RENT WITH LEASE

VALLEY CENTRAL SCHOOL DISTRICT

ANTICIPATED UNIVERSAL PREKINDERGARTEN APPLICATION 2025-2026

Applications give eligible students access to be included in the *random lottery selection process. Please be reminded that completion of this application does not guarantee enrollment for your child in the Valley Central School District Universal Prekindergarten Program.

Please complete all required parts of the UPK application. Please make sure that all forms (front and back) are completely filled out, signed, and dated. **WE CANNOT MAKE PHOTOCOPIES FOR YOU. YOU MUST PROVIDE YOUR OWN COPIES.** In addition to the attached forms, the following items must be provided:

1. Copy of Birth Certificate **(UPK applicants must be 4 years old on or before December 1, 2025. Five year olds are not eligible per New York State Regulations)**
2. Immunization Record
3. Proof of Residency (see "Documents" #15-#16 on page 2 and Proof of Address List on page 3)
4. Custody/Legal Guardianship Papers (if applicable)

FEBRUARY 14, 2025

All eligible applications received by 4:00 pm on February 14, 2025 will be included in the lottery. All eligible applications received after 4:00 PM on February 14, 2025 will be placed on the waiting list.

We accept UPK applications all year long!

RETURN APPLICATIONS TO:

Tammy Coleman/UPK
Central Office Administration
944 State Route 17K
Montgomery, NY 12549

Applications can be mailed to the address above or dropped off at the front desk of the Central Office Administration building between the hours of 9:00 AM – 3:00 PM. UPK staff are unable to answer questions or personally accept your application if you choose to drop it off. If you have any questions about the application or required documentation, please call or email the UPK Office ***BEFORE*** bringing your application to the Central Office Administration building at (845) 457-2400 ext. 18134 or UPK@vcsdny.org.

***Random Lottery Selection Process**

Applications for half-day, full-day, and expanded-day prekindergarten will be accepted beginning on January 23, 2025 and ending on February 14, 2025. As required by the NYS Commissioners' Regulations, a random lottery selection process has been developed for choosing all prekindergarten students who will utilize the grant funds. After the application deadline each eligible application will be numbered and chosen randomly by the Board of Education and/or its designee. ALL applicants will be notified via email of the lottery results. Those students selected will be placed at one of the UPK Providers based on selection number and availability of space. If necessary, waiting lists will be created. Once a student has been selected, a full registration through the Valley Central School District will be required; all parents/guardians of students selected will be emailed information about the registration process.

Website link: https://www.vcsd.k12.ny.us/about-us/universal-pre-kindergarten
UPK Director Tammy Coleman: tammy.coleman@vcsdny.org 845-457-2400 ext. 18120
UPK Office Assistant Gheri Cola: UPK@vcsdny.org 845-457-2400 ext. 18134
UPK Nurse Christine Fenner: upknurse@vcsdny.org 845-457-2400 ext. 13700

RENT WITH LEASE

2025-2026 UPK APPLICATION CHECKLIST

The following checklist will help you to get all of your paperwork organized.
It is very important that you completely fill out and submit **ALL** of these forms.

FILL OUT & SUBMIT THESE FORMS & DOCUMENTS TO THE UPK OFFICE BY FEB. 14, 2025.
WE CANNOT MAKE PHOTOCOPIES FOR YOU. YOU MUST PROVIDE YOUR OWN COPIES.

FORMS:

1. ____ Prekindergarten Information Form (2 pages)
2. ____ Provider Selection Sheet
3. ____ Health Inventory Form (2 pages)
4. ____ NYS School Health Examination Form (2 pages) (only **THIS** form and forms from **Crystal Run** will be accepted; **MUST** be **signed/stamped & dated** by your child's Dr.; physical must have been completed within last year)
5. ____ Confidential Medical Emergency Form
6. ____ Lead Screening Information Form with Lead Results Filled In (required)
7. ____ Dental Health Certificate Form (recommended)
8. ____ Home Language Questionnaire (2 pages)
9. ____ Speech Form
10. ____ Computer Student User Agreement
11. ____ Housing Questionnaire (English-side 1/Spanish-side 2)
12. ____ How Did You Hear About UPK Form?

DOCUMENTS:

13. ____ Copy of Birth Certificate **(date of birth must be between 12/02/2020-12/01/2021)**
    Five (5) year olds will not be considered per New York State regulations
14. ____ Immunization Record (must be **signed/stamped & dated** by your child's physician)
15. ____ Photocopy of Lease (must be signed by tenant **&** landlord, must show start/end dates of lease)
16. ____ Most recent utility bill – electric, cable, garbage, water or fuel delivery (choose only 1)
17. ____ Court Issued Custody/Legal Guardianship Papers (if applicable)
18. ____ Copy of parent or legal guardian driver's license

WHAT RESIDENCY FORMS/DOCUMENTS DO I NEED TO SUBMIT?

OPTION #1 **HOMEOWNER**	**OPTION #2** **RENT W/LEASE**	**OPTION #3** **RENT W/O LEASE**	**OPTION #4** **LIVE W/DISTRICT RESIDENT**	
I am the Parent/Legal Guardian and Own my Residence	**I am the Parent/Legal Guardian and Rent my Residence, I Have a Current Lease**	**I am the Parent/Legal Guardian and Rent my Residence, but I <u>Do Not</u> Have a Current Lease** (month to month rental)	**I am the Parent/Legal Guardian and Live with a School District Resident** (my parent, my grandparent, my friend)	
			<u>Parent/Legal Guardian</u>	**<u>District Resident</u>**
Housing Questionnaire Form	Housing Questionnaire Form	Housing Questionnaire Form	Housing Questionnaire Form	Choose Your Type of Residence - Option #1, #2 or #3 & submit **<u>ALL</u>** items in that column
Most recently paid tax bill OR most recent mortgage statement	Photocopy of Lease (must be signed by tenant **&** landlord, must show start/end dates of lease)	Landlord Statement Form **(NOTARIZED)**	Affidavit for *<u>Parent</u>* Living With a District Resident **(NOTARIZED)**	Affidavit for *<u>Resident</u>* Who is Claiming Parent & Child Lives With Them **(NOTARIZED)**
Current utility bill - electric, cable, garbage, water or fuel delivery (choose only 1)	Current utility bill - electric, cable, garbage, water or fuel delivery (choose only 1)	Current utility bill - electric, cable, garbage, water or fuel delivery (choose only 1)	Three (3) documents from the **Proof of Address List** (**<u>documents must be dated within the last 30 days</u>**)	
		One (1) document from the **Proof of Address List** (**<u>document must be dated within the last 30 days</u>**)		

PROOF OF ADDRESS LIST

Electric Bill
Cable/Direct TV Bill
Garbage or Water Bill
Propane or Oil Delivery Bill
Telephone/Internet Bill
Cell Phone Bill
Paystub
Income Tax Return
Bank Statement
Health Care Benefits Statement
Auto Insurance ID Card
Motor Vehicle Registration
DSS Verification

Valley Central
2025-2026 Universal Prekindergarten
UPK Provider Open House Schedule

UPK PROVIDER	OPEN HOUSE	WEBSITE	PHONE #	ADDRESS
Montgomery Nursery School	Saturday, January 25, 2025 10:00 AM – 12:00 PM	https://montgomerynurseryschool.org/ Find Us on Facebook	845-457-5754	21 Wallkill Avenue & 137 Clinton Street., Montgomery
School Time Children's Center (Coldenham)	Tuesday, January 28, 2025 6:30 PM – 7:30 PM	Find Us on Facebook	845-567-9548	469 Coldenham Road, Walden
School Time Children's Center (Scofield)	Monday, January 27, 2025 6:30 PM – 7:30 PM	Find Us on Facebook	845-778-1362	70 Scofield Street, Walden
Miss Cindy's Neighborhood Nursery School	Monday, January 27, 2025 6:00 PM – 7:30 PM	https://www.misscindysschool.com/	845-564-8426	1860 Route 300, Newburgh
Most Precious Blood School	Monday, January 27, 2025 5:30 PM – 7:30 PM	https://mpbschool.org/upk-1	845-778-3028	180 Ulster Avenue, Walden
Learning Together	Thursday, January 30, 2025 6:00 PM – 7:00 PM	https://learningtogetherinc.com/	845-293-5600	228 Ward Street, Montgomery

FOR OFFICE USE ONLY

School Entered: **UPK** UPK Program: **HALF / FULL / EXPANDED** Student ID#: _____

____ Custody Papers Joint _____ has physical
50/50 Sole

____ Restraining Order ____ Foster
____ Guardianship Papers ____ Migrant
____ Request for Attendance ____ MV
____ No Release of Information ____ T3EI

Enter Date: _____

Class of: 20_____ - 20_____
New _____
PS (Active) _____
PS (Inactive) _____
Sibling _____

VALLEY CENTRAL SCHOOL DISTRICT
Prekindergarten Information Form

_____ _____
Student's Last Name First Name Middle Name Gender

_____ _____ _____
Date of Birth Phone (Type: Cell/Home/Work) Birth Place: City / State / Country

_____ _____
Residence Address Mailing Address (if different than residence address)

_____ _____
City / State / Zip City / State / Zip (if different than residence address)

The following information is voluntary and confidential:

Is the student Hispanic, Latino, or of Spanish Origin?

___ YES, Hispanic ___NO, Non-Hispanic

STUDENT'S PRIMARY LANGUAGE:

_____

RACE (please choose one or more):

__ American Indian or Alaskan Native
__ Asian
__ Black or African American
__ Native Hawaiian or Other Pacific Islander
__ White (Caucasian)

PARENT/GUARDIAN INFORMATION

Parent/Guardian 1 Full Name: _____

Address (if different from student): _____

_____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Print Email Address **Legibly** Below: (all UPK correspondence will be emailed)

Email:_____

STUDENT LIVES WITH:
__ Both Biological Parents
__ Biological Mother Only
__ Biological Father Only
__ Legal Guardians Names: _____
__ Mother/**Stepfather's** Name: _____
__ Father/**Stepmother's** Name: _____
__ Foster Parents Names: _____
__ Other (explain) _____
_____

Parent/Guardian 2 Full Name: _____

Address (if different from student): _____

_____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Print Email Address **Legibly** Below: (all UPK correspondence will be emailed)

Email:_____

Is either Parent or Legal Guardian an Active Duty Member of the Armed Forces? _____ (if yes, please specify below)

Parent Name: _____

Entry Date: _____ Exit Date: _____

Parent Name: _____

Entry Date: _____ Exit Date: _____

STUDENT EDUCATIONAL BACKGROUND

Has child been enrolled in a preschool or nursery school program? (This does NOT include Daycare)

_____ YES _____ NO

If yes, please indicate DATES: _____and HOURS PER WEEK: _____

Name and address of School/Program: _____

STUDENT'S SPECIAL PROGRAMS

Has your child received: ___ Counseling ___ Occupational Therapy ___ Early Intervention Services

___ Speech ___ Physical Therapy ___ Other (Explain) _____

Comments or Requests:_____

_____

SIBLINGS / OTHER CHILDREN LIVING AT SAME ADDRESS

Name	Gender	Birth Date	Grade	Present School

Is there any address where you would like to have school reports and other information sent other than the home address? YES / NO

If so, give complete name and address: _____

_____

Reason: _____

_____

I declare under penalty of perjury, under the laws of the State of New York, that all statements contained in this application and any accompanying documents are true and correct, with full knowledge that all statements made in this application are subject to investigation.

_____ _____

Parent/Legal Guardian Signature Date

Revised 1/30/24

2025-2026
VALLEY CENTRAL SCHOOL DISTRICT
UPK PROVIDER SELECTION SHEET

STUDENT LAST NAME _____, FIRST NAME _____

Instructions: In the table below is a list of all UPK provider choices for the 2025-2026 school year.

Indicate at least your first 5 **UPK Provider** choices in the table below. 1=1st choice, 2=2nd choice, 3=3rd choice, etc.*

Please Indicate at least your 1st, 2nd, 3rd, 4th & 5th choices in the first column below.

# Your Choices 1-5	Program	UPK Provider	Class Start Time	Class End Time	Address
	Half-Day	Miss Cindy's Neighborhood Nursery School	8:45 AM	11:40 AM	1860 Route 300, Newburgh
	Half-Day	Montgomery Nursery School**	9:00 AM	11:30 AM	21 Wallkill Avenue, Montgomery
	Half-Day	Montgomery Nursery School**	12:30 PM	3:00 PM	21 Wallkill Avenue, Montgomery
	Full-Day	Learning Together	8:30 AM	2:30 PM	228 Ward Street, Montgomery
	Full-Day	Montgomery Nursery School	9:00 AM	3:00 PM	137 Clinton Street, Montgomery
	Full-Day	Most Precious Blood School	8:30 AM	2:30 PM	180 Ulster Avenue, Walden
	Full-Day	School Time Children's Center - Coldenham	8:30 AM	2:30 PM	469 Coldenham Road, Walden
	Full-Day	School Time Children's Center - Coldenham	8:45 AM	2:45 PM	469 Coldenham Road, Walden
	Full-Day	School Time Children's Center - Scofield	8:30 AM	2:30 PM	70 Scofield Street, Walden
	Full-Day	School Time Children's Center - Scofield	8:45 AM	2:45 PM	70 Scofield Street, Walden
	Expanded-Day	Most Precious Blood School	8:30 AM	2:30 PM	180 Ulster Avenue, Walden
	Expanded-Day	School Time Children's Center - Coldenham	8:30 AM	2:30 PM	469 Coldenham Road, Walden
	Expanded-Day	School Time Children's Center - Coldenham	8:45 AM	2:45 PM	469 Coldenham Road, Walden
	Expanded-Day	School Time Children's Center - Scofield	8:30 AM	2:30 PM	70 Scofield Street, Walden
	Expanded-Day	School Time Children's Center - Scofield	8:45 AM	2:45 PM	70 Scofield Street, Walden

All Expanded-Day providers are open from 7:00 AM-6:00 PM Daily.
***There is no guarantee of first choices being granted. Choices are granted based upon lottery selection number and available space.**
****Providers that offer both an AM & PM half-day class will determine which class students are placed in, not the UPK Office.**

Valley Central does not provide busing for UPK. Parents must provide transportation for UPK.

VALLEY CENTRAL SCHOOL DISTRICT

Alternative Learning Center at Maybrook
120 Broadway, Maybrook, NY 12543
PHONE: 845-457-2400 EXT 13700
FAX: 845-457-8549
www.vcsd.k12.ny.us

Christine Fenner
Registered Nurse

Mara Costagliola
Director of Pupil Services &
Special Programs

Dear Parent(s) and Guardian(s),

This letter is to inform you of the immunization requirements for school entrance. Due to a change in the public health law, **religious exemptions from vaccinations are no longer permitted in New York State for students as of June 13, 2019.** However, medical exemptions are permitted and must be completed on a medical exemption form issued by NYSDOH. The medical exemption should specify which immunization is detrimental to the child's health, provide information as to why the immunization is contraindicated based on current accepted medical practice, and specify the length of time the immunization is medically contraindicated, if known. Please note, medical exemptions must be re-issued yearly.

You may have titers drawn to determine immunity status if your child is behind in his/her vaccinations. Please note that evidence of immunity can only be for the following diseases: Measles, Mumps, Rubella, Varicella, and Hepatitis B and a lab report will need to be provided to the school as proof of immunization. **All children MUST be fully immunized prior to the beginning of the 2025-26 school year.**

If your child has any allergies (non-threatening or life threatening) or any chronic illnesses such as asthma, diabetes, seizures, etc, it must be documented by a healthcare provider to ensure the school nurse can provide accurate and safe medical attention to your child. Please have your child's health care provider fill out any necessary health forms provided by the Valley Central School District or provide the school with a treatment plan from his/her office.

Lastly, your child MUST have a current physical at the beginning of the 2025-26 school year. No expired physicals will be accepted. If your child has a physical or receives immunizations during the school year, please be sure to forward me updated copies of both records.

Thank you for your cooperation and consideration in this matter. Please do not hesitate to contact me at (845) 457-2400 ext 13700 or upknurse@vcsdny.org with any questions.

Best Regards,

Christine Fenner, RN, BSN
UPK Nurse
Valley Central School District

11-18-24

___ UPK ___BE ___EC ___MO ___WA ___MS ___HS

Valley Central School District
Health Inventory

Student's Name: _____ Gender: _____ DOB: _____ Grade: _____

Address: _____ Primary Phone: _____

Primary Guardian Name: _____ Relationship: _____

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

Primary language spoken in the home: _____

Health History - mark with an "**X**" if applicable and describe below under "Comments" if necessary

Anemia		Asthma		Diabetes	
Convulsions / Seizures		Bronchitis		Ear Infections (more than 3 a year)	
Epilepsy		Bed Wetting		Sore or Strep Throats (more than 6 a year)	
Nose Bleeds		Pneumonia		Broken Bones	
Heart Disease		Chicken Pox		TB (in family or contact with TB)	
Sickle Cell Disease / Trait		Scarlet Fever		Rheumatic Fever	
Urinary Problems		Serious Burns		Lyme Disease	
Nephritis Infections		Lead Poisoning		Any Other Problems Not Listed Above	

Comments (please use additional sheet if necessary):

_____

_____

Has your child ever been hospitalized? **Yes** **No** Please list date and reason below:

_____

_____

Has your child ever had a visual exam? **Yes** **No** Has your child ever had a hearing evaluation? **Yes** **No**

Does your child wear glasses or a hearing aid? **Yes** **No** Reason? _____

Does your child have a heart problem? **Yes** **No** ***If yes, please complete the following section*:**

Heart murmur _____ Innocent _____ Grade (if known) _____ Mitral Valve Prolapse _____ Extra heartbeat _____

Has your child ever had an EKG? **Yes** **No** Date: _____ Echocardiogram? **Yes** **No** Date: _____

Has your child seen a Cardiologist? **Yes** **No** Date:_____ MD Name: _____

Has your child been released by the doctor for regular activities? **Yes** **No** If no, please explain below:

_____

_____

Has your child been seen by any of the following Health Care Professionals?

Specialty	Name/Phone Number of Specialist	Date Seen	Reason
Allergist			
Eye, Ear, Nose, Throat			
Orthopedist			
Psychiatrist			
Psychologist/Therapist			
Social Worker/Counselor			
Physical Therapist			
Occupational Therapist			
Neurologist			
Speech Pathologist			
Other			

Comments (please use additional sheet if necessary):

_____

_____

Does your child have any allergies (medicines, foods, bee stings, insect bites, environmental, other)? What happens when your child has an allergic reaction? Is medication needed in school to treat this allergy? If so please list the medication(s).

_____

_____

_____

Does your child have any chronic illnesses (asthma, reactive airways, other) or physical limitations? If so does this condition limit participation in Physical Education, Physical Activities or Recess?

_____

_____

Is your child on any medication? Please name the medicine and reason it is needed.

_____

_____

Is there any other information that the school should know in order to safeguard your child's health?

_____

_____

I understand that this confidential information will be shared with the school personnel deemed appropriate by the health professional in my child's building.

Parent/Guardian Signature: _____Date: _____

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: ☐ 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**	☐ 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 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors:Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

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

Hyperlipidemia: ☐ Yes ☐ 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	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/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 PreK or K, 1, 3, 5, 7, & 11

Vision Screening	**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 Screening: 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: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

<u>If Restrictions Apply</u> – 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, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** 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.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

UPK BE EC MO WA MS HS

VALLEY CENTRAL SCHOOL DISTRICT

Confidential Medical Emergency Form

Student Last Name: _____ First Name: _____ DOB: _____

Home Phone: _____ Grade: _____ Student's Gender: _____

Parent/Guardian #1 Name: _____ Resides with (circle one): **Y N**

Relationship: _____ Cell #: _____ Work #: _____

Email Address of Parent/Guardian #1: _____

Parent/Guardian #2 Name: _____ Resides with (circle one): **Y N**

Relationship: _____ Cell #: _____ Work #: _____

Email Address of Parent/Guardian #2: _____

Please complete the information below to assist us in knowing current information about your child. *(This confidential information will be shared with the school personnel deemed appropriate by the health professional in your child's building.)*

Known Allergies: _____

Current Medications: _____

Other Medical Conditions: _____

Family Physician: _____ Physician's Phone Number: _____

Medical Emergency Contact Information

In the event of a medical emergency, the district will call parents/guardians listed above first, then follow the sequence below.

First Contact Name: _____ Relationship: _____ Phone: C H W _____	**Third Contact** Name: _____ Relationship: _____ Phone: C H W _____
Second Contact Name: _____ Relationship: _____ Phone: C H W _____	**Fourth Contact** Name: _____ Relationship: _____ Phone: C H W _____

If the School District is unable to reach a parent/guardian, I do hereby authorize the School District to call the family physician listed. In the event the physician cannot be reached, I do hereby authorize the School District to transport the child to a hospital emergency room if in the judgment of the School District such emergency treatment seems warranted. This authorization also includes authority to release pertinent medical records needed.

Parent/Guardian Signature: _____ Date: _____

This page intentionally left blank

What Your Child's Blood Lead Test Means

The blood lead test tells you how much lead is in your child's blood. Lead can harm a child's growth, behavior, and ability to learn. The lower the test result, the better.

Most lead poisoning occurs when children lick, swallow, or breathe in dust from old lead paint. Most homes built before 1978 have old lead paint, often under newer paint. If paint peels, cracks, or is worn down, the chips and dust from the old lead paint can spread onto floors, windowsills and all around your home. Lead paint dust can then get onto children's hands and toys, and into their mouths.

Most children have had some contact with lead in old paint, soil, plumbing, or another source. This is why New York State requires doctors to test all children with a blood lead test at age **1 year** and *again* at age **2 years**. For children up to age six years, your doctor or nurse should ask you at every well child visit about ways your child may have had contact with lead. Children who have had contact with lead should be tested.

A high test result using blood from a fingertip should be checked again with a second test using blood taken from a vein (often in the arm). If the second result is still high, you should follow the steps below.

Test Result in micrograms per deciliter (mcg/dL)	**Next Steps**
0-4	• **There is very little lead in your child's blood.** • The average lead test result for young children is about 2 mcg/dL.
5-9	• **Your child has a little more lead than most children.** • Talk with your doctor and local health department to find out how your child might have come into contact with lead, and ways to protect your child. • Your doctor might want to test your child again in 3 to 6 months.
10-14	• **Your child's lead level is high. A result of 10 or higher requires action.** • Your doctor and local health department will talk with you to help you find sources of lead, and ways you can protect your child. • Your child should be tested again in 1 to 3 months.
15-44	• **Your child's lead level is quite high. You and your doctor should act quickly.** • Talk with your doctor or nurse about your child's diet, growth and development, and possible sources of lead. • Talk with your local health department about how to protect your child. They may visit your home to help you find sources of lead. • If the lead level is 15 to 24, your child should be tested again in 1 to 3 months. • If the lead level is 25 to 44, your child should be tested again in 2 weeks to 1 month.
45 or higher	• **Your child needs medical treatment right away.** • Your doctor or health department will call you as soon as they get the test result. • Your child might have to stay in a hospital, especially if your home has lead. • Your local health department will visit your home to help you find sources of lead. • Your child should not go back home until the lead sources are removed or fixed. • Your child needs to be tested again after treatment.

Child's Name: _____ Test Result: _____ mcg/dL Date: _____

If the test result is not written here, ask your doctor or nurse for it, write it down, and save for your records.

VALLEY CENTRAL SCHOOL DISTRICT

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, Pre K or K, 1, 3, 5, 7, 9 & 11. Your child may have a dental check-up during this school year to assess his/her/their fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she/they started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

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

Child's Name: Last First Middle

Birth Date: / / Month Day Year | Gender: | Will this be your child's first oral health assessment? ☐ Yes ☐ No

School Name: | Grade:

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

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

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

Parent's Signature: Date:

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

I. The dental health condition of _____ on_____ (date of assessment.)

The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her/their attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her/their attendance at the public schools.

NOTE: Not in fit condition of dental health means, that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address:

(please print or stamp)	**Dentist's/Dental Hygienist's signature**

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

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

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

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

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

II. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

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

Elisa Alvarez, Associate Commissioner Office of
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Brooklyn, New York 11217
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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 ❑ Female ❑ Non-Binary
Month	*Day*	*Year*
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 *specify*	❑ Parent 2 *specify*	❑ Guardian(s) *specify*
4. What language(s) does your child understand?	❑ English	❑ Other	*specify*
5. What language(s) does your child speak?	❑ English	❑ Other *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other *specify*	❑ Does not write

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

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
Valley Central School District 944 Route 17K, Montgomery, NY 12549	
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:

___ UPK ___BE ___EC ___MO ___WA

Valley Central School District Speech Form

(for Kindergarten and Universal Pre-K students only)

Student's Name _____ Date of Birth _____

Parent/Guardian Name _____ Today's Date _____

Your child's adjustment to and progress in school may be affected by their ability to be understood when they speak. Please answer the following questions so that the school speech therapist can determine whether or not your child should have a special speech evaluation.

1. Do you usually understand your child's speech? YES NO
2. Do other people usually understand your child's speech? YES NO
3. Does your child have a hearing loss? YES NO
4. Has your child ever had a special speech evaluation? YES NO
5. Is your child in a special speech program at this time? YES NO
6. Does your child have difficulty expressing ideas and concepts? YES NO
7. At what age did your child first begin to speak? _____

Please check any of the following that describe your child's speech.
If none apply, leave blank.

- ☐ Does not talk
- ☐ Speaks very little
- ☐ Uses "baby talk"
- ☐ Substitutes speech sounds
- ☐ Omits speech sounds
- ☐ Speaks through nose
- ☐ Hesitates or stutters while speaking
- ☐ Has unusual breathing patterns while speaking
- ☐ Voice sounds strained, breathy or hoarse
- ☐ Speaks too high or too low
- ☐ Cleft-palate speech

Please circle **Y** for yes or **N** for no to answer the following questions regarding your child's hearing.

Does your child seem to have difficulty hearing? **Y N**

Does your child turn up the TV louder than other members of the family? **Y N**

Does your child seem to favor one ear over the other? **Y N**

Does your child jump or appear more startled than others if there is a sudden noise? **Y N**

Does your child hear you if you whisper? **Y N**

Does your child make you speak loudly or repeat things frequently? **Y N**

Does your child become confused in following more than two verbal directions at a time? **Y N**

Do you suspect any hearing problems? **Y N**

VALLEY CENTRAL SCHOOL DISTRICT

Computer And Networked Information Resources Student User Agreement

I, the undersigned, agree to act responsibly and comply with all rules and regulations promulgated by the Valley Central Board of Education regarding the use of District computers and networked information resources (including the Internet).

- *Students are only allowed to have access to District computers and/or networked information resources (including the Internet) under the direct and immediate charge of a supervising adult who must be present during the entire duration of the process Uploads, downloads, file transfers, Etc. must be approved by the supervising adult..*
- *Students are only allowed to use District computers and/or networked information resources (including the Internet) for school-related research and/or communication.*
- *Students must use the appropriate language and etiquette in electronic transmission and information searches and must not give out personal information and/or e-mail addresses unless approved by a supervising adult.*
- *Use of computing facilities, networks, or other resources shall not be used to interfere with the work of other students and/or the educational process.*
- *Any student who receives any communication that is inappropriate shall immediately bring the incident to the attention of the supervising teacher or administrator.*

Computer and all networking resources remain the exclusive property of the District; therefore, students have no reasonable expectation of privacy in anything created, stored, sent, received or accessed on District computers including but not limited to information on computer hard drives, e-mail messages, and on-line activities.

Any person who is determined to have used computers and/or networked information resources (including the internet) inappropriately or who violates the District's Policies and its Regulations will have his/her use of school on-line privileges terminated. Further, such a breach may subject a user to disciplinary action consistent with the Student Code of Conduct, and state and federal law, and may result in the user being referred to appropriate law enforcement officials where the breach is suspected to be illegal.

This agreement must be signed by the parent/legal guardian. Grade **PK** School **UPK**

***Student User (Print)* _____ ***Half-Day _____ *Full-Day _____*
Expanded-Day_____

Student User (Signature) * Date_* * * * *

I, the parent/legal guardian of the above named-student, have read the contents of this agreement, understand it, and agree to be bound by its terms and conditions.

***Parent/Legal Guardian (Signature)*_____ ***Date*_____

This signed document must be filed with the Building Principal

Adoption date: February 8, 1999
Revised: June 10, 2002; August 11, 2003; August 8, 2005; August 18, 2008

VALLEY CENTRAL SCHOOL DISTRICT

HOUSING QUESTIONNAIRE

Student Name	Grade	Date of Birth	Gender	School

Current/New Address:_____

Previous Address: _____

Previous School District: _____

Daytime Phone Number: _____**Home Phone Number**: _____

The answer you give below will help the district determine what services you or your child(ren) may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where are you currently living? (*Please check only **one** box.*)

- ☐ In permanent housing
- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____

_____

_____

_____ _____

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

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

_____

Date

- ☐ EXISTING FAMILY CHANGE OF ADDRESS
- ☐ NEW FAMILY/ STUDENT
- ☐ COPY TO MV LIAISON

VALLEY CENTRAL SCHOOL DISTRICT

CUESTIONARIO DE VIVIENDA

Nombre del Estudiante	Grado	Fecha de Nacimiento	Género	Nombre de la Escuela

Dirección actual / nueva: _____

Dirección anterior: _____

Distrito escolar anterior: _____

Número de teléfono durante el día: _____ Número de teléfono de la casa: _____

Su respuesta abajo permitirá al distrito escolar definir los servicios que puede aprovechar su hijo/hija según el Acto de McKinney-Vento. Los estudiantes elegibles tienen derecho a la inscripción inmediata en la escuela, aun si ellos no tienen los documentos necesarios tales como: prueba de residencia, documentos escolares, documentos de inmunización, o partida de nacimiento. Los estudiantes elegibles según el Acto de McKinney-Vento tienen además derecho al transporte gratuito y otros servicios que ofrece el distrito escolar.

¿Donde está el estudiante viviendo actualmente? (*Por favor marque **una** caja*.)

- ❑ En un hogar permanente
- ❑ En un refugio
- ❑ Con otra familia o otra persona debido a la pérdida del hogar o a dificultades económicas
- ❑ En un hotel/motel
- ❑ En un carro, parque, autobús, tren, o camping
- ❑ Otra vivienda temporal (Por favor describa):

  _____

_____ _____

Nombre de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

Firma de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

_____

Fecha

- ☐ EXISTING FAMILY CHANGE OF ADDRESS
- ☐ NEW FAMILY/ STUDENT
- ☐ COPY TO MV LIAISON

2025-2026: How Did You Hear About UPK?

Student Name: _____

			✓
Doctor's Office:	Cornerstone Family Healthcare		
	Horizon Family Medical Group		
	Monroe Pediatrics		
	Orange Pediatric Associates		
	Sun River Health Wallkill Valley		
	Washingtonville Pediatrics		
Library:	Maybrook		
	Montgomery		
	Walden		
	Newburgh		
	Wallkill		
Newspaper:	Times Herald Record		
	Wallkill Valley Times		
Spectrum Cable TV:	Maybrook		
	Montgomery		
	Walden		
UPK Provider	Learning Together		
	Miss Cindy's Neighborhood Nursery School		
	Montgomery Nursery School		
	Most Precious Blood School		
	School Time Children's Center		
Valley Central:	Central Office		
	Facebook Page		
	UPK Web Site		
	Valley Central Staff Member		
	Berea Elementary School:	Flyer	
		Thursday Folder	
		Monthly Newsletter	
		Marquee Sign in Front of School	
	East Coldenham Elementary School:	Flyer	
		Thursday Folder	
		Monthly Newsletter	
		Marquee Sign in Front of School	
	Montgomery Elementary School:	Flyer	
		Thursday Folder	
		Monthly Newsletter	
		Marquee Sign in Front of School	
	Walden Elementary School:	Flyer	
		Thursday Folder	
		Monthly Newsletter	
		Marquee Sign in Front of School	
	Alternative Learning Center	Flyer/Monthly Newsletter	
		Marquee Sign in Front of School	
	Middle School/High School:	Flyer/Monthly Newsletter	
		Marquee Sign in Front of School	
Village Recreation Department:	Maybrook		
	Montgomery		
	Walden		
Other:	Word of Mouth		
	Previously Participated in UPK		
	Please Indicate:		

Applied for:
___ Half-Day
___ Full-Day
___Expanded-Day

Revised 10/25/24