



KELLY E. SEIBERT
ASSISTANT SUPERINTENDENT FOR BUSINESS
AND MANAGEMENT SERVICES; DISTRICT CLERK
BYRAM HILLS CENTRAL SCHOOL DISTRICT
KSEIBERT@BYRAMHILLS.ORG
(914) 273-4198 x5931

To Prospective Registrants:

Thank you for considering the Byram Hills School District for your child(ren). Our schools are a great place to learn!

This packet is designed for your use in registering your child(ren) in the Byram Hills School District and is **Part I** of the registration process from the District Business Office.

The packet includes a checklist (Form A), which describes the required documentation that must be submitted to meet the requirements for District registration.

After gathering the required documentation and completing the enclosed forms, please return all forms, along with the required documentation, to the District Business Office.

You may return the completed packet and required documents to the Registrar, Bridget Kirby, one of the following ways:

- scan and email to bkirby@byramhills.net
- mail to BHCSO 10 Tripp Lane, Armonk, NY 10504
- call to set up an appointment to drop off, **914-273-4198 x5930**

Upon completion of **Part I** of the process (District registration), the school(s) will be notified when you have satisfied proof of residency and the school(s) will contact you to begin **Part II** of the registration process.

Sincerely,

Kelly E. Seibert

Mr. Kelly E. Seibert
Assistant Superintendent for Business & Management Services



BYRAM HILLS SCHOOL DISTRICT

10 Tripp Lane, Armonk, New York 10504
Office: 914-273-4198 Fax: 914-273-4199

REQUIREMENTS TO VERIFY RESIDENCY

Education Law (Section 3202.1) states that the residency of the parent is the official residency of the student.

Parents need to present Form B along with the documents below to the school Registrar. If these documents are not available, the parent will need to meet with the Assistant Superintendent for Business.

Please note that documentation requirements will be waived for unaccompanied, undocumented and homeless children. Such children will be admitted first, with documentation to be collected after enrollment, and as available.

DOCUMENTS REQUIRED TO VERIFY RESIDENCY AT THE TIME OF REGISTRATION OR FOR CHANGE OF ADDRESS:

For Homeowners:

- Notarized Affidavit (Form B)
- Property Tax Bill OR Closing Statement OR Deed
- Any two (2) of the following supporting documents: Utility bills, updated driver's license, auto registration, auto insurance, Voter's Registration Card

For Renters:

- Notarized Affidavit (Form B)
- Signed Lease
- Any two (2) of the following supporting documents: Utility bills, updated driver's license, auto registration, auto insurance, Voter's Registration Card

For Families living with friends or family:

- Notarized Affidavit (Form B)
- Notarized Affidavit of Homeowner [Click here for Homeowner Affidavit](#)
- Any two (2) of the following supporting documents: Utility bills, updated driver's license, auto registration, auto insurance, Voter's Registration Card

BYRAM HILLS SCHOOL DISTRICT
10 TRIPP LANE
ARMONK, NEW YORK 10504

FORM B
Please have notarized

PROOF OF RESIDENCY FORM
(required for all children)

Parent(s) or Guardian(s) Name: _____

Address: _____

Record all children, residing in the district, WHO WILL BE ENROLLING in Byram Hills Schools						
Child's Name	Sex M/ F	Child's DOB	School(s) Previously Attended	Current Grade (If entering between Sept. and June)	Last Grade Completed (If entering July or August)	District Use Only: Student ID

OTHER CHILDREN LIVING AT HOME					
Record all Preschool & Non-school Age children/School-Age NOT attending Byram Hills Schools					
Child's Name	Sex M/ F	Child's DOB	Current School (if applicable)		District Use Only: Student ID

In order for your child/children to attend the Byram Hills School District, you must be a resident of the School District. Section 210.45 of the Penal Law of the State of New York prohibits the making of a false written statement. Therefore, statements contained in your registration application must be true and accurate. If the School District determines that you are not a resident, your child/children will be excluded from attending the Byram Hills Schools. Further, you will be liable to the School District for payment of tuition from their date of enrollment through their date of exclusion, as well as the costs of collection.

I certify that I am the parent or guardian¹ of (list all names) _____

and reside at the address listed above. I have attached a copy of my tax bill, contract of sale, closing statement, lease or other documentation of ownership or tenancy. I have also provided (*or will be providing in a timely manner*) at least two other forms of documentation for proof of residency (examples: current tax forms, current utility bill, current car registration, etc.).

Signature of Parent/Guardian

Subscribed to and sworn before me this

_____ day of _____, 20____

Notary Public Signature
Commission expires on:
(Seal/Stamp)

¹If someone other than a natural parent is attempting to register a student, approval from the Superintendent's office may be required. In such case, satisfactory documentation will be required showing that responsibility for the child's care, custody, expenses, and educational decision-making have been assumed.

²Please note that documentation requirements will be waived for unaccompanied, undocumented and homeless children. Such children will be admitted first, with documentation to be collected after enrollment, and as available.

Byram Hills School District

Registration Form

HOUSEHOLD INFORMATION

Family's Last Name _____ Today's Date _____

Residence Type (choose one): Lease Own Rent Other: _____

Household Residence Address: _____

Household Mailing Address, if different from residence address: _____

Primary Household Phone: _____ Is this a Cell Phone? YES NO

Language Spoken at Home _____

Have **any** of your children previously attended a Byram Hills school or received special services from the School District?

YES NO If YES, Last school year/ date of attendance _____

Address at the time, **if different** than current address _____

RESIDING "IN HOUSEHOLD" – PARENT/GUARDIAN #1

First Name _____ Last Name _____

Salutation Mr. Mrs. Ms. Dr. Other _____ Gender: Male Female

Relationship to Student: Mother Father Other _____

Cell Phone _____ Work Phone _____

Email Address _____ Custodial Parent/Guardian?: Yes No

Is parent full-time, active-duty member of US Armed Forces or National Guard? Yes No If Yes, Entry Date _____

RESIDING "IN HOUSEHOLD" – PARENT/GUARDIAN #2

First Name _____ Last Name _____

Salutation Mr. Mrs. Ms. Dr. Other _____ Gender: Male Female

Relationship to Student: Mother Father Other _____

Cell Phone _____ Work Phone _____

Email Address _____ Custodial Parent/Guardian?: Yes No

Is parent full-time, active-duty member of US Armed Forces or National Guard? Yes No If Yes, Entry Date _____

RESIDING "OUTSIDE THE HOUSEHOLD" – PARENT/GUARDIAN

First Name _____ Last Name _____

Salutation Mr. Mrs. Ms. Dr. Other _____ Gender: Male Female

Relationship to Student: Mother Father Other _____

Out of Household Address: _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Custodial Parent/Guardian?: Yes No

Is parent full-time, active-duty member of US Armed Forces or National Guard? Yes No If Yes, Entry Date _____

Byram Hills School District

Registration Form

STUDENT #1 REGISTRATION

Student First Name _____	Student Last Name _____
Date of Birth: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
PREVIOUS SCHOOL INFORMATION	
Name of Last School Attended: _____ Phone _____	
Street Address: _____ City _____ State _____ Zip _____	
Last Date /school year of attendance: _____	
Has this student previously attended Byram Hills CSD schools? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If Yes, Last Grade Attended at Byram Hills _____ Last Date/Year of Attendance _____	
STUDENT RACIAL AND ETHNICITY: The State and Federal Education Departments have adopted a policy which requires the collection and recording of the ethnic identity of students in accordance with the federal categories and definitions. The Byram Hills School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with State and Federal student privacy laws and regulations.	
Is Student Hispanic, Latino or of Spanish Origin? Hispanic, Latino or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin. <input type="checkbox"/> Yes - Hispanic <input type="checkbox"/> No – Not Hispanic	
Choose Race. Check off all boxes that apply . <input type="checkbox"/> WHITE: A person having origins in any of the original peoples of Europe including Spain, North Africa or the Middle East. <input type="checkbox"/> BLACK: A person having origins in any of the black racial groups of Africa. <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"/> ASIAN: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam <input type="checkbox"/> NATIVE AMERICAN INDIAN OR NATIVE ALASKAN: A person having origins in any of the original peoples of North and South America (including Central America) and who derives tribal affiliation or attachment. e.g. Cherokee, Mohawk, Inuit, Mayan, Inca (but not limited to those listed)	
Child's Dominant Language: _____	Resides With _____
Place of Birth: (City/State/Province/Region) _____	Country of Birth _____
Total Years Previously Attended U.S. Schools (ages 3-21) _____	
Entering Grade _____	Entering School _____
Has the child been identified as having a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please complete the Special Services Form.	
[For District Use only]	
Student ID #: _____	Proof of Birth: <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Passport

Byram Hills School District Registration Form

STUDENT #2 REGISTRATION

Student First Name _____	Student Last Name _____
Date of Birth: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
PREVIOUS SCHOOL INFORMATION	
Name of Last School Attended: _____ Phone _____	
Street Address: _____ City _____ State _____ Zip _____	
Last Date /school year of attendance: _____	
Has this student previously attended Byram Hills CSD schools? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If Yes, Last Grade Attended at Byram Hills _____ Last Date/Year of Attendance _____	
STUDENT RACIAL AND ETHNICITY: The State and Federal Education Departments have adopted a policy which requires the collection and recording of the ethnic identity of students in accordance with the federal categories and definitions. The Byram Hills School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with State and Federal student privacy laws and regulations.	
Is Student Hispanic, Latino or of Spanish Origin? Hispanic, Latino or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin. <input type="checkbox"/> Yes - Hispanic <input type="checkbox"/> No – Not Hispanic	
Choose Race. Check off all boxes that apply .	
<input type="checkbox"/> WHITE: A person having origins in any of the original peoples of Europe including Spain, North Africa or the Middle East.	
<input type="checkbox"/> BLACK: A person having origins in any of the black racial groups of Africa.	
<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"/> ASIAN: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam	
<input type="checkbox"/> NATIVE AMERICAN INDIAN OR NATIVE ALASKAN: A person having origins in any of the original peoples of North and South America (including Central America) and who derives tribal affiliation or attachment. e.g. Cherokee, Mohawk, Inuit, Mayan, Inca (but not limited to those listed)	
Child's Dominant Language: _____	Resides With _____
Place of Birth: (City/State/Province/Region) _____	Country of Birth _____
Total Years Previously Attended U.S. Schools (ages 3-21) _____	
Entering Grade _____	Entering School _____
Has the child been identified as having a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please complete the Special Services Form.	
[For District Use only]	
Student ID #: _____	Proof of Birth: <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Passport

Byram Hills School District

Registration Form

STUDENT #3 REGISTRATION

Student First Name _____	Student Last Name _____
Date of Birth: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
PREVIOUS SCHOOL INFORMATION	
Name of Last School Attended: _____ Phone _____	
Street Address: _____ City _____ State _____ Zip _____	
Last Date /school year of attendance: _____	
Has this student previously attended Byram Hills CSD schools? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If Yes, Last Grade Attended at Byram Hills _____ Last Date/Year of Attendance _____	
STUDENT RACIAL AND ETHNICITY: The State and Federal Education Departments have adopted a policy which requires the collection and recording of the ethnic identity of students in accordance with the federal categories and definitions. The Byram Hills School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with State and Federal student privacy laws and regulations.	
Is Student Hispanic, Latino or of Spanish Origin? Hispanic, Latino or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin.	
<input type="checkbox"/> Yes - Hispanic <input type="checkbox"/> No – Not Hispanic	
Choose Race. Check off all boxes that apply .	
<input type="checkbox"/> WHITE: A person having origins in any of the original peoples of Europe including Spain, North Africa or the Middle East.	
<input type="checkbox"/> BLACK: A person having origins in any of the black racial groups of Africa.	
<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"/> ASIAN: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam	
<input type="checkbox"/> NATIVE AMERICAN INDIAN OR NATIVE ALASKAN: A person having origins in any of the original peoples of North and South America (including Central America) and who derives tribal affiliation or attachment. e.g. Cherokee, Mohawk, Inuit, Mayan, Inca (but not limited to those listed)	
Child's Dominant Language: _____	Resides With _____
Place of Birth: (City/State/Province/Region) _____	Country of Birth _____
Total Years Previously Attended U.S. Schools (ages 3-21) _____	
Entering Grade _____	Entering School _____
Has the child been identified as having a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please complete the Special Services Form.	
[For District Use only]	
Student ID #: _____	Proof of Birth: <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Passport



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

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

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

Home Language Questionnaire (HLQ)

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

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

HOME LANGUAGE CODE

Language Background

(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<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"/> Parent 1	_____	<input type="checkbox"/> Parent 2
		<i>specify</i>	<i>specify</i>
	<input type="checkbox"/> Guardian(s)	_____	<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak
		<i>specify</i>	
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
		<i>specify</i>	
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write
		<i>specify</i>	

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

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

District Name (Number) & School:

Address:

Home Language Questionnaire (HLQ)—Page Two

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: _____ PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING

Mo. DAY YR.

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



SPECIAL SERVICES AND HEALTH SERVICES

BYRAM HILLS CENTRAL SCHOOL DISTRICT

JILL BOYNTON
DIRECTOR
JBOYNTON@BYRAMHILLS.ORG
(914) 273-2280 x9992

MEREDITH BRIANT
ASSISTANT DIRECTOR GRADES K-5
MBRIANT@BYRAMHILLS.ORG
(914) 273-2280 x9999

COLLEEN O'CONNOR
ASSISTANT DIRECTOR GRADES 6-12
COCONNOR@BYRAMHILLS.ORG
(914) 273-2280 x9994

Welcome to Byram Hills!

If your child is entering the Byram Hills Central School District and has a current Individualized Education Program (IEP) or a Section 504 Plan, please take a moment to fill out this form.

Name of Child: _____
Date of Birth: _____
Current Grade: _____

My Child currently has an:
IEP
Section 504 plan

* Please attach current IEP or 504 document(s)

The following is a release information that will allow the Byram Hills Special Services Department to contact your child's most recent school district to obtain copies of their IEP/504 and any other pertinent reports or evaluations that are part of your child's educational record.

Permission is hereby given to the Byram Hills School District's Special Services Department to obtain all confidential records of my child, **(Student Name)** _____, from

Name of School: _____

School Address: _____

Parent's Signature

Address

Date

* If your child does not have an IEP and you would like information regarding the referral process, please refer to "A Parent's Guide to Special Education" on the NYSED website: <http://www.p12.nysed.gov/specialed/parentpubs.htm>.
Or, you can also contact Ms. Boynton, Director, or Ms. Saponè, Asst. Director, or Ms. O'Connor, Asst. Director, in Special Services at 914-273-2280.

Rev: 5/2/23

**Byram Hills Central School District
Office of Special Services and Health Services
12 MacDonald Avenue
Armonk, NY 10504
Phone: (914) 273-2280
Fax: (914) 273-2517**

Dear Parents / Guardians of New Registrants,

Welcome to Byram Hills! A Wonderful Place to Learn....

The goal of the District's Health Services program is to advance the well-being, health and lifelong achievement of our students. This letter outlines the requirements necessary for school entrance which are to be submitted during the registration process. All required Health Services forms are included in this packet.

You must submit an immunization record and health appraisal form (physical examination), which is signed and stamped by your family physician, to your child's School Nurse. **New York State Education Law §914(1) requires that every child attending school submit proof of the immunizations required by Public Health Law §2164.** The immunization record will be reviewed by your respective School. If you submit these documents at the time of residency verification, the Business Office Secretary will forward to the appropriate school nurse.

We are here to help you and to make your transition to our school and community pleasurable. If you have questions related to student Health Services, you can contact your child's school nurse while school is in session. Between July 1 and the first day of school, you can direct your calls to Jill Boynton, Director of Special Services, at 273-2280 x 3992.

2025-26 School Year

New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

All children must be age-appropriately immunized to attend school in New York State. 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 shown on the schedule 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 gradeless 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
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)²	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older and the series was started at less than 1 year of age or 3 doses if 7 years or older and the series was started at 1 year or older	3 doses	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)³	Not applicable		1 dose given after age 10 years	
Polio vaccine (IPV/OPV)⁴	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)⁵	1 dose	2 doses		
Hepatitis B vaccine⁶	3 doses	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 years through 15 years		
Varicella (Chickenpox) vaccine⁷	1 dose	2 doses		
Meningococcal conjugate vaccine (MenACWY)⁸	Not applicable		Grades 7, 8, 9, 10 and 11: 1 dose	Grade 12: 2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)⁹	1 to 4 doses	Not applicable		
Pneumococcal Conjugate vaccine (PCV)¹⁰	1 to 4 doses	Not applicable		

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.
*Serological titers are never accepted for tetanus, diphtheria, pertussis, meningococcal, haemophilus influenzae type b, and pneumococcal diseases.
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.
 - d. For further information, refer to the [CDC Catch-Up Guidance for Children 4 Months through 6 Years of Age](#).
 - e. For further information, refer to the [CDC Catch-Up Guidance for Children 7 through 9 Years of Age](#).
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 11: 10 years; minimum age for grade 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 2025-26, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 11; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grade 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.
 - d. For further information, refer to the [CDC Catch-Up Guidance for Children 10 through 18 Years of Age](#).
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 New York State 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.
 - e. For further information, refer to the [CDC Catch-Up Guidance for Children 4 Months through 17 Years of Age](#).
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 pre-kindergarten. Two doses are required for grades kindergarten through 12.
 - c. Mumps: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.
 - d. Rubella: At least one dose is required for all grades (pre-kindergarten 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 12: 10 years).
 - a. One dose of meningococcal conjugate vaccine 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](#). *Depending on vaccine brand, schedule may change.

For further information, contact:

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

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

New York State Department of Health/Division of Vaccine Excellence
health.ny.gov/immunization

**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/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	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$	
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>			

System Review Within Normal Limits
 Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

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

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	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
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					
Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done
Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> Other Accommodations* : (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.					
MEDICATIONS					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					



BYRAM HILLS SCHOOL DISTRICT

10 Tripp Lane, Armonk, New York 10504
Office: 914-273-4198 Fax: 914-273-4199

Dear Parent:

We are including a voter registration form which will be used to enter your name and address into our election management system. Please note the completion of this form is not a requirement of registering your children in Byram Hills. Our goal is to make sure our election records are up to date with new residents or those who have not voted in our district in the past. Completing the form at this time will ensure that your name and address are in our election system prior to the Board of Election and budget vote in May of each year.

Welcome to Byram Hills School District.

NEW or RE- ACTIVATED REGISTRANT (VOTER)	CURRENT INFORMATION (PLEASE PRINT CLEARLY)						
	Last Name:		First Name:		MI	Jr/ Sr	Date of Birth
	House #		Street Name		Apt #	City	State Zip
	Phone # ()		Gender <input type="checkbox"/> M or <input type="checkbox"/> F				
GENERAL QUALIFICATIONS:							
• I am a citizen of the United States.							
• I am (or will be) 18 years old or more on the date of the election.							
• I have lived in this school district for at least 30 days before this election.							
• This is my signature or mark on the line below. •The above information is true.							
Registrant Signature						Date:	

UPDATE VOTER INFORMATION	YOUR CORRECT OR CURRENT INFORMATION (PLEASE PRINT CLEARLY)						
	Last Name:		First Name:		MI	Jr/ Sr	Date of Birth
	House #		Street Name		Apt #	City	State Zip
	INCORRECT INFORMATION ONLY AS IT APPEARS IN THE REGISTRATION BOOK:						
	PRINTED IN BOOK AS - Last Name:		PRINTED IN BOOK AS - First Name:		MI	Jr/Sr	
	House #		Street Name		Apt#	City	State Zip
Date of Birth			PAGE #		LINE #		
Registrant Signature						Date:	

DELETE OR REMOVE VOTER	DELETE (REMOVE) VOTER:				☑ REASON BELOW	
	PAGE #:		LINE #:		<input type="checkbox"/> Moved out of District	
	Last Name:				<input type="checkbox"/> Duplicate	
	First Name:		Date of Birth		<input type="checkbox"/> Voter Deceased	
	Info Source: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Family Member:				<input type="checkbox"/> Other: _____	
Source Signature				Date:		

****For Official use only****

Check if applicable:

- County BOE Permitted Registrant to Vote (name not found in our books).
- Change the Registrant's Poll Place: From: _____ To: _____

Inspector Signature: 	Print Name:	Date
District Clerk's Authorization: 	Date:	****PRINT SCHOOL DISTRICT NAME:****



NEW YORK STATE MIGRANT EDUCATION PROGRAM
IDENTIFICATION & RECRUITMENT OFFICE
PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Every Student Succeeds Act (ESSA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take few minutes to complete this questionnaire.

**Have you or has someone in your family worked on a farm?
 Have you moved during the past three years?**

- Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- Work related to logging, harvesting, or initial processing of trees.
- Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



If you answer YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____ City/Town _____

Telephone number: (____)-____-____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____ Grade _____

Student name: _____ Age _____ Grade _____

**To submit this referral please fax to 845-257-2953 or mail to Mid-Hudson Migrant Education Program-
 353 VH Annex 1 Hawk Drive New Paltz, NY 12561**





FAXED BY _____ BYRAM HILLS SCHOOL DISTRICT
PROGRAMA DE EDUCACIÓN PARA MIGRANTES DEL ESTADO DE
NEW YORK

OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Ley Cada Estudiante Triunfa (ESSA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, sin importar su nacionalidad o estado legal. Este programa es gratuito para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito, excursiones, programa de verano, actividades de involucramiento para padres, programa de emergencias y referidos a otras organizaciones o agencias.

Por favor tome unos minutos para completar este cuestionario.

**¿Usted o alguien en su familia ha trabajado en la agricultura?
 ¿Se han mudado durante los últimos 3 años?**

- Cualquier trabajo agrícola (como plantando, seleccionando, o cosechando frutas o vegetales, cultivando o cortando flores o árboles, trabajo en lechería u otro rancho de animales, pescando, etc.)
- Trabajando en la cultivación o procesamiento de los árboles.
- Trabajando en una planta de procesamiento, empacando, lavando o cortando vegetales, frutas o carnes.



Si usted contestó que sí, por favor complete la siguiente información:

Nombre del Padre/Encargado: _____

Dirección Física: _____ Ciudad _____

Teléfono: (____)-____-____ Mejor tiempo para ser contactado _____ AM/PM

Dirección anterior: _____

Nombre del estudiante: _____ Edad _____ Grado _____

Nombre del estudiante: _____ Edad _____ Grado _____

Para someter este referido, por favor envíelo por fax a 845-257-2953, o por correo a Mid-Hudson Migrant Education Program- 353 VH Annex - 1 Hawk Drive New Paltz, NY 12561



