



Welcome

Welcome to the Putnam Valley Central School District. All students in **grades K–12** must enroll with the **District Registrar**, located in the District Office.

Registration Appointments

Please schedule an appointment by using the following link, you will see a Google calendar link to set up your appointment: <https://pvcsd.org/index.php/district/parent-resources/register/>

- **Preschool Special Education (ages 3–5):** Please contact the **Special Education Office** at **(845) 528-8130 ext. 1317**.

Parent Notice: Parents/guardians have the right to refer their child for a **special education evaluation** if they believe their child may have an educational disability. For additional information, please contact the **CSE Chairperson** at **(845) 528-8130 ext. 1307**.

Required Documents to Begin Registration

A registration packet is provided for you to complete. In addition, you **must bring the documents listed below** to begin the registration process.
All residency documents are subject to verification.

Bring ALL That Apply

- ☐ **ONE Proof of Age** (original documentation required):
 - ☐ Birth Certificate (original)
 - ☐ Baptismal Certificate (original)
 - ☐ Passport (original)
- ☐ **Completed Immunization Record and Physical** (signed and stamped by a physician)
 - Physical must be dated **within 12 months** of the student's school entry
- ☐ **Educational Records**, if applicable:
Report card, IEP, Section 504 Plan, ELL services documentation, High School transcript

- ☐ **Divorce / Separation / Custody Papers**, if applicable
 - ☐ **Guardianship Papers**, if applicable
 - ☐ **Care / Control Papers**, if applicable
 - ☐ **Foster Child Data Sheet**, if applicable
 - ☐ **Order of Emancipation or Affidavit of Emancipation**, if applicable
-

Proof of Residency Checklist

Please use this checklist to ensure you bring the correct documents.

Required for ALL Families

All documents must show your **current physical address**.
P.O. Box addresses are not accepted.

Homeowners Checklist

Step 1: Provide ONE (1) of the following (check only one):

- ☐ Deed
- ☐ Most recent **School or Property Tax Bill**
- ☐ Most recent **Mortgage Statement**

Important: You do **NOT** need all three — **only ONE** is required.

Step 2: Provide TWO (2) current documents (dated within the last 30 days) in the homeowner's name:

- ☐ Utility Bill (gas, electric, oil, telephone, or cable/satellite)
- ☐ Utility Bill (second bill, if applicable)
- ☐ Property Insurance Certificate

(Select any two from the options above.)

Renters Checklist

Step 1: Provide ALL of the following:

☐ Valid, fully executed lease including:

- Rental property address
- Landlord's name, address, and phone number
- ☐ Completed, signed, and notarized **Affidavit of Property Owner/Landlord if you do not have a copy of your lease. This form is provided within the registration packet.**

Step 2: Provide TWO (2) current documents (dated within the last 30 days) in the renter's name:

- ☐ Utility Bill (gas, electric, oil, telephone, or cable/satellite)
- ☐ Utility Bill (second bill, if applicable)
- ☐ Section 8 or Municipal Housing Statement

If utilities are included in your rent, please contact the registration office to discuss other acceptable proof of residency.

Important Reminders

- ☐ All documents must reflect the **current physical address**
- ☐ Documents with **P.O. Box only** addresses will **not** be accepted
- ☐ Original documents are required

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PUTNAM VALLEY CENTRAL SCHOOL DISTRICT

171 Oscawana Lake Road • Putnam Valley, NY 10579

REQUEST FOR RELEASE OF RECORDS

Student's Last Name, First Name: _____ DOB: _____

Name of Last School Attended: _____

Address of School: _____

School's Phone: _____ School's Fax: _____

In accordance with the provisions of the Family Educational and Privacy Act of 1974, I hereby request that the Board of Education transfer copies of all school records and reports including:

- Student's complete file including Kindergarten through date of transfer.
- Grades to date of withdrawal from your school and date of withdrawal.
- Current report card
- Standardized test scores
- Psychological test results of special placement
- Any attendance and discipline records

Please indicate if this student is in need of:

☐ special education services

☐ 504 plan services

☐ ELL services

☐ psychological services

High School Students Only:

☐ High School transcript, including any high school courses taken in the 8th grade

☐ Copies of all science labs IF student is taking a lab science course

Parent/Guardian Signature: _____ Parent/Guardian Print: _____

PLEASE FORWARD ALL RECORDS TO:

Elementary School (K-4)

Main Office
Putnam Valley Elementary School
171 Oscawana Road
Putnam Valley, NY 10579
Tel: 845-528-8092
Fax: 845-528-8171

Middle School (5-8)

Guidance Department
Putnam Valley Middle School
142 Peekskill Hollow Road
Putnam Valley, NY 105789
Tel: 845-528-8101
Fax: 845-528-8145

High School (9-12)

Lynn Keller - Guidance
Department
Putnam Valley High School
146 Peekskill Hollow Road
Putnam Valley, NY 10579
Tel: 845-526-7810 Fax: 845-526-7814
Email: lkeller@pvcasd.org

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PUTNAM VALLEY CENTRAL SCHOOL DISTRICT

Student Registration Form

Please complete this entire form. Provide birth verification and proof of residency at the time of enrollment.

I. STUDENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME
GENDER	DATE OF BIRTH	PLACE OF BIRTH
HOME ADDRESS	HOME PHONE	
HAS IEP? (CIRCLE ONE) YES / NO	HAS 504 PLAN? (CIRCLE ONE) YES / NO	RECEIVES ENL SERVICES? (CIRCLE ONE) YES / NO

* Federal & State programs require reporting student ethnicity and race. Please check appropriate options.

1. ETHNICITY:

☐ Hispanic / Latino ☐ Not Hispanic / Latino

2. RACE (CHECK ALL THAT APPLY):

☐ Black/African Amer. ☐ Asian ☐ Hawaiian/Pac. Isl.

☐ Amer. Indian/AK ☐ White

II. CONTACT INFORMATION

Field	Parent / Guardian #1	Parent / Guardian #2	Emergency Contact (Other)
Full Name			
Relationship			
Lives with Student?	(Circle) Yes / No	(Circle) Yes / No	N/A
Address (If no)			
Home Phone	()	()	()
Work Phone	()	()	()
Cell Phone	()	()	()
Email Address			Not required
Employer			Not required
Primary Language			

Are there any custody concerns? (circle one) YES / NO (In case of divorce, separation, or legal guardianship, please provide court custody paperwork.)

III. SIBLING INFORMATION (IF APPLICABLE)

Sibling Full Name	Date of Birth	Present School	Grade
1.			
2.			
3.			

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

PARENT / GUARDIAN SIGNATURE

DATE

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New York State Housing Questionnaire

Identifying and serving students in temporary housing under the McKinney-Vento Act and NYS Ed Law §3209

This form is to be completed when a student first enrolls, and any time a change in housing status occurs. There are no wrong answers. This form may be filled out independently, or the McKinney-Vento Liaison can assist. To access a list of McKinney-Vento Liaisons, please visit <https://www.nysteachs.org/liaisons>

District or LEA	School Name
About this form and your rights Schools are required by federal and state law to identify students living in temporary housing and ensure they can enroll, attend, and succeed in school. The McKinney-Vento Homeless Assistance Act, together with New York State Education Law Section §3209, protects students and families who no longer have a permanent, stable place to live; families who have lost housing; are staying with others temporarily; or are living somewhere that was never meant to be a home. Eligible students have the right to: ✓ Stay in the school they attended when last permanently housed (called the school of origin), for as long as they are in temporary housing. ✓ Immediately enroll in the local school where they are temporarily staying (the school of current location). ✓ Enroll and start school right away, even without a birth certificate, proof of residency, immunization records, or school records. ✓ Receive free transportation to and from the school of attendance, as well as after-school activities (If within 50 miles). ✓ Receive free school meals without income paperwork as well as access to other school services including McKinney-Vento Grant resources, if available. This information is confidential and will be shared only with school staff who have a legitimate educational need to support student access to McKinney-Vento rights and services. Providing this information is voluntary and will be used only to determine eligibility for services under the McKinney-Vento Act and NYS Education Law §3209. Please note that this information will not affect your immigration status, your child's enrollment, or your eligibility for other school services.	

STUDENT INFORMATION:

Student Name (Last, First)	Student Grade Level (Preschool-12)
Student Gender ☐ M ☐ F ☐ X= Nonbinary	Student Date of Birth (Month/Day/Year)
Parent, Legal Guardian Name	
Phone Number	E-Mail Address
Address where the student is currently living	

Where is the student residing right now?

Under the McKinney-Vento Act, students are protected when their nighttime residence is not **fixed, regular, and adequate**. Check every box that describes where **the student** is residing right now.

- ☐ Permanent housing: you own, rent or lease a fixed, regular, and adequate home
- ☐ Doubled-up: staying with another family or person due to a loss of housing, economic hardship, eviction, or other similar reason
- ☐ In an emergency, transitional, or domestic violence shelter. Shelter or program name: _____
- ☐ In a hotel or motel because there is no other alternative, adequate place to stay
- ☐ In a car, park, campsite, bus/train station, abandoned building, or another place not meant for stable habitation or established dwelling
- ☐ In a place with no heat, running water, or electricity, or that is otherwise structurally unsafe or inadequate to reside in
- ☐ Displaced by a fire, flood, natural disaster, or other emergency
- ☐ Another temporary situation not listed here: _____

Is there anything else you would like us to know about your situation? (optional)

Is the student an Unaccompanied Homeless Youth (UHY)?

The McKinney-Vento Act identifies students who are not living with a parent or legal guardian, and are not residing in permanent housing, as **Unaccompanied Homeless Youth (UHY)**. UHYs have the right to enroll in school and to complete and sign this form independently, without a parent or adult present. The McKinney-Vento Liaison can assist UHYs with this process.

☐ **Please check the box if you believe the student identified above may meet the McKinney-Vento eligibility criteria described above.**

Additional Children within the Household?

To help us identify and support all eligible children and youth, please list every child who is currently living with you, regardless of age or school enrollment status. This includes infants, preschool-aged children, and school-aged children.

Student Name (Last, First)	Date of Birth	Grade	Current or Recent School	Last School Attended Before Current or Recent

Student Name (Last, First)	Date of Birth	Grade	Current or Recent School	Last School Attended Before Current or Recent

Accuracy of Information and Signature

The person completing this form certifies that the information provided above is correct and accurate to the best of their ability.

Name (print): _____

Signature: _____ Date: _____

An unaccompanied homeless youth may sign on their own behalf.

Need help? Contact the McKinney-Vento Liaison listed at the top of this form or call the NYS-TEACHS Helpline at 800-388-2014. Visit nysteachs.org for more information.

OFFICIAL USE ONLY (School Staff)

Date received: _____ Received by: _____ Eligibility: ☐ Eligible ☐ Not Eligible ☐ Pending

Homeless Primary Nighttime Residence Code (SIRS):

☐ D = Doubled-up ☐ S = Shelter ☐ H = Hotel/Motel ☐ U = Unsheltered ☐ T = Transitional Housing

Unaccompanied Homeless Youth (UHY): ☐ Yes ☐ No

Designation Form: ☐ Yes ☐ N/A ☐ Coded in Student Information System (SIS)

Liaison notified (initials): _____ Date: _____ ☐ Family declined to provide information

Notes:

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STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Elisa Alvarez, Associate Commissioner Office of
Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Person in Parental Relation:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
		☐ Male
Month	Day	Year
☐ Female		
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	☐ English	☐ Other	_____
			specify
2. What was the first language your child learned?	☐ English	☐ Other	_____
			specify
3. What is the Home Language of each parent/guardian?	☐ Parent 1	☐ Parent 2	_____
	☐ Guardian(s)		_____
			specify
4. What language(s) does your child understand?	☐ English	☐ Other	_____
			specify
5. What language(s) does your child speak?	☐ English	☐ Other	_____ ☐ Does not speak
			specify
6. What language(s) does your child read?	☐ English	☐ Other	_____ ☐ Does not read
			specify
7. What language(s) does your child write?	☐ English	☐ Other	_____ ☐ Does not write
			specify

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT
INFORMATION SYSTEM:

District Name (Number) & School:

Address:

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes* No Not sure

☐
☐
☐

*If yes, please explain: _____

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

10a. Has your child ever been **referred** for a special education evaluation in the past? ☐ No ☐ Yes* **Please complete 10b below*

10b. **If referred for an evaluation*, has your child ever **received** any special education services in the past?

☐
☐

No Yes – Type of services received: _____

Age at which services received *(Please check all that apply):*

☐

Birth to 3 years (Early Intervention)

☐

3 to 5 years (Special Education)

☐

6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ☐ No ☐ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

Month: Day: Year:

Signature of Parent or of Person in Parental Relation

Date

Relationship to student: ☐ Parent ☐ Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ No ☐ Yes

**DATE OF INDIVIDUAL
INTERVIEW:

MO.

DAY

YR.

OUTCOME OF
INDIVIDUAL
INTERVIEW:

☐ ADMINISTER NYSITELL

☐ ENGLISH PROFICIENT

☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL
ADMINISTRATION:

MO.

DAY

YR.

PROFICIENCY LEVEL
ACHIEVED ON
NYSITELL:

☐ ENTERING

☐ EMERGING

☐ TRANSITIONING

☐ EXPANDING

☐ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ Allergies	Type:	
	☐ Medication/Treatment Order Attached	☐ Anaphylaxis Care Plan Attached
☐ Asthma	Type: ☐ Intermittent ☐ Persistent ☐ Other:	
	☐ Medication/Treatment Order Attached	☐ Asthma Care Plan Attached
☐ Seizures	Type:	☐ Date of Last Seizure:
	☐ Medication/Treatment Order Attached	☐ Seizure Care Plan Attached
☐ Diabetes	Type: ☐ 1 Type: ☐ 2	
	☐ Medication/Treatment Ordered Attached	☐ Diabetes Medical Management Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: Consider screening for T2DM if BMI % > 85% and has 2 or more risk factors: Family History 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: ☐ Yes ☐ No ☐ Not Done

Hypertension: ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K
TB-PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥ 5 $\mu\text{g/dL}$
Sickle Cell Screen-PRN	☐	☐		

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings—List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ 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:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for New Entrants, PreK or K, 1, 3, 5, 7, & 11					
Vision	With Correction ☐ Yes ☐ No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
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		☐
Notes:					
Scoliosis Screening Required for Boys grade 9 and Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		☐	☐	☐	☐
Notes:					
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
☐ Family cardiac history reviewed – required for sports (Dominic Murray Sudden Cardiac Arrest Prevention Act)					
☐ Student may participate in all activities without restrictions.					
If Restrictions Apply , complete the information below.					
☐ Student is restricted from participation in:					
☐ Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, or Wrestling.					
☐ Limited Contact Sports: Baseball, Fencing, Softball, or Volleyball					
☐ Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, or Track & Field.					
☐ Other Restrictions:					
☐ Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use the additional space below to explain.					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
MEDICATIONS					
☐ Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
☐ Confirmed free of communicable disease during exam			☐ Record Attached ☐ Reported in NYSIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

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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.

CONDITION / ITEM	NO	YES	DATES	DESCRIPTION	CONDITION / ITEM	NO	YES	DATES	DESCRIPTION
ALLERGIES					MUSCULOSKELETAL				
ALLERGIES: FOOD	☐	☐	_____	_____	BACK/NECK/SPINE PAIN OR INJURY	☐	☐	_____	_____
ALLERGIES: MEDICATION	☐	☐	_____	_____	FRACTURES/DISLOCATIONS	☐	☐	_____	_____
ALLERGIES: INSECT STINGS	☐	☐	_____	_____	JOINT SPRAIN/LIGAMENT TEAR	☐	☐	_____	_____
ALLERGIES: ENVIRONMENT (HAY FEVER)	☐	☐	_____	_____	KNEE INJURY/PAIN	☐	☐	_____	_____
ALLERGIES: OTHER	☐	☐	_____	_____	WEAR BRACE/SPLINT FOR GYM OR SPORTS	☐	☐	_____	_____
ASTHMA					MUSCLE PULLS	☐	☐	_____	_____
EPI-PEN OR INHALER PRESCRIBED?	☐	☐	_____	_____	VISION				
INTERNAL					EYE PROBLEMS/VISION LOSS	☐	☐	_____	_____
BLADDER/KIDNEY INJURY OR PROBLEM	☐	☐	_____	_____	UNCORRECTABLE LOSS OF VISION IN ONE	☐	☐	_____	_____
SPLEEN INJURY	☐	☐	_____	_____	WEAR CORRECTIVE GLASSES/CONTACT LE	☐	☐	_____	_____
STOMACH ULCER	☐	☐	_____	_____	OTHER EYE/VISION PROBLEMS	☐	☐	_____	_____
TESTICULAR PROBLEMS	☐	☐	_____	_____	HEARING				
FAINTING					EAR PROBLEMS/HEARING LOSS	☐	☐	_____	_____
FAINTING SPELLS	☐	☐	_____	_____	HEARING LOSS IN ONE OR BOTH EARS	☐	☐	_____	_____
FAINTING DURING EXERCISE	☐	☐	_____	_____	USE HEARING ASSISTANCE DEVICE	☐	☐	_____	_____
LOSS OF CONSCIOUSNESS FROM BLOW TO HEAD	☐	☐	_____	_____	ORAL				
LOSS OF MEMORY FROM BLOW TO HEAD	☐	☐	_____	_____	HAVE ORTHODONTIC APPLIANCES	☐	☐	_____	_____
CONVULSIONS/SEIZURES	☐	☐	_____	_____	HAVE CAPPED TEETH	☐	☐	_____	_____
CARDIO					DISEASES				
HEART MURMUR	☐	☐	_____	_____	MONONUCLEOSIS	☐	☐	_____	_____
CHEST PAIN	☐	☐	_____	_____	DIABETES	☐	☐	_____	_____
ELEVATED BLOOD PRESSURE	☐	☐	_____	_____	VARICELLA (CHICKEN POX)	☐	☐	_____	_____
OTHER HEART PROBLEM	☐	☐	_____	_____	RHEUMATIC FEVER	☐	☐	_____	_____
					OTHER DISEASES	☐	☐	_____	_____
					OTHER				
					HEADACHES/MIGRAINES	☐	☐	_____	_____
					NOSE BLEEDS (FREQUENT OR SEVERE)	☐	☐	_____	_____
					HAD A SURGICAL PROCEDURE SINCE LAST	☐	☐	_____	_____
					BEEN ILL FOR 5 OR MORE CONSECUTIVE D	☐	☐	_____	_____
					SUDDEN DEATH OF FAMILY MEMBER UNDI	☐	☐	_____	_____
					ONGOING				
					TAKING MEDICATION (PLEASE SPECIFY)	☐	☐	_____	_____
					ANY SIGNIFICANT INJURY SINCE LAST YE	☐	☐	_____	_____
					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 GUARDIAN IS UNAVAILABLE.

CONTACT #1: _____ PHONE #: _____

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PUTNAM VALLEY CENTRAL SCHOOL DISTRICT

171 Oscawana Lake Road • Putnam Valley, NY 10579

AFFIDAVIT OF PROPERTY OWNER/LANDLORD

STATE OF NEW YORK)

COUNTY OF PUTNAM)

_____ being duly sworn deposes and says I am the owner and landlord of the
(Name of Property Owner/Landlord)
premises known and designated as _____ New York. These premises
(Address)
constitute a (multiple dwelling, single dwelling) residence.

_____ is a tenant occupying these premises; occupying same under (oral) (written)
(Name of parent/guardian)
rental agreement commencing on the _____ 20 _____ occupies said residence with
_____ who is a minor and plans to attend School in Putnam Valley. Utilities Included in
(Name of Student)
Lease? (y/n) _____

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

I CERTIFY that the information provided on this form is true and correct and that the statements made herein are being made under the penalties of perjury, knowing that the Putnam Valley Central School District will rely upon them in determining whether the above-named child(ren) will be admitted to its school system. I understand that in the event the information contained in this affidavit is determined to be inaccurate or false, in whole or in part, the District may commence legal proceedings against me personally to collect the costs of educating such child(ren) and/or seek criminal action against me for falsifying business records and/or filing a false instrument.¹

Signature of Property Owner/Landlord: _____

Sworn to before me this _____ day of _____ 20 _____

Notary Public: _____

NOTE: THE DISTRICT RESERVES THE RIGHT TO CONTACT THE APPROPRIATE MUNICIPALITY TO VERIFY THAT THE USE OF THE PREMISES IS IN COMPLIANCE WITH LOCAL LAWS AND CODES. Penal Law §175.05 (Falsifying Business Records in the Second Degree)- Class A Misdemeanor. Penal Law §175.20 (Tampering with Public Records in the Second Degree)- Class A Misdemeanor. Penal Law §175.25 (Tampering with Public Records in the First Degree)- Class D Felony. Penal Law §175.30 (Offering a False Instrument for Filing in the Second Degree)- Class A Misdemeanor. Penal Law §175.35 (Offering a False Instrument for Filing in the First Degree)- Class E Felony.