VOORHEESVILLE ELEMENTARY SCHOOL
129 MAPLE AVENUE
VOORHEESVILLE, NEW YORK 12186

PHONE: (518) 765-2382
FAX: (518) 765-3842
WEB ADDRESS: Voorheesville.org

MR. JEFFREY P. VIVENZIO
Principal

Dear Parent or Guardian:

Welcome to the Voorheesville Central School District! Please take some time and carefully complete, in detail, each of the following documents. Along with a completed registration packet, the following documentation is also required in order to enroll your child within the Voorheesville Central School District.

- Your child's **original** birth certificate.
- Your child's official immunization record (signed and stamped by physician or clinic staff).
- A physical examination record (signed and stamped by physician or clinic staff).
- Custody papers, if applicable. (If the student is not your biological child, you must present documentation that proves a permanent and total transfer of custody and control has been achieved.)
- Three (3) **original** proofs of residency within the school district. This information must include the name and address of a parent or guardian as well as be dated within the previous 30 days. This **must** include:
  - A deed or other documentation of real property ownership.
  - A lease or rental agreement.

  Examples of two other proofs of residency:
  - A utility bill in the parent's name showing the address within the district.
  - The address on the parent's driver's license.
  - A record of the parent's voter registration.
  - A recent income tax return showing the parent's name and address within the district.
  - A current paycheck stub showing the parent's name and address within the district.

Important note regarding students entering Kindergarten: Each May, VCSD conducts Kindergarten Registration Screening. Please check the school calendar for upcoming dates or contact the registration office at (518)-765-2382 Ext. 504.

If you have any questions while completing the registration application, please do not hesitate to contact me at school.

Sincerely,

Mr. Jeffrey P. Vivenzio
Principal/District Registrar

Records Release Form

VOORHEESVILLE ELEMENTARY SCHOOL
129 MAPLE AVENUE
VOORHEESVILLE, NEW YORK 12186

Phone: (518) 765-2382
FAX: (518) 765-3842

JEFFEREY VIVENZIO
Principal

KAREN JONES
Director of Special Education

The following student(s)_____ will enter the

Voorheesville Central School District on _____. I hereby

authorize the sharing of information between _____ and the

Voorheesville Central School District. This must include the following records:

- **ACADEMIC** (Report Cards, Progress Reports, etc.)
- **HEALTH AND MEDICAL** (Immunizations/physical forms, etc.)
- **CSE** (any IEP, 504 Plans, or CSE notes on file)
- **ANY OTHER** information to assist us in academic and social programming

Signed: _____ Relationship:

_____

Date:_____

Please give the name and address of the school your child/children will be withdrawing from:

_____

_____

_____

_____

_____

NOTICE TO PARENTS

SPECIAL EDUCATION SERVICES

If you suspect that your child may have a disability and due to that disability may require special education supports, services or accommodations, you have the right to contact the District for information on options, and/or you may refer your child to the District's Committee on Special Education or Section 504 Team for an evaluation, and a determination as to whether your child is eligible to receive special education services, related services, accommodations and/or other program aids and services. More information regarding your rights is set forth in the New York State Education Department's *Parents Guide to Special Education in New York State for Children Ages 3-21,* available at https://www.p12.nysed.gov/specialed/publications/policy/parentsguide.pdf

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

Karen Jones
Pupil Personnel Services Director
Voorheesville Central School District
PO Box 468
129 Maple Avenue
Voorheesville, NY 12186
Phone: 518-765-2382, ext. 501
Email: kjones@voorheesville.org

VOORHEESVILLE CENTRAL SCHOOL DISTRICT
HOUSEHOLD INFORMATION

CPSE ONLY
St. Id#
Date
Area of Concern

Is the child in permanent housing? ☐ **In permanent housing**

If **the child is not in permanent housing; please indicate his/her current living situation:**

☐ **In a shelter** ☐ **In a hotel/motel** ☐ **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 car, park, bus or train station, or campsite**
☐ **Other temporary living situation (Including situations for seasonal employment) Describe:**_____
☐ **Temporarily housed in a shelter awaiting foster care placement**

Student Name: _____ (Male Female Non-Binary) DOB: _____ Grade Entering: ____

Physical Address: _____ Home Phone: _____
City/Zip Code: _____ IS THIS A CELL NUMBER? YES NO

Mailing address (if applicable) _____

Own ____ Rent ____ Lease ____ Other/Please explain: _____

Have you ever attended VCSD before? Yes or No

Parents/Guardians
Name and relationship to student:
1. _____ relationship: _____ occupation/employer: _____
2. _____ relationship: _____ occupation/employer: _____

Parent/Guardian(s) in active Military status: Yes_____ No_____

If parent/guardians are separated, what legal arrangements are in place:
Joint Custody Sole Custody Visitation Rights Foster Students

If applicable, name and contact information of parent ***NOT*** *residing with child:*
_____ Phone: _____
_____ Phone: _____

Duplicate mailings requested: Yes No

NOTE: A complete certified copy of the court custody decision bearing its case number and including the official stamp and signature are required.

Contact Information: Please list, in order, contact information for people (and their relationship to the child) to be notified should your child become ill. **(Parents/Guardians should be first, followed by people to contact if parents aren't available.) Please list what type of phone the number is, for example: C=cell, H=home, W=work.**

1) _____ Relationship _____ #1 _____ #2 _____ #3 _____
2) _____ Relationship _____ #1 _____ #2 _____ #3 _____
3) _____ Relationship _____ #1 _____ #2 _____ #3 _____

Children being registered and name of last school attended:

1) _____ DOB: _____ Grade: _____
2) _____ DOB: _____ Grade: _____
3) _____ DOB: _____ Grade: _____

Other children in household: Please list all children living in the household (not of school age or beyond school age)

1) _____ DOB: _____
2) _____ DOB: _____
3) _____ DOB: _____
4) _____ DOB: _____

E-mail address: Please list any e-mail addresses that we may use to contact you:

Name: _____ e-mail address: _____

Name: _____ e-mail address: _____

Name: _____ e-mail address: _____

I understand that if I provide false information on the registration forms and/or on the supporting materials that I may be committing the crime of perjury in the third degree (a class A misdemeanor); If I provided false information on these forms to the Voorheesville Central School District with the intent to defraud the District, I may be committing the crime of perjury in the second degree (a class E Felony); and I may be prosecuted on the criminal charges for such false information.

Signature of parent/guardian: _____ Date: _____

If any of the above information changes, please be sure to contact the school as soon as possible to provide updated information.

AFFIDAVIT OF RESIDENCY

Voorheesville Central School District

State of New York County of _____

_____being duly sworn, deposes and says:
(Name of Parent)

1. I reside at _____
(Legal Residence of Parent)
Telephone Number _____

2. _____is/are my _____
(Name of Child/Children) (Relationship)

and he/she has been living with me at the above address since _____
(Relevant Date)

3. If your child's/children's other parent does not reside at the same location, then provide the following information:

_____ _____ _____
(Other Parent's Name) (Address) (Phone Number)

4. I make this affidavit for the purpose of establishing residency within the Voorheesville Central School District.

Complete Either 5A or 5B

5A. In support of the above, as a homeowner I have attached the most recent copy of at least three of the following proofs of residency. Place a check in front of each item attached.

_____Property tax bill _____ Telephone bill _____ Water tax bill

_____ Electric bill _____ Bank Statement _____Voter Registration Card

_____Other (specify)_____

5B. In support of the above, as a renter, I have attached the original and current lease including the landlord's name, address, and telephone number and most recent copy of at least two of the following proofs of my residency. Place a check mark in front of each item attached.

_____ National Grid bill with current name and address
_____ License and car registration with current name and address
_____ Paycheck with current name and address
_____ Certificate of occupancy issued by town/village
_____ Automobile insurance policy with current name and address
_____ Bank/Credit Union account statement with current name and address
_____ Voter registration card with current name and address

6. If you are a renter, complete the following: Landlord's name _____
Landlord's phone number _____

Sworn to before me this _____ _____
(Signature of Resident Adult)

Day of _____ 20_____

_____
(Notary Public)

Anyone providing false information on this affidavit of residency is subject to criminal charge.

VOORHEESVILLE CENTRAL SCHOOL DISTRICT
www.voorheesville.org

Jeffrey Vivenzio
Principal/District Registrar
(518) 765-2382, Ext. 504

Information Packet

Print Student's Name_____ Grade_____

Please sign and date below that you have reviewed the following items together.

1. **Code of Conduct** (Voorheesville.org/about-us/policies-and-procedures/)

Print Parent's/Guardian's Name	Parent's/Guardian's Signature	Date
Print Student's Name	Student's Signature	Date

2. **Computer Network Policy found here:**
   https://www.voorheesville.org/departments/technology/

Print Parent's/Guardian's Name	Parent's Guardian's Signature	Date
Print Student's Name	Student's Signature	Date

Please complete and return the following items if applicable:

1. Family Application for Free and Reduced Price School Meals
   Voorheesville.org/departments/food-services/

VOORHEESVILLE CENTRAL SCHOOL
REQUEST FOR TRANSPORTATION

Student Last Name: _____ First Name: _____ M.I. ___ Grade _____

Mailing Address if Different than Residential Address:

_____
_____
_____

Date of Birth _/_/__ Male Female non-Binary Are there siblings currently in school? Yes/ No

Full Name of Parent/ Guardians	Relationship to Student	Home Phone	Work Phone	Cell Phone	Email Address
1)					
2)					

Resides With: ☐ Both Parents ☐ Father ☐ Mother ☐ Other :

Emergency Contacts	Relationship to Student	Home Phone	Work Phone	Cell Phone	Email Address
1)					
2)					

*Special Pick Up Point or Drop Off Point **IF** different from Home Address:*

PICK UP POINT Name: _____
Address: _____
Phone: _____

DROP OFF POINT Name: _____
Address: _____
Phone: _____

Is there anything that the Transportation Department needs to be made aware of? (such as allergies, motion sickness, etc.)

_____
_____
_____

Transportation Use Only

Siblings Y / N Data Entered Y/N Geocoded Y/N Routed Y/N

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 Elementary and Secondary Education Act (ESEA). 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 school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take a few minutes to complete this questionnaire.

Has anyone in your family worked, or looked for work at the following occupations during the past 3 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: _____

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 607-436-3606, or by mail to
NYS Migrant Education Program Identification and Recruitment Office:
100 Saratoga Village Blvd, Suite 41,
Ballston Spa, NY 12020.

NEW YORK STATE MIGRANT EDUCATION PROGRAM
OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO-
ENCUESTA PARA PADRES

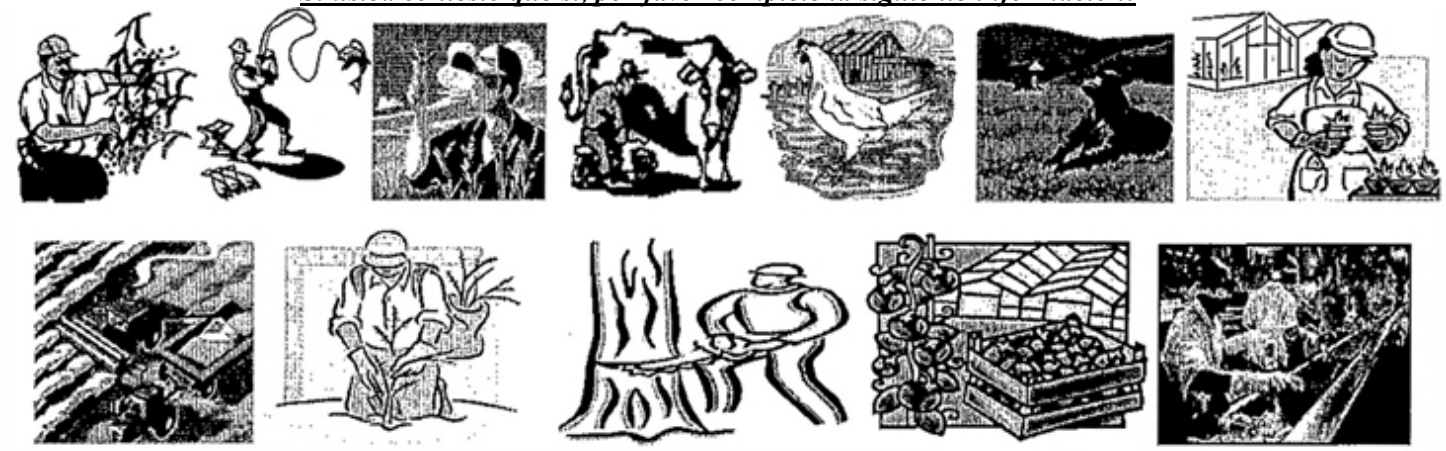
El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Acta de Educación Elemental y Secundaria (ESEA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, sin importar su nacionalidad o estado legal. Este programa es gratuito para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito en la escuela, 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 algún miembro de su familia ha trabajado o buscado trabajo en algunas de las siguientes ocupaciones en los pasados 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: _____

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 607-436-3606, o por correo a
NYS Migrant Education Program- Identification & Recruitment Office
100 Saratoga Village Blvd,
Suite 41,
Ballston Spa, NY 12020

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234

Office of P12

Elisa Alvarez, Associate 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 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.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER: ❑ Male ❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to*

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:	
2. What was the first language your child learned?	❑ English	❑ Other:	
3. What is the Home Language of each parent/guardian?	❑ Parent 1 _____ *specify*	❑ Parent 2 _____ *specify*	
	❑ Guardian(s) _____ *specify*		
4. What language(s) does your child understand?	❑ English	❑ Other:	
5. What language(s) does your child speak?	❑ English	❑ Other:	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other:	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other:	❑ 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:*	

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

Relationship 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: ❑ YES ❑ NO

****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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

VOORHEESVILLE, NEW YORK 12186

MR. FRANK MACRI
Superintendent of Schools

PHONE: (518) 765-3313

FAX: (518) 765-2751

To All Parents / Guardians:

The Voorheesville Central School District has adopted a policy which requires the collection and recording of the ethnic identity of students in the Voorheesville Central School District in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and Federal Education Departments
- Plan educational programs and make sure that they are readily available to all students.
- Analyze differences in academic performance, attendance, and completion of school.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the back of this page. Put a check (✓) in the box for the category or categories which best describes your child. The Voorheesville Central School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the students appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff: This form will be filed in the student's permanent record as confidential information.

To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below:

The Family Education Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student's name or student identification number.

PLEASE COMPLETE THE FORM ON THE REVESE SIDE OF THIS PAGE.

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

STUDENT RACIAL AND ETHNIC IDENTIFICATION

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Name of School	
School District Student Identification Number:	Date of Birth (Month/Day/Year)
Student Name: Last First, Middle:	Grade Level:

DIRECTIONS TO PARENT/ GUARDIAN

PLEASE ANSWER QUESTIONS (1) AND (2). PLEASE READ THEM BEFORE YOU RESPOND. (For question (1), check the box that best described your child). Check only ONE box.

1. **Is the student Hispanic, Latino, or of Spanish origin?** Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

   - ❑ YES, Hispanic
   - ❑ NO, not Hispanic

2. Select one or more races from the following five racial groups (Check all groups that apply to your child; check at least ONE box).

- ☐ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- ☐ **ASIAN: A** person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: A** person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **BLACK OR AFRICAN AMERICAN:** A person having origins in any of the Black racial groups of Africa.
- ☐ **WHITE:** A person having origins in any or the original peoples of Europe, North Africa, or the Middle East.

_____ _____

Signature of Parent/ Guardian/ Other — Date

Relationship to Student (Please check one box below)

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify): _____

See reverse for important message to Parents / Guardians and Confidentiality Procedures and Regulations

VOORHEESVILLE CENTRAL SCHOOL DISTRICT
www.voorheesville.org

Jeffrey Vivenzio
Principal/District Registrar
(518) 765- 2382, Ext.502

Dear Parents/Guardians:

There are many instances throughout the school year where there are opportunities for photographs for school events. Pictures may be taken to document classroom projects, field trips, club activities or similar events. At times we may use these photos for educational purposes or publicity to highlight the many wonderful things that go on in our school. In most cases, students will be unidentified or only identified using first names and last initials. Students who are recognized for outstanding achievement, service or awards may be identified by their full names.

If, for any reason, you do not want your student's photograph used, please return the form below. Feel free to call your school principal with any questions.

If for any reason you <u>do not</u> want your child's photograph used, please return the form below. Feel free to call me with any questions.

I DO NOT wish to have my child's photograph used for publicity or other educational purposes.

Student Name: _____

Grade and Teacher: _____

Parent/Guardian Signature:_____Date: _____

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

School Health Services

Dear Parent or Guardian:

As a part of your child's requirements for school, NYSED requires an annual New York State physical exam for students in grades K,1,3, and 5 as well as those entering the school district for the first time. A law was recently enacted that expands health screenings to include the dental health of students in New York State.

In addition, when we require that your child have a physical examination, we will be requesting a dental certificate as well. There is a sample certificate available for you to take to your child's dentist and once it is completed, it should be returned to the School Nurse as it will be filed in our child's Cumulative Health Record.

Thank you for your cooperation in this new health endeavor. Our students benefit when we work together to promote the health and achievement of all students.

Please call the school's Health Office if you have any questions or concerns.

Middle/High School Health Office (518) 765-3314 ext 210

Elementary School (518) 765-2382 ext 506

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:

☐ 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.

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

Dental Health Certificate

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:

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.

VOORHEESVILLE ELEMENTARY SCHOOL
EMERGENCY HEALTH INFORMATION

Name of Student _____ DOB_____ Age_____
(Last) (First)

Home Address _____

Grade _____ Teacher _____ Home Phone _____

*Parent/Guardian _____ Located at _____
(During school hours) (Phone number)

*Parent/Guardian _____ Located at _____
(During school hours) (Phone number)

*Step-Parent or Guardian _____ Located _____
(During school hours) (Phone number)

*Please put a priority as to who you would like called first.

In the event of early dismissal, illness or injury, if parents/guardians cannot be reached, contact the following for care/transportation:

NOTE: PLEASE ADVISE THESE INDIVIDUALS YOU ARE LISTING THEM FOR EMERGENCY CARE IN CASE THE SCHOOL IS UNABLE TO REACH YOU.

1. _____ at _____
(Phone Number)

Or _____ at _____
(Phone Number)

1. Child's Physician _____ at _____
2. Family Dentist _____ at _____
3. Hospital _____ (in event of serious injury)
4. Has your child had medical, dental or surgical treatment, or any other serious illness or injury?

_____

_____

_____

Parent/Guardian Signature _____ Date _____

OVER

Has your child ever had any of the following? Please give dates

Anemia	Pneumonia	Chicken Pox
Rheumatic Fever	Diabetes	Rheumatic Fever
Tuberculosis	Mumps	Epilepsy
Nephritis	Contact with TB	Heart Disease
Bladder Infection	Whooping Cough	Orthopedic Injuries

1. Does your child have asthma and if so what makes him/her wheeze or get short of breath? _____
   _____
2. Please list any medication your child takes_____
   _____
3. Please list any allergies your child has and the medication (if any) they are taking
   _____
   _____
4. Does your child have or has had a history of chest pain with exertion? Please explain _____
   _____
5. Does your child have a history of fainting with exertion? Please explain
   _____
   _____
6. Does your child have a history of shortness of breath with exertion? Please explain _____
   _____
7. Does your child have a family history related to cardiac cause? Please explain
   _____
   _____
8. Does your child have chronic/frequent ear infections?____
   a. If so, does your child have tubes in their ears?_____
9. Any problems with toilet training for bladder or bowels?_____
10. Does your child wear glasses? If so, all the time or for classwork?_____
11. Is there anything concerning the health of your child which the school should know so that we may better understand your child's health needs?
    _____
    _____
    _____

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

New York State Education Law requires that every child have a physical examination upon entering the school district for the first time, as well as in grades 2 and 4. The school offers school physicals for students in grades 2, 4, 7 and 10. However, if you wish to have your child examined by your own physician (or pediatrician), who may know your child best, you are free to do so. If you choose an exam by your private physician he/she must fill out the attached form to be returned to school. A recent medical exam, completed within the past 12 months, is acceptable. In this case, you may mail the form to your doctor requesting them to complete it and return it to school.

The school physician does not diagnosis medical problems. These will be reported to you immediately and you will be advised to bring them to the attention of your family doctor. We will request a report of your physician's findings and treatments.

Please check the appropriate statement below and return this form to school as soon as possible. If we do not receive a response from you, we will make arrangements to have your child examined by the school physician.

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

Student's Name _____ Grade _____

I prefer to have my child examined by the school physician, Dr. Silverman.

I prefer to have my child examined by our private physician. Private physician's appointment date is _____. (Bring the attached form to this appointment and have the physician fill it out and return it to school.)

My child was examined by Dr. _____ on _____.
I will have the physician fill out the form and return it to school.

_____
Parent's Signature