CPSE PARENT
REGISTRATION CHECKLIST

- ◻ Parental Referral to CPSE Letter
- ◻ Putnam Valley Central School District Registration Form
- ◻ Proof of Age (Birth Certificate, Passport, etc.)
- ◻ Health History Update Form
- ◻ Health Appraisal Form
- ◻ Physical Examination Form

Proof of Residency: 3 Forms are required

- ◻ (1) Deed, Recent Tax Bill, Lease or Landlord Affidavit Attesting to Rental Agreement
- ◻ (2 & 3) Original cable, gas or telephone bill is acceptable proof, but must be the most recent bill and must reflect name and current address. (Print outs from your computer are okay as long as your name and address are on the printed statement.)

Please note that you must bring with you ALL of the required documents referenced above or we will not be able to complete the registration.

We only need to view the original documentation. We will make a copy to maintain in our files and you will take the originals back home with you.

Parental Referral to CPSE

Name:____

Address:_____________________________________

____

Phone:_______________________________________

Melissa Cafaro, Ph.D.
CPSE/CSE Chairperson
Putnam Valley Central School District
146 Peekskill Hollow Road
Putnam Valley, New York 10579

Dear Dr. Cafaro,

I am writing to refer my child to the Committee on Preschool Special Education.
My child's name is _________________________and he/she was born on _________________.
I am concerned with:
( )- Overall cognitive development
( )- Speech and Language skills
( )- Articulation skills
( )- Social and emotional development
( )- Fine motor skills
( )- Gross motor skills
( )- Other:____

Please accept this letter as my formal referral to the Committee on Preschool Special Education.

Sincerely,

____ ________________
Signature Date

PUTNAM VALLEY CENTRAL SCHOOL DISTRICT

146 Peekskill Hollow Road
Putnam Valley, NY 10579

Landlord Affidavit

STATE OF NEW YORK)
COUNTY OF PUTNAM)

____, being duly sworn deposes and says I am the owner and landlord of the premises known and designated as
____, New York.
(Address)

These premises constitute a (multiple dwelling, single dwelling) residence.

____, is a tenant occupying theses
(Name of parent/guardian)

premises; occupying same under (oral) (written) rental agreement commencing on the

________ Day of _________ 20___. ______________________________ occupies said

residence with _________________________________who is a minor and plans to attend
(Name of Student)
School in Putnam Valley.

This affidavit is made in order to induce the Putnam Valley Central School District to accept ____ in the District based upon the
(Name of Student)
residency as stated herein.

I made this sworn affidavit knowing full well that the Putnam Valley Central School District is relying upon the truthfulness of the facts contained herein.

____
Signature

Sworn to before me this ___________ day
of _______________, 20___________

____
Notary Public

FORM A

Putnam Valley Central School District
Registration Form

I. STUDENT INFORMATION

Please complete this entire section about the student. Be prepared to provide birth verification and proof of residency (see below*) at the time of enrollment.

***Property owners** must provide an original Property/School Tax bill **PLUS** any two of the following recent original bills: Gas/Electric bill, Oil bill, Telephone bill, Mortgage bill.

***Renters** must provide an original Lease or Notarized Landlord Affidavit (Form R-1, from school) **PLUS** any two of the following recent original bills: Gas/Electric bill, Oil bill, Telephone bill, Cable/Satellite bill.

Last Name ____________________ First: ____________________ Middle ________ Sex: ______________

Home Address: ____

____

Home Phone: ____________________ Date of Birth: ______________ Place: ________________________

Previous School: ________________________ Grade: ________ School Address: ________________________

____

For certain Federal and State programs, the district must report student ethnicity. Please check the appropriate designation for your child.

_____African American (not Hispanic origin) _____Asian/Pacific Islander _____Hispanic

_____American Indian/Alaska Native _____Caucasian (not Hispanic origin)

II. CONTACT INFORMATION

Please complete this entire section. You must provide information for three contacts. For additional contacts use a blank page.

	PARENT/GUARDIAN	OTHER PARENT/GUARDIAN	EMERGENCY CONTACT (OTHER THAN PARENT)
Contact full name			
Relationship to student			
Lives with student? (Circle one)	Yes / No If no, provide address here. ____________________ ____________________	Yes / No If no, provide address here. ____________________ ____________________	Please provide address here. ____________________ ____________________ ____________________
Home phone	( )	( )	( )
Work phone	( )	( )	( )
Cell phone	( )	( )	( )
Email address			This information not needed
Employer			This information not needed
Primary language if other than English			

III. SIBLING INFORMATION

Complete this section only if applicable.

SIBLING FULL NAME	DATE OF BIRTH	PRESENT SCHOOL	GRADE

The information provided above is true to the best of my knowledge

____ ________________________

Parent/Guardian Signature *Date*

OFFICE USE ONLY: Start Date: ______________ Grade/Homeroom: ________________________ Bus: ________________

DISTRIBUTION OF COPIES: Student file, Nurse, Guidance, Transportation

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH APPRAISAL FORM

Name: ______________________________ **Date of Birth:** ______________________________

School: ____________________ **Gender:** ❑ M ❑ F **Grade:** ______________________________

IMMUNIZATIONS / HEALTH HISTORY

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

Sickle Cell Screen: ❒ Positive ❒Negative ❒ Not done Date: ____________
PPD: ❒ Positive ❒Negative ❒ Not done Date: ____________
Elevated Lead: ❒ Yes ❒ No ❒ Not done Date: ____________
Dental Referral ❒ Yes ❒ No ❒ Not done Date: ____________

____

Significant Medical/Surgical History: ❒ See attached ____

____

Specify current diseases: ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2 ❒ Hyperlipidemia ❒ Hypertension
❒ Other: ____

Allergies: ❒ **LIFE THREATENING** ❒ Food: ____________ ❒ Insect: ________________ ❒ Other: ________________
❒ Seasonal ❒ Medication: ______________________________ ________________

PHYSICAL EXAM

Height: ______________ Weight: ______________ Blood Pressure: ______________ Date of Exam: ________________

Body Mass Index: _____ _____ . _____						Referral
Weight Status Category (BMI Percentile):			Vision - without glasses/contact lenses	R	L	
			Vision - with glasses/contact lenses	R	L	
❑ less than 5th	❑ 5th through 49th	❑ 50th through 84th	Vision - Near Point	R	L	
❑ 85th through 94th	❑ 95th through 98th	❑ 99th and higher	Hearing ❑ Pass 20 db sc both ears or:	R	L	

❒ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❒ Negative ❒ Positive: ________________

Specify any abnormality (use reverse of form if needed): ____

____

____

MEDICATIONS

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

Name: ______________________________ Dosage/Time: ______________________________

Name: ______________________________ Dosage/Time: ______________________________

If AM dose is missed at home: ____

I assess this student to be self-directed ❒ Yes ❒ No Student may self carry and self administer medication ❒ Yes ❒ No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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

❒ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

❒ **Specify medical accommodations needed for school**: ______________________________ ❒ None

❒ **Known or suspected disability:** ______________________________ ❒ Please monitor

❒ **Restrictions:** ______________________________ ❒ Please monitor

❒ **Protective equipment required:** ❒ Athletic Cup ❒ Sport goggles/impact resistant eyewear ❒ Other: ________________

(Stamp below)

Provider's Signature: ______________________________ Phone: ________________

Provider's Name/Address: ______________________________ Fax: ________________

Parent Signature: ______________________________ Date: ________________

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. Rev. 10/3/07

Putnam Valley Central School District

HEALTH HISTORY UPDATE

STUDENT NAME________________________________ **GRADE**_____ **DATE OF BIRTH**__________

To be completed by parent or guardian: Please provide the following information and approximate dates. Use additional sheets if necessary.

	NO	YES	DATES	DESCRIPTION
ALLERGIES				
ALLERGIES: FOOD				
ALLERGIES: MEDICATION				
ALLERGIES: INSECT STINGS				
ALLERGIES: ENVIRONMENT (HAY FEVER)				
ALLERGIES: OTHER				
ASTHMA				
EPI-PEN OR INHALER PRESCRIBED?				
INTERNAL				
BLADDER/KIDNEY INJURY OR PROBLEM				
SPLEEN INJURY				
STOMACH ULCER				
TESTICULAR PROBLEMS				
FAINTING				
FAINTING SPELLS				
FAINTING DURING EXERCISE				
LOSS OF CONSCIOUSNESS FROM BLOW TO HEAD				
LOSS OF MEMORY FROM BLOW TO HEAD				
CONVULSIONS/SEIZURES				
CARDIO				
HEART MURMUR				
CHEST PAIN				
ELEVATED BLOOD PRESSURE				
OTHER HEART PROBLEM				
MUSCULOSKELETAL				
BACK/NECK/SPINE PAIN OR INJURY				
FRACTURES/DISLOCATIONS				
JOINT SPRAIN/LIGAMENT TEAR				
KNEE INJURY/PAIN				
WEAR BRACE/SPLINT FOR GYM OR SPORTS				
MUSCLE PULLS				
VISION				
EYE PROBLEMS/VISION LOSS				
UNCORRECTABLE LOSS OF VISION IN ONE EYE				
WEAR CORRECTIVE GLASSES/CONTACT LENSES				
OTHER EYE/VISION PROBLEMS				

	NO	YES	DATES	DESCRIPTION
HEARING				
EAR PROBLEMS/HEARING LOSS				
HEARING LOSS IN ONE OR BOTH EARS				
USE HEARING ASSISTANCE DEVICE				
ORAL				
HAVE ORTHODONTIC APPLIANCES				
HAVE CAPPED TEETH				
DISEASES				
MONONUCLEOSIS				
DIABETES				
VARICELLA (CHICKEN POX)				
RHEUMATIC FEVER				
OTHER DISEASES				
OTHER				
HEADACHES/MIGRAINS				
NOSE BLEEDS (FREQUENT OR SEVERE)				
HAD A SURGICAL PROCEDURE SINCE LAST YEAR				
BEEN ILL FOR 5 OR MORE CONSECUTIVE DAYS				
SUDDEN DEATH OF FAMILY MEMBER UNDER 50				
ONGOING				
TAKE MEDICATION (PLEASE SPECIFY)				
ANY SIGNIFICANT INJURY SINCE LAST YEAR				
UNDER MEDICAL CARE NOW				

DOES YOUR CHILD HAVE A REGULAR PHYSICIAN? PHYSICIAN PHONE:			PHYSICIAN ADDRESS:
COVERED UNDER HEALTH INSURANCE			CARRIER
I agree to emergency medical treatment as deemed necessary by the physician/nurse designated by school authorities.	YES	NO	LIMITATIONS (IF ANY)
I give permission for my child's condition to be shared with staff when necessary in case of a medical emergency.	YES	NO	LIMITATIONS (IF ANY)

EMERGENCY CONTACT: Please contact in emergency if parent or guadian is unavailable:

CONTACT #1 ____________________ PHONE # ____________________

CONTACT #2 ____________________ PHONE # ____________________

PARENT/GUARDIAN SIGNATURE ____________________ PHONE # ____________________

PRINT NAME ____________________ ALTERNATE PHONE NUMBER ____________________