



Dear Parents:

Welcome to Bethlehem Central School District. Enclosed are the registration forms to be filled out completely and neatly. Along with the forms enclosed, please bring the following documentation when registering your child, to Central Registration located at 700 Delaware Avenue, Delmar, NY 12054:

- **Proof of Residency**

- A copy of a resident lease or proof of ownership of a house or condominium, such as a deed or mortgage statement; or
- A statement by a third-party landlord, owner or tenant from whom the parent or person in a parental relationship leases or with whom they share property within the District, which may be sworn or unsworn; or
- Such other statement by a third party relating to the parent or person in parental relation's physical presence in the District; or
- Other forms of documentation and/or information establishing physical presence in the District which may include but are not limited to:
  - Pay stub;
  - Income tax form;
  - Utility or other bills;
  - Homeowners, renters or auto insurance;
  - Voter registration documents(s);
  - Official driver's license, learner's permit or non-driver identification;
  - State or other government issued identification; or
  - Documents issued by federal, state or local agencies (e.g., local social service agency, Federal Office of Resettlement).

- **Proof of Age**

- A certified transcript of a birth certificate; or
- A record of baptism confirming the date of birth for the child to be enrolled in the District (a foreign birth certificate of record of baptism will also be accepted).

If a certified transcript of a birth certificate or a record of baptism is not available, please submit a copy of the child's passport. A foreign passport will be accepted.

In the event you cannot provide a passport, the District will consider an executed written affidavit of the child's age or any of the following documents as long as it was issued two or more years ago:

1. Official driver's license;
2. State or other government issued identification;
3. School photo identification with date of birth;
4. Consulate identification card;
5. Hospital or health records;
6. Military dependent identification card;
7. Documents issued by federal, state or local agencies, such as local social service agency or federal Office of Refugee Resettlement;
8. Court orders or other court-issued documents;
9. Native American tribal document; or
10. Records from non-profit international aid agencies and voluntary agencies.

- **Proof of Custody and/or Lawful Residence**

In order for the District to confirm your custody of and/or lawful residence with your child, please submit either:

- A written affidavit indicating that you are the parent(s) with whom the child lawfully resides; or
- A written affidavit indicating that you are the person(s) in a parental relation to the child, over whom you have total and permanent custody and control and describing how you obtained total and permanent custody and whether it is through a guardianship or otherwise.
- A judicial custody order or guardianship papers may, but need not be, submitted.

The District will also accept other proof of custody and/or lawful residence such as documentation which indicates that the child has been placed by a federal agency with a sponsor.

- **Current Immunization Record (official record signed by physician)**

The student's recent report card, standardized test results, I.E.P., or any other information from the previous school would be helpful.

**Enrollment and Registration Process:**

Upon request, your child will be enrolled and permitted to attend school in the District the next school day, or as soon as practicable.

Within three (3) business days of the child's initial enrollment, the Board of Education ("Board"), or its designee, will review all of the registration/enrollment documentation submitted and determine whether the child is entitled to attend school in the District. If it is determined that the child does not reside in the District, the Board, within two (2) business days, will issue a written notification confirming the basis for this determination and the date the child is to be excluded from the District. The written notification will also confirm the parent's right to appeal the Board's decision to the New York Commissioner of Education within thirty (30) days and advise that the instructions, forms and procedures for an appeal, including translated instruction forms and procedures can be found at the following:

- Online at the Office of Counsel, [www.counsel.nysed.gov](http://www.counsel.nysed.gov);
- Mail addressed to the Office of Counsel, New York State Education Department, State Education Building in Albany, New York 12234; or
- Calling the Appeals Coordinator at (518) 474-8927.

Thank you in advance for your cooperation with the District's registration and enrollment process. I look forward to meeting you and if you have any questions, please feel free to call me at 439-2442.

Sincerely,

Melissa Haas,  
Central Registrar

# Welcome to Bethlehem Schools!

## STAY CONNECTED TO BETHLEHEM IN MANY WAYS

*For a large portion of the day, you leave your children in our care. The education of the students in our community is a responsibility we don't take lightly, and something we know doesn't stop when students leave school. Working together has always been a huge part of our process, so please stay connected!*

### District Website

[www.bethlehemschools.org](http://www.bethlehemschools.org)

Have you been to Bethlehem Central's website lately?

Visit [www.bethlehemschools.org](http://www.bethlehemschools.org) to access all kinds of information about district activities, programs and announcements.

### BC on Social Media



Follow us on Twitter!  
[@BethlehemCSD](https://twitter.com/BethlehemCSD)

Get up-to-date district news, live-tweets of important district meetings, and answers to your questions.



Become a fan on Facebook!  
[www.facebook.com/BethlehemSchools](https://www.facebook.com/BethlehemSchools)  
View photos of what's happening in our schools and receive updates on events and school activities.



Follow us on Instagram!  
[@bethlehemschools](https://www.instagram.com/bethlehemschools)  
View photos and stories from our classrooms, athletics, the arts and from events across the district.

### Aspen

[www.bethlehemschools.org/aspen](http://www.bethlehemschools.org/aspen)

Aspen is a password protected portal that offers parents and students online access to a secure site with personalized information about a student's academic program and progress. Your contact information you share at registration is uploaded automatically to Aspen by our District Registrar.

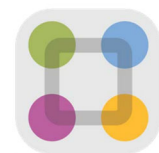
Student report cards and bus schedules are posted to Aspen, as well as iReady progress

reports K-8 and academic schedules for students in grades 6-12. Some teachers also use Aspen to post assignments and to communicate with individual students/families. Always be sure to keep your contact information up to date. When you have changes to your address, phone or email, please contact the District Registrar to make sure those changes are reflected in Aspen.

### Introducing ParentSquare

In the 2023-24 school year, the district will begin using ParentSquare for most school-to-home communications. BCSD will be consolidating the many communications tools used by the district, schools and by teachers so parents and guardians will have a one-stop communications tool with ParentSquare.

As a parent or guardian, you are automatically registered for ParentSquare through your contact information that is stored in Aspen. As long as the district has your correct contact information on file, you will receive timely, important updates from the district and your child's school. ParentSquare also allows you to customize the delivery of routine news and announcements by creating your own ParentSquare account. The ParentSquare mobile app provides even greater customization with push notifications that can be sent to your phone or mobile device. You can log into ParentSquare using the QR code below. If you need assistance, please contact [bcsdcommunications@bethlehemschools.org](mailto:bcsdcommunications@bethlehemschools.org).



ParentSquare

### ACCURATE CONTACT INFO IS IMPORTANT

If you need to update to your contact information, contact our District Registrar.

**Melissa Haas**  
[mhaas@bethlehemschools.org](mailto:mhaas@bethlehemschools.org)



### Email us

All faculty and staff in the Bethlehem Central School District can be reached by email. Most email addresses are the first initial of the first name and the full last name and the domain name [bethlehemschools.org](http://bethlehemschools.org). Ex. Ann Roberts is [aroberts@bethlehemschools.org](mailto:aroberts@bethlehemschools.org). A searchable email directory is available on the district website.

### Follow your BC Eagles

Be where the action is! The BCSD Athletics Departments posts all sports information regularly on Twitter [@BCSDAthletics](https://twitter.com/BCSDAthletics)

# PARENT-TEACHER COMMUNICATIONS

*The following information was adapted from Parent Today.*

The key to productive parent-teacher conversations is keeping in mind that you are on the same team, working together to ensure your child's success. When you tell the teacher about your child's skills, interests and personality, the teacher has better insight into your child as an individual. And when the teacher shares insights about your child, you can promote a more positive learning environment at home.

## Emails and phone calls

When you need to discuss a serious issue with a teacher or other staff member, keep in mind that it's sometimes difficult to interpret tone in written words. Talking directly to the teacher can, at times, be more effective than an email. Whether it's an email or a phone call, your child's teacher will do their best to respond as soon as possible. Please allow them 24 hours to respond.

## Parent-Teacher Conferences

Parent-teacher conferences for elementary students are held in late fall. In order to maximize this time, the following tips from the Harvard Research Family Project can help you arrive prepared. These tips are also helpful for all types of parent-teacher interaction, in all grades K-12.

To get off to a solid start when meeting with your child's teacher, be prompt, stay positive and focus on the following:

### PROGRESS

Find out how your child is doing by asking questions like: Is my child performing at grade level? How are they doing compared to the rest of the class? What do you see as their greatest strengths? In what areas could they improve? What can I do at home to help my child succeed in the classroom?

### ASSIGNMENTS AND ASSESSMENTS

If your teacher has not already done so, ask to see examples of your child's work. Ask how the teacher assigns grades and homework.

### SUPPORT LEARNING AT SCHOOL

Be sure to share your thoughts and feelings about your child's learning style, needs or concerns. Tell the teacher what you think your child is good at. Explain what your child may need more help with.

Find out what services are available at the school to help your child. Ask how the teacher will both challenge your child and support your child when they need it.

### SUPPORT LEARNING AT HOME

Ask what you can do at home to help your child learn. Ask if the teacher knows of other programs or services in the community that could also help your child. Explore clubs, recreational and other activities that take place after school or in the community to ensure your child is engaged with their learning peers even after the school day ends.



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## BETHLEHEM CENTRAL SCHOOL DISTRICT

### EAGLE ELEMENTARY SCHOOL

*Dianna Reagan, Principal*  
27 Van Dyke Rd.  
Delmar, NY 12054  
518-694-8825

### ELSMERE ELEMENTARY SCHOOL

*Kate Kloss, Principal*  
247 Delaware Ave.  
Delmar, NY 12054  
518-439-4996

### GLENMONT ELEMENTARY SCHOOL

*Laura Heffernan, Principal*  
328 Rte. 9W  
Glenmont, NY 12077  
518-463-1154

### HAMAGRAEL ELEMENTARY SCHOOL

*Ian Knox, Principal*  
1 McGuffey Lane  
Delmar, NY 12054  
518-439-4905

### SLINGERLANDS ELEMENTARY SCHOOL

*Andrew Baker, Principal*  
25 Union Ave.  
Delmar, NY 12054  
518-439-7681

### BETHLEHEM CENTRAL MIDDLE SCHOOL

*Michael Klugman, Principal*  
332 Kenwood Ave.  
Delmar, NY 12054  
518-439-7460

### BETHLEHEM CENTRAL HIGH SCHOOL

*David Doemel, Jr., Principal*  
700 Delaware Ave.  
Delmar, NY 12054  
518-439-4921

# Student Residency Questionnaire

**Note:** The Bethlehem Central School District uses this page to help identify students in homeless situations as required by the McKinney-Vento Homeless Assistance Improvements Act, 42 U.S.C.11435. Answers to this residency information help determine the services the student may be eligible to receive. Assistance is provided by our Homeless Liaison, Mr. David F. Hurst. He can be reached at (518) 439-3102 or in the Educational Service Center at 700 Delaware Avenue.

Name of School: \_\_\_\_\_

Name of Student: \_\_\_\_\_ Gender: M/ F/ X  
*Last First Middle*

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Grade: \_\_\_\_\_ Student ID #: \_\_\_\_\_  
*Month Day Year (optional)*

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**The answer you give below will help the district determine what services you or your child 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 is the student currently living?** (Check one box.)

- In a motel/hotel
- 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 car, park, bus, train, or campsite
- Other temporary living situation (Please describe): \_\_\_\_\_
- In permanent housing

\_\_\_\_\_  
**Print Name** of Parent, Guardian, or Student (for unaccompanied homeless youth)

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

\_\_\_\_\_  
**Date**

If the student is **NOT** living in permanent housing, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled**. The district's LEA liaison is required to assist the student obtaining any necessary documents, including immunization or school records after the student has been enrolled.



**Bethlehem Central School District**  
 Office of the Registrar  
 700 Delaware Avenue  
 Delmar, NY 12054  
 (518) 439-2442  
 www.bethlehemschools.org

For Office Use Only							
Enroll Date _____	Proofs of Residence _____						
Immunizations: Y or N		Birth Certificate: Y or N		Other _____			
Student ID# _____				Family # _____			
Home School:	EAG	EL	GL	HAM	SL	MS	HS

## STUDENT ENROLLMENT FORM

The information on this form is very important. **PLEASE PRINT CLEARLY.**

**Student Name** \_\_\_\_\_ **Gender:**  F  M  X **Grade:** \_\_\_\_\_  
*(First name, Middle initial, Last name as it appears on birth certificate)*

**Preferred Name** \_\_\_\_\_ *Preferred name will be used on all unofficial district documents. Official documents (transcripts, etc.) will use the legal name above.*

**Date of Birth** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

**Home Address** \_\_\_\_\_  
 (Number) (Street) (Town) (Zip Code)

**Mailing Address (if different and/or P.O. box)** \_\_\_\_\_

**Previous School District Attended:** \_\_\_\_\_

**Has your child ever attended a Bethlehem school?** YES or NO **If Yes, When?** \_\_\_\_\_ **Last Grade** \_\_\_\_\_

**Name(s) of siblings residing with student:** (Attach additional sheet if needed.)

Name (First, Middle initial, Last)	F / M / X	Birth date (m/d/yy)	Grade	School
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Are there any restricted releases for this child?** [Documentation required. Please attach.] \_\_\_\_\_

**Parent 1 Name:** Dr. / Mr. / Mrs. / Ms. \_\_\_\_\_  
*(First name, Middle initial, Last name)*

**Relationship to student** \_\_\_\_\_

**Address (if different from student)** \_\_\_\_\_

- Lives with Student  Has Custody of Student  Should Receive Student Mailings/Aspen

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

**Primary Email Address:** \_\_\_\_\_

**Employer's Name:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Parent 2 Name:** Dr. / Mr. / Mrs. / Ms. \_\_\_\_\_  
(First name, Middle initial, Last name)

Relationship to student \_\_\_\_\_

Address (if different from student) \_\_\_\_\_

Lives with Student       Has Custody of Student       Should Receive Student Mailings/Aspen

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Primary Email Address: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Position: \_\_\_\_\_

***If parent/guardian cannot be reached please contact:***

**Emergency Contact 1 Name:** Dr. / Mr. / Mrs. / Ms. \_\_\_\_\_  
(First name, Middle initial, Last name)

Relationship to student \_\_\_\_\_

Address \_\_\_\_\_

Lives with Student       Has Custody of Student       Should Receive Student Mailings/Aspen

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Primary Email: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Position: \_\_\_\_\_

**Emergency Contact 2 Name:** Dr. / Mr. / Mrs. / Ms. \_\_\_\_\_  
(First name, Middle initial, Last name)

Relationship to student \_\_\_\_\_

Address \_\_\_\_\_

Lives with Student       Has Custody of Student       Should Receive Student Mailings/Aspen

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Primary Email: \_\_\_\_\_

Employer's Name \_\_\_\_\_ Position: \_\_\_\_\_

If your child has received special education services or accommodation through an Individualized Education Program (IEP) or a Section 504, please sign a consent for the release of special education records so that special education services can begin as soon as possible.

***Consent for release of special education records  
signed?***

YES       NO

**Parent Statement:**

I certify the above information is true and correct. Any misinformation regarding residency may result in being billed to cover the cost of instruction and/or exclusion from attending the Bethlehem Central School District.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



# 2023-24 School Year

## New York State Immunization Requirements for School Entrance/Attendance<sup>1</sup>

**NOTES:**  
All children must be age-appropriately immunized to attend school in NYS. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the [“ACIP-Recommended Child and Adolescent Immunization Schedule.”](#) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes must meet the immunization requirements of the grades for which they are age equivalent.

**Dose requirements MUST be read with the footnotes of this schedule**

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
<b>Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)<sup>2</sup></b>	<b>4 doses</b>	<b>5 doses or 4 doses</b> if the 4th dose was received at 4 years or older or <b>3 doses</b> if 7 years or older and the series was started at 1 year or older	<b>3 doses</b>	
<b>Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)<sup>3</sup></b>	<b>Not applicable</b>		<b>1 dose</b>	
<b>Polio vaccine (IPV/OPV)<sup>4</sup></b>	<b>3 doses</b>	<b>4 doses or 3 doses</b> if the 3rd dose was received at 4 years or older		
<b>Measles, Mumps and Rubella vaccine (MMR)<sup>5</sup></b>	<b>1 dose</b>	<b>2 doses</b>		
<b>Hepatitis B vaccine<sup>6</sup></b>	<b>3 doses</b>	<b>3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years</b>		
<b>Varicella (Chickenpox) vaccine<sup>7</sup></b>	<b>1 dose</b>	<b>2 doses</b>		
<b>Meningococcal conjugate vaccine (MenACWY)<sup>8</sup></b>	<b>Not applicable</b>		<b>Grades 7, 8, 9, 10 and 11: 1 dose</b>	<b>2 doses or 1 dose</b> if the dose was received at 16 years or older
<b>Haemophilus influenzae type b conjugate vaccine (Hib)<sup>9</sup></b>	<b>1 to 4 doses</b>	<b>Not applicable</b>		
<b>Pneumococcal Conjugate vaccine (PCV)<sup>10</sup></b>	<b>1 to 4 doses</b>	<b>Not applicable</b>		

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019, and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.
2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
  - b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
  - c. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 9: 10 years; minimum age for grades 10, 11, and 12: 7 years)
  - a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
  - b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2023-2024, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 9; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 10, 11, and 12.
  - c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.
4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
  - b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
  - c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
  - d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.
5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
  - a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
  - b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
  - c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
  - d. Rubella: At least one dose is required for all grades (prekindergarten through 12).
6. Hepatitis B vaccine
  - a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).
  - b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.
7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
  - a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
  - b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.
8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 10: 10 years; minimum age for grades 11 and 12: 6 weeks)
  - a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
  - b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
  - c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.
9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
  - b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
  - c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
  - d. If dose 1 was received at 15 months or older, only 1 dose is required.
  - e. Hib vaccine is not required for children 5 years or older.
  - f. [For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.](#)
10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
  - b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
  - c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
  - d. If one dose of vaccine was received at 24 months or older, no further doses are required.
  - e. PCV is not required for children 5 years or older.
  - f. [For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.](#)

For further information, contact:

**New York State Department of Health  
Bureau of Immunization  
Room 649, Corning Tower ESP  
Albany, NY 12237  
(518) 473-4437**

**New York City Department of Health and Mental Hygiene  
Program Support Unit, Bureau of Immunization,  
42-09 28th Street, 5th floor  
Long Island City, NY 11101  
(347) 396-2433**

New York State Department of Health/Bureau of Immunization  
health.ny.gov/immunization



## IMMUNIZATION REQUIREMENTS FOR SCHOOL ENTRANCE/ATTENDANCE

### Acceptable Proofs of Immunizations

Health care practitioner record, signed by practitioner licensed in New York State. **Records acceptable without a signature:** NYSIIS Record; Official registry from another State; Electronic health record; School health record, (must be transferred **directly** from one school to another); Official record from a foreign nation

### Diagnosis of Disease as Evidence of Immunity

ONLY allowed for varicella. Must be diagnosed by a physician, nurse practitioner, or physician's assistant.

### Serological Evidence of Immunity

Allowed for measles, mumps, rubella, varicella, hepatitis B and poliomyelitis (all three serotypes must be positive. Testing for all three polio serotypes is no longer available in the United States.)

### Medical Exemptions

A student may attend school without the required immunizations if they have a medical exemption. Bethlehem Central School District requests that the following NYSDOH form <https://www.health.ny.gov/forms/doh-5077.pdf> be completed by a physician licensed to practice medicine in NYS certifying that the immunization may be detrimental to the child's health. It must contain sufficient information to identify a medical contraindication to a specific immunization, and specify the length of time the immunization is medically contraindicated. Once the completed form is received it will be reviewed by the District's Medical Director to determine if additional documentation is required. **A medical exemption must be reissued annually.**

## References

New York State Department of Health, **Immunization Laws**  
[https://www.health.ny.gov/prevention/immunization/laws\\_regs.htm](https://www.health.ny.gov/prevention/immunization/laws_regs.htm)

New York State **Immunization Requirements for School Entrance / Attendance**  
<https://www.health.ny.gov/publications/2370.pdf>

New York State Department of Health, **Childhood and Adolescent Immunizations**  
[https://www.health.ny.gov/prevention/immunization/childhood\\_and\\_adolescent.htm](https://www.health.ny.gov/prevention/immunization/childhood_and_adolescent.htm)

Albany County Department of Health, **Immunization Program**  
[https://www.albanycounty.com/departments/health/programs-services/immunization-program#:~:text=Vaccines%20are%20provided%20against%20childhood,\(518\)%20447%2D4589.](https://www.albanycounty.com/departments/health/programs-services/immunization-program#:~:text=Vaccines%20are%20provided%20against%20childhood,(518)%20447%2D4589.)

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM  
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR  
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

**Note:** NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

**STUDENT INFORMATION**

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <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 $\geq 5$ $\mu\text{g}/\text{dL}$
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

**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:	
<b>SCREENINGS</b>					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
<b>Vision</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"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
Notes					
<b>Hearing</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					
Scoliosis Screening: 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> (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
<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>					



ACADEMICS  
CHARACTER  
COMMUNITY  
WELLNESS

Dear Parent or Guardian:

As part of your child's requirement for school, a physical examination is required for students in kindergarten, grades 1, 3, 5, 7, 9, 11 and all new entrants. A NYS School Health Examination Form is attached, to be filled out by your private physician.

Per a recently enacted law, the grades your child has a physical examination we also **request** a dental certificate. A sample certificate is attached. It should be returned to the school nurse and will be filed with your child's cumulative health record when completed.

Thank you for your cooperation in these health endeavors to promote wellness and academic success. Please feel free to contact the Health Office at your child's school if you have any questions or concerns.

Bethlehem Central High School  
(518) 439-4921

Bethlehem Central Middle School  
(518) 439-7705

Eagle Elementary School  
(518) 694-3953

Elsmere Elementary School  
(518) 439-3019

Glenmont Elementary School  
(518) 434-1246

Hamagrael Elementary School  
(518) 439-8889

Slingerlands Elementary School  
(518) 439-8984

**Bethlehem Central School District**

**Dental Health Certificate**

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

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

Child's Name:		
Last	First	Middle
Birth Date:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first oral health assessment ? <input type="checkbox"/> Yes <input type="checkbox"/> No
Month   Day   Year		
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>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.</p> <p>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.</p>		
Parent's Signature	Date	

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

**I. The dental health condition of \_\_\_\_\_ on \_\_\_\_\_ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:**

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

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

**Dentist's/ Dental Hygienist's name and address**  
(please print or stamp)

**Dentist's/Dental Hygienist's Signature**

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

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

- Yes  No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
- Yes  No **Untreated Caries** – Does this child have an open cavity? [At least 1/2 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.



Bethlehem Central  
School District  
Office of the Registrar  
700 Delaware Avenue  
Delmar, NY 12054  
(518) 439-2442

## HEALTH HISTORY FOR NEW ENTRANTS

*This form should be completed and signed by the parent or guardian*

Home School (Please circle one) EAG ELS GLE HAM SLI

Name \_\_\_\_\_ DOB \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Last visit to M.D. (date, reason) \_\_\_\_\_ Date of last physical \_\_\_\_\_ Next M.D. visit (date, reason) \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

**Pregnancy History** (gestational diabetes, bed rest, medication needs)

Labor and Birth History (emergency delivery, premature labor, birth trauma, delayed discharge from hospital): \_\_\_\_\_

Gestation: \_\_\_\_\_ Full term \_\_\_\_\_ Premature Delivery: \_\_\_\_\_ Vaginal \_\_\_\_\_ Cesarean Birth Weight: \_\_\_\_\_

**Growth and Development** / Walked at age: \_\_\_\_\_ Spoke first word at age: \_\_\_\_\_ Spoke sentences at age: \_\_\_\_\_

### Health History

Serious illness: \_\_\_\_\_

Serious injury: \_\_\_\_\_

Surgery: \_\_\_\_\_

**Check if your child has, or has had, any of the following and provide date when appropriate:**

- |                                   |                                  |                                 |
|-----------------------------------|----------------------------------|---------------------------------|
| _____ Allergies                   | _____ Cystic Fibrosis            | _____ Pneumonia                 |
| _____ Animals                     | _____ Diabetes                   | _____ Rheumatic Disease         |
| _____ Bee sting                   | _____ Ear Infections             | _____ Rubella Disease           |
| _____ Food                        | _____ History of PE Tubes        | _____ Scarlet Fever             |
| _____ Medication                  | _____ Eye Conditions             | _____ Seizure Disorder          |
| _____ Seasonal                    | _____ Hearing Problem            | _____ Speech Problem            |
| _____ Other                       | _____ Heart Disease              | _____ Strep Throat              |
| _____ Anemia                      | _____ Hypotonia                  | _____ TB, <b>date:</b>          |
| _____ Asthma                      | _____ Kidney Disease             | _____ Chest X-ray, <b>date:</b> |
| _____ Cerebral Palsy              | _____ Learning Disabilities      | _____ Urinary Infections        |
| _____ Chicken Pox (documentation) | _____ Leukemia                   | _____ Urinary Reflux            |
| _____ Colds & Sore Throats        | _____ Lyme Disease, <b>date:</b> | _____ Vision Problem            |
| _____ Concussion, <b>date:</b>    | _____ Measles                    | _____ Last Vision Exam:         |
| _____ Convulsions                 | _____ Mononucleosis              | _____ Vision Specialist:        |
| _____ With fever                  | _____ Mumps                      | _____ Glasses Worn: YES NO      |
| _____ Without fever               | _____ Orthopedic Conditions      | _____ Whooping Cough            |

**Current Health Status** (Please state if your child is, or has been, under treatment, or taking medication):

Health conditions under treatment: \_\_\_\_\_

Medical provider(s) providing treatment: \_\_\_\_\_

**Medication(s)** Please list all over the counter and prescription medications, including dose and frequency: \_\_\_\_\_

**Will medications need to be given while your child is at school?**

\_\_\_\_\_ Yes \_\_\_\_\_ Not known at this time

**Are the any physical restrictions or limitations for physical education or other activities at school?**

\_\_\_\_\_ Yes \_\_\_\_\_ No \* If restrictions or limitations, M.D. documentation is required

**Has your child ever received, or is currently receiving, the following services:**

\_\_\_\_\_ OT \_\_\_\_\_ PT \_\_\_\_\_ Speech \_\_\_\_\_ Other

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

\_\_\_\_\_  
Date





**Bethlehem Central  
School District**  
Office of the Registrar  
700 Delaware Avenue  
Delmar, NY 12054  
(518) 439-2442

## EAR HEALTH HISTORY

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Child's Age \_\_\_\_\_

*Please help us better understand your child by answering the following questions:*

1. Does your child have normal hearing (when ears are clean and healthy)? \_\_\_\_\_  
\_\_\_\_\_

2. Did your child ever have ear infections? If so, how many total? \_\_\_\_\_

Between birth to 1 year old \_\_\_\_\_ 3 to 4 years old \_\_\_\_\_

1 to 2 years old \_\_\_\_\_ 4 to 5 years old \_\_\_\_\_

2 to 3 years old \_\_\_\_\_ 5+ years old \_\_\_\_\_

How long did the ear infections last? \_\_\_\_\_

How often did they re-occur? \_\_\_\_\_

3. Has your child had myringotomies and PE tubes inserted? \_\_\_\_\_

If so, how many times and at what ages? \_\_\_\_\_

4. Has your child ever been seen by an ear, nose, and throat doctor? \_\_\_\_\_

5. Has your child ever been seen by an audiologist for hearing testing? \_\_\_\_\_

6. Has your child received speech/language therapy? \_\_\_\_\_

If so, at what ages and for how long? \_\_\_\_\_

Therapy was for: \_\_\_\_\_ articulation \_\_\_\_\_

language or other \_\_\_\_\_ (please explain) \_\_\_\_\_

7. Has your child received amplification during periods of not hearing? \_\_\_\_\_  
\_\_\_\_\_

8. Is there anything else in your child's ear health history that may be helpful in understanding your child's educational needs?  
\_\_\_\_\_  
\_\_\_\_\_

9. What concerns do you have about your child and school? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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>		
<i>First</i>	<i>Middle</i>	<i>Last</i>
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
		<input type="checkbox"/> Male
<i>Month</i>	<i>Day</i>	<i>Year</i>
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
<i>Last Name</i>	<i>First Name</i>	<i>Relation to Student</i>

HOME LANGUAGE CODE

### 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	_____
	<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: _____ _____	

## Eligibility Screen for Migrant Education Services

\*\*\* Migrant Education Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed. \*\*\*

Has your family moved to a different school district in the last 3 years? YES \_\_\_\_\_ NO \_\_\_\_\_

In the last three years, **has the parent or guardian** of the child enrolling **done farm work as a paid job?** (Did they work on a dairy farm, planting, picking/harvesting fruits or vegetables, food processing or packaging, logging or tree farming?) YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, what farm did you work on? \_\_\_\_\_ Where? \_\_\_\_\_ When? \_\_\_\_\_



If you can answer **YES** to **BOTH** of the above questions, your family **MAY** qualify for Migrant Education services. To be contacted by a Migrant Education recruiter, please complete the information below.

Child's name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade \_\_\_\_\_  
Child's name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade \_\_\_\_\_  
Child's name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade \_\_\_\_\_  
Child's name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade \_\_\_\_\_

### Parents/ Guardians

Mother's name \_\_\_\_\_ Father's Name \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone # \_\_\_\_\_  
(Street Address)

(city, town or village) (Zip) \_\_\_\_\_  
Work or Message # \_\_\_\_\_

School District \_\_\_\_\_ School Building \_\_\_\_\_

School Contact Person \_\_\_\_\_ Contact Number \_\_\_\_\_

Other Useful information (directions, farm names, best time to contact, etc.) \_\_\_\_\_

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

To submit this referral please fax to the Herkimer BOCES at (315) 867-2087 or mail to the address above. For more information please call the Migrant Program at (315) 867-2079. Thank you for your assistance.

## Cuestionario de Elegibilidad para Servicios de Educación Migrante

\*\*\* Servicios del Programa de Educación Migrante son gratuitos y pueden incluir tutoría, ayuda con necesidades de salud, viajes educacionales, programas del verano, actividades de involucrar a los padres, educación para adultos, ayuda de emergencia y referidos a otros servicios como necesario. \*\*\*

¿Ha mudado su familia a un distrito escolar diferente en los últimos 3 años? Sí NO \_\_\_\_\_

¿En los últimos 3 años ha trabajado un padre o guardián en granja como: lechería, plantando, cosechando frutas o legumbres, el procesamiento o empacar de comida, corta de árboles o cultivo de árboles? Sí NO \_\_\_\_\_

Si UD dijo que si, ¿en que granja?

¿Donde?

¿Cuándo?



Si Usted contestó que **Sí** a **AMBOS** preguntas de arriba, su familia **PUEDA** calificar para servicios de Educación Migrante. Para estar contactado por una reclutadora del Programa de Educación Migrante, favor de llenar la información de abajo.

Nombre del niño(a) \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_ Grado \_\_\_\_\_  
Nombre del niño(a) \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_ Grado \_\_\_\_\_  
Nombre del niño(a) \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_ Grado \_\_\_\_\_  
Nombre del niño(a) \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_ Grado \_\_\_\_\_

### Padres/ Guardianes

Nombre de la Mamá \_\_\_\_\_ Nombre del Papá \_\_\_\_\_  
Dirección de la Casa \_\_\_\_\_ Numero de teléfono en casa \_\_\_\_\_  
(Dirección de la Calle) \_\_\_\_\_ # de teléfono del trabajo o de Mensaje \_\_\_\_\_  
\_\_\_\_\_  
(Ciudad o Pueblo) (Código Postal) \_\_\_\_\_  
Distrito escolar \_\_\_\_\_ edificio escolar \_\_\_\_\_  
Persona para contactar \_\_\_\_\_ numero para contactar \_\_\_\_\_  
Otra información Útil (direcciones, nombres de granjas, mejor hora de llamar, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Para someter este referido, favor de mandarlo por fax al Herkimer BOCES a  
(315) 867-2087 o mandar por correo al dirección de arriba.  
Para más información, favor de llamar al Programa Migrante a (315) 867-2079. Gracias.



## BETHLEHEM CENTRAL SCHOOL DISTRICT

### BCSD STUDENT BUS REGISTRATION FORM 2024-25

Please fill out the Student Bus Registration Form to indicate your child's **general bus transportation needs** for the 2021-22 school year below. Eligibility for bus transportation at BC has not changed.

Your child is eligible for school bus transportation if:

- ▶ **ELEMENTARY SCHOOL:** All children
- ▶ **MIDDLE SCHOOL:** More than 1/2 mile from school
- ▶ **HIGH SCHOOL:** More than 1 mile from school

Important: If you have a child entering grade 6 or grade 9, please be aware that they may not be eligible for transportation based on the criteria listed above.

Thank you for your cooperation.

STUDENT NAME \_\_\_\_\_ DOB \_\_\_\_\_

STUDENT'S  
PRIMARY  
ADDRESS \_\_\_\_\_

SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

#### MORNING (TO SCHOOL)

- YES, my child is eligible for transportation and WILL need transportation in the a.m.
- NO, my WILL NOT need transportation in the a.m.

#### AFTERNOON (FROM SCHOOL)

- YES, my child is eligible for transportation and WILL need transportation in the p.m.
- NO, my WILL NOT need transportation in the p.m.

*Please note: Students at BCHS and BCMS who participate in afterschool activities will still be able to take the late afternoon transfer buses that run during the school year even if that student does not need regular afternoon transportation from school.*

### ADDITIONAL INFORMATION REGARDING STUDENT TRANSPORTATION

- ▶ Information provided above will be entered in Aspen, the district's Student Information System (SIS). Information can only be changed by request of a parent or guardian.
- ▶ If you answer "no" to either question listed above, your child will still be able to request transportation at a later date, if they meet the eligibility criteria listed above.
- ▶ To request a transportation change for your child, please email the BCSD Transportation Department at [transportation@bethlehemschools.org](mailto:transportation@bethlehemschools.org). Please allow up to two (2) business days for confirmation of the change request.

PARENT/GUARDIAN  
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Date Mailed or Faxed:



Bethlehem Central School District  
Office of the Registrar  
Educational Service Center  
700 Delaware Avenue  
Delmar, New York 12054  
(518) 439-2442  
(518) 475-0352 FAX

Authorization for the Release or Transfer of Information

**Student Name:** \_\_\_\_\_

Name and address of school last attended:

**School:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone and /or Fax:** \_\_\_\_\_

The above student has enrolled in our school district. **Please forward all school records including health, psychological, discipline including records of suspension, academic and other data.** Thank you for your assistance.

**SEND TO:**

Bethlehem Central School District  
Office of Central Registration  
700 Delaware Avenue  
Delmar, New York 12054  
(518) 439-2442  
(518) 475-0352 fax  
Email: [mhaas@bethlehemschools.org](mailto:mhaas@bethlehemschools.org)

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date