Duanesburg Elementary School is excited to offer a free Universal Preschool Program for four-year-old children. Students who will turn four by December 1st will be eligible for the opportunity to attend an enriching, well-balanced school readiness program.

At this time, we are able to offer eighteen slots at Duanesburg Elementary School and eight slots at Whispering Pines Preschool for a full day program. There will be transportation to and from either program for families who make the request. Please complete the attached transportation sheet to indicate if you have interest in bus transportation for your child.

To enroll in the program, parents will need to register their child with the Duanesburg School by completing the enclosed paperwork and returning it to the Elementary School. If you have further questions, please do not hesitate to contact Andrea Conover, Principal of Duanesburg Elementary(aconover@duanesburg.org) or Joanne Boyd, District Registrar(jboyd@duanesburg.org).

In the event that the district has more interest than it has available UPK slots, a random lottery will be used to determine selection. All students not selected would automatically be listed on a wait-list and called in order of their selection if a slot becomes available.

Wrap-Around Child Care program

We are very excited to welcome your child to our UPK program in the fall. I wanted to inform you of an opportunity for after school care. The YMCA is offering after school care for students in our preschool program. If you are interested, please contact the person mentioned below. Pricing for the 2022-2023 school year is: Full time YMCA $295.00 per month. Part time YMCA $255.00 per month.

Cheryl Misiewicz
Duanesburg Early Learning Center Director
CAPITAL DISTRICT YMCA
185 Mott Rd
Duanesburg, NY 12056
518-356-6400
cmisiewicz@cdymca.org

Student Enrollment Form

FIRST CHOICE/SECOND CHOICE: UPK Elementary School _____ UPK Whispering Pines Preschool _____

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)

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

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?

UPK Student Emergency Information Sheet

Student Name	
List any life threatening medical conditions (i.e. bee/peanut/tree nut allergy, febrile seizure)	
Custodial Parent	
Home Phone (Custodial)	
Work Phone (Custodial)	
Noncustodial Parent	
Home Phone (Noncustodial)	
Work Phone (Noncustodial)	
Emergency Contact Person	
Emergency Contact Phone	

Emergency Dismissal

This plan will only be used in the event that school should close early due to inclement weather or another emergency related situation and you as the parent, are unable to provide transportation. Please indicate two individuals that your child may be released to in the event of an emergency.

Emergency Contact #1	
Relationship to student	
Phone Number	
Emergency Contact #2	
Relationship to student	
Phone Number	

Free and Reduced Price Meals

All children from households meeting income guidelines for the federal Free & Reduced Price Meals Program and whose parents/guardians apply for the program receive free meals: New York State is covering the $0.25 cost of reduced price breakfast and lunch that was previously paid by the student.

Income guidelines change from year to year. Once approved, children within the household can receive the benefit for the entire school year. Applying is easy and can be done any time during the school year.

Frequently Asked Questions about free and reduced price meals

Households that receive benefits from the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations, or Temporary Assistance to Needy Families (TANF), can get free meals and should indicate their case number on their application.

Other eligible households must fill out an application each year to be eligible for free and reduced price meals. Families can apply for free and reduced price meals **at any time** during the school year. Return completed applications to Mary Jewell, 163 School Dr., Delanson NY 12053.

Free and Reduced Price Meals Application

If you need help accessing or completing the application, call the Food Services Department at (518) 895-5350, ext. 228, or (518) 895-3000, ext. 228.

Income guidelines (2020-21)

Families whose **gross annual income** is less than the figure listed here may be eligible to receive free or reduced price meals.

- Household of 1: $23,606
- Household of 2: $31,894
- Household of 3: $40,182
- Household of 4: $48,470
- Household of 5: $56,758
- Household of 6: $65,046
- Household of 7: $73,334
- Household of 8: $81,622

For each additional person, add $8,288.

Transportation Form

Residency Address:_____

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

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

Right:_____Left:_____Across:_____

List all children including your UPK child

Complete Name	Grade	Completed by office	Completed by Transportation
		Homeroom	Bus Route & Times

Parent(s) Complete Name	Home Phone	Work Phone	Cell Phone

Emergency Dismissal House Owner	
Emergency Dismissal Address	

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.

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:

Parent/Guardian Signature: _____
Date: _____

Residency Information

Name of LEA: DUANESBURG CSD

Name of School: DUANESBURG ES

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

Date of Birth: ____/____/____ Grade: _____ ID #: _____
(preschool-12) (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 MKinney-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.

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 BY PRIVATE HEALTH CARE 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	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ 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: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥ **5** µg/dL				

☐ **System Review and Abnormal Findings Listed Below**

☐ 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	*Required only for students with an IEP receiving Medicaid

Name:	DOB:

Vision & Hearing SCREENINGS - Required for PreK or K, 1, 3, 5, 7, & 11

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
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** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY 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: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

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

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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

Dental Health Certificate

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

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

Child's Name: Last First Middle

Birth Date: 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.