



**Central Registrar**  
143 Hibbard Road • Horseheads, NY 14845  
(607) 739-5601, x4251 • Fax (607) 795-2435  
[www.horseheadsdistrict.com](http://www.horseheadsdistrict.com)

February 18, 2026

Dear Parent/Guardian:

According to our records, you have a child who will be four years old on or before December 1 of this year, and your primary residence is within the Horseheads Central School District. This makes your child eligible for the Horseheads Central School District Universal Pre-Kindergarten (UPK) Program beginning in September 2026.

We are pleased to invite you to attend UPK registration on one of the following dates:

- Monday, March 9 from 10:00 a.m. to 6:00 p.m.
- Monday, March 16 from 8:00 a.m. to 3:00 p.m.
- Tuesday, March 17 from 10:00 a.m. to 6:00 p.m.

Please note that registration is **by appointment only**. If there is a weather-related closure or delay on the above dates, parents will be notified, and an alternate time will be scheduled.

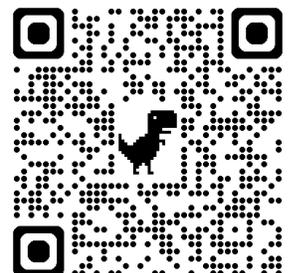
Included in this packet is important information regarding registration and the UPK program. Please take time to read all materials carefully and complete all required forms prior to registration. Note that all pages in this packet are double-sided—be sure to review and complete both sides of each page.

If you have questions regarding UPK online scheduling, registration, or the program itself, please feel free to contact me by phone or email.

Thank you,

*Genie Connel*

Genie Connel  
Central Registrar &  
Information Specialist  
Horseheads Central School District  
(607) 739-5601, x4251  
[gconnel@horseheadsdistrict.com](mailto:gconnel@horseheadsdistrict.com)





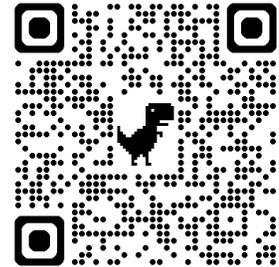


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## We are looking for the Class of 2040! UPK Registration dates for the 2026-27 school year

**Location:** Ridge Road Elementary – 112 Ridge Road, Horseheads, NY 14845 – Room 134  
**Directions:** Please use the side dirt entrance to the 4<sup>th</sup> grade wing due to ongoing construction. The entrance is located diagonally across from the CAN-DO Redemption Center.

Monday, March 9, 2026 – 10am - 6pm  
Monday, March 16, 2026 – 8am - 3pm  
Tuesday, March 17, 2026 – 10am - 6pm



**By appointment only:** Go to <https://cfapps.gstbores.org/hhds/registration/> **or**  
Scan the QR Code to schedule an appointment.

### **Please Bring:**

1. Enclosed registration forms, completed and signed by a parent/guardian.
2. The back of this form filled out with school location preferences.
3. Child's original birth certificate (we will make a copy for district files).
4. Current NYS Required Physical and immunizations from a NYS Medical Provider.
5. Proof of Residency within the Horseheads Central School District.
  - a. Must provide two separate proofs
  - b. Must show recent date, name, and physical address
  - c. See attached documentation for examples of acceptable documents
6. Custody Paperwork (if applicable).
7. **It is not necessary to bring your child to registration.**

**Cost:** Free! Our program is mainly funded by the Universal Pre-Kindergarten (UPK) grant from the state, allowing this program to be at no cost to the families. **\*Note: Transportation is not provided\***

**Eligibility:** Children must be born between December 2, 2021, and December 1, 2022. In accordance with New York State law, children who are eligible for kindergarten or who were born after December 1, 2022, are not eligible to enroll in the Universal Pre-Kindergarten program.

**Lottery:** Please note that placement in our UPK program is not guaranteed, as we have a limited number of Universal Pre-Kindergarten (UPK) openings. Enrollment is not first-come, first-served. If the number of registered students is greater than the number of available UPK spots, we will hold a lottery to determine placement. All children who are eligible and fully registered will be included in the lottery. Names will be drawn until all available spots are filled. Children who are not selected in the lottery will be placed on a waiting list. You can find more details about our district's lottery procedures in the information sheet provided.

**Staffing:** All UPK Classrooms are staffed by certified teachers and teaching assistants. All curriculum guidelines are approved by the New York State Education Department.

**Please be aware that our Universal Pre-Kindergarten Program  
is based on the approval of both State and Local budgets.**

**UPK locations for the 2026-27 school year**

To help inform our process of where eligible students are placed within our UPK program, **please rank each school from 1 (most preferred) to 3 (least preferred)** in order of your location preference. As student names are drawn, the district will attempt to align placement with the preference of families to the extent possible. While UPK placement is not based on your elementary school boundary, attending your zoned elementary school can help your child become familiar with the school before kindergarten.

<b>Big Flats Elementary</b>	<b>Full Day, 9am-2:30pm</b>	_____
<b>Gardner Road Elementary</b>	<b>Full Day, 9am-2:30pm</b>	_____
<b>Ridge Road Elementary</b>	<b>Full Day, 9am-2:30pm</b>	_____

**\*\* Please note that construction at our elementary buildings may impact the availability of UPK classrooms in certain buildings \*\***

Names will be drawn at random, and placements will be made according to parents’ preferences until all available spots are filled. Please note, that placement in the program and location preference, is not guaranteed.

**Before or After Daycare**

The YWCA Kids World Program provides before- and after-school childcare at our elementary schools, based on need and staff availability. Families who require this service are responsible for all associated childcare costs and must contact the YWCA directly to arrange enrollment. To inquire about availability and pricing, please contact the YWCA at 607-733-5575.

**Transportation**

Transportation is not provided by the district until kindergarten.

**How to Schedule an Appointment**

To schedule your UPK Registration Appointment, visit [https://cfapps.gstboeces.org/hhds/registration/](https://cfapps.gstbooces.org/hhds/registration/) **or** scan the QR Code



You will need a valid email address to receive a PIN that allows you to complete your appointment request. On the appointment scheduling site, enter the required information; a PIN will be emailed to you. Use this PIN to continue and finalize your appointment. Once your online scheduling is complete, you will receive a confirmation email with your appointment date and time.

If you do not have internet access or a valid email address, please contact Genie Connel, Central Registrar, at 607-739-5601 ext. 4251 or [gconnel@horseheadsdistrict.com](mailto:gconnel@horseheadsdistrict.com) to schedule an appointment.

## Universal Pre-Kindergarten (UPK) Lottery Information

### Why a Lottery?

When the number of eligible children is greater than the number of available UPK spots, a lottery (random selection process) is used. This ensures that placement is handled in a fair and transparent way for all families.

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### Who Can Participate?

To be eligible for the Horseheads Central School District's UPK program:

- Your child must be four years old on or before December 1 of the school year they will attend.
  - Your family must live within the Horseheads Central School District boundaries.
- 

### How Registration Works

- Registration materials are shared each year in February and March through district mailings, the district website, and social media.
  - Parents/guardians must complete the registration packet and submit it with required proof of age and residency by the stated deadline to be included in the lottery.
- 

### How the Lottery Works

- The lottery is held after the registration deadline.
  - It is conducted by the Central Registrar using a random selection method (such as a computer randomizer or number drawing).
  - The lottery is conducted in the presence of two impartial witnesses to ensure fairness.
  - Names are drawn until all UPK spots are filled.
  - Additional names are drawn to create a waiting list in case spots become available later.
- 

### After the Lottery

- Families will receive an email within one week of the lottery with their child's placement or waiting list status.
- If your child is offered a UPK spot, you'll have one week to confirm acceptance. If a spot is declined, it will be offered to the next child on the waiting list.
- The district keeps lottery records and results for at least one year, and the process is reviewed annually by the Superintendent as part of state requirements.

**Please be aware that our Universal Pre-Kindergarten Program  
is based on the approval of both State and Local budgets.**

# Acceptable Proofs of Residency

To register your child, the Horseheads Central School District requires **two (2)** current proofs of residency.

Each document must include your **name and current address** and be **dated within the past month**.

## Examples of Acceptable Documents

- A driver's license or government-issued photo ID showing your current district address
- A recent utility bill (gas, electricity, water, or phone)
- A deposit receipt for new utility service (gas, electricity, or phone)
- A payroll stub with your current address
- A bank contract or mortgage statement showing home ownership with your name and address
- A signed and dated lease or rental agreement, including the landlord's name, address, and phone number, or a DSS-processed landlord statement
- A current bank statement with your name and address printed (the district may verify the account with the bank)
- A change-of-address confirmation from the U.S. Postal Service or business mail postmarked with your address
- A receipt from a moving company or local business showing delivery of newly purchased major furniture or appliances
- Income tax documents (e.g., W-2, 1099-INT)
- A voter registration document
- Official correspondence from a federal, state, or local government agency (e.g., Department of Social Services, Office of Refugee Resettlement)

## Important Reminders & Information

- Child must be 4 years old on or before December 1, 2026
- Eligible birthdates: December 2, 2021 – December 1, 2022
- Must reside in the Horseheads Central School District
- Children eligible for kindergarten or born 12/2/22 or after are not eligible
- Registration is by appointment only. If these dates and times do not work for you, please contact Genie Connel, Central Registrar, 607-739-5601 ext. 4251 or [gconnel@horseheadsdistrict.com](mailto:gconnel@horseheadsdistrict.com).
- Remember to bring all completed and signed paperwork, as well as Birth Certificate, proof of residence, and any custody paperwork (if applicable). We have a copier on site.
- Ensure you rank each elementary school based on preference; we will try to honor your preference, but it is not guaranteed. PreK is not tied to an elementary school boundary, however students will be required to attend their home boundary school for kindergarten.
- Placement is not guaranteed.
- Student building placement will take place during the **last week of May**; this is dependent on State and local budget approvals. If a lottery becomes necessary, parents will be notified.
- You will be notified of your child's building placement in the **first week of June**; this is dependent on State and Local budget approvals. If the status of State and Local budgets delay building placement, you will be notified.

Horseheads Central School District  
2026-27 Pre-Kindergarten Registration Form

Please print clearly in ink.

Student Name \_\_\_\_\_ Gender Male or Female  
Last First Middle (circle)

Student resides with \_\_\_\_\_ Both Father & Mother \_\_\_\_\_ Mother Only \_\_\_\_\_ Father Only  
(check one)  
\_\_\_\_\_ Legal Guardian (specify relationship to child) \_\_\_\_\_

Name(s) of Adults this Student lives with \_\_\_\_\_

If both parents do not reside in same household, please answer below and provide documentation of custody agreement.

Custody is: \_\_\_\_\_ Sole \_\_\_\_\_ Joint \_\_\_\_\_ Protection Order

Physical Custody with \_\_\_\_\_ Legal Custody with \_\_\_\_\_

Please Note: we will do most of our placement notification by e-mail, so please provide an e-mail address that is checked regularly.

E-mail Address: \_\_\_\_\_

\*\*\*\*\*

Student's Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_  
mm/dd/yyyy city, state country

If birthplace was not in the United States, please give the date and location the student was first enrolled in a US School:

\_\_\_\_\_ Number of Years in U.S. Schools \_\_\_\_\_  
date location

Has the student ever previously attended another New York State School? \_\_\_\_\_ No \_\_\_\_\_ Yes (if yes, how many years has this student attended in a NYS School? \_\_\_\_\_)

Is the student Hispanic, Latino or of Spanish origin (a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race)? \_\_\_\_\_ No \_\_\_\_\_ Yes, Hispanic

Please circle one or more races that apply to this student from the following 5 racial groups:

American Indian or Alaskan Native Asian Black White Native Hawaiian or Other Pacific Islander

\*\*\*\*\*

Is this student under your care as a foster child? \_\_\_\_\_ No \_\_\_\_\_ Yes (if yes, please complete a & b below)

a. If yes, in what school district does the student's parent reside? \_\_\_\_\_

b. Caseworker Name and Telephone Number \_\_\_\_\_  
Name Telephone (w/ area code)

\*\*\*\*\*

Is this child's mother, father, or legal guardian Active Duty Military or a civilian working on a military post? \_\_\_\_\_ No \_\_\_\_\_ Yes (if yes, please state who below)

*\* Please be aware that the program depends upon the approval of both the State and Local budgets \**

Please also complete the reverse side

Does this student have a current IEP (Individualized Education Plan)? \_\_\_\_\_ No \_\_\_\_\_ Yes

Does this student receive any support services? \_\_\_\_\_ No \_\_\_\_\_ Yes

If you answered Yes to either of the above questions, please complete an "Additional Education Services Information" form.

\*\*\*\*\*

Does the student have any health/special needs? \_\_\_\_\_ No \_\_\_\_\_ Yes (if yes, please explain below)

\_\_\_\_\_

\*\*\*\*\*

**Parent/Guardian Statement**

I understand that proof of New York State required immunizations for polio, mumps, measles, diphtheria, hepatitis, and rubella from a physician or clinic is required for admission to school. If there is a medical or religious exemption, statements of such must be presented. Failure to present either proof of immunization or exemptions will result in the exclusion of the pupil from school until such time as an appropriate immunization statement is submitted.

I certify that the information provided is accurate to the best of my knowledge and that I have legal custody of the above named child.

Signature \_\_\_\_\_ Date \_\_\_\_\_

***\* Please be aware that the program depends upon the approval of both the State and Local budgets \****

\*\*\*\*\*

**\* Below for District Use Only \***

Date Registered \_\_\_\_\_

Reg. Number \_\_\_\_\_

Student ID \_\_\_\_\_

Home School BF GR RR

Placed in BF GR

Notified parent \_\_\_\_\_ by phone or email

**Parent presented the following documentation:**

- \_\_\_\_\_ Proof of Residency (two) \_\_\_\_\_
- \_\_\_\_\_ Original Birth Certificate (reviewed by \_\_\_\_\_) initials
- \_\_\_\_\_ Immunizations (must receive within 14 days)
- \_\_\_\_\_ Physical dated \_\_\_\_\_
- \_\_\_\_\_ Custody Papers (if applicable)
- \_\_\_\_\_ Lead Assessment Questionnaire
- \_\_\_\_\_ Dental Certificate

\*\*\*\*\*

**\* Below for Central Registrar Use Only \***

Family ID \_\_\_\_\_

Residence Link \_\_\_\_\_

SMS Updated \_\_\_\_\_

Census dbase Updated \_\_\_\_\_

Central Registrar Initials and Date: \_\_\_\_\_

**Horseheads Central School District  
Household Information Form**

Please list ALL children under 21 residing in the household, include date of birth and grade (if applicable).

Student Name (last, first, middle)	Date of Birth	Grade	Student Name (last, first, middle)	Date of Birth	Grade
1			4		
2			5		
3			6		

Please list the residential address and mailing address for the above children and please note that proof of residency in the Horseheads district is required at the time of registration.

Residence

\_\_\_\_\_

house number                      street name                      apt or lot #

\_\_\_\_\_

city    state    zip code

Mailing

(if different  
from Residence)

\_\_\_\_\_

house number                      street name                      apt or lot #

\_\_\_\_\_

city    state    zip code

Is this address a temporary living arrangement?  No  Yes    If Yes, is this living arrangement due to loss of housing or economic hardship?  No  Yes    If both are yes, please complete a Student Residency Questionnaire.

Information on Adults who are living with children	1 <sup>st</sup> Adult Guardian living at above address Primary Contact			2 <sup>nd</sup> Adult Guardian living at above address Secondary Contact		
	Father	Mother	Step-Parent	Father	Mother	Step-Parent
Relationship to children (circle one)	Other (specify) _____			Other (specify) _____		
Parent/Guardian Name (last, first)						
Landline Telephone	( )	-		( )	-	
Cell Phone	( )	-		( )	-	
Employer						
Work Telephone	( )	-	ext	( )	-	ext
E-mail Address						

If the natural mother and/or father do not live with the children at above address, please list their information below:

Parent/Guardian Information	1 <sup>st</sup> Parent NOT living at above address			2 <sup>nd</sup> Parent NOT living at above address		
	Father	Mother	Step-Parent	Father	Mother	Step-Parent
Relationship to children (circle 1)						
Parent Name (last, first)						
Address (street address) (city, state, zip)						
Landline Telephone	( )	-		( )	-	
Cell Phone	( )	-		( )	-	
Employer						
Work Telephone	( )	-	ext	( )	-	ext
E-mail Address						
Is this parent allowed to have contact with children?		Yes      No			Yes      No	
Should this parent receive mailings such as report cards?		Yes      No			Yes      No	

Please also complete the reverse side

Emergency Contacts Other than Parents/Guardians

It is mandated, in case a parent or legal guardian cannot be reached during the school day, to give the names of two **nearby** relatives or reliable neighbors who will come for and take care of your child should he/she become ill or injured during the school day. All attempts will be made to reach parents first. If they are not reachable, the school will attempt to reach the emergency contacts below:

<b>Adults other than Parents or Legal Guardians</b>	<b>1<sup>st</sup> Emergency Contact</b>	<b>2<sup>nd</sup> Emergency Contact</b>
Emergency Contact Name (last, first)		
Landline Telephone	(     )     -	(     )     -
Relationship to children (i.e. grandparent, sitter, neighbor)		
Address (street address) (city, state, zip)		
Cell Phone	(     )     -	(     )     -

If you have any specific custody arrangements or issues that the Horseheads Central School district needs to be aware of, please use the space below to explain. Please note that you must provide proof of custody.

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Please list the name, date of birth and special needs (if any) of any child younger than Kindergarten living in your home:

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I certify that the information provided is accurate to the best of my knowledge and that I have legal custody of the above named children.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

The district is collecting your phone number for communications purposes. By providing phone number(s) on this document, you agree that the district may contact you by phone, text, or email (including auto-calls and auto-emails) regarding school emergencies, events, and other communications, including, but not limited to, attendance calls, lunch balance calls, and school event reminders.

**Please note: Proof of residency in the Horseheads district is required at the time of registration.**



Lisette Colón-Collins, Assistant 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 Guardian:  
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.*

Please write clearly when completing this section.		
<b>STUDENT NAME:</b>		
_____		
First	Middle	Last
_____	_____	_____
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
Month	Day	Year
_____	_____	_____
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
_____		
_____	_____	_____
Last Name	First Name	Relation to Student

HOME LANGUAGE CODE

_____
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### Language Background (Please check all that apply.)

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

### 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

<b>Educational History</b>
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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *If yes, please explain: _____
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes*    *Please complete 10b below
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____
Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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? _____

_____ <i>Signature of Parent or of Person in Parental Relation</i>	Month:    Day:    Year: _____ <i>Date</i>
Relationship to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <small>MO.    DAY    YR.</small>	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <small>MO.    DAY    YR.</small>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:  _____ _____	

**Horseheads Central School District**  
***Parent Portal Registration***

A Parent Portal account allows parents to electronically view their child's grades, assignments, and attendance from the SchoolTool website. **A valid email address is required.**

***Please note: In order to sign up for the Parent Portal, you must visit the office of the school your child attends, complete this form and show proper ID. Thank you.***

Date \_\_\_\_\_

Student Name \_\_\_\_\_

Grade \_\_\_\_\_

Student Address \_\_\_\_\_

house number

street name

apt or lot #

City

State

Zip Code

Parent Name \_\_\_\_\_

Phone \_\_\_\_\_

E-Mail Address (**required**) \_\_\_\_\_

Parent Address (if different from student)

house number

street name

apt or lot #

City

State

Zip Code

**User Authorization Agreement - Required**

As a user of the Horseheads Central School District Parent Portal, I agree not to:

- Obtain unauthorized access to and use of an account for purpose other than those for which they were permitted to the user (do not share accounts).
- Read or use private files/data without proper authorization.
- Divulge the contents of any database holding personal and confidential information related to children, parents, or school business operations.
- Attempt, without authorization, to modify system software.
- Use the mail system to send, store or forward unsolicited, non-educational personal messages.
- Use another person's name to fraudulently send or receive messages.

I have read fully and agree to abide by the above:

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**For Office Use Only:** Date \_\_\_\_\_ ID checked \_\_\_\_\_  
Custodial or Non Custodial Staff Initials \_\_\_\_\_





# Horseheads Central School District

## ***Parents as Partners*** ***Questionnaire for Pre-Kindergarten***

My child's name: \_\_\_\_\_

My child's birthday: \_\_\_\_\_

Parent(s)/Guardians name(s): \_\_\_\_\_

Here is a list of children starting Pre-K in a Horseheads class who my child is related to or neighbors with:

\_\_\_\_\_  
\_\_\_\_\_

Has your child attended an educational setting/daycare?  Yes  No

If so, where? \_\_\_\_\_

Has your child received CPSE and/or Early Intervention Services?  Yes  No

If Yes, please check:  OT  PT  Speech  SEIT

My child can do the following things by himself/herself:

- |  |   |
|--|---|
| <input type="checkbox"/> cut with scissors | <input type="checkbox"/> dress without help             |
| <input type="checkbox"/> put on shoes      | <input type="checkbox"/> put on coat                    |
| <input type="checkbox"/> zip clothing      | <input type="checkbox"/> independently use the bathroom |

*continued...*

My child demonstrates the following on a regular basis:

- |   |  |
|---|--|
| <input type="checkbox"/> relationships with friends | <input type="checkbox"/> listening to others |
| <input type="checkbox"/> respect for others         | <input type="checkbox"/> self-esteem         |
| <input type="checkbox"/> paying attention to others | <input type="checkbox"/> self-control        |

Sometimes my child has trouble doing these things, or may need help learning how to do them better:

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Here are some things I would like you to know about our family:

(Examples – traditions, holidays celebrated, holidays not celebrated, life experiences, culture, any other languages spoken at home, any restrictive diet due to allergies or culture, any other information you would like me to know)

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for sharing your child's information with me!

This information is great for me to get to know your child better.



## Comprehensive Interdisciplinary Developmental Services, Inc.

1580 Lake St.

Suite 1

Elmira, New York 14901

(607) 733-6533 Fax: (607) 733-0939

**Kacey O. Gergel, M. Ed**

Executive Director

Dear Parent/Guardian:

C.I.D.S. is an agency that offers various services to all children in Chemung County. One of the services C.I.D.S. provides is **free developmental screenings** for children from birth to age five. These screenings are a great tool to see how your child is learning and growing. The screenings are not meant to provide a diagnosis, but will help to identify possible areas of development that may need further review. New York State requires screenings for all children entering Pre-Kindergarten. CIDS is pleased to partner with the Horseheads Central School District to provide these screenings.

### What Is a Developmental Screening?

Your child will take part in a **short, play-based activity** during the school day. We look at:

- Movement and hand skills
- Talking and understanding language
- Playing and social skills
- Learning and problem-solving
- **Vision and hearing screens are also completed at this time.**

### What to Expect:

- Fun, child-friendly activities
- No preparation needed
- Development screenings only take approximately 20 minutes

If a screening shows an area that may need follow-up, our team will contact you and help guide next steps.

Please bring the completed permission form with you stop by the CIDS table at registration. There you will also sign up for an appointment day/time for your child's screening. We look forward to meeting you!

📍 Screening dates: **July 20-23 and July 27-30**

📍 Screening location: **CIDS Office  
1580 Lake St. Suite 1  
Elmira, NY 14901**

If you would like more information regarding the screening process, please call our office at **607-733-6533** to speak with a Developmental Screening Associate. We will be very happy to answer any questions.

Sincerely,

*Cassandra Gerow & Sandy Space*

Cassandra Gerow & Sandy Space  
Early Childhood Screening Team  
CIDS





**ADDITIONAL INFORMATION**

Check any illness or conditions your CHILD has now or has had in the past.

- Allergies     Hay Fever     Asthma     Constant Cold     Ear Infections     Tonsillitis
- Ear Tubes     Seizures     Encephalitis     Loss of Skills     Whooping Cough     Tics

Other: \_\_\_\_\_

Please check any behaviors which pose a problem for your CHILD at this time. (For children 3 years or older)

- Drooling     Anxious     Too Active     Wets Bed     Difficulty Chewing or Swallowing
- Stuttering     Too Shy     Distractible     Clings to Caregiver/Others     Difficulty Sleeping
- Can't Toilet Train     Difficulty Regulating Emotions     Child Unaware of Others/Surroundings

Other: \_\_\_\_\_

Prenatal Care: Was there regular prenatal care?     Yes     No    Birth Weight \_\_\_\_\_

Premature    Weeks Early \_\_\_\_\_

Mother's health during pregnancy for this child: Please check appropriate items.

- Anemia     Diabetes     Surgery     Bleeding     Convulsions     Pre-Eclampsia
- Bed Rest     Edema     Accident     Hypertension     Anxiety

Is there family history of any of the following with regard to the CHILD'S parents, grandparents or siblings?

- Seizures     Convulsions     Anemia     Asthma     Learning Disability     Allergies

Please list all additional people living in your home other than those listed on the front page.

<u>Name</u>	<u>Age</u>	<u>Gender</u>	<u>Relationship to Child</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any specific concerns that you would like the screeners to know at this time?

\_\_\_\_\_  
\_\_\_\_\_



## Pre-K Registration Health Documentation Checklist

Dear Parent/Guardian,

Our school nurses are excited to welcome your student to Pre-K and look forward to supporting their health and safety as they begin school. To help ensure a healthy start, we are required to collect specific health information for your student's school record. Please review the requirements below.

**Health Examination (Physical):** A current physical is required for all new students and for specific grade levels, including Pre-K. Exams must be completed by a New York State licensed provider and documented on the NYS School Health Examination Form (available from your provider or the district website). Physicals must be submitted within 30 days of school entry.

**Immunizations:** New York State Public Health Law requires all students to meet state immunization requirements. Our school nurses can access most in-state vaccination records through the New York State Immunization Information System (NYSIIS); however, please provide official documentation for any immunizations your child received out of state or for any vaccines that do not appear in the NYSIIS registry.

**Health History for School Admission form:** Submitting a completed health history form is important because it gives the nurse essential information to keep your student safe at school. It helps us understand any medical needs, medications, allergies, or conditions so we can provide the right care and respond quickly in an emergency.

**Dental Health Certificate:** A Dental Health Certificate is requested for all new students and for specific grade levels, including Pre-K. Forms are available from your dental provider or the district website. This certificate is requested but not required for registration.

**Lead Screening:** Schools must request documentation that children entering Pre-K or Kindergarten received routine lead testing at ages 1 and 2. Our school nurses can view lead test results that have been entered into the state system; however, please submit documentation if testing was completed out of state or does not appear in the system. If your child has not yet been tested, please contact your healthcare provider to arrange it.

**Medical Release of Information:** This optional form allows the school nurse to request and receive your student's required physical exam, immunization records, and other necessary health documentation directly from your child's healthcare provider.

**Medication at School:** A medical provider's written order and parent/guardian signature are required for all medications given at school, including over-the-counter items.

**Activity Restrictions:** If your student has an injury, physical limitation, or medical condition that may affect participation in gym, recess, or any part of the school day, please provide a note from a licensed healthcare provider.

For any health-related questions or concerns, please contact your school nurse or the district nurse practitioner.

Kristen Raniewicz FNP-C, District Nurse Practitioner

Phone: (607) 739-5601 ext. 1769, Fax: (607) 795-2510, Email: [kraniewicz@horseheadsdistrict.com](mailto:kraniewicz@horseheadsdistrict.com)



## Health History for School Admission

<b>Legal Name:</b>	<b>DOB:</b>
<b>Affirmed (preferred) Name</b> (if applicable):	
<b>Sex Assigned at Birth:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	(if applicable): <b>Gender Identity:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> Other: <b>Pronouns:</b> <input type="checkbox"/> She/Her <input type="checkbox"/> He/Him <input type="checkbox"/> They/Them <input type="checkbox"/> Other:
<b>Primary Care Provider:</b>	<b>Dentist:</b>
<b>Grade:</b>	<b>Date Form Completed:</b>
<b>To be completed and signed by Parent/Guardian – Give details to any YES answers on the last page</b>	

<i>Does or Has Your Student</i>		
General Health	YES	NO
<b>Have an ongoing medical condition?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Take any medication?</b>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list name and reason for taking:		
<b>Ever Had Surgery?</b>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list:		
<b>Spent the night in the hospital?</b>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, why?		
<b>Current injuries/restriction from activity?</b>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, why?		
Allergies & Anaphylaxis	YES	NO
<input type="checkbox"/> <b>Food allergy:</b> <i>If yes, list:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b>Medication allergy:</b> _____		
<input type="checkbox"/> <b>History of anaphylaxis</b>		
<input type="checkbox"/> <b>Carries epinephrine auto-injector</b>		
<input type="checkbox"/> <b>Insect sting allergy</b>		
<input type="checkbox"/> <b>Animal allergy:</b> _____		
<input type="checkbox"/> <b>Latex allergy</b>		
<input type="checkbox"/> <b>Environmental allergy (pollen, etc.)</b>		
<input type="checkbox"/> <b>Other:</b> _____		

<i>Does or Has Your Student</i>		
Neurodevelopmental Conditions	YES	NO
<input type="checkbox"/> <b>Autism</b>		
<input type="checkbox"/> <b>ADHD</b>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b>Developmental Delay/Learning Differences</b>		
<input type="checkbox"/> <b>Speech/Language Disorder</b>		
<input type="checkbox"/> <b>Intellectual Disability</b>		
<input type="checkbox"/> <b>Sensory Processing Disorder</b>		
<input type="checkbox"/> <b>Other:</b> _____		
Mental & Emotional Health	YES	NO
<input type="checkbox"/> <b>Anxiety</b>		
<input type="checkbox"/> <b>Depression</b>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b> OCD</b>		
<input type="checkbox"/> <b> ODD</b>		
<input type="checkbox"/> <b>Mood Disorder</b>		
<input type="checkbox"/> <b>PTSD/Trauma related concerns</b>		
<input type="checkbox"/> <b>Receiving counseling/therapy</b>		
<input type="checkbox"/> <b>Other behavioral concerns</b>		
<input type="checkbox"/> <b>Other:</b> _____		
Neurologic Conditions	YES	NO
<input type="checkbox"/> <b>History of concussion or head injury</b> <i>If yes, date(s):</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b>Seizure disorder or epilepsy</b> <i>If yes, type:</i> <input type="checkbox"/> Tonic–Clonic <input type="checkbox"/> Focal <input type="checkbox"/> Absence <input type="checkbox"/> Febrile <input type="checkbox"/> Other: _____  <i>Date of last seizure:</i> _____		
<input type="checkbox"/> <b>Migraines or frequent/recurrent Headaches</b>		
<input type="checkbox"/> <b>Tic disorder / Tourette Syndrome</b>		
<input type="checkbox"/> <b>Neuromuscular disorder</b> <i>(e.g., muscular dystrophy, weakness, motor coordination disorder)</i>		
<input type="checkbox"/> <b>Other:</b> _____		

<b>Legal Name:</b>	<b>DOB:</b>
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<i>Does or Has Your Student</i>		
Musculoskeletal Conditions	YES	NO
<input type="checkbox"/> Orthopedic injury <input type="checkbox"/> Joint problems <input type="checkbox"/> Scoliosis <input type="checkbox"/> Hyperflexibility/Ehlers–Danlos <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Conditions	YES	NO
<input type="checkbox"/> Asthma <input type="checkbox"/> Reactive Airway Disease <input type="checkbox"/> Chronic respiratory illness <input type="checkbox"/> Uses inhaler or nebulizer <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine / Metabolic Conditions	YES	NO
<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Growth/endocrine disorder <input type="checkbox"/> Hypoglycemia concerns <input type="checkbox"/> Metabolic condition <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
ENT (Ear, Nose, Throat)	YES	NO
<input type="checkbox"/> Hearing impairment <input type="checkbox"/> Wear a hearing aid <input type="checkbox"/> Vision issues / one functioning eye <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal & Nutrition	YES	NO
<input type="checkbox"/> Reflux/GERD <input type="checkbox"/> Chronic constipation <input type="checkbox"/> Special diet or food restrictions <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

<i>Does or Has Your Student</i>		
Renal / Genitourinary	YES	NO
<input type="checkbox"/> Kidney disease <input type="checkbox"/> Urinary condition <input type="checkbox"/> One functioning GU/GI organ <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Skin Conditions	YES	NO
<input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart & Blood Conditions	YES	NO
<input type="checkbox"/> Heart condition: _____ <input type="checkbox"/> Fast or slow heart rate <input type="checkbox"/> Heart murmur <input type="checkbox"/> High/low blood pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Blood disorder <input type="checkbox"/> Sickle cell trait/disease <input type="checkbox"/> Implantable cardiac defibrillator <input type="checkbox"/> Followed by a cardiologist <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Medical Devices & Supports	YES	NO
<input type="checkbox"/> Glucose monitor (CGM) <input type="checkbox"/> Insulin pump <input type="checkbox"/> Orthotics / braces <input type="checkbox"/> Wheelchair / mobility device <input type="checkbox"/> Ostomy <input type="checkbox"/> Require any other medical services at school? _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

**If you answered YES to any questions above, or if there is anything else the school nurse should know, please provide details or additional information below:**


**I certify that the information provided is accurate to the best of my knowledge:**

Parent/Guardian Signature:	Date:
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# CONSENT FOR RELEASE OF INFORMATION

**HORSEHEADS CENTRAL SCHOOL DISTRICT  
143 HIBBARD RD  
HORSEHEADS, NY 14845**

<b>Student Name:</b>	<b>Date of Birth:</b>	<b>Gender:    M   F   NB</b>
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**This form permits the mutual exchange of information between the following parties:**

<b>Horseheads Central School District 143 Hibbard Rd. Horseheads, NY 14845</b>	<b>Medical Provider Name: _____ Medical Office Name: _____ Address: _____ Phone Number: _____</b>
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**Extent or Nature of Information to be Released:**

<input checked="" type="checkbox"/> <b>Medical records and evaluations</b> <input checked="" type="checkbox"/> <b>Immunization records</b> <input type="checkbox"/> <b>Other (specify): _____</b>	
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**Purpose or Need for Information:**

<b>The information will be used in relation to services provided in the educational environment.</b>
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**Acknowledgement of Terms of Release of Information:**

<ol style="list-style-type: none"><li>1. I understand that I may revoke this authorization at any time by notifying, in writing, either of the parties listed above; however, that revocation won't have any effect on any actions taken before the receipt of the revocation.</li><li>2. I acknowledge, and hereby consent, that the released information may contain alcohol, drug abuse, HIV testing, HIV results, or AIDS information. If I do <u>not</u> consent to the release of such information, I must initial here. _____ (Initials)</li><li>3. I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal medical privacy regulations.</li><li>4. I understand that the person or organization providing the information may not condition my treatment, payment for that treatment, enrollment or eligibility for benefits on my signing this authorization.</li><li>5. I understand that I may refuse to sign this authorization and that it is strictly voluntary.</li></ol>
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I hereby authorize the release of the information indicated above. I understand that the information to be released is confidential and protected from disclosure. If the signer is not the student, I further certify that I am the parent or legally appointed guardian of the student and have the authority to sign this release for the above-referenced student.

This consent to release information will be in effect until the student is no longer enrolled in the Horseheads Central School District or otherwise revoked, whichever is sooner.

<b>Signature of student/person acting for student:</b>	<b>Relationship</b>	<b>Date Signed</b>		
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# Horseheads Central School District

*Child's Name* \_\_\_\_\_ *Date* \_\_\_\_\_

*Parent/Guardian* \_\_\_\_\_ *District RN Initials* \_\_\_\_\_

## *Lead Exposure Risk Assessment Questions*

In addition to the required screening at ages one and two, assessments of risk for high-dose lead exposure should be done at least annually for each child six months to six years of age. The following questions serve as a risk assessment tool based on currently accepted public health guidelines. Children found to be at risk for lead exposure should receive a blood lead test whenever such risk is identified.

<i>Risk Assessment Questionnaire</i>	Yes	No
<p>1. Does your child live in or regularly visit a house/building built before 1978 with peeling or chipping paint, or with recent, ongoing or planned renovations or remodeling</p> <p>Note: This could include a day care center, preschool, and the home of a babysitter or a relative.</p>		
<p>2. Has your family/child ever lived outside the United States or recently arrived from a foreign country?</p>		
<p>3. Does your child have a brother, sister, housemate or playmate being or treated for lead poisoning?</p>		
<p>4. Does your child frequently put things in his/her mouth such as toys, jewelry, or keys? Does your child eat non-food items (pica)?</p> <p>Note: Should emphasize the possibility of mouthing behaviors on toys due to the recent recalls.</p>		
<p>5. Does your child frequently come in contact with an adult whose job or hobby involves exposure to lead?</p> <p>Note: Jobs such as house painting, renovations, construction, welding or making. Hobby examples are making stained glass or pottery, fishing, making firearms and collecting lead figurines.</p>		
<p>6. Does your child live near an active lead smelter, battery recycling plant, or another industry likely to release lead or does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?</p> <p>Note: May need to alert parent/caregiver if such an industry is local. Ask any additional questions that may be specific to situations in a particular community.</p>		

*If the answer to any of the above questions is YES, then the child is considered to be at risk of high dose lead exposure and should be screened with a blood lead test*

# REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

## TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

**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: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

### HEALTH HISTORY

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

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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/m<sup>2</sup>

**Percentile (Weight Status Category):**  < 5<sup>th</sup>  5<sup>th</sup>- 49<sup>th</sup>  50<sup>th</sup>- 84<sup>th</sup>  85<sup>th</sup>- 94<sup>th</sup>  95<sup>th</sup>- 98<sup>th</sup>  99<sup>th</sup> and >

**Hyperlipidemia:**  Yes  Not Done      **Hypertension:**  Yes  Not Done

### PHYSICAL EXAMINATION/ASSESSMENT

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Lead Level</b> Required for PreK & K
TB-PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

**System Review Within Normal Limits**

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid	

Name:		Affirmed Name (if applicable):			DOB:	
<b>SCREENINGS</b>						
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11						
<b>Vision Screening</b>	<b>With Correction</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>	
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>	
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>	
Color Perception Screening		<input type="checkbox"/> Pass <input type="checkbox"/> Fail			<input type="checkbox"/>	
Notes						
<b>Hearing Screening:</b> 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.					<b>Not Done</b>	
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes		<input type="checkbox"/>	
Notes						
<b>Scoliosis Screening:</b> Boys grade 9, Girls grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	
<b>FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK</b>						
<input type="checkbox"/> <b>*Family cardiac history reviewed</b> – required for Dominick Murray Sudden Cardiac Arrest Prevention Act						
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b>						
<b>If Restrictions Apply</b> – Complete the information below						
<input type="checkbox"/> <b>Student is restricted from participation in:</b>						
<input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.						
<input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.						
<input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.						
<input type="checkbox"/> <b>Other Restrictions:</b>						
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level.						
<b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V						
<input type="checkbox"/> <b>Other Accommodations*:</b> Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):						
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.						
<b>MEDICATIONS</b>						
<input type="checkbox"/> Order Form for medication(s) needed at school attached						
<b>COMMUNICABLE DISEASE</b>				<b>IMMUNIZATIONS</b>		
<input type="checkbox"/> Confirmed free of communicable disease during exam				<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
<b>HEALTHCARE PROVIDER</b>						
Healthcare Provider Signature:						
Provider Name: <i>(please print)</i>						
Provider Address:						
Phone:				Fax:		
<b>Please Return This Form to Your Child's School Health Office When Completed.</b>						

## **UPK Registration Checklist**

Please review this list carefully and bring all required items to your registration appointment. Incomplete packets or missing documents may delay processing.

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### **Before Your Appointment**

- Read all materials in the registration packet thoroughly (both sides of each page).
  - Rank your UPK location preferences (1–3) on the registration form.
  - Schedule your registration appointment using the online scheduling link and PIN emailed to you.
  - Confirm your appointment date and time by checking your confirmation email.
  - If you do not have internet access or an email address, call Genie Connel, Central Registrar, at 607-739-5601 ext. 4251 or email [gconnel@horseheadsdistrict.com](mailto:gconnel@horseheadsdistrict.com) to schedule your appointment.
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### **Documents to Bring**

- Child's proof of age – original birth certificate or passport. Please bring original documents (copies cannot be accepted for proof of age). We will make copies and return the originals to you.
  - Two current proofs of residency (dated within the last month of your appointment date) showing parent/guardian name and district address. Please see the attached information regarding acceptable proofs of residency.
  - Completed & Signed Registration Paperwork
- 

### **At Your Appointment**

- Arrive on time to your scheduled appointment at Ridge Road Elementary School, 112 Ridge Road, Horseheads, NY 14845.
  - Use the side dirt entrance (across from the CAN-DO Redemption Center) due to construction.
  - You will be buzzed in and escorted to room 134.
  - Submit all required documents to complete registration.
  - You will speak with the central registrar, district nurse, and CIDS. Appointment will take approximately 10-15 minutes.
  - Ask any questions you may have regarding the lottery process, location preferences, or before/after care options (YWCA Kids World).
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### **After Your Appointment**

- Watch for an email notification at the beginning of June, for location placement. If a lottery becomes necessary, parents will be notified.
  - Confirm your child's location placement within one week of notification.
  - If requested, please turn in any additional paperwork needed, as soon as possible.
-