Tri-Valley Central School District

34 Moore Hill Road • Grahamsville, New York 12740

Phone (845) 985-2296

Universal Pre-Kindergarten

REGISTRATION CHECK LIST

Student's Name_____

Registration Appointment Date: _____ Time: _____

ITEMS REQUIRED

- ☐ Original Birth Certificate (or certified copy) or other satisfactory proof of age
- ☐ Custody Papers (if applicable)
- ☐ Parent/Guardian's Photo ID
- ☐ Two Proofs of Residency (deed, lease, utility bill, driver's license or other photo identification card with address, voter registration, income tax return, current paycheck with address on it, affidavit, third party statement, or government issued document)
- ☐ Any other information regarding your child, such as a recent report card, IEP, testing results, etc.
- ☐ Recent Physician's Physical (form included in General Registration Packet)
- ☐ Recent Dental Health Certificate (form included in General Registration Packet)
- ☐ Immunization Record signed by physician
- ☐ Other: _____
- ☐ Other: _____

Tri-Valley Central School District

Pupil Personnel Services

34 Moore Hill Road • Grahamsville, New York 12740

Danielle Cornish, Director
Faith Dymond, Secretary

Phone (845) 985-2296 Ext. 5308
Fax (845) 985-2481

If you suspect that your child may have a physical, cognitive, or emotional disability, you have the right to refer your child to the Tri-Valley Committee on Special Education for an evaluation, and a determination as to whether your child is eligible to receive special education services and programs. More information regarding your rights is set forth in the New York State Education Department's Parent Guide to Special Education Services in New York State for Children, available at

http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm

To refer your child to the Committee on Special Education, or to obtain more information regarding the District's special education services and programs, please contact:

Danielle Cornish- Director of Pupil Personnel Services-(845) 985-2296 Ext 5516
or e-mail daniellecornish@trivalleycsd.org

Faith Dymond - Secretary to the Director-(845) 985-2296, Ext. 5308
or e-mail faithdymond@trivalleycsd.org

Tri-Valley Central School

34 Moore Hill Rd.
Grahamsville, NY 12740 **PLEASE PRINT IN INK**

For Office Use Only:
Grade _____ Homeroom _____ Bus # _____ ID# _____
Date of Entry _____ ☐ Proof of Residency Supplied
Proof of Birth: ☐ Birth Cert. ☐ Baptism Cert ☐ Physician's Cert ☐ Hospital Cert.

STUDENT'S NAME *(First, Middle, Last):* _____

Date of Birth _____ **Gender:** ☐ **Female** ☐ **Male** ☐ **Non Binary**

Grade: _____

Place of Birth _____
City *State/Province* *Country*

Mailing Address: _____
Street

_____
City *State* *Zip*

911 Address (if different from above): _____
Street

_____
City *State* *Zip*

Child Resides With:
☐ Both Parents
☐ One Parent: _____
☐ Other: _____

Home Telephone: _____ **County of Residence:** _____

Is your current address a temporary living arrangement? ☐ Yes ☐ No

If **yes**, please complete the student residency questionnaire.

TRANSPORTATION INFORMATION (Transportation can only be provided within the Tri-Valley district)

Please Circle: My child will be transported to school from: At HOME or BABYSITTER
dismissal my child will be transported to: HOME or BABYSITTER

Babysitter's Name: _____ Phone Number: _____

Babysitter's 911 Address: _____
Street(not P.O. Box) *City*

If **LEGAL CUSTODY** has been established, then fill in this portion.

Custody Type: ☐ Sole ☐ Joint ☐ 50/50 ☐ Temporary ☐ Foster ☐ Visitation

_____
(person(s) with legal custody or guardianship) *(when established)*

_____
(person(s) with right to make educational decisions)
Special considerations/visitations/restrictions: _____

Parent/Guardian:

Full Name: _____
Relationship to Student: _____
Cell: _____
E-mail: _____
Would you like to sign up for Parent Portal? ☐ Yes ☐ No
Address*: _____
Employer: _____ Work Phone: _____
(*if different from student)
☐ Should Receive Mailings ☐ Emergency Contact ☐ Pick-up Rights

Parent/Guardian:

Full Name: _____
Relationship to Student: _____
Cell: _____
E-mail: _____
Would you like to sign up for Parent Portal? ☐ Yes ☐ No
Address*: _____
Employer: _____ Work Phone: _____
(*if different from student)
☐ Should Receive Mailings ☐ Emergency Contact ☐ Pick-up Rights

TECHNOLOGY INFORMATION

Is your child able to reliably access the Internet at home? ☐ Yes ☐ No

NYS MIGRANT EDUCATION PROGRAM (PARENT SURVEY)

Have you or has someone in your family worked on a farm? ☐ Yes ☐ No
Have you moved during the past 3 years? ☐ Yes ☐ No

Others living in the child's household:

Name	*Age (if child)*	*Grade (if child)*	*Gender*	*Relationship to Child*

OTHERS TO BE CONTACTED IN CASE OF EMERGENCY *(other than parent/guardian, in the order to be called)*

	Name	*Home Phone*	*Cell Phone*	*Work Phone*	*Relationship to child*	*Emergency Contact*	*Authorized Pick-up*
1)						☐	☐
2)						☐	☐
3)						☐	☐
4)						☐	☐
5)						☐	☐
6)						☐	☐
7)						☐	☐

Physician to be called in an emergency: _____ Tel.# _____

Hospital to be called in an emergency: _____ Tel.# _____

STUDENT BACKGROUND

Previous School: _____ City_____State:_____

Dates Attended: _____ Grades Attended: _____

Was your child ever retained in a grade? ☐ Yes ☐ No If yes, which grade? _____

Does your child have an IEP or 504 Plan? ☐ Yes ☐ No

Has your child ever been Home Schooled? ☐ Yes ☐ No

Language(s) Spoken in Home? _____ Do you require a translator? ☐ Yes ☐ No

Is your child Hispanic, Latino, or of Spanish origin? ☐ YES, Hispanic ☐ NO, not Hispanic

Child's Ethnicity: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ White

Health Comments: ☐ Glasses ☐ Hearing ☐ Seizures ☐ Asthma ☐ Allergies_____

Other Health Comments: _____

AUTHORIZATIONS

1.) By signing the below, I authorize the Tri-Valley School District to release my child to the individuals selected for “authorized pick-up” above.

2.) I understand that the Tri-Valley School District will request my child's academic records, birth certificate, immunization records, attendance records, standardized testing, psychological evaluations, special education recommendations, health and dental records from their previous school district and or the physician's office listed above.

3.) I understand that falsification of any information or documents required for this verification may result in revocation of registration and exclusion of the student, and the parents/guardians and/or student may be subject to legal action for recovery of tuition

_____ _____

(Parent/Guardian Signature) (Date)

Tri-Valley Central School District

34 Moore Hill Road • Grahamsville, New York 12740

Phone (845) 985-2296 Brianna Comando, Registrar

Request For Records

_____

Student's Name

(Grade _____DOB _____) has enrolled in the Tri-Valley Central School District. Please forward copies of the information listed to the address(es) below:

- ✓ academic records
- ✓ birth certificate
- ✓ immunization records
- ✓ attendance records
- ✓ standardized testing
- ✓ health and dental records

Tri-Valley Central School
Registration Office
34 Moore Hill Road Grahamsville,
NY 12740

Phone: (845) 985-2296 x 5405

Email: registration@trivalleycsd.org

Date: _____

Requesting Records From:

❑ School: _____

Street: _____

City: _____

State/Zip: _____

Phone: _____

Fax: _____

Email: _____

❑ Physician: _____

Fax: _____

✓ Psychological evaluations and special education recommendations (if any), should be sent to the address below:

Tri-Valley Pupil Personnel Services
34 Moore Hill Road
Grahamsville, NY 12740
(845) 985-2296 x 5308
Fax: (845) 985-2481

_____ Date:_____

Parent/Guardian Signature

_____ Date:_____

Brianna Comando, Tri-Valley Central School District Registrar

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(Parent permission is no longer required when records are requested by authorized school personnel. (Family Educational Rights and Privacy Act, Final Rule on Education Records, Federal Register, June 17, 1976, Vol. 41, NO> 118, page 24673)

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

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

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

Home Language Questionnaire (HLQ)

Dear Parent or 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 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.

Please write clearly when completing this section.

STUDENT NAME:		
First	*Middle*	*Last*

DATE OF BIRTH:			GENDER:
Month	*Day*	*Year*	❑ Male ❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to Student*

HOME LANGUAGE CODE _____

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or 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?	❑ Mother _____ *specify*	❑ Father _____ *specify*	❑ Guardian(s) _____ *specify*
4. What language(s) does your child understand?	❑ English	❑ Other _____ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other _____ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other _____ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other _____ *specify*	❑ Does not write

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

SCHOOL DISTRICT INFORMATION:		STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School	*Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes* ***No*** ***Not sure***
❑ ❑ ❑ ***If yes,** please explain:_____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ No ❑ Yes* **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
❑ No ❑ Yes – Type of services received:_____

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ❑ No ❑ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

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

Relationship to student: ❑ Mother ❑ Father ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ **POSITION:** _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

****DATE OF INDIVIDUAL INTERVIEW:** _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:** _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

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

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

Tri-Valley Central School District

34 Moore Hill Road • Grahamsville, New York 12740

Phone (845) 985-2296

Student Residency Questionnaire

Name of Student: _____

Last *First* *Middle*

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? ☐ Yes ☐ No

2. Is this temporary living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No

Signature of Parent/Legal Guardian _____ Date _____

If you answered YES to the above questions, please complete the remainder of this form. If you answered NO, you may stop here.

_____ _____

Parent Signature **Date**

Where is the student presently living? (*Check one box.*)

- ☐ In a motel/hotel due to lack of housing
- ☐ In a shelter
- ☐ With relatives or others due to lack of housing
- ☐ In an abandoned apartment/building
- ☐ In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite
- ☐ Temporarily housed in a shelter awaiting foster care placement

Name of Parent(s)/Legal Guardian(s) _____

Address _____ Zip _____ Phone_____

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002(3)(d).

I agree to the release of the above information to the Academic Support for Kids Program (ASK).
I understand as a result of this referral a representative from ASK will be contacting me.

_____

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

_____ _____

Date *McKinney-Vento Act Liaison Signature*

CC: PPS

GO BEARS!

Bus Authorization

The following people are authorized to take my child/children from the bus throughout the school year:

Child/Children Name/s:_____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Date: _____

Parent/Guardian Signature: _____

Parent/Guardian Contact Phone Number: _____

Physical Exams Offered At TVCS

I, _____, would like my child or ward: _____
Parent/Guardian *Student Name*

to have a: (check one)

☐ PRIVATE PHYSICAL (obtained at a doctor's office), or

☐ A cost free SCHOOL PHYSICAL performed by Crystal Run Healthcare (obtained at the Tri-Valley Central School District Health Office), during their enrollment

Educational Law and Regulations of the Commissioner of Education require physical exams of children when they:

- Are entering the school district for the first time
- Are in Grades Pre-K or K, 1, 3, 5, 7, 9, and 11 **(NYS Screening & Health Exam Requirements are posted on the school website under health services)**
- Are referred by/to the Committee on Special Education
- Are signing up to participate in interscholastic sports

It is required to provide a physical to the health service department within 30 days from the first day the student starts school. After 30 days a notice will be sent to you. If a physical is not promptly provided, the student will be scheduled for a school physical with the medical director.

I understand that all reasonable precautions and care will be taken in giving health physicals to my child. The physical exams are done by the school district's Medical Director and with the assistance of a registered nurse. The School Nurse will repo1i to the parents in writing all significant findings which may require further professional attention. The medical evaluation consists of the history and physical exam.

_____ _____
Parent/Guardian Signature *Date*

I UNDERSTAND THAT ALL REPORTS, TESTING, AND MEDICAL ISSUES WILL BE SHARED ONLY WITH NECESSARY PERSONNEL (IE: teachers, administrators, coaches).

_____
Parent/Guardian Signature

Updated: April, 2022
CC: Nurse

Tri-Valley Central School District

34 Moore Hill Road • Grahamsville, New York 12740

Phone (845) 985-2296

Parent and Physician's Authorization for Administration of Medication in School and School Activities

A. **To be completed by physician:**
I request that my patient, as listed below, receive the following medication:

Name of Student: _____ DOB: _____

Diagnosis: _____

_____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINSTRATION

Possible Side Effects and Adverse Reactions (if any): _____

_____

PLEASE CHECK ONE:

☐ **Self-directed student:** means that the student can: Identify the correct medicine, identify the purpose of the medication, determine dosage being administered, describe what will happen if the medication is not taken, and able to refuse the medication if the student has any concerns about its appropriateness.

☐ **Non self-directed student**: means that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

I assess this student to be self-directed ☐ Yes ☐ No
Student may self-carry and self-administer medication ☐ Yes ☐ No

NOTE: The school nurse will also assess self-direction for the school setting. Parent should send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given at home.

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

- All medications for K-5 are held in the nurse's office, during the field trip, the teacher carries the medication.
- Medication must be in the original pharmacy labeled container with specific orders and the name of the medication.
- Medication and refills must be brought to school by parent, guardian or responsible adult.

B: To be completed by Parent/Guardian:
Your signature below indicates your approval for your child to be self-directing and able to follow the medication order(s) listed above while in school and/or on school trips.

Parent Signature: _____ Date: _____

School Nurse: _____ Date: _____

CC: Nurse

FAXED BY _____ **DISTRICT** _____

PROGRAMA DE EDUCACIÓN PARA MIGRANTES DEL ESTADO DE NEW YORK

OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

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

Por favor tome unos minutos para completar este cuestionario.

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

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

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

Nombre del Padre/Encargado: _____

Dirección Física: _____ Ciudad_____

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

Dirección anterior: _____

Nombre del estudiante: _____ Edad_____ Grado_____

Nombre del estudiante: _____ Edad_____ Grado_____

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

FAXED BY _____ DISTRICT_____

NEW YORK STATE MIGRANT EDUCATION PROGRAM

IDENTIFICATION & RECRUITMENT OFFICE

PARENT SURVEY

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

Please take few minutes to complete this questionnaire.

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

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

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

Parent/Guardian Name: _____

Home address: _____City/Town_____

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

Previous Address: _____

Student name: _____ Age _____Grade_____

Student name: _____ Age _____Grade_____

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

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
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL			

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **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:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*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 <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 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- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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.