

**HALDANE CENTRAL SCHOOL DISTRICT**  
**COLD SPRING, NEW YORK 10516**  
New Student Registration Checklist

Grade Entering: \_\_\_\_\_

Student Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Please use this checklist to make sure you have all the required materials for registration. The student will not be allowed to begin classes until all information below has been completed, submitted, and approved. All documentation for grades 1 through 12 should be returned to Jessie Des Marais in the District Office. Mrs. Des Marais can be reached at 845-265-9254, ext. 111 with any questions. All Kindergarten registration should be returned to Jodi Champlin in the Elementary School Office.

- \_\_\_\_\_ Completed Registration Information Form
- \_\_\_\_\_ Birth Certificate
- \_\_\_\_\_ Verification of Residency
  - Homeowner (3 documents required)
  - Renters - See **Requirements to Verify Residency** form for further instruction (4 documents required)
- \_\_\_\_\_ Denial of Media Coverage/Opt-Out Form For Students
- \_\_\_\_\_ Completed Release of Information Form for records from previous school district
- \_\_\_\_\_ Questionnaire: Home Language (if applicable)
- \_\_\_\_\_ Questionnaire: Housing Student/Family Domicile (if applicable)
- \_\_\_\_\_ Medical Information:
  - \_\_\_\_\_ Student Health History                      \_\_\_\_\_ Emergency Authorization
  - \_\_\_\_\_ Hearing/Vision Questionnaire                      \_\_\_\_\_ Waiver (Potassium Iodide)
  - \_\_\_\_\_ Report of Physical Examination (including Immunization Record)
- \_\_\_\_\_ Most Recent Report Card
- \_\_\_\_\_ Individualized Education Plan or 504 (provide documentation, if applicable)
  - \*Special Education Notice: Please note that under section 4402 of the NYS Education Law, all parents who suspect that their child may have a disability are entitled to receive a special education evaluation and submit a referral to the Committee on Special Education.
- \_\_\_\_\_ Free/Reduced Priced Lunch Information (if applicable)
- \_\_\_\_\_ Bus Routes

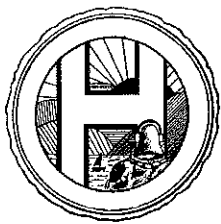
***For official use only***

\_\_\_\_\_ Added to Power School \_\_\_\_\_ Email to Enrollment Group \_\_\_\_\_  
(Date) (Date)

Medical Information has been reviewed and is complete \_\_\_\_\_  
School Nurse

Student Folder has been reviewed and is complete: \_\_\_\_\_  
Superintendent

\_\_\_\_\_ Folder Provided to Building Principal \_\_\_\_\_  
Date



**REGISTRATION FORM**  
**HALDANE CENTRAL SCHOOL DISTRICT**  
**COLD SPRING, NY 10516**  
**(845) 265-9254**

Office use only:

Student # \_\_\_\_\_ Lunch Pin # \_\_\_\_\_

Grade Level: \_\_\_\_\_

Entry Date: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE NAME

HOME ADDRESS: \_\_\_\_\_

CITY/ZIP: \_\_\_\_\_

MAILING ADDRESS

(IF DIFFERENT): \_\_\_\_\_

CITY/ZIP: \_\_\_\_\_

HOME/PRIMARY PHONE: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

GENDER: (M/F) \_\_\_\_\_ IS THE CHILD HOMELESS (Y/N): \_\_\_\_\_ PRIMARY HOME LANGUAGE: \_\_\_\_\_

YEARS IN U.S. SCHOOLS: \_\_\_\_\_ PREVIOUS SCHOOL: \_\_\_\_\_

CHILD'S RACE(S): American Indian ☐ Asian ☐ Black ☐ Native Hawaiian/Other Pacific Islander ☐  
White ☐ Hispanic ☐

**FAMILY INFORMATION**

Full Name

Full Name

Parent/Guardian: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_

Is this parent an active member of the armed services? Yes/No  
If yes, date entered active duty: \_\_\_\_\_

Is this parent an active member of the armed services? Yes/ No  
If yes, date entered active duty: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Child Lives With: Both Parents ☐ Father ☐ Mother ☐ Other \_\_\_\_\_

**(If duplicate school information is requested by a non-custodial parent, please provide the name and address)**

Please list below all children in your family ranging from birth to age 21 years. NOTE: If more space is needed, please attach.

Last Name, First Name	Age	Date of Birth	Gender M/F	Grade	Name of School Child will be attending

Has your child ever attended school in other districts? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list: \_\_\_\_\_

Is your child presently under suspension from another school district? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Has your child repeated a grade? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Has your child ever been referred for a special education evaluation in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

If referred for an evaluation, has your child ever received any special education services in the past? ☐ IEP ☐ 504 ☐ Other

Type of service received: \_\_\_\_\_

**(Provide a copy of plan with this registration.)**

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)

Has your child ever received remedial math? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your child ever received remedial reading and/or writing services? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your child ever received speech or language services? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Has your child ever received English as a New Language (ENL) services? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Has your child ever had difficulties in school (attendance, behavior, academic, etc.)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Are there circumstances or experiences in your child's life that may impact your child's performance in school? Yes\_\_ No \_\_

If yes, please explain: \_\_\_\_\_

In an effort to better know your child, please use the area below to offer additional information that you wish to share with us.


**I hereby attest that all registration information provided to the Haldane Central School District for the child named on this form is accurate. I understand that providing any false information will prohibit this child from entering our schools and may result in other penalties.**

Parent or Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_

**HALDANE CENTRAL SCHOOL DISTRICT**  
**15 Craigside Drive**  
**Cold Spring, New York 10516**

**Release Of Information**

This is a request for records for the following individual.

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
will be attending: Haldane Central School District, Cold Spring, NY 10516

Previous School Name, Address, Phone & Fax:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Home Phone & Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

These records should include:

<b>Regular Education Records</b>	<b>Special Education Records</b>
<input type="checkbox"/> Regular education records	<input type="checkbox"/> Current IEP
<input type="checkbox"/> Cumulative health records	<input type="checkbox"/> Most recent psychological evaluation
<input type="checkbox"/> Attendance records	<input type="checkbox"/> Social History
<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Scripts
<input type="checkbox"/> NYS exam scores	<input type="checkbox"/> Related service evaluations
<b>High School</b> <input type="checkbox"/> <b>(in addition to the above)</b>	<input type="checkbox"/> Other evaluations
<input type="checkbox"/> Official Transcripts	<input type="checkbox"/> Other:
<input type="checkbox"/> Exit grades (if applicable)	
<input type="checkbox"/> Science Labs documentation (proof of hours)	

I authorize that school records for the above-referenced student be sent to the Haldane Central School District, c/o Mrs. Jessie Des Marais, 15 Craigside Drive, Cold Spring, NY 10516 or (Fax 845-265-9213) for the purposes of school registration. Mrs. Des Marais, Registrar, can be reached at 845-265-9254, ext. 111 with any questions.

Signed \_\_\_\_\_

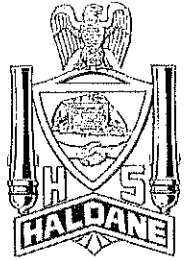
Relationship to Student \_\_\_\_\_ Date \_\_\_\_\_



# HALDANE CENTRAL SCHOOL DISTRICT OFFICE

15 Craigside Drive  
Cold Spring, New York 10516

Phone: 845 265-9254 Fax: 845 265-9213  
www.haldaneschool.org



## VERIFICATION OF RESIDENCY REQUIREMENTS

The Haldane Central School District requires proof of residency and may make reasonable inquiry to verify residency and eligibility for admission to its schools.

*To verify residency at the time of registration the following are required:*

**A. For Homeowners - You must present three (3) documents, as follows:**

Real property tax receipt or signed closing statement from Attorney and deed (including Westchester County or Putnam County Recording Cover Sheet)

**AND**

Two (2) of the following current documents in the Homeowner's name:

Mortgage Statement  
Utility bill  
Recent W2 Form  
Cable TV bill

Property Insurance Certificate  
Fuel Oil bill  
Driver's License, Learner's Permit, Non-Diver ID  
(with new address)

**Note: Documents with only a P.O. Box address will not be accepted.**

**B. For Renters - You must present four (4) documents, as follows:**

A Completed, Signed and Notarized Affidavit of Property Owner/Landlord (LCSD Form)

**AND**

A valid and fully executed lease for the rental unit and a rent receipt signed by the landlord, including the landlord's address and telephone number and property address (within the past 30 days).

**AND**

Two (2) of the following current documents in the Renter's name:

Utility bill  
Fuel Oil bill  
Cable TV bill  
DSS Budget Sheet  
Section 8 or Municipal Housing  
Statement

Property Insurance Certificate  
Voter Registration Card  
Recent W2 Form  
Letters from Agencies or caseworkers  
Driver's License, Learner's Permit, Non-Diver ID  
(with new address)

**Note: Documents with only a P.O. Box address will not be accepted.**

**C. For parents/students who reside with a family member/friend, you must present five (5) documents, as follows:**

A Completed, Signed and Notarized Affidavit of Property Owner/Landlord (LCSD Form)

**AND**

Two (2) documents verifying the residency of the family member/friend (see above for Homeowners and Renters).

**AND**

Two (2) of the following documents in the Parents' name:

Utility bill	Property Insurance Certificate
Fuel Oil bill	Voter Registration Card
Cable TV bill	W2 Form
Section 8 or Municipal Housing	DSS Budget Sheet
Statement	Letters from Agencies or caseworkers
Checkbook, bank statement,	Credit card statement
Car insurance statement/card	
Government Agency Documents (food stamps, medical cards, DMV change of address)	

**Proof of guardianship if a student lives with an individual other than his/her parents.**

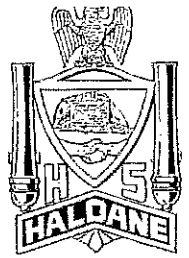
**Note: Documents with only a P.O. Box address will not be accepted.**



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## AFFIDAVIT OF PROPERTY OWNER/LANDLORD IN SUPPORT OF ADMISSION TO HALDANE CENTRAL SCHOOL DISTRICT

STATE OF NEW YORK )  
 ) SS.:  
COUNTY OF )

I, \_\_\_\_\_, a property owner  
(Name of Property Owner/Landlord or Property Manager)

or manager/agent of the dwelling located at \_\_\_\_\_  
(Street #, Address, City, State, Zip)

\_\_\_\_\_, in the Town/Village of \_\_\_\_\_

hereby certify that I am renting space in this dwelling on a \_\_\_\_\_ to \_\_\_\_\_ basis  
(Week/Month/Year)  
beginning on \_\_\_\_\_  
(Date)

The following persons are identified as tenants having the right to be occupants in the dwelling:

- Maternal Parent/Guardian: \_\_\_\_\_
- Paternal Parent/Guardian: \_\_\_\_\_

Name of Child(ren) in Application for Admission:

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ and  
Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

List all other persons residing in the dwelling:

Last Name

First Name

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this a multiple dwelling? Yes \_\_\_\_\_ No \_\_\_\_\_

Is the payment of Electric Utility Bill included in rent: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, a copy of the "mutually acceptable written agreement" for shared meter usage must be submitted in accordance with Public Service Law §52, Part 2(b)(i).

**NOTE: THE DISTRICT RESERVES THE RIGHT TO CONTACT THE APPROPRIATE MUNICIPALITY TO VERIFY THAT THE USE OF THE PREMISES IS IN COMPLIANCE WITH LOCAL LAWS AND CODES.**

As property owner/landlord, **I CERTIFY** that I will notify the Haldane Central School District Superintendent's Office, 15 Craigsides Drive, Cold Spring, NY 10516 within 30 days of termination of this tenancy. **I CERTIFY** that the information provided on this form is true and correct and that the statements made herein are being made under the penalties of perjury, knowing that the Haldane Central School District will rely upon them in determining whether the above-named child(ren) will be admitted to its school system. I understand that in the event the information contained in this affidavit is determined to be inaccurate or false, in whole or in part, the District may commence legal proceedings against me personally to collect the costs of educating such child(ren) and/or seek criminal action against me for falsifying business records and/or filing a false instrument.<sup>1</sup>

\_\_\_\_\_  
(Signature of Property Owner/Landlord)

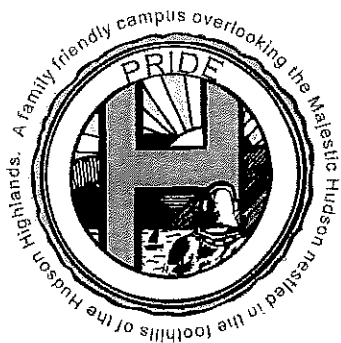
\_\_\_\_\_  
(Print Name & Title)

\_\_\_\_\_  
Property Owner/Landlord Address and Telephone #

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ Notary  
Public

<sup>1</sup> Penal Law §175.05 (Falsifying Business Records in the Second Degree - Class A Misdemeanor).  
Penal Law §175.20 (Tampering with Public Records in the Second Degree - Class A. Misdemeanor).  
Penal Law §175.25 (Tampering with Public Records in the First Degree - Class D Felony).  
Penal Law §175.30 (Offering a False Instrument for Filing in the Second Degree) - Class A Misdemeanor.  
Penal Law §175.35 (Offering a False Instrument for Filing in the First Degree) - Class E Felony.

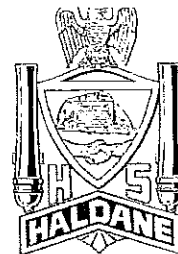




# HALDANE CENTRAL SCHOOL DISTRICT OFFICE

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Cold Spring, New York 10516

Phone: 845 265-9254 Fax 845 265-9213  
www.haldaneschool.org



## DENIAL OF MEDIA COVERAGE/USE OF STUDENT WORK OPT-OUT FORM FOR STUDENTS

Dear Parent/Guardian:

The Haldane Central School District interviews and takes photographs and videos of students involved in school activities throughout the year for submission to newspapers, television, radio, other media and affiliate organizations, school and district publications and websites, and for airing on the district's cable television channels. In addition, student work may be showcased.

Information released about students may include student name, school, grade level, awards, and participation in officially recognized school and district activities and sports.

This request will remain in effect for your child's time at Haldane and can be rescinded at any time.

**By not returning this form, parents/guardians give their consent to have their child interviewed, photographed, or recorded, and/or to have their work displayed at activities or events sanctioned by the school district.**

If you do not want your child or his/her work included in pictures, videos, or interviews in any of the district's publications, websites, cable television channels, or other media outlets, please return this form to the school. If you have any questions, please feel free to the building principal.

**Please return this form ONLY if you want to DENY media permission for your child.**

Student Name \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_



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

Lisette 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.		
<b>STUDENT NAME:</b>		
First	Middle	Last
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
Month	Day	Year
<input type="checkbox"/> Male <input type="checkbox"/> Female		
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	_____ specify
	<input type="checkbox"/> Guardian(s)		_____ specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> 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? \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or of Person in Parental Relation

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

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:

## **HEALTH OFFICE INFORMATION**

**Haldane Central School**

**Kathryn O'Hara, RN**

**Tina Kamrowski LPN**

**School Nurses**

### **SPECIAL HEALTH CONSIDERATIONS**

Please notify the health office of any special health needs your child may have. Examples would include the following:

- Bee sting or other allergy and any required medication (see policy below)
- Any illness or condition requiring special care
- Any difficulty with vision, hearing or speech
- Need for medication during school hours
- Need for special aids such as crutches, wheelchairs, special transportation, etc.

### **MEDICATION**

**\*\*Please note: Students cannot carry medication to and from school.**

We have to abide by very specific New York State Education Law pertaining to the administration of medication (including over-the-counter medications) in school. If your child needs to be medicated in school, the following must be provided:

1. Written orders from the health care provider
2. Written parental permission
3. Medication in its original container, clearly labeled.

**Again, please do not send medication to school with your child!**

**IMMUNIZATIONS – See attached chart from NYS Department of Health**

### **SCHOOL INJURIES/HEALTH EMERGENCIES**

You will be notified of any serious injury or health emergency. Your child will be given appropriate first aid until you, or someone designated by you, can authorize further treatment. If your child should require transportation by ambulance to an emergency room, an adult designated by the school will accompany your child to the hospital. With the exception of lifesaving measures, no treatment will be given at the emergency room without proper consent from you or your designee.

According to school policy, any student diagnosed with a concussion will be prohibited from returning to PE/sports for at least 7 days. In addition, the student must provide written medical clearance to return to sports/PE from his/her private physician, after which the school physician will certify this clearance.

The white "Emergency Care Card" enables you to list persons and doctors whom you wish to be contacted in an emergency if you cannot be reached. The need for these emergency contacts is crucial, especially if both parents are away from home during the school day. It is for the benefit of your child that we have the emergency card on file, completed on **both** sides and **signed**.

## SCREENING

The following screenings will be performed during the school year:

- Vision: grades K, 1, 3, 5, 7, 9 and 11
- Hearing: grades K, 1, 3, 5, 7, 9 and 11
- Scoliosis: girls grades 5 & 7, and boys grade 9

You will be notified in writing of any results which are not within normal guidelines as provided by the New York State Education Department.

Education Law requires that schools check for scoliosis (curvature of the spine). This screening is performed by the school nurse in the privacy of the health office. The purpose of the school scoliosis screening is early discovery and treatment of any spinal abnormalities. If your child's health care provider notifies us in writing (e.g. notation made on physical form) that a check for scoliosis has been performed, the screening will not have to be repeated in the health office.

## LICE

Please be alert for the **scratching** that may signify the presence of head lice. Examine your child's head regularly for nits (eggs that are attached to the hair shaft near the scalp, appear similar to sesame seeds and are very difficult to remove) as well as adult lice. The most effective way to prevent the spread of head lice is to counsel the students to try to refrain from touching heads and for girls with long hair to keep it pulled back so it cannot fall forward. Parents have informed me that there are several non-toxic products on the market that, when applied to a child's hair on a regular basis, will help prevent that child from getting head lice.

## PHYSICAL EXAMINATIONS

In New York State, physicals are mandated for all **NEW** students and those in grades K, 1, 3, 5, 7, 9 and 11. Exams performed within one year prior of the first day of school are acceptable. If for some reason a physical cannot be performed by the child's own doctor, a school physical can be arranged. However, a private physical is recommended and a form is attached for that purpose. Please have the form completed at the time of the visit and return it to this office.

Any students in grades 7-12 who participate in sports are required to have a physical **each** year. Any physical performed within 12 months of participation will qualify, unless there has been a recent injury or prolonged illness.

The height and weight measurements from the physical examinations are used to determine the student's body mass index or "BMI". The BMI lets the physician know if the student's weight status is in the healthy range or is too high or too low. New York State is now requiring that BMI and weight status be included as part of the student's physical. A sample of school districts will be selected to take part in a survey by the NYS Department of Health. If our school is selected to be part of the survey, we will be reporting information about our students' weight status groups. No names or information about individual students are sent. However, if you do not wish for your child's weight status to be included in this survey, please notify us in the Health Office in writing.

## PLEASE NOTE

During the school year, if any aspect of your child's health changes or concerns you, please call me at 265-9254, ext. 125 or email [kohara@haldaneschool.org](mailto:kohara@haldaneschool.org) or [tkamrowski@haldaneschool.org](mailto:tkamrowski@haldaneschool.org). In return we will inform you of any concerns we have. By working together, we can promote optimum health for all Haldane students.

# 2018-19 School Year

## New York State Immunization Requirements for School Entrance/Attendance<sup>1</sup>

**NOTES:**

Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades pre-k through 10, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: intervals between doses of polio vaccine DO NOT need to be reviewed for grades 5, 11 and 12.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 11 and 12. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

**Dose requirements MUST be read with the footnotes of this schedule.**

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3 and 4	Grade 5	Grades 6, 7, 8, 9 and 10	Grades 11 and 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) <sup>2</sup>	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older or 3 doses if 7 years or older and the series was started at 1 year or older		3 doses	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap) <sup>3</sup>		Not applicable		1 dose	
Polio vaccine (IPV/OPV) <sup>4</sup>	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older	3 doses
Measles, Mumps and Rubella vaccine (MMR) <sup>5</sup>	1 dose		2 doses		
Hepatitis B vaccine <sup>6</sup>	3 doses		3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine <sup>7</sup>	1 dose	2 doses	1 dose	2 doses	1 dose
Meningococcal conjugate vaccine (MenACWY) <sup>8</sup>		Not applicable		Grades 7, 8 and 9: 1 dose	Grade 12: 2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) <sup>9</sup>	1 to 4 doses		Not applicable		
Pneumococcal Conjugate vaccine (PCV) <sup>10</sup>	1 to 4 doses		Not applicable		

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.
2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday.
  - b. If the fourth dose of DTaP was administered at 4 years or older, the fifth (booster) dose of DTaP vaccine is not required.
  - c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
  - d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older. A Tdap vaccine (or incorrectly administered DTaP vaccine) received at 7 years or older will meet the 6th grade Tdap requirement.
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
  - a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap. A dose received at 7 years or older will meet this requirement.
  - b. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.
4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
  - b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
  - c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
  - d. Intervals between the doses of polio vaccine do not need to be reviewed for grades 5, 11 and 12 in the 2018-19 school year.
  - e. If both OPV and IPV were administered as part of a series, the total number of doses and intervals between doses is the same as that recommended for the U.S. IPV schedule. If only OPV was administered, and all doses were given before age 4 years, 1 dose of IPV should be given at 4 years or older and at least 6 months after the last OPV dose.
5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
  - a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
  - b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
  - c. Mumps: One dose is required for prekindergarten and grades 11 and 12. Two doses are required for grades kindergarten through 10.
  - d. Rubella: At least one dose is required for all grades (prekindergarten through 12).
6. Hepatitis B vaccine
  - a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks.
  - b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.
7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
  - a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
  - b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.
8. Meningococcal conjugate ACWY vaccine. (Minimum age: 6 weeks)
  - a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7, 8 and 9.
  - b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
  - c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.
9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
  - b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
  - c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
  - d. If dose 1 was received at 15 months or older, only 1 dose is required.
  - e. Hib vaccine is not required for children 5 years or older.
10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
  - b. Unvaccinated children ages 7 through 11 months of age are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
  - c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
  - d. If one dose of vaccine was received at 24 months or older, no further doses are required.
  - e. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: [www.health.ny.gov/prevention/immunization/schools](http://www.health.ny.gov/prevention/immunization/schools)

For further information, contact:

New York State Department of Health  
Bureau of Immunization  
Room 649, Corning Tower ESP  
Albany, NY 12237  
(518) 473-4437

New York City Department of Health and Mental Hygiene  
Program Support Unit, Bureau of Immunization,  
42-09 28th Street, 5th floor  
Long Island City, NY 11101  
(347) 396-2433

**HALDANE CENTRAL SCHOOL  
CRAIGSIDE DRIVE  
COLD SPRING, NEW YORK 10516**

**STUDENT HEALTH HISTORY**

Today's Date \_\_\_\_\_

Student's Name \_\_\_\_\_

Grade \_\_\_\_\_

Address \_\_\_\_\_

Sex M/F \_\_\_\_\_

Date of Birth \_\_\_\_\_

**MEDICAL HISTORY (infancy to present) Please check all that apply:**

Allergies _____	Asthma _____	Behavior Problems _____
Bladder Frequency _____	Cardiac problems _____	Cerebral Palsy _____
Concussion _____	Constipation _____	Cystic Fibrosis _____
Diabetes _____	Eating Problems _____	Frequent Diarrhea _____
Frequent Fevers _____	Frequent Nose Bleeds _____	Headaches _____
Hearing difficulties _____	Hearing aids _____	Hyperactivity _____
Incontinence _____	Indigestion _____	Juvenile Arthritis _____
Mental Illness _____	Migraines _____	Persistent cough _____
Recurrent Ear Infections _____	Scars or birthmarks _____	Seizure Disorder _____
Serious Head Injury _____	Sinus Problems _____	Skin Conditions _____
Stomach Aches _____	Vision problems _____	Glasses/Contacts _____
Vomiting _____	Weight Problems _____	Other _____

Please Explain :

**ALLERGIES** - please give all details:

TYPE	SPECIFIC ALLERGENS	TYPE OF REACTION	MEDICATION
<i>Food</i> _____	_____	_____	_____
<i>Environmental</i> _____	_____	_____	_____
<i>Drugs</i> _____	_____	_____	_____
Medication to be kept at school:		YES _____	NO _____

Is this child on any medication?

YES \_\_\_\_\_

NO \_\_\_\_\_

Describe:



Will medication be given at school? YES \_\_\_\_\_ NO \_\_\_\_\_

Any serious injuries? (include dates) \_\_\_\_\_

\_\_\_\_\_

Any hospitalizations? \_\_\_\_\_

\_\_\_\_\_

Surgical history? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

**For the health and safety of your child the information you have reported for medical conditions such as allergies and asthma will be shared with the teachers and staff, Please sign below only if you do NOT want to have this information shared with teaching or other staff members.**

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

**EMERGENCY AUTHORIZATION**

In the event of a serious health emergency, medical treatment cannot be administered without the consent of either a child's parent or guardian, a relative over 18 years of age, or another party authorized by the parent in writing.

This form provides parents with the opportunity to designate another person to act on their behalf if emergency treatment is needed and they cannot be contacted.

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STUDENT'S NAME

---

DATE OF BIRTH

---

ADDRESS

---

HOME PHONE NUMBER

---

PARENT/GAURDIAN

---

BUSINESS PHONE NUMBER

---

PARENT/GAURDIAN

---

BUSINESS PHONE NUMBER

---

RELATIVE'S NAME AND ADDRESS

---

PHONE NUMBER

---

PHYSICIAN'S NAME AND ADDRESS

---

PHONE NUMBER

---

PHYSICIAN'S HOSPITAL AFFILIATION

---

PHONE NUMBER

---

DENTIST'S NAME AND ADDRESS

---

PHONE NUMBER

Please read and sign the following:

*If none of the above can be reached, I authorize Haldane School officials to provide consent for any necessary emergency treatment for my child.*

---

DATE

---

SIGNATURE OF PARENT OR GUARDIAN

**HALDANE CENTRAL SCHOOL**  
Cold Spring, NY 10516

**DATE:** \_\_\_\_\_

**NAME:** \_\_\_\_\_

**BIRTHDATE:** \_\_\_\_\_

**HEARING/VISION QUESTIONNAIRE**  
(to be completed by parent)

**HEARING**

**Check One**

Has this child ever had any ear/hearing examination or treatment? Yes\_\_\_ No\_\_\_  
When \_\_\_\_\_ With Whom \_\_\_\_\_ Results \_\_\_\_\_

Do you suspect any hearing problems? Yes\_\_\_ No\_\_\_  
Explain \_\_\_\_\_

Does either parent have hearing problems? Yes\_\_\_ No\_\_\_  
Who \_\_\_\_\_ Problem \_\_\_\_\_ Since when \_\_\_\_\_

Does your child:

- |  |              |
|--|--------------|
| 1. Seem to have difficulty hearing?  | Yes___ No___ |
| 2. Turn up the TV louder than other members of the family?                       | Yes___ No___ |
| 3. Seem to favor one ear over the other?   | Yes___ No___ |
| 4. Jump or appear to be more startled than others if<br>there is a sudden noise? | Yes___ No___ |
| 5. Seem to hear you if you talk in a whisper?                                    | Yes___ No___ |
| 6. Make you talk loudly or repeat frequently?                                    | Yes___ No___ |

**VISION**

Has your child ever had any vision examination or treatment? Yes\_\_\_ No\_\_\_  
When \_\_\_\_\_ With whom \_\_\_\_\_ Results \_\_\_\_\_

Do you suspect any vision problems? Yes\_\_\_ No\_\_\_  
Explain \_\_\_\_\_

Does either parent wear glasses? Yes\_\_\_ No\_\_\_  
Who \_\_\_\_\_ Distance/Reading \_\_\_\_\_ Since when \_\_\_\_\_

Does your child:

- |  |              |
|--|--------------|
| 1. Seem to have difficulty seeing small lines or pictures? | Yes___ No___ |
| 2. Seem to have a problem seeing things far away?          | Yes___ No___ |
| 3. Squint?   | Yes___ No___ |
| 4. Wear glasses?   | Yes___ No___ |
| 5. Have eyes that turn in?                                 | Yes___ No___ |
| 6. Have eyes that turn out?                                | Yes___ No___ |
| 7. Sit very close to the television?                       | Yes___ No___ |
| 8. Rub eyes a lot?   | Yes___ No___ |

**HALDANE CENTRAL SCHOOL  
MEDICATION AUTHORIZATION FORM**

**Parent and Prescriber's Authorization for Administration of Medication in School**

**\*\*A new form must be completed each school year\*\***

**To be completed by a parent or guardian:**

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

I request that my child receive the medication prescribed below by our licensed care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse or other assigned person will assist in the administration of the medication.

Signature (Parent or Guardian) \_\_\_\_\_ Date \_\_\_\_\_

**To be completed by the licensed health care prescriber:**

Diagnosis: \_\_\_\_\_

Medication: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Time(s): \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Duration of treatment: \_\_\_\_\_

Prescriber Name and Title (print): \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Stamp:

**Healthcare Provider Permission or Independent Use and Carry:**

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed above safely and effectively and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff.

Prescriber signature \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Permission for Independent Use and Carry:**

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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

## STUDENT INFORMATION

Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

## HEALTH HISTORY

<b>Allergies</b> <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Environmental	

<b>Asthma</b> <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	

<b>Seizures</b> <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

<b>Diabetes</b> <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____	Date Drawn: _____

### Risk Factors for Diabetes or Pre-Diabetes:

Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI \_\_\_\_\_ kg/m2 Percentile (Weight Status Category): ☐ <5<sup>th</sup> ☐ 5<sup>th</sup>-49<sup>th</sup> ☐ 50<sup>th</sup>-84<sup>th</sup> ☐ 85<sup>th</sup>-94<sup>th</sup> ☐ 95<sup>th</sup>-98<sup>th</sup> ☐ 99<sup>th</sup> and >

Hyperlipidemia: ☐ No ☐ Yes Hypertension: ☐ No ☐ Yes

## PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
<b>TESTS</b>	Positive	Negative	Date	<b>Other Pertinent Medical Concerns</b>
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
<b>Lead Level Required Grades Pre- K &amp; K</b>			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 10$ $\mu$ g/dL				<input type="checkbox"/> Other: _____

☐ System Review and Exam Entirely Normal

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

☐ Additional Information Attached

Name:			DOB:	
<b>SCREENINGS</b>				
<b>Vision</b>	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Notes</b>
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
<b>Hearing</b>	<b>Right dB</b>	<b>Left dB</b>	<b>Referral</b>	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Scoliosis</b> Required for boys grade 9	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	
And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:	Trunk Rotation Angle:			
<b>Recommendations:</b>				
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>				
<input type="checkbox"/> <b>Full Activity</b> without restrictions including Physical Education and Athletics.				
<input type="checkbox"/> <b>Restrictions/Adaptations</b> Use the Interscholastic Sports Categories (below) for Restrictions or modifications				
<input type="checkbox"/> <b>No Contact Sports</b> Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling				
<input type="checkbox"/> <b>No Non-Contact Sports</b> Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field				
<input type="checkbox"/> <b>Other Restrictions:</b>				
<input type="checkbox"/> <b>Developmental Stage for Athletic Placement Process ONLY</b> Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports Student is at <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> <b>Accommodations:</b> Use additional space below to explain				
<div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> Brace*/Orthotic</div> <div><input type="checkbox"/> Colostomy Appliance*</div> <div><input type="checkbox"/> Hearing Aids</div> </div>				
<div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> Insulin Pump/Insulin Sensor*</div> <div><input type="checkbox"/> Medical/Prosthetic Device*</div> <div><input type="checkbox"/> Pacemaker/Defibrillator*</div> </div>				
<div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> Protective Equipment</div> <div><input type="checkbox"/> Sport Safety Goggles</div> <div><input type="checkbox"/> Other:</div> </div>				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
<b>MEDICATIONS</b>				
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School attached</b>				
List medications taken at home:				
<b>IMMUNIZATIONS</b>				
<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIS		Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>HEALTH CARE PROVIDER</b>				
Medical Provider Signature:			Date:	
Provider Name: <i>(please print)</i>			Stamp:	
Provider Address:				
Phone:				
Fax:				
<b>Please Return This Form To Your Child's School When Entirely Completed.</b>				

## Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination 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 dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> 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

I. The Dental Health condition of \_\_\_\_\_ on \_\_\_\_\_ (date of exam) The date of the exam 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 name and address (please print or stamp)

Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here.

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### 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 1/2 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**

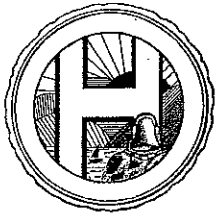
Other problems (Specify): \_\_\_\_\_

### III. 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.



Haldane Central School District  
15 Craigside Drive  
Cold Spring, NY 10516

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Dear Parents and/or Guardians:

The New York State Department of Health is currently distributing potassium iodide (KI) to schools which are located within a ten-mile radius of a nuclear energy facility. Because we lie within ten miles of Indian Point, we have been asked to distribute KI to all of our students in the event of a nuclear emergency. In such an emergency, radioactive iodine may be released in the air and may be inhaled or swallowed. It may then enter the thyroid from the bloodstream and damage it. Children are particularly susceptible to this damage to the thyroid. Potassium iodide can prevent this by saturating the thyroid with non-radioactive iodine thus preventing or reducing the amount of radioactive iodine that will be taken up by the thyroid.

We have a supply of potassium iodide provided by the state and, according to the guidelines provided, will administer a dosage of it to all students in the event of a nuclear emergency while they are in school. If you would **not** like for your child to be given the potassium iodide, please sign the waiver below and return it to the health office. Please inform me if your child has an allergy to iodine which would automatically preclude him/her from getting the potassium iodide.

If you have any questions please do not hesitate to contact me at 265-9254, ext. 125.

Sincerely,

Kathryn O'Hara, RN  
School Nurse

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Potassium iodide **should not** be given to my child in the event of a nuclear emergency. I do understand the risk associated with the intake of radioactive iodine but **DO NOT** want my child to receive any KI.

Child's Name (please print) \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian Name (print) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_