



Name: _____

Address: _____

Place of Birth: _____

Is the student His
a person of Cuban
origin, regardless

_____ Yes, H

Select one or more
[check all that apply]

_____ American

_____ Asian

FAT

Name: _____

Address: _____

Cell _____

Occupation: _____

Highest Grade/Level _____

Separated: _____

Email: _____

Signature of _____



[The remainder of the page is heavily obscured by digital noise and artifacts, rendering the text illegible.]

Home Language Questionnaire (HLQ)—Page Two

[The page contains a series of horizontal lines for writing, which are mostly obscured by heavy black redaction bars.]



Bay Shore Union Free School District

DISTRICT ADMINISTRATIVE OFFICES

75 WEST PERKAL STREET, BAY SHORE, NEW YORK 11706

Phone: (516) 833-2100 Fax: (516) 833-2101 www.bayshore.edu

Open House

Registration year-end Open House/Information for Students and Parents will be held on **Monday, December 10, 2007** from **6:00 AM to 8:00 AM** at the **Bay Shore Union Free School District**.

Open House Information

For more information, please contact the District Office at (516) 833-2100.

or E-mail: Registration@bayshore.edu

or www.bayshore.edu

or www.bayshore.edu/Registration

or www.bayshore.edu/Registration for a complete list of registration information.

For more information, please contact the District Office at (516) 833-2100.

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SPORT: _____



BAY SHORE UNION FREE SCHOOL DISTRICT

Private Physician's Report of Student Medical Examination

Address _____ School _____ Grade _____ Sex _____

Immunization record attached

Immunizations and Dates

	Date	Date	Date		Date	Date	Date	Date	Date
MMR				DTaP					
Varicella				Hib					
Hepatitis B				Polio					
Tdap				Pneumococcal					
Hepatitis A				Meningococcal					
Lead screening				Tuberculin					

Height _____ Weight: _____ Blood Pressure: _____ Date: _____

Body Mass Index: _____

Weight Status Category (BMI Percentile):

less than 5th 5th through 49th 50th through 84th

85th through 94th 95th through 98th 99th and higher

Vision - [R] 20/____ [L] 20/____ with / without glasses

Hearing - pass 25 db se both ears or [R] ____ [L] ____

UA: _____ Scoliosis: _____

EXAM ENTIRELY NORMAL

Specify any other results: _____

Medications: _____

Allergies: Type: _____

Asthma Diabetes: Type 1 Type 2 Hypertension Hyperlipidemia

Recommendations: Full activity/Sports/PE

BAY SHORE UNION FREE SCHOOL DISTRICT

PUPIL PERSONNEL SERVICES

75 West Perkal Street, Bay Shore, NY 11706

Russell Endes, Ph.D.
Executive Director

THIS FORM MUST BE FILLED OUT BY PARENT/GUARDIAN

HEALTH AND SOCIAL HISTORY

PART I

Date _____

File # _____

NAME _____ GRADE _____ DOB _____
ADDRESS _____ PHONE # _____
FATHER'S NAME _____ MOTHERS NAME _____
WORK # _____ WORK # _____
HISTORY TAKEN BY _____ HISTORY GIVEN BY _____

1. What is the child's general health at present (persistent complaints, presently on medication, special diet, etc.)?

Name and number of pediatrician _____