

Central Office
133 School Drive
Delanson, NY 12053
(518) 895-2279

Elementary School
165 Chadwick Road
Delanson, NY 12053
(518) 895-2310

Middle/High School
163 School Drive
Delanson, NY 12053
(518) 895-3000

"Partnering with families and community, Duanesburg Central School will provide a safe, supportive, and inclusive environment."

*We are committed to cultivating **integrity**, fostering **community**, and instilling **pride** to prepare every student for success."*

Enrollment Registration

Dear Parent/Guardian,

Welcome to the Duanesburg Central School District! We are excited that you are considering becoming part of our school community.

If you are a district resident and would like to enroll your child(ren) in our schools, please contact me, Serena Killenberger, PK–12 District Registrar, at (518) 895-2279 ext. 241. I am happy to assist you throughout the registration process and answer any questions you may have.

Please note that students must reside within the Duanesburg Central School District to be eligible for resident enrollment. Ownership of property within the district does not, by itself, establish residency. We do, however, welcome tuition-paying students who reside outside of the district, subject to district policies and availability.

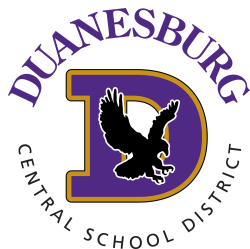
To begin the enrollment process, please complete the attached registration forms. For the protection of our students, all enrollment documents must be completed and submitted by the child's legal parent or guardian.

We look forward to meeting your family and welcoming you to the Duanesburg Central School District!

Sincerely,

Serena Killenberger

Serena Killenberger
District Registrar
Duanesburg Central School District
(518) 895-2279 ext. 241



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AUTHORIZATION FOR ACCESS OF INFORMATION

SCHOOL: _____

ADDRESS: _____

PHONE #: _____ FAX #: _____

NAME	GRADE	BIRTHDATE

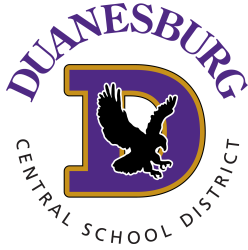
I hereby consent that Duanesburg Central School may have access to all records of my child/children, referenced above, (academic, health/immunizations, standardized tests, attendance, psychological/social work, IEP, Section 504, teacher reports, miscellaneous material). Please forward records to Duanesburg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

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133 School Drive



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Delanson, New York 12053
Office # (518) 895-2279, ext.241
Fax # (518) 704-3617

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

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: _____
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 an _____ IEP or _____ 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)

DATE

Registrar's Signature:

Date:

Student Emergency Information Sheet

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

Date of Birth: ____/____/____ STUDENT NAME: _____
Last Name First Name

Home Phone Number: _____ ☐ unlisted

Mailing Address: _____ 911 Address: _____
(Complete with) _____ (Complete or) _____
(City, Zip) _____ (write "SAME") _____

PARENT or GUARDIAN INFORMATION

Name Parent/Guardian: _____ Mailing Address : _____
(Complete) _____

Home Phone No.: _____ Cell No.: _____
Email address _____

Place of Employment: _____ Address: _____
Work Phone No. _____

PARENT or GUARDIAN INFORMATION

Name Parent/Guardian: _____ Mailing Address: _____
(Complete) _____

Home Phone No.: _____ Cell No.: _____
Email address _____

Place of Employment: _____ Address: _____
Work Phone No. _____

IN CASE PARENT/GUARDIAN IS NOT AVAILABLE:

Emergency contact: Name: _____ Phone No.: _____
Relationship: _____

Emergency contact: Name: _____ Phone No.: _____
Relationship: _____



Does this child have any **life-threatening** medical conditions?

- ☐ None
- ☐ Severe food allergy (e.g., peanuts, tree nuts, milk, eggs, shellfish) specify: _____

- ☐ Severe insect sting allergy
- ☐ Severe medication allergy
- ☐ Anaphylaxis (history of severe allergic reaction)
- ☐ Asthma requiring emergency medication
- ☐ Diabetes (Type 1 or insulin-dependent)
- ☐ Seizure disorder/Epilepsy requiring emergency medication
- ☐ Cardiac condition specify: _____
- ☐ Adrenal insufficiency
- ☐ Bleeding disorder (e.g., hemophilia)
- ☐ Other life-threatening medical condition: _____

GRADES UPK-8 CHILD CARE & PARENT 2026-2027 **TRANSPORTATION FORM**

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

Address: _____

Home Phone: _____

Parent Work/Emergency Phone: _____ **Cell** _____

Parent Work/Emergency Phone: _____ **Cell** _____

=====

CHILD CARE (EXAMPLE: CKC AFTER SCHOOL PROGRAM)

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:

PARENT PICK-UP PM:

I will transport my child to school every day: _____ 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 Caregiver 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.
Parent/Guardian Signature: _____ DATE: _____

THIS FORM IS REQUIRED YEARLY

**UNANNOUNCED EMERGENCY DISMISSAL PLAN ONLY FOR
ALL K-12 STUDENTS**

Students Name: _____

This emergency dismissal plan will only be used for an unannounced school closing due to inclement weather or another emergency. Please select the dismissal plan that should be followed for your child. If your child attends the CKC After-School Program, which does not operate during emergency dismissals, you **must** select **Choice C** and provide alternate instructions.

If you have completed a Child Care/Parent Transport Form to pick up your child, you **must** select **Choice A** or **Choice C** and complete the required information.

During an emergency dismissal, the District cannot contact parents for dismissal instructions. Your child will be dismissed according to the plan you have selected.

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 caregiver:

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: _____ Bus Rte: _____
Address: _____ Phone No.: _____

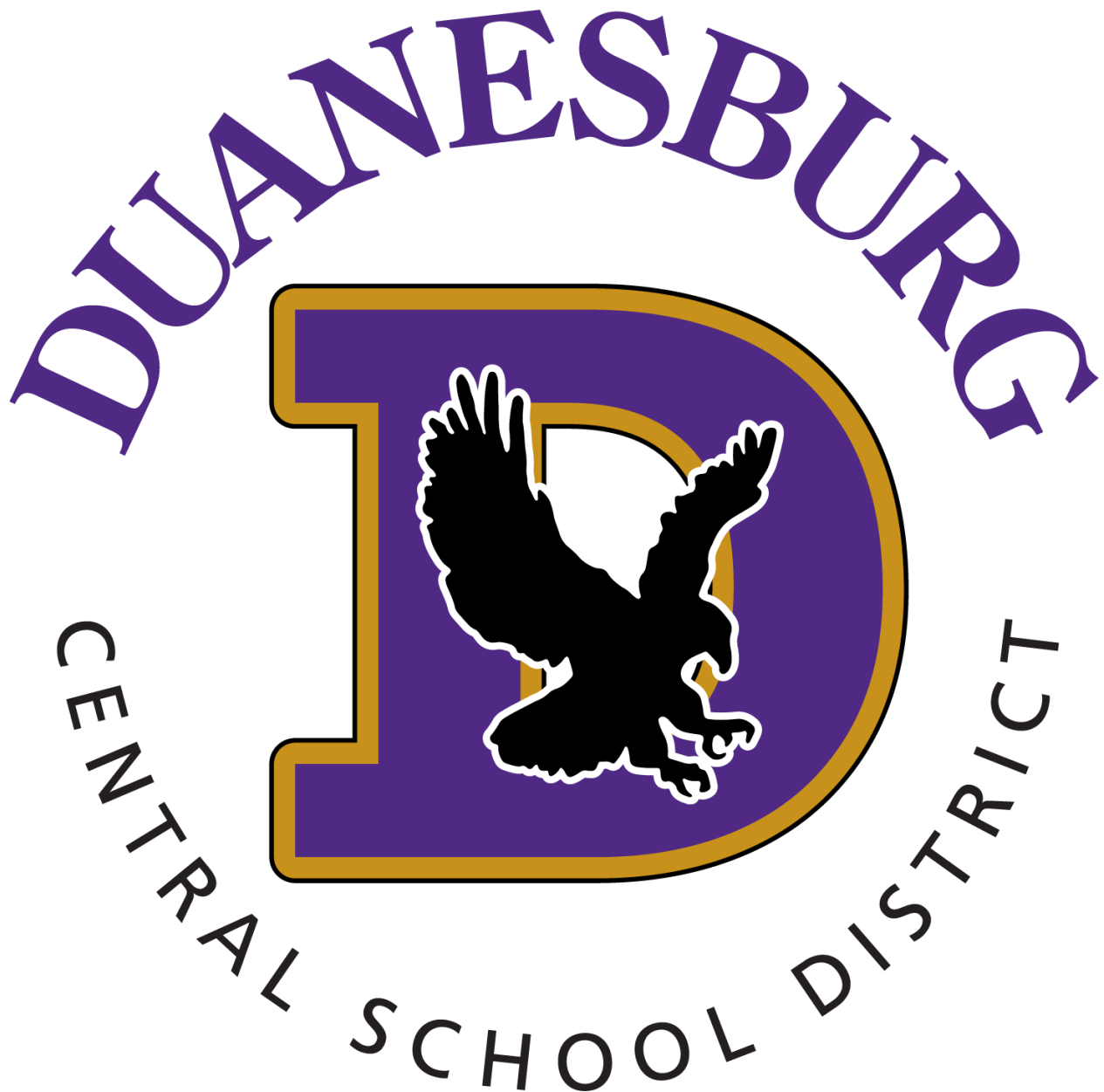
Family Doctor: _____ Telephone No: _____
(i.e. Guilderland Pediatrics, Rotterdam Family Medicine, etc.)

Hospital Preference: _____
(If your child must be taken to the hospital.)

PARENT/GUARDIAN SIGNATURE: _____

Date: _____

PLEASE FILL THIS FORM OUT COMPLETELY AND THE CHILD CARE FORM ON THE REVERSE SIDE



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.

HOME LANGUAGE QUESTIONNAIRE (HLQ)

STUDENT NAME:

First Middle Last

DATE OF BIRTH:

GENDER:

☐ Male

☐ Female

Month Day Year

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name

First Name

Relation to

HOME LANGUAGE

Language Background

(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home residence? ☐ English ☐ Other _____
specify

2. What was the first language your child learned? ☐ English ☐ Other _____
specify

3. What is the Home Language of each parent/guardian? ☐ Parent 1 _____
specify ☐ Parent 2 _____
specify ☐ Guardian(s)- _____

4. What language(s) does your child understand? ☐ English ☐ Other _____
specify

5. What language(s) does your child speak? ☐ English ☐ Other _____ ☐ Does not write
specify

6. What language(s) does your child read? ☐ English ☐ Other _____ ☐ Does not write
specify

7. What language(s) does your child write? ☐ English ☐ Other _____ ☐ Does not write
specify

1

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? _____

Signature of Parent or of Person in Parental Relation Month: _____ Day: _____ Year: _____
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

PROFICIENCY LEVEL

ADMINISTRATION:

ACHIEVED ON

☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

NYSITELL:

MO. DAY YR.

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

Student Ethnicity _____

New York State Housing Questionnaire

Identifying and serving students in temporary housing under the McKinney-Vento Act and NYS Ed Law §3209

This form is to be completed when a student first enrolls, and any time a change in housing status occurs. There are no wrong answers. This form may be filled out independently, or the McKinney-Vento Liaison can assist. To access a list of McKinney-Vento Liaisons, please visit <https://www.nysteachs.org/liaisons>

District or LEA
Superintendent, Kimberly Ross

School Name
Duanesburg Central School District

About this form and your rights

Schools are required by federal and state law to identify students living in temporary housing and ensure they can enroll, attend, and succeed in school. The **McKinney-Vento Homeless Assistance Act**, together with **New York State Education Law Section §3209**, protects students and families who no longer have a permanent, stable place to live; families who have lost housing; are staying with others temporarily; or are living somewhere that was never meant to be a home. **Eligible students have the right to:**

- ✓ Stay in the school they attended when last permanently housed (called the school of origin), for as long as they are in temporary housing.
- ✓ Immediately enroll in the local school where they are temporarily staying (the school of current location).
- ✓ Enroll and start school right away, even without a birth certificate, proof of residency, immunization records, or school records.
- ✓ Receive free transportation to and from the school of attendance, as well as after-school activities (if within 50 miles).
- ✓ Receive free school meals without income paperwork as well as access to other school services including McKinney-Vento Grant resources, if available.

This information is confidential and will be shared only with school staff who have a legitimate educational need to support student access to McKinney-Vento rights and services. Providing this information is voluntary and will be used only to determine eligibility for services under the McKinney-Vento Act and NYS Education Law §3209. Please note that this information will not affect your immigration status, your child's enrollment, or your eligibility for other school services.

STUDENT INFORMATION:

Student Name (Last, First)	Student Grade Level (Preschool-12)
Student Gender ☐ M ☐ F ☐ X= Nonbinary	Student Date of Birth (Month/Day/Year)
Parent, Legal Guardian Name	
Phone Number	E-Mail Address
Address where the student is currently living	

Where is the student residing right now?

Under the McKinney-Vento Act, students are protected when their nighttime residence is not **fixed, regular, and adequate**. Check every box that describes where **the student** is residing right now.

- ☐ Permanent housing: you own, rent or lease a fixed, regular, and adequate home
- ☐ Doubled-up: staying with another family or person due to a loss of housing, economic hardship, eviction, or other similar reason
- ☐ In an emergency, transitional, or domestic violence shelter. Shelter or program name: _____
- ☐ In a hotel or motel because there is no other alternative, adequate place to stay
- ☐ In a car, park, campsite, bus/train station, abandoned building, or another place not meant for stable habitation or established dwelling
- ☐ In a place with no heat, running water, or electricity, or that is otherwise structurally unsafe or inadequate to reside in
- ☐ Displaced by a fire, flood, natural disaster, or other emergency
- ☐ Another temporary situation not listed here:

Is there anything else you would like us to know about your situation? (optional)

Is the student an Unaccompanied Homeless Youth (UHY)?

The McKinney-Vento Act identifies students who are not living with a parent or legal guardian, and are not residing in permanent housing, as **Unaccompanied Homeless Youth (UHY)**. UHYs have the right to enroll in school and to complete and sign this form independently, without a parent or adult present. The McKinney-Vento Liaison can assist UHYs with this process.

☐ Please check the box if you believe the student identified above may meet the McKinney-Vento eligibility criteria described above.

Additional Children within the Household?

To help us identify and support all eligible children and youth, please list every child who is currently living with you, regardless of age or school enrollment status. This includes infants, preschool-aged children, and school-aged children.

Student Name (Last, First)	Date of Birth	Grade	Current or Recent School	Last School Attended Before Current or Recent

The person completing this form certifies that the information provided above is correct and accurate to the best of their ability.

Name (print):

Signature: _____ **Date:** _____

An unaccompanied homeless youth may sign on their own behalf.

Need help? Contact the McKinney-Vento Liaison listed at the top of this form or call the NYS-TEACHS Helpline at 800-388-2014. Visit nysteachs.org for more information.

OFFICIAL USE ONLY (School Staff)

Date received: _____ **Received by:** _____ Eligibility: ☐ Eligible ☐ Not Eligible ☐ Pending

Homeless Primary Nighttime Residence Code (SIRS):

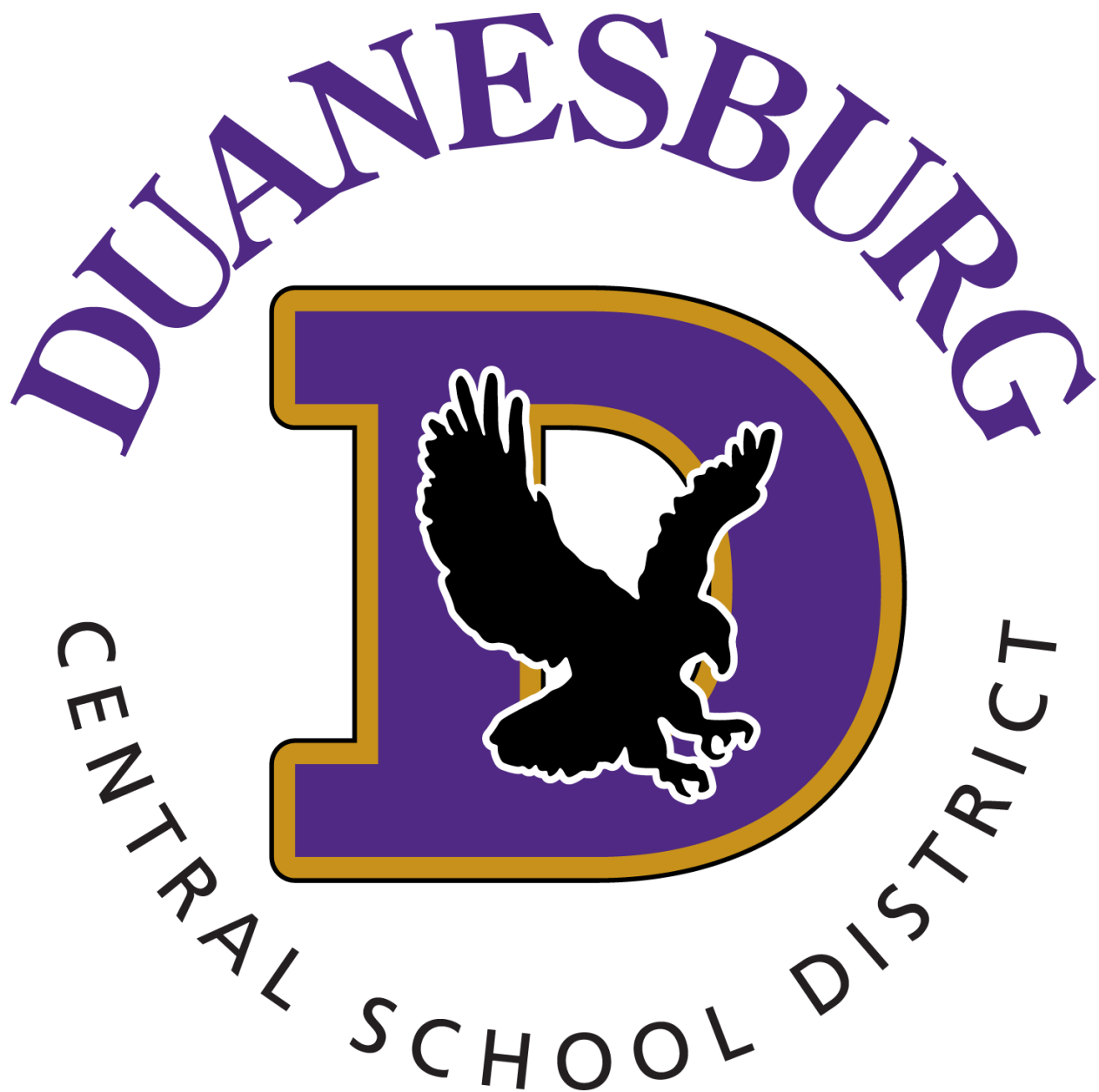
☐ D = Doubled-up ☐ S = Shelter ☐ H = Hotel/Motel ☐ U = Unsheltered ☐ T = Transitional Housing

Unaccompanied Homeless Youth (UHY): ☐ Yes ☐ No

Designation Form: ☐ Yes ☐ N/A ☐ Coded in Student Information System (SIS)

Liaison notified (initials): _____ Date: _____ ☐ Family declined to provide information

Notes:



STUDENT HEALTH HISTORY

Name:	DOB: _____	Age: _____	Grade: ____z-	Gender: ☐ M ☐ F
Parent/Guardian:	Home Phone: Cell Phone:			Date:

Has your child ever:	YES	N O	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	N O	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: _____

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 _____

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 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: ☐ Female ☐ Male		Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X			
School:				Grade:	Exam Date:
HEALTH HISTORY					
If yes to any diagnoses below, check all that apply and provide additional information.					
☐ Allergies	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached				
☐ Asthma	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached				
☐ Seizures	Type: _____ Date of last seizure: _____ ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached				
☐ Diabetes	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/m ²					
Percentile (Weight Status Category): ☐ < 5 th ☐ 5 th - 49 th ☐ 50 th - 84 th ☐ 85 th - 94 th ☐ 95 th - 98 th ☐ 99 th 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	
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥ 5 $\mu\text{g/dL}$	
Sickle Cell Screen-PRN	☐	☐			
☐ System Review Within Normal Limits					
☐ Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)					
☐ HEENT ☐ Dental ☐ Mental Health	☐ Lymph nodes ☐ Cardiovascular ☐ Lungs	☐ Abdomen ☐ Back/Spine/Neck ☐ Genitourinary	☐ Extremities ☐ Skin ☐ Neurological	☐ Speech ☐ Social Emotional ☐ 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 ☐ Yes ☐ No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	☐ Yes	☐
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		☐
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		☐	☐	☐ Yes	☐
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
☐ *Family cardiac history reviewed – required for Dominic Murray Sudden Cardiac Arrest Prevention Act					
☐ Student may participate in all activities without restrictions. If Restrictions Apply – Complete the information below ☐ 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 <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: ☐ I ☐ II ☐ III ☐ IV ☐ V					
☐ 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					
☐ Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
☐ Confirmed free of communicable disease during exam			☐ Record Attached ☐ 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.	

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: / / Sex: ☒ Male ☐ Female Will this be your child's first oral health assessment ? ☐ Yes ☐ No
Month Day Year

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

Duanesburg Central School

ELECTRONIC TECHNOLOGY ACCEPTABLE USE PROCEDURE

The purpose of the Duanesburg Central School District-Local and Wide Area Networks, and Internet Access Network is to advance and promote education in all of its school buildings within the District. It is intended to assist in the collaboration and exchange of information among all who are concerned and involved with education. The goal of infusing technology into daily operations of our classrooms, libraries and offices is to promote high quality technological resources in an equitable, efficient and cost effective manner. Such technology includes and is not limited to electronic mail, local computer networks, the Internet, and other online services.

The benefit of being connected to the internet and other on-line services is that it expands classroom teaching dramatically by making many fascinating resources, including original source materials from all over the world, available to students, teachers, parents, and administrators. These services bring information, data, images, and even computer software into the classroom from places around the globe, and it does this almost instantaneously. Access to these resources can involve students in individual and group projects, cross-cultural collaborations, and idea sharing not found in schools that lack Internet and on-line-services access.

While the benefits of the Internet and other on-line services are enormous, parents need to be aware that they are open systems, which contain pockets of material that many people would disapprove of and keep away from children. The Duanesburg School District will make an effort to prevent student's access to inappropriate materials on the Internet and other on-line services, but we cannot guarantee that they will not encounter text, pictures, or references that are objectionable. The District asks parents for assistance in developing responsible attitudes, reinforcing appropriate behaviors and observing security practices on the network. System users should have no expectation of privacy with respect to files saved or maintained on the District's computer systems. Network administrators and District officials will have access to all files in order to ensure system integrity and compliance with this procedure.

The use of the Local Area Network, Wide Area Network, and Internet is a privilege, not a right. Users are responsible for what they say and do on the networks. Because communication with thousands of others is so quick and easy, it is important to think before communicating and to show respect for other people and for their ideas. The use of computers must be in support of education and research, and consistent with the educational objectives and the Mission of the Duanesburg Central Schools. Use of the Duanesburg District's network or that of another organization's connected network or computing resources must comply with the rules appropriate for each network.

It is imperative that staff, students and visitors conduct themselves in a responsible, decent, ethical, and polite manner while using such equipment and networks. This procedure does not attempt to articulate all required or proscribed behavior by its users. The following general guidelines are provided to illustrate appropriate conduct and use. This is not an exhaustive list, but rather indicative of the type of conduct which will be considered acceptable by the district:

- A. Any use of the Duanesburg Central School District equipment or information networks for inappropriate, illegal, obscene or sexual harassment purposes is prohibited. Illegal activities shall be defined as a violation of local, state and/or federal laws as well as the District's rules and regulations. Inappropriate use shall be defined as a violation of the intended purpose of the network. Obscene activities shall be defined as a violation of generally accepted social standards for use of a publicly owned and operated communication vehicle;
- B. Any use of the district's equipment for commercial purpose, or for individual profit or gain, or unauthorized access to databanks is prohibited;
- C. Any use of equipment for private business advertisement or political lobbying is prohibited;
- D. Any use of the district's equipment that will disrupt use by other users or invade the privacy of an individual is prohibited;
- E. The district's on-line network accounts shall be used only by authorized students and staff approved by the Building Principal, and the Superintendent or his/her designee. Users are ultimately responsible for all activity under their operating or individual accounts, which includes but is not limited to unnecessary long distance charges, per minute (unit) surcharges and/or equipment or line costs, liability or damages caused by users who misuse the equipment, software, or networks;
- F. Prudent use of the district's finite resources and shared technological resources is expected.

Users may not intentionally write, produce, generate, copy, propagate, or attempt to introduce any computer code designed to self-replicate (e.g. computer virus, malware, spyware), damage or otherwise hinder the performance of any computer's memory, file system or software;

G. The use of personal devices (jump or flash drives, including wireless devices) is allowed for educational purposes only. These devices are permitted as long as the user engages in the required login and authentication process. Any personal devices utilized in concert with District hardware will continue to be the responsibility of the user. Technical support, maintenance and care for non-District owned equipment is the responsibility of the owner or student and use of such devices is at his/her own risk; (*See Devices Policy*)

H. Only approved hardware is to be connected to the network. Users may not tamper with networks, switches, modems, pc's, terminals, printers, wiring, etc.;

I. Software is protected by copyright laws; therefore, users are not allowed to make, install, use or secure unauthorized copies of software on or from District computers;

J. Plagiarism is not acceptable. All information accessible via the network should be assumed to be private property. Users will properly acknowledge all sources (Internet, email, CDs, etc....) for borrowed words, sounds, music and images with appropriate citation;

K. Storage on the network and or hard drives of any Duanesburg Central School District computer is not permanent. Users have the responsibility to save work as instructed and to maintain backups of important files on flash drives or cloud storage.

L. Students, staff, parents, and administration must agree not to give out students' records, personnel information, confidential records, or internal financial data to unauthorized receivers;

M. All users' traffic that traverses another network will be subject to that network's acceptable use policy;

N. As applicable, student use will be permitted provided there is parent notification and administrative authorization and proper supervision maintained by the staff;

O. District users must recognize and observe applicable copyright laws and regulations. Unauthorized duplication or other forms of infringement of copyright materials is prohibited;

P. Students who leave or graduate and staff who leave the employment of the District may not maintain a network account or have access to District equipment;

Q. Each building administrator shall have the first level of responsibility to review alleged infractions and to determine appropriate action. The Superintendent shall receive a report on any incident and the results of the administrator's investigations;

R. The Superintendent of Schools for the Duanesburg Central School District shall remain the final authority on the issuance of user accounts and on use of the networks.

Duanesburg Central School

ELECTRONIC TECHNOLOGY ACCEPTABLE USE PROCEDURE

Student Signature Page

This form must be signed by both the parent/legal guardian of the student and the student indicating that you have read, discussed and understand the school's electronic technology policy.

Student Name: _____ Grade: _____
(Please Print)

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____