DES 2020-21

Duanesburg Central School District

Central Office	Elementary School	Jr/Sr High School
133 School Drive	165 Chadwick Road	163 School Drive
Delanson, NY 12053	Delanson, NY 12053	Delanson, NY 12053
Phone 518-895-2279	Phone 518-895-2580	Phone 518-895-3000
Fax 518-895-2626	Fax 518-895-2090	Fax 518-895-9971

Enrollment/Registration

Dear Parent/Guardian:

Duanesburg Central School District residents may enroll their children in our schools by contacting the K-12 registrar at 895-2580. To enroll you must reside in the district, solely owning property or a home does not constitute residency. The district DOES accept tuition students.

The attached documents are required to be completed for enrollment. All documents must be completed by the child's legal guardian only.

If you have any questions, please call the Registrar at 895-2580 x243. Thank you for your assistance in providing a smooth transition and transfer of your child.

Duanesburg Central School District

Central Office	Elementary School	Jr./Sr. High School
133 School Drive	165 Chadwick Road	163 School Drive
Delanson, NY 12053	Delanson, NY 12053	Delanson, NY 12053
(518) 895-2279	(518) 895-2580	(518) 895-5350
Fax (518) 895-2626	Fax (518) 895-2090	Fax (518) 895-9971

AUTHORIZATION FOR ACCESS OF INFORMATION

TO THE PRINCIPAL OF:

SCHOOL: ____

ADDRESS: ____

____

PHONE #: ____________________ FAX #: ____________________

NAME	GRADE	BIRTHDATE

I hereby consent that Duanesburg Central School may have access to all records of my child/children, referenced above, (academic, health/immunizations, standardized tests, attendance, psychological/social work, IEP, Section 504, teacher reports, miscellaneous material). Please forward records to Duanesburg Central Schools.

I understand that such records will not be released to other persons without my further consent with the following exception: ***This form is to be used for the release of school records to colleges, other schools, employers, scholarship or financial aid programs, courts or probation departments and other third parties.***

I also understand that according to the Family Educational Rights and Privacy Act Final Rule on Education Records, Federal Register, June 1976, volume 41, number 1118, page 24567 – parental permission is no longer required when records are requested by authorized school personnel.

This information is to be directed to the attention of the following:

Duanesburg Elementary	Duanesburg Jr./Sr. HS Guidance Office
165 Chadwick Road	163 School Drive
Delanson, New York 12053	Delanson, NY 12053
(518) 895-2580, ext.243	(518) 895-3000, ext. 227
(518) 895-2090 (fax)	(518) 895-3090 (fax)

____

*Signature of Parent/Guardian/Student/School Official / Date
(*Student must be over 18 years of age to give consent.)

STUDENT ENROLLMENT FORM UPK__yes __no

NAME: Last, First (all children in home)	Date of Birth (must submit proof of age*)	Sex	Grade	IEP/504	Parent/Guardian	Student ID (office use only)

(Please Print)

***PROOF OF VERIFICATION OF AGE PROVIDED:**

[ ] Birth Certificate;
[ ] Passport;
[ ] Official driver's license;
[ ] State or other government issued identification;
[ ] Military ID card;
[ ] Native American tribal documents;
[ ] Baptismal document

Street Address: (Actual residence NOT PO Box)

____

____

Mailing Address: (PO Box Acceptable)

____

____

Parent/guardian: _________________________
Address: (if different) _________________________
Telephone: Home: _________________________
Work: _________________________
Cell: _________________________

Parent/guardian: _________________________
Address: (if different) _________________________
Telephone: Home: _________________________
Work: _________________________
Cell: _________________________

PROOF OF VERIFICATION OF RESIDENCE (3 forms required):

[ ] Copy of Deed;
[ ] Copy of Purchase Contract, with Letter from Attorney (including date/time of closing);
[ ] Lease Agreement or Statement from Landlord, Owner or Tenant from whom you lease;
[ ] Notarized statement from a third party establishing the physical presence of the guardian;
[ ] Pay sub;
[ ] Income tax form;
[ ] Utility or other bills;
[ ] Official driver's license;
[ ] Vehicle registration/vehicle insurance;

CUSTODY: Child's legal custodian is ___________________________Relationship_______
Child lives with ____________________________________Relationship_________________
*Must submit proof of custody

***EVIDENCE OF CUSTODY PROVIDED:**

[ ] Judicial custody orders;
[ ] Guardianship papers;
[ ] Signed affidavits;
[ ] Other: ____

Is there a current order of protection? _____Yes _____No
(If yes, it must be submitted to the building Principal at the time of enrollment)

Is this a foster placement? _____Yes _____No **If yes, name of county**______________
If yes, copy of DSS 2999 Form required

Check here (and provide details) if student lives in a shelter, abandoned apartment/building, motel/hotel, camping ground, car, or train/bus station; if the student lives with relatives or others due to lack of housing or other similar situation; or if the student is temporarily housed in a shelter awaiting permanent foster care placement _______________________________________ (living arrangements). If box is checked, please complete STAC-202 form. The answer you give 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.

Does your child presently have a _____IEP _____504 Plan?

Is there anything you wish to tell us regarding your child, please explain?

____

____

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

Registrar's Signature	Date

DUANESBURG CENTRAL SCHOOL 2020-2021

HmRm________
Bus Rte_______

STUDENT EMERGENCY INFORMATION SHEET

Website: www.duanesburg.org

1. Please print clearly. ***2. Call the office with any updated information during the school year.***

PUPIL INFORMATION: Date of Birth____/____/____ ____

Home **Phone** Number__________________ unlisted ☐ Student Last Name First Name

Mailing Address: ______________________________ **911 Address**: ______________________________

(Complete with) ______________________________ (Complete or) ______________________________

(City, Zip) ______________________________ (write "SAME") ______________________________

PARENT or Guardian INFORMATION **(Please be Complete)** **PARENT or Guardian INFORMATION**

(Custodial parents/Guardian Information needed.)

Name Parent/Guardian_________________________	Name Parent/Guardian_________________________
Mailing Address______________________________	Mailing Address______________________________
(Complete) ______________________________	(Complete) ______________________________
______________________________	______________________________
Home Phone No.______________________________	Home Phone No.______________________________
Cell/Beeper No.______________________________	Cell/Beeper No. ______________________________
Email address ____________________________	Email address ____________________________
Place of **Employment**_________________________	Place of **Employment**_________________________
Address______________________________________	Address______________________________________
Work Phone No.____________________	Work Phone No.____________________

In case parent/guardian is not available:

Emergency contact(s) ____________________________________ Phone No(s).______________________________

____Relationship______________________________

Does this child have any life threatening medical condition? ____

(i.e. bee/peanut/tree nut allergy, febrile seizure)

EMERGENCY DISMISSAL PLAN ONLY FOR ALL K-12 STUDENTS

This plan will only be used in the event that school should close early due to inclement weather or another emergency related situation. The following plan that you **indicate will be in effect for your child. If your child attends the YMCA After-School Program (which will not be held in an emergency situation), you MUST check Choice C** for alternate instructions, then complete the information requested. If you have filled out a Child Care/Parent Transport Form to pick up your child you must check **Choice A or C**, and complete the information requested. In an emergency situation, PHONING parents is NOT AN OPTION.

Choose ONE of the following dismissal plans, and SIGN BELOW.

A. _______ I want my child to go home.

B. _______ I want my child to go to his/her Care Giver: Name_______________________________ Bus Rte________
Address______________________________________ Phone No.____________________

C. _______ I want my child to follow the alternate instructions I have specified below.

Send my child to the home of:
Name____
Address (specify road and number location)
____
Phone____
Bus Route (call bus garage if unknown)___________________

Family Doctor:___________________________________Telephone No:______________________ Hospital Preference:___________________
(i.e. Guilderland Pediatrics, Rotterdam Family Medicine, etc.) (If your child must be taken to the hospital.)

From time to time radio, television and newspaper photos and names are taken in your child's school. Please put a check mark below **if you do not wish** to have your child's photograph and/or name used for such school promotion and media projects:

☐ CHECK HERE IF YOU DO NOT WISH TO HAVE YOUR CHILD'S PHOTO OR NAME USED FOR SCHOOL PUBLICITY.

PARENT/GUARDIAN SIGNATURE:____ **Date:**___________

PLEASE FILL this FORM OUT COMPLETELY, and the CHILD CARE FORM on the REVERSE SIDE.

X_______________
Date filled out

Grades K-8 CHILD CARE & PARENT TRANSPORTATION Form

School Year 2020-21

STUDENT'S NAME: ______________________________ **Bus Route No.** _______ **Homeroom** _______ **(leave blank)**

Address:____

Home Phone: _______________

Parent Work/Emergency Phone**:** ____________________ **Cell**__________________

Parent Work/Emergency Phone**:** ____________________ **Cell**___________________

==

CHILD CARE: **Pick up every AM at Child Care Address?:** _____ **Drop off every PM at Child Care Address?:** _____

Provider's full name: ______________________________ Child Care Phone #'s: ________________

Address: ____ Bus Route #: ______

==

PARENT DROP-OFF AM:

I will transport my child to school every day: _____

PARENT PICK-UP PM:

I will transport my child home from school every day: _____

==

IN AN EMERGENCY:

A. I want my child to go home _______
B. I want my child to go to his/her Care Giver listed above _________
C. Send my child to the home of:
   Name ______________________________
   Address (specify road and number location): ____
   Phone #: ___________ Bus Route______

☐ **My child will be transported to and from school by school transportation from our home.**

X Parent/Guardian Signature: ____

Parents requiring Child Care/Parent Transport forms must submit a NEW Child Care/Parent Transport Form each year. Child Care/ Parent Transport Forms are due – no later than 7/24/20. The Transportation office will be *unable to accept* busing *change requests* from 8/17/20-9/11/20. Forms received late will be processed and put in place on 9/14/20. Any changes to this form after 9/11/20 will be honored 3 days after such changes are received.

DCS, 2020-21

FOR SCHOOLYEAR **2020-2021**

TRANSPORTATION FORM

(Karen Weiler, Bus Dispatcher at 895-2511, ext. 235)

(list **ALL** school children including your "K" child) (completed by office) (completed by bus garage)

Student(s) Complete Name:	Grd	Homeroom:	Bus Route	& Times:
____________________________	___	___________	__________	AM Pickup:_____ PM Drop:______
____________________________	___	___________		
____________________________	___	___________		
____________________________	___	___________		

Parent(s) Complete Name:	Home Phone:	Work Phone:	Cell Phone:
____________________________	____________	____________	___________
____________________________	____________	____________	___________

911 Address:____

Name of former owner (if applicable):____________________________

Other means of identifying home location (i.e. house color, style, mailbox, etc.):

____

House in on right or left side of road when driving in what direction:

____

Facing your home, neighbor's names on each side and across road, where applicable:

Right:________________ Left:_________________ Across:____________

Bus garage personnel will be putting together bus run routes over the summer. Kindergarten, new transfer students and all students bussed will be notified by ***the transportation department the bus route number and pick-up/drop-off times*** in an August Mailing. An important piece of information to put together is a balanced bus routing and having all child-care information in advance regarding the pick-up and drop-off location is necessary. Please complete a child-care form and submit it by 7-24-20 to the main office.

____

Parent/Guardian Signature

Duanesburg Central School
Jr/HS - 163 School Drive, Delanson, NY 12053
Elementary – 165 Chadwick Road, Delanson, NY 12053

Student Enrollment - Residency Questionnaire

Name of LEA: Penny Hardenstine

Name of School: Duanesburg Central School

Name of Student: ______________________ Gender: ☐ Male ☐ Female
Last First Middle

Date of Birth: ____/____/____ Grade: ______ (preschool-12) ID #: ____________ (school identification number 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? (*Please check **one** box.*)

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

- ☐ 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**. **After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a designation Form is completed.

The University of the State of New York ● The State Education Department ● Office of Bilingual Education
Albany, New York 12234

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 English. Your assistance in answering these questions is greatly appreciated.

Thank you

TO BE COMPLETED BY SCHOOL PERSONNEL

Please print or type clearly

District: Duanesburg Central Schools

School: (circle one) CSE out HS MS Elem. Home Schooled

Student Name:

Date of Birth: *Month* *Day* *Year*

Student ID #

Country of Birth: Ancestry:

No. of Years Enrolled
In School, outside the U.S.

Name/Position of School
Personnel Completing this Section: A. Conover / JB

Determination: ☐ Possible LEP
☐ English Proficient

(☑ boxes that apply)

1. What language(s) is spoken in the student's home or residence?	☐ **English**	☐ **Other** ____ specify
2. What language(s) is spoken most of the time to the student in the home or residence?	☐ **English**	☐ **Other** ____ specify
3. What language(s) does the student understand?	☐ **English**	☐ **Other** ____ specify
4. What language(s) does the student speak?	☐ **English**	☐ **Other** ____ specify
5. What language(s) does the student read?	☐ **English**	☐ **Other** ____ specify ☐ **Does Not Read**
6. What language(s) does the student write?	☐ **English**	☐ **Other** ____ specify ☐ **Does Not Write**

7. In your opinion, how well does the student understand, speak, read and write English?

	Very well	**Only a little**	**Not at all**
Understands English	☐	☐	☐
Speaks English	☐	☐	☐
Reads English	☐	☐	☐
Writes English	☐	☐	☐

Student Ethnicity ________________

Signature of Parent/Guardian/Other

Date: *Month* *Day* *Year*

HLQ (2/00) 99-337 PM

Duanesburg Elementary School

STUDENT HEALTH HISTORY

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Has had acute illness (Chicken Pox, Scarlet Fever, Measles, Tuberculosis, Mononucleosis, Whooping Cough, Hepatitis, Fifth's Disease, or other)	☐	☐	☐ Illness :___________________________________
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections

☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Conditions
☐ High Blood Pressure
☐ Mental Health Condition
(depression, eating disorder, anxiety, OCD, ODD, etc.)

☐ Scoliosis
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition
☐ Speech Condition
☐ Urinary Condition
☐ Premature/Concerns at time of Birth

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?
☐ No ☐ Yes: ____

Please list any additional concerns: (use back of sheet if necessary) ____
____

Parent/Guardian Signature: ____ Date: _________________

Duanesburg Elementary School
165 Chadwick Road
Delanson, NY 12053
518-895-8310 fax- 518-895-2090

Duanesburg JR/Sr High School
163 School Drive
Delanson, NY 12053
518-895-3000 fax 518-895-8560

Authorization for Use or Disclosure of Protected Health Information

In order to share protected health information with the school district, your healthcare provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays in care for your child.

I, ____ authorize my child's healthcare provider(s) listed below:
Name____Phone__________________FAX________________
Name____Phone__________________FAX________________
Name____Phone__________________FAX________________

to release the medical records of my child, ____________________________________, DOB ______________ to the district's: ☼ Medical Director ☼ School Nurse ☼ Athletic Trainer (AT) ☼ Counselor ☼ Occupational Therapist (OT) ☼ Physical Therapist (PT) ☼ Psychologist ☼ Social Worker ☼ Speech Therapist (ST)
☼ other ____

The healthcare provider may disclose the following information: (Parent/School: check all that apply)
☼ Immunizations ☼ Health Appraisals ☼ Past/Current Medical Conditions and impact on attendance, athletics, or school programming or therapy ☼ Other____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (Parent/School: check all that apply)
☼ To develop care or therapy plans for routine and emergent school management
☼ To design appropriate educational, school, or athletic programs
☼ To assess the impact of the medical condition(s) on school programming and/or attendance
☼ To share school observations/concerns surrounding behavior
☼ To assess a medical basis for modification of transportation and/or home tutoring
☼ Medication delivery or therapy prescriptions
☼ At patient's request with no specified purpose
☼ Other____

PARENT: Please select one.
☼ This authorization is valid for the entire academic school year 20 - 20
☼ This authorization is valid for the duration of attendance within the school district
☼ This authorization shall expire on ____/_______/______ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building. I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

____
Signature of Parent/Guardian or student if over 18 Relationship Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE ADULT PATIENT OR PARENT OF THE MINOR CHILD

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No	☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type	☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No	☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ______________________________

Seizures ☐ No	☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Yes, indicate type	☐ Type: _____________________________ Date of last seizure: _______________

Diabetes ☐ No	☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type	☐Type 1 ☐ Type 2 ☐ HbA1c results: _____________ Date Drawn: ______________

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: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
Sickle Cell Screen/PRN	☐	☐		☐ Concussion – Last Occurrence: ___________________________
Lead Level Required Grades Pre- K & K			**Date**	☐ Mental Health: _________________________________
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL				☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list)	ICD-10 Code
___________________________	______________
___________________________	______________
___________________________	______________
___________________________	______________

☐ Additional Information Attached

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** — **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** — **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: ____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. 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: / / (Month Day Year)

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment ? ☐ Yes ☐ No

School: Name

Grade

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

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

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

Parent's Signature________________________________ Date

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

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

☐ Yes, The student listed above is in fit condition of dental health to permit his/her 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 ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):____

II. Treatment Needs (check all that apply)

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

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

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