



**Alba Illescas
Registrar**

Registration Office, 400 S. Division Street, Peekskill, NY 10566-3499

Phone: (914)737-3300 ext. 7535 Fax: (914) 737-0113

Email: aillescas@peekskillschools.org

REGISTRATION CHECKLIST

1. PARENT/GUARDIAN'S DRIVER'S LICENSE OR PASSPORT

2. TWO PROOFS OF RESIDENCY IN PEEKSKILL, SUCH AS:

- CON EDISON BILL
- WATER BILL
- LEASE
- PRINTED RENT RECEIPT STATEMENT
(NO HANDWRITTEN RECEIPTS)
- NOTARIZED LANDLORD CERTIFICATION
- DEED OR MORTGAGE STATEMENT

If you cannot produce the above required documents, you may submit a notarized letter stating that you are living with a Peekskill resident who has one of the above documents, a copy of which must also be submitted.

(PHONE/CABLE BILL/REGULAR MAIL ARE NOT ACCEPTED)

3. BIRTH CERTIFICATE OR PASSPORT

4. CERTIFICATE OF IMMUNIZATIONS

5. PROOF OF TUBERCULOSIS TESTING (PPD) or QUANTIFERON-TB GOLD

6. UP-TO-DATE PHYSICAL EXAMINATION

An appointment card indicating an upcoming physical exam can be used if an up-to-date physical examination is unavailable.

7. RECENT REPORT CARD OR TRANSCRIPT; NAME, ADDRESS, PHONE, FAX OF PREVIOUS SCHOOL ATTENDED (IF AVAILABLE)

8. IF SPECIAL EDUCATION SERVICES ARE REQUIRED, BRING MOST RECENT IEP

NOTE: MUST MAKE APPOINTMENT. IT IS OPTIONAL FOR THE CHILD TO BE PRESENT AT THE TIME OF REGISTRATION



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Student ID# _____

Student Registration/McKinney-Vento Enrollment Form

Student Census / Enrollment Information

Please Print

Student's Full Legal Name: _____
Last First Middle Suffix

Grade: _____ Gender: M ☐ F ☐ Date of Birth: _____
Month Day Year

City/State/Country of Birth: _____

Date Entered USA: _____ Years in US: _____
Month Day Year

Current Address: _____ Apt/Floor: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____ Apt/Floor: _____

City: _____ State: _____ Zip: _____

Current Home/Cell Phone Number: _____

HOUSING QUESTIONNAIRE

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this housing questionnaire will help our District determine the services that your child may be eligible to receive.

Where is the student currently living? (Please check one box)

- | | |
|---|---|
| <input type="checkbox"/> In a shelter | <input type="checkbox"/> In a transitional housing program |
| <input type="checkbox"/> In a motel or hotel? | <input type="checkbox"/> In a car, park, bus, train or campsite |
| <input type="checkbox"/> In a rented trailer/motor home on private property | <input type="checkbox"/> In a single room occupancy building |
| <input type="checkbox"/> In a rented garage due to loss of housing | |
| <input type="checkbox"/> Awaiting foster placement | <input type="checkbox"/> Other place unfit for human habitation |
| <input type="checkbox"/> Temporarily in another's family house or apt due to loss of housing? | |
| <input type="checkbox"/> Temporality with an adult that is not the parent/legal guardian due to loss of housing? | |
| <input type="checkbox"/> With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up") | |
| <input type="checkbox"/> Other temporary living situation (Please describe): _____ | <input type="checkbox"/> NONE OF THESE CHOICES APPLY |

Parent/Guardian Signature: _____ Date: _____



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Student ID# _____

Student Racial and Ethnic Identification

Please answer both questions (1) AND (2)

(1) Is the student Hispanic, Latino or of Spanish origin?

☐

YES

☐

NO

Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

(2) Please check one or more races from the following racial groups.

Check all groups that apply to your child.

| | |
|--------------------------|--|
| <input type="checkbox"/> | American Indian or Alaska Native A person having origins in any of the original peoples of North and South America (including Central America), and who maintains cultural identification through tribal affiliation or community attachment, (e.g. Cherokee, Mohawk, Inuit) |
| <input type="checkbox"/> | Asian A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent for example, Cambodia, China, India, Japan, Korea, Malaysia Pakistan, the Philippine Islands, Thailand. And Vietnam. |
| <input type="checkbox"/> | Native Hawaiian or Other Pacific Islander A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. |
| <input type="checkbox"/> | Black or African American A person having origins in any of the black racial groups of Africa |
| <input type="checkbox"/> | White A person having origins in any of the original people of Europe, North Africa, or the Middle East. |

Parent/Guardian Signature: _____ **Date:** _____



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Student ID# _____

Registration Form- Student Census/Enrollment Information

Student Lives With: Please check one box

- ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Mother/Stepfather
☐ Father/Stepmother ☐ Relatives _____ ☐ Other _____

Note: When a student does not reside with both parents, additional information must be on file so that the school can determine who is responsible for the student. There must be applicable legal documents (custody papers), a copy of which should be provided to the school. In the event of an emergency situation, the school will provide the necessary form(s) for the parent/guardian to complete.

Parent/Guardian Information

Name: _____

Relationship to Student: _____ Legal Guardian ☐ Yes ☐ No

Current Address: _____

Household Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Additional Information: _____

Parent/Guardian Information

Name: _____

Relationship to Student: _____ Legal Guardian ☐ Yes ☐ No

Current Address: _____

Household Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Additional Information: _____

Parent/Guardian Signature: _____ **Date:** _____



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Student ID# _____

Registration Form- Student Census/Enrollment Information

Parent Not Living with the Student

Name: _____

Relationship to Student: _____ Legal Guardian ☐ Yes ☐ No

Current Address: _____

Household Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Additional Information: _____

Name: _____

Relationship to Student: _____ Legal Guardian ☐ Yes ☐ No

Current Address: _____

Household Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Additional Information: _____

Sibling(s)

Student's Full Legal Name: _____

Last First Middle Suffix

Grade: _____ Gender: M ☐ F ☐ Date of Birth: _____ School: _____

Student's Full Legal Name: _____

Last First Middle Suffix

Grade: _____ Gender: M ☐ F ☐ Date of Birth: _____ School: _____

Parent/Guardian Signature: _____ Date: _____



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Student ID# _____

Registration Form- Student Census/Enrollment Information

Sibling(s)

Student's Full Legal Name: _____
Last First Middle Suffix

Grade: _____ Gender: M ☐ F ☐ Date of Birth: _____ School: _____

Student's Full Legal Name: _____
Last First Middle Suffix

Grade: _____ Gender: M ☐ F ☐ Date of Birth: _____ School: _____

Other Emergency Contact Information

Emergency Contact # ☐ 1 ☐ 2 ☐ 3 ☐ 4 (Check only one)

Name: _____ Relationship to Student: _____

Household Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact # ☐ 1 ☐ 2 ☐ 3 ☐ 4 (Check only one)

Name: _____ Relationship to Student: _____

Household Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact # ☐ 1 ☐ 2 ☐ 3 ☐ 4 (Check only one)

Name: _____ Relationship to Student: _____

Household Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact # ☐ 1 ☐ 2 ☐ 3 ☐ 4 (Check only one)

Name: _____ Relationship to Student: _____

Household Phone: _____ Work Phone: _____ Cell Phone: _____

Parent/Guardian Signature: _____ Date: _____



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Student ID# _____



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

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. | | |
|--|------------|---------------------|
| STUDENT NAME: | | |
| First | Middle | Last |
| DATE OF BIRTH: | | GENDER: |
| Month | Day | Year |
| <input type="checkbox"/> Male <input type="checkbox"/> Female | | |
| PARENT/PERSON IN PARENTAL RELATION INFO: | | |
| Last Name | First Name | Relation to Student |

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 _____ <i>specify</i> <input type="checkbox"/> Father _____ <i>specify</i> <input type="checkbox"/> Guardian(s) _____ <i>specify</i> | |
| 4. What language(s) does your child understand? | <input type="checkbox"/> English <input type="checkbox"/> Other _____ <i>specify</i> | |
| 5. What language(s) does your child speak? | <input type="checkbox"/> English <input type="checkbox"/> Other _____ <i>specify</i> <input type="checkbox"/> Does not speak | |
| 6. What language(s) does your child read? | <input type="checkbox"/> English <input type="checkbox"/> Other _____ <i>specify</i> <input type="checkbox"/> Does not read | |
| 7. What language(s) does your child write? | <input type="checkbox"/> English <input type="checkbox"/> Other _____ <i>specify</i> <input type="checkbox"/> 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: |
| District Name (Number) & School _____ Address _____ | |

Parent/Guardian Signature: _____ Date: _____



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Student ID# _____

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* <input type="checkbox"/> No <input type="checkbox"/> Not sure <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? _____ | |

Signature of Parent or of Person in Parental Relation _____

Month: _____ Day: _____ Year: _____
Date

Relationship to student: ☐ Mother ☐ Father ☐ 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: _____ Mo. DAY YR. | 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: _____ Mo. DAY YR. | 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: _____ | |

Parent/Guardian Signature: _____ Date: _____



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Student ID# _____

Language Assessment

What is the first language the student learned to speak?

☐ English ☐ Spanish ☐ Arabic ☐ Other – please specify _____

Is the answer above a language OTHER than English? ☐ Yes ☐ No

Is a language OTHER than English regularly used by the parent(s) or guardian(s)? ☐ Yes ☐ No

If Yes, please specify - ☐ English ☐ Spanish ☐ Arabic ☐ Other – please specify _____

The student speaks:

☐ No English ☐ Some English ☐ Another Language and English Equally ☐ Mostly or Only English

Special Services Information

Is your child receiving special education services? ☐ Yes ☐ No

Does your child have a current 504 Plan? ☐ Yes ☐ No

If **yes**, please indicate if related to: ☐ Academics ☐ Health

Was your child in any Gifted/Talented programs? ☐ Yes ☐ No if **yes**, please list _____

Has your child ever received Academic Intervention Services? ☐ Yes ☐ No

Does your child receive any other services (Remedial Reading, etc.)? ☐ Yes ☐ No

If **yes**, please indicate _____

Does your child participate in sports? ☐ Yes ☐ No If **yes**, please indicate _____

Does your child have any medical alerts? ☐ Yes ☐ No if **yes**, please explain:

Parent/Guardian Signature: _____ **Date:** _____



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Student ID# _____

Previous School Information

Has the student attended any United States school in any 3 years during his/her lifetime? ☐ Yes ☐ No

Last School Attended: _____

Grade: _____ School Year: _____ City: _____ State: _____

Previous School Attended (Include Pre-School and Nursery Schools):

| School name | Address | Grade | Dates Attended |
|-------------|---------|-------|----------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Date entered 9th Grade: _____
Month Year

List the **first time** the student was enrolled in **any school in the US** (including Pre-School and Kindergarten):

Month Year Grade (Pre-school – 12)

List the **most recent** time the student was enrolled in **any school in the US** (including Pre-School and Kindergarten):

Month Year Grade (Pre-school – 12)

Parent/Guardian Signature: _____ **Date:** _____



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Student ID# _____

This form will be given to the Nurse after registration.

Doctor/Primary Care Provider

Name: _____

Telephone: _____ Extension: _____

Hospital: _____

Date of Last Visit: _____ Name of Dentist: _____

In an emergency situation, the student will be transported to the nearest hospital and/or if the parents' hospital of choice is on divert, the Emergency Personnel will select the alternative site.

*If a parent or legal guardian cannot be notified and immediate medical care is indicated, the school will call 911.
However, the Peekskill City School District will in no case accept financial responsibility for care.*

Health Concerns

Parents/Guardians are responsible for providing full details on any medical condition to the school nurse

Any problems during pregnancy or delivery? (any drugs or medication during pregnancy, etc.) ☐ Yes ☐ No

Was the pregnancy full term? ☐ Yes ☐ No Child's birth weight: _____ lbs. _____ oz.

Does your child wear glasses? ☐ Yes ☐ No Does your child wear contacts? ☐ Yes ☐ No

If yes, name of eye doctor: _____

Has your child been seen by a psychologist, psychiatrist or neurologist or social worker? ☐ Yes ☐ No

If so, explain:

Medical consent to contact your health care provider when necessary? ☐ Yes ☐ No

Parent/Guardian Signature: _____ **Date:** _____



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Student ID# _____

This form will be given to the Nurse after registration.

Medical Alerts (Asthma, Allergies, etc.)

Medical Alert 1: _____

Medical Alert 2: _____

Medication Information

Is your child taking any medication regularly? ☐ Yes ☐ No

If yes, please list the medication(s): _____

Is your child allergic to any medication(s)? ☐ Yes ☐ No

If yes, please list the medication(s): _____

Indicate allergic reaction: _____

Student Medication Request Release Agreements are available at the school office. This form must be completed for any medication a student will need to take during school hours.

Current Medications

| Name | Dose | Time Taken | Doctor | Reason |
|------|------|------------|--------|--------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Immunization Information

*In order for your child to attend school, immunization documentation needs to be on file at the school by the first day of attendance. If immunization documentation is **NOT** complete, the student **MUST** see the school nurse or designee before enrollment can be completed.*

Parent/Guardian Signature: _____ **Date:** _____



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Student ID# _____

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Health Questionnaire

HAS THIS CHILD EXPERIENCED ANY OF THE FOLLOWING:

| Yes | No | | Yes | No | |
|-----|-----|---|-----|-----|--------------------------------|
| ___ | ___ | Head Injury | ___ | ___ | Hypertension |
| ___ | ___ | Loss of Consciousness | ___ | ___ | Diabetes |
| ___ | ___ | Headache | ___ | ___ | Stomach Aches |
| ___ | ___ | Seizures | ___ | ___ | Constipation / Diarrhea |
| ___ | ___ | Attention Deficit Disorders | ___ | ___ | Dietary Restrictions |
| ___ | ___ | Visual Problems | ___ | ___ | Bed Wetting |
| ___ | ___ | Anemia | ___ | ___ | Menstrual Cramps (Severe) |
| ___ | ___ | Nose bleeding | ___ | ___ | Motion Sickness |
| ___ | ___ | Chronic Ear Infections (More than 2 years) | ___ | ___ | Skin Problems |
| ___ | ___ | Hearing Difficulties | ___ | ___ | Lyme Disease |
| ___ | ___ | Frequent Sore Throat | ___ | ___ | Lead Poisoning: Date Tested___ |
| ___ | ___ | | ___ | ___ | Chicken Pox or (Vaccine___) |
| ___ | ___ | Asthma / Wheezing | ___ | ___ | Sickle Cell Anemia |
| ___ | ___ | Heart Problems / Murmur | ___ | ___ | Weight Problem |

Parent/Guardian Signature: _____ Date: _____



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Student ID# _____

This form will be given to the Nurse after registration.

Parent/Guardian Informed Consent Form

Potassium Iodide Administration During School Hours In The Event Of a Nuclear Emergency

Reason for Taking Potassium Iodide

In the event of an accident at a nuclear power plant or what is known as a radiological emergency, radioactive iodine may be released into the air. This material may be inhaled or ingested and enter the thyroid gland where it can cause cancer and/or disease. Children and infants are the most vulnerable to this occurrence. When taken by pill, Potassium Iodide (KI) floods the thyroid with non-reactive iodine and prevents the thyroid from absorbing the radioactive material. Potassium Iodide needs to be given before or shortly after exposure to radiation. Potassium Iodide works only to prevent the thyroid from absorbing radioactive iodine.

Potential Side Effects of Potassium Iodide

It is possible to experience any or all of the following side effects when taking Potassium Iodide:

Upset stomach, Rash, Allergic reaction - A reaction can range from mild (rash, metallic taste in the mouth, sometimes stomach upset and diarrhea) to severe (fever, joint pain, swelling of parts of the face and body and at times severe shortness of breath requiring immediate medical attention).

Risks of Taking Potassium Iodide

Taking Potassium iodide is safe for most people*. Potassium Iodide should not be taken if someone:

Is allergic to Iodine, Has Graves' Disease, Has any other thyroid illness, Takes thyroid medication

* Parents/guardians are requested to contact their child's physician if they have specific questions regarding the safety of KI administration to their child prior to returning this consent form to the school nurse.

Administration of Potassium Iodide

Potassium Iodide will only be given:

In the event of a radiological emergency

When it is recommended by public health officials

If a parent/guardian signs a consent form for a child under the age of 18 years

Informed Consent: Please complete the following information and return to the school nurse at your child's school.

Child's Name: _____ Age: _____ Date of Birth: _____

☐ **I do not consent** to have my child receive Potassium Iodide in the event of a nuclear emergency

☐ **I consent** to have the school nurse or his/her designee administer Potassium Iodide to my child

Parent/Guardian Name: _____ Telephone Number: _____

Parents Address: _____

If consent is given, can your child swallow pills?

☐ Yes

☐ No

If **No**, please explain below:

Parent/Guardian Signature: _____ Date: _____



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Student ID# _____

This page is intentionally left blank.

Parent/Guardian Signature: _____ Date: _____



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Student ID# _____

This form will be given to the Transportation Department after registration.

Transportation Request Form (Only For Grades K – 5)

Student's Full Legal Name: _____
Last First Middle Suffix
Grade: _____ Gender: M ☐ F ☐ Date of Birth: _____ School: _____

Sibling's Full Legal Name: _____
Last First Middle Suffix
Grade: _____ Gender: M ☐ F ☐ Date of Birth: _____ School: _____

Sibling's Full Legal Name: _____
Last First Middle Suffix
Grade: _____ Gender: M ☐ F ☐ Date of Birth: _____ School: _____

Parent/Guardian Name: _____ Relationship to Student: _____
Current Address: _____
Household Phone: _____ Work Phone: _____ Cell Phone: _____

Parent/Guardian Name: _____ Relationship to Student: _____
Current Address: _____
Household Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact
Name: _____ Relationship to Student: _____
Household Phone: _____ Work Phone: _____ Cell Phone: _____

***** PLEASE NOTE** – If bussing to a baby-sitter and/or day care is needed, please contact the Transportation Department at 914-737-3300 x 7702 to make these arrangements.

Parent/Guardian Signature: _____ Date: _____



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Student ID# _____

This form will be given to the Transportation Department after registration.

Parent-Student Compact for Bus Safety

BUS DISCIPLINE

Misconduct and Unacceptable Behavior:

Behaviors such as using profanity; disrespectful to the driver, monitor or other students; throwing objects on or from the bus; standing while bus is in motion; climbing over seats; eating or drinking; and any other behavior not consistent with the Peekskill City School District Code of Conduct for students. Transportation is a continuation of the school day. All conduct reports that require disciplinary action will be forwarded to the Principal of the School your child attends who will then determine the course of action.

1st Offense: Verbal Warning
2nd Offense: Written Warning
3rd Offense: 1-Day Bus Suspension

Smoking on Bus:

1st Offense: Written Warning
2nd Offense: 1-Day Bus Suspension
3rd Offense: 3-Day Bus Suspension
Recurring Offenses: Indefinite Bus Suspension and Superintendent Review

Physical Assaults/Fighting or Threats of Any Type:

1st Offense: Minimum of a 3-Day Bus Suspension (depending on severity of action)
2nd Offense: Indefinite Bus Suspension and Superintendent Review
Each situation May Require Referral to Police Agency

Use of Drugs or Alcohol:

Any Offense: Referral to Police Agency, Indefinite Bus Suspension and Superintendent Review

Vandalism to the Bus:

Any Offense: Referral to Police Agency, Indefinite Bus Suspension and Superintendent Review

THE PARENT/GUARDIAN MUST SIGN AND RETURN THIS FORM NO LATER THAN THE SECOND WEEK IN SEPTEMBER TO THE TRANSPORTATION DEPARTMENT. AFTER THE THIRD WEEK IN SEPTEMBER STUDENTS WILL NOT BE ALLOWED ON THE BUS UNTIL THIS FORM HAS BEEN SIGNED AND RETURN.

I certify that I am the legal parent/ guardian of the child named below and that I have received and understand; and have discussed with my child the Compact for Bus Safety as well as the consequences of inappropriate behavior. I am also aware that I am responsible for providing the Transportation Office with any changes to the information provided below.

Student's Full Legal Name: _____
Last First Middle Suffix

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____



Alba Illescas
Registrar

Registration Office, 400 S. Division Street, Peekskill, NY 10566-3499
Phone: (914)737-3300 ext. 7535 Fax: (914) 737-0113
Email: aillescas@peekskillschools.org

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Student ID# _____

Release of Information

The registrar of the City School District of Peekskill, New York is requesting all records including academic records, health records, birth certificates, etc. Send these records to the attention of the Registrar.

If the student is receiving Special Education Services, please forward all confidential evaluations (i.e. **PSYCHOLOGICAL, SOCIAL HISTORY, EDUCATIONAL, SPEECH/LANGUAGE, PHYSICAL, etc. including IEP to the attention of the Director of Special Education.**

STUDENT(s) _____ **DOB** _____

SCHOOL NAME/ADDRESS _____

RECORDS COMING FROM: _____

Phone #: _____ **Fax #:** _____

IF STUDENT ATTENDS SPECIAL EDUCATION CLASSES, PLEASE LIST ADDRESS AND PHONE # OF SPECIAL EDUCATION OFFICES BELOW:

Phone #: _____ **Fax #:** _____

Signed Consent for Records: I have been told that in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, and will be in effect for 1 year after the date of my signature, unless specified. I also understand that I may revoke this authorization in writing except to the extent that action has been taken in reliance thereon. Refusal to sign this authorization will not impact treatment. HIV-related information contained in the parts of the record will not be released through this consent. A separate consent is required to release HIV-related information.

Parent/Guardian Signature

(Date)

SEND RECORDS TO:

Registration Office
400 S. Division Street
Peekskill, NY 10566
Phone (914) 737-3300 x 7535
Fax (914) 737-0113

If Special Education:

CSE/CPSE Chairperson
Peekskill City Schools
1031 Elm Street
Peekskill, New York 10566
Phone (914) 737-3300 x 1525 / Fax (914) 788-7584

Parent/Guardian Signature: _____ **Date:** _____

