household:**

<u>Name (Last, First)</u>	<u>Date of Birth (optional)</u>	<u>Relationship to applicant</u>

*** This information is to contact you in the future when your child becomes eligible for Pre-K.**

How did you find out about our program (check one): ____Newspaper Ad ____Friend ____Yard Sign ___Flyer ___Previous child in program ____TV/Radio ____School Poster ____ Website ____ BOCES/School Staff ____Other (specify): _____

<u>To be signed by parent/guardian</u>:

I hereby submit this application for services on behalf of my child. The information furnished is true and correct to the best of my knowledge and belief. I understand that in order to be considered for the Pre-K program, I must also submit a copy of my <u>child's birth certificate</u>, a copy of my child's <u>immunization record</u>, <u>proof of residency</u>, a <u>completed school lunch form</u>, a <u>completed transportation form</u>, and a <u>completed information/health record form</u>. I fully understand my obligation as a parent to become involved in the Pre-K Program should my child be accepted.

I hereby authorize the release of information to professional personnel involved in the education of my child. I understand that information and verifications will be used to determine program eligibility and information will be kept strictly confidential.

Form completed by: _____ Date: _____

Relationship to child: _____ Signature: _____

CONFIDENTIAL – This form will only be used for Pre-K eligibility purposes. Once your child is accepted and enrolled, a new form will be distributed by the district your child is enrolled in for meal eligibility.

2024-2025 FREE AND REDUCED PRICE SCHOOL MEALS FAMILY APPLICATION

Part 1. Children in School (Use a separate application for each foster child)

Names of all children in school (First, Middle Initial, Last)	School Name	Grade	Food Stamp or TANF case # (if any). **Skip to Part 5 if you list a Food Stamp or TANF case #**

Part 2. If the child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [your school, homeless liaison, migrant coordinator at phone #] Homeless ❑ Migrant ❑ Runaway ❑

Part 3. Foster Child

If this application is for a child who is the legal responsibility of a welfare agency or court, check this box ❑ and then list the amount of the child's personal use monthly income: $__________. Skip to Part 5.

Part 4. Total Household Gross Income—You must tell us how much and how often

1. Name (List **everyone** in household)	**2. Gross income and how often it was received** *Example: $100/monthly $100/twice a month $100/every other week $100/weekly*				**3. Check if NO income**
	Earnings from work before deductions	Welfare, child support, alimony	Pensions, retirement, Social Security	All Other Income	
(Example) Jane Smith	$200/weekly	$150/weekly	$100/monthly	$____/____	❑
	$____/____	$____/____	$____/____	$____/____	❑
	$____/____	$____/____	$____/____	$____/____	❑
	$____/____	$____/____	$____/____	$____/____	❑
	$____/____	$____/____	$____/____	$____/____	❑
	$____/____	$____/____	$____/____	$____/____	❑
	$____/____	$____/____	$____/____	$____/____	❑
	$____/____	$____/____	$____/____	$____/____	❑
	$____/____	$____/____	$____/____	$____/____	❑

Part 5. Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 4 is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign here: X______________________________Print name:______________________________Date: ______________

Address:____Phone Number:______________________

Social Security Number: __ __ __ - __ __ - __ __ __ __ ❑ I do not have a Social Security Number

Part 6. Children's racial and ethnic identities (optional)

Mark one or more racial identities:
❑ Asian ❑ American Indian or Alaska Native
❑ White ❑ Native Hawaiian or Other Pacific Islander
❑ Black or African American ❑ Other

Mark one ethnic identity:
❑ Hispanic or Latino
❑ Not Hispanic or Latino

Don't fill out this part. This is for school use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24 Monthly x 12

Total Income: ____________ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: ________

Categorical Eligibility: ___ Date Withdrawn: ________Eligibility: Free___ Reduced___ Denied___ Reason: ______________________

Temporary: Free_____ Reduced_____ Time Period: ___________ (expires after _____ days)

Determining Official's Signature: ____ Date: ______________

Confirming Official's Signature: __________________ Date: _______ Follow-up Official's Signature: __________________ Date: ______

INSTRUCTIONS FOR FORM COMPLETION

If your household gets FOOD STAMPS OR TANF, follow these instructions:

List child(ren)'s name, school, grade, and a Food Stamp or TANF case number.
Check the appropriate box, if any.
Skip this part.
Skip this part.
Sign the form. A Social Security Number is not necessary.
Part 6: Answer this question if you choose to.

Check the appropriate box and contact [your school, homeless liaison, migrant coordinator]. Fill out application by following instructions for ALL OTHER HOUSEHOLDS.

If you are applying for a FOSTER CHILD, follow these instructions:

Part 1: Use a separate application for each foster child. List the child's name, school, and grade.
Part 2: Skip this part.
Part 3: Check the box and list the child's personal use monthly income, if any.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is not necessary.
Part 6: Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List each child's name, school, and grade.
Part 2: Check the appropriate box, if any.
Part 3: Skip this part.
Part 4: Follow these instructions to report total household income from last month.

Column 1–Name: List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends). You must include yourself and all children living with you. Attach another sheet of paper if you need to.

Column 2 –Gross income last month and how often it was received. Next to each person's name list each type of income received last month, and how often it was received. For example, *Earnings from work:* List the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly). *All other income:* List the amount each person got last month from welfare, child support, alimony, (second column) pensions, retirement, Social Security (third column), and ALL OTHER INCOME SOURCES (fourth column). In the All Other column, include Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household, and ANY OTHER INCOME. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.

Column 3–Check if no income: If the person does not have any income, check the box.

Part 5: An adult household member must sign the form and list his or her Social Security Number, or mark the box if he or she doesn't have one.
Part 6: Answer this question if you choose to.

Madison-Oneida BOCES
2024-25 Pre-Kindergarten Program

Transportation To/From Home/Child Care/Special Request Form

Student Name: _____ DOB _____

Home Address: _____ City: _____ Zip:_____

Parent/Guardian: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact#1: _____ Phone: _____

Relationship to Child: _____

Emergency Contact#2: _____ Phone:_____

Relationship to Child: _____

Pickup & Drop off locations MUST be within your child's school district

AM Pickup Address: _____ Phone:_____

Individual Responsible: _____ Relationship:_____

AM Drop Off Address: _____ Phone:_____

Individual Responsible:_____Relationship: _____

PM Pickup Address:_____ Phone: _____

Individual Responsible:_____ Relationship: _____

PM Drop Off Address: _____ Phone: _____

Individual Responsible:_____Relationship: _____

Additional Information:_____

_____

Signed _____ Date _____

PRE-KINDERGARTEN PROGRAM
MADISON-ONEIDA BOCES

Child's Name: _____ School District: _____

BELOW, PLEASE WRITE DIRECTIONS OR DRAW A MAP TO YOUR HOME. PLEASE INCLUDE DESCRIPTION OF LOCATION OF RESIDENCE: HOUSE COLOR, ROAD INTERSECTIONS, LANDMARKS, ETC.

PLEASE WRITE DIRECTIONS TO YOUR CHILD'S PICK UP AND DROP OFF ADDRESS IF DIFFERENT FROM HOME ADDRESS.
PLEASE INCLUDE DESCRIPTION OF LOCATION OF RESIDENCE: HOUSE COLOR, ROAD INTERSECTIONS, LANDMARKS, ETC.

MADISON-ONEIDA BOCES
2024-25 PRE-KINDERGARTEN PROGRAM INFORMATION/HEALTH FORM

Parent/Guardian Name: _____

Child's Name: _____

School District: _____

Date of Birth: _____ Sex: Male Female

Do any of the following statements describe your child? Check all that apply.

___ My child is not talking.

___ It is difficult for others to understand my child's speech.

___ My child does not understand when I speak to him/her.

___ My child's behavior is very hard to manage.

___ My child is overly aggressive/has temper tantrums often.

___ My child had or has difficulty walking, crawling or jumping.

___ My child is not completely toilet trained. (please explain)
_____
_____

___ My child's daily schedule includes rest/nap time as follows:
Time of rest/nap: _____ Length of rest/nap: _____

Has your child ever been evaluated for a delay in development? _____ Yes _____ No

If yes, by whom?_____When?_____

Does your child have an Individualized Education Plan (I.E.P.)? _____ Yes _____ No
If yes, please list district where the I.E.P. was created: _____

Please check if your child is currently receiving or has ever received any of the following services:

Please indicate who the service provider is next to the service.

_____ Speech Therapy _____
_____ Physical Therapy _____
_____ Occupational Therapy _____
_____ Special Class Placement (where?)_____
_____ Special Education Itinerant Services (SEIT) _____
_____ Other (please specify): _____

Please Complete Both Sides

HEALTH INFORMATION

Child's Primary Doctor:_____ Date of last physical:_____

Is your child currently on medication? ☐ Yes ☐ No

If YES is selected:

Reason:_____ Type of Medication:_____

Prescribing Doctor:_____ Time of day given:_____

Date Prescribed: _____

Does your child have allergies? (Please be specific- Food/Drug/Environmental) ☐ Yes ☐ No

If YES is selected:

Allergies: _____ Epi pen prescribed? ☐ Yes ☐ No

Food intolerances:_____

(Please check)	Had previously	Currently Has
Ear Infections		
Ear tubes		
Constipation		
Stomach Aches		
Asthma		
Headaches		
Nose bleeds		
Heart Condition		
Fluid in Ears		

(Please check)	Had previously	Currently Has
Vision Deficit (Glasses)		
Diarrhea		
Fevers		
Strep Infections		
Diabetes		
Seizures		
Nightmares		
Pneumonia		
History of COVID19		

Describe any health conditions:_____

If conditions allow, vision and hearing screenings are provided free of charge for all students enrolled in the Pre-Kindergarten program. I give my permission for my child to receive these screenings. I also give permission for these results to be shared with the classroom teacher.

_____ _____

Parent Signature Date

MORRISVILLE-EATON CENTRAL SCHOOL

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

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

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: Name

Grade

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

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

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

Parent's Signature _____ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ on_____ (date of assessment) The date of the assessment 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/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist's Signature

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

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

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

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

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

II. 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.

(3/2018)

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:	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma	☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes	Type: ☐ 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):

Hyperlipidemia: **Hypertension:**

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:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/		○
Near Vision Acuity	20/	20/		○
Color Perception Screening				

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**	**Left**	**Referral**	

Notes

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**

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

Developmental Stage for Athletic Placement Process <u>ONLY</u> 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: Age of First Menses (if applicable):

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, 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.

2024-2025 Pre-Kindergarten Registration
Parent Checklist

Applications will not be considered for acceptance until the following forms/documents are submitted and complete:

Application	Proof of Residency
School Lunch Form	Transportation Form
Birth Certificate	Information/Health Form
Immunization Record	

Today I submitted:

☐ Proof of Residency ☐ Birth Certificate

☐ Application ☐ School Lunch Form ☐ Immunizations ☐ Dental

☐ Transportation Form ☐ Information/Health Form ☐ Physical Exam Form

I still need to submit

☐ Proof of Residency ☐ Birth Certificate

☐ Application ☐ School Lunch Form ☐ Immunizations ☐ Dental

☐ Transportation Form ☐ Information/Health Form ☐ Physical Exam Form

New York State Law requires your child to have a physical exam upon entering school.

- The physical report must be submitted by the first day of school.
- The physical must have been done within 12 months prior to entering school.
- **A reminder, too, that New York State Law requires the following immunizations for entrance into school:**
  - 3 Polio
  - 1 MMR
  - 3 DTaP
  - 3 Hep B
  - 3 HiB
  - 1 Varivax
  - Pneumococcal

Official proof of these immunizations must be submitted at the time of registration.
New York State Law requests provision of a dental certificate signed by a licensed dentist.

Immunizations are available by calling Oneida County at 315-798-5748 or Madison County at 315-366-2361. A sliding fee scale will be used for those without insurance.

You may fax the above items to us at 315-361-5653, or send them to us at:

Madison-Oneida BOCES
Pre-Kindergarten Program
4937 Spring Road PO Box 168
Verona, New York 13478-0168

Please call the Early Childhood Office at 315- 361-5903 if you have any questions.