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 is to be returned to the registrar in the District Office. The registrar can be reached at 845-265-9254, ext. 111 with any questions.

_____ 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)
_____ 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

Folder Provided to Building Principal _____
Date

Revised 1/5/21

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: _____
GRADE LEVEL: _____

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): Is the child Hispanic or Latino Yes ☐ No ☐

American Indian ☐ Asian ☐ Black ☐ Native Hawaiian/Other Pacific Islander ☐

White ☐ Hispanic☐

FAMILY INFORMATION

Full Name
Parent/Guardian: _____
Is this parent an active member of the armed services? Yes/No
If yes, date entered active duty: _____
Relationship to Child: _____
Cell Phone: _____
Place of Employment: _____
Work Phone: _____
E-Mail: _____

Full Name
Parent/Guardian: _____
Is this parent an active member of the armed services? Yes/No
If yes, date entered active duty: _____
Relationship to Child: _____
Cell Phone: _____
Place of Employment: _____
Work Phone: _____
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☐ 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:

Regular Education Records	**Special Education Records**
Regular education records	Current IEP
Cumulative health records	Most recent psychological evaluation
Attendance records	Social History
Birth Certificate	Scripts
NYS exam scores	Related service evaluations
High School (in addition to the above)	Other evaluations
Official Transcripts	Other:
Exit grades (if applicable)	
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 DesMarais, 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_____

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	Property Insurance Certificate
Utility bill	Fuel Oil bill
Recent W2 Form	Driver's License, Learner's Permit, Non-Diver ID
Cable TV bill	*(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	Property Insurance Certificate
Fuel Oil bill	Voter Registration Card
Cable TV bill	Recent W2 Form
DSS Budget Sheet	Letters from Agencies or caseworkers
Section 8 or Municipal Housing Statement	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 Statement	DSS Budget Sheet
Checkbook, bank statement, Car insurance statement/card	Letters from Agencies or caseworkers
	Credit card statement

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.

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 Craigside 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.[1]

_____ _____
(Signature of Property Owner/Landlord) (Print Name & Title)

_____
Property Owner/Landlord Address and Telephone #

Sworn to before me this _____ day of _____, 20___
_____ Notary Public

[1] 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.

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

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

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

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

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

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

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

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

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

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

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

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

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

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

Relationship to student: ❑ Parent ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

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

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

NAME: _____ **POSITION:** _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

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

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

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:** _____

DATE OF NYSITELL 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:

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

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

Cuestionario de Idioma del Hogar (Home Language Questionnaire - HLQ)

Estimados padres o persona en relación parental:
Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura de él o ella, escritura y comprensión en el inglés, así como conocer su educación previa e historial personal. Por favor, llene con su información las secciones "Conocimientos de idiomas" e "Historial educativo". Apreciamos mucho su colaboración respondiendo a estas preguntas.
Gracias.

NOMBRE DEL ESTUDIANTE:		
Nombre	*Segundo nombre*	*Apellido*
FECHA DE NACIMIENTO:		GÉNERO:
Mes *Día* *Año*		❑ Masculino ❑ Femenino
INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL		
Apellido	*Primer Nombre*	*Relación con el estudiante*

HOME LANGUAGE CODE _____

Conocimientos de idiomas
(Por favor, marque todas las opciones que sean aplicables)

1. ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante?	❑ Inglés	❑ Otro	_____ *especifique*	
2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?	❑ Inglés	❑ Otro	_____ *especifique*	
3. ¿Cuál es el idioma primario de cada padre / tutor?	❑ Padre 1 _____ *especifique*	❑ Padre 2 _____ *especifique*		
	❑ Tutor(es) _____ *especifique*			
4. ¿Qué idioma o idiomas entiende su hijo(a)?	❑ Inglés	❑ Otro	_____ *especifique*	
5. ¿Qué idioma o idiomas habla su hijo(a)?	❑ Inglés	❑ Otro	_____ *especifique*	❑ No sabe hablar
6. ¿Qué idioma o idiomas lee su hijo(a)?	❑ Inglés	❑ Otro	_____ *especifique*	❑ No sabe leer
7. ¿Qué idioma o idiomas escribe su hijo(a)?	❑ Inglés	❑ Otro	_____ *especifique*	❑ No sabe escribir

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*	

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

8. Indique con un número el total de años que su hijo(a) lleva inscrito en una escuela _____

9. ¿Cree usted que su hijo(a) pueda tener dificultades, interferencias o problemas educacionales que le afecten su capacidad para entender, hablar, leer o escribir en inglés o en cualquier otro idioma? En caso afirmativo, por favor descríbalos.

*Sí**	*No*	*No se sabe*	
❑	❑	❑	*** En caso afirmativo, por favor explique:** _____

¿Qué gravedad considera usted que tienen estas dificultades educacionales? ❑ Poca gravedad ❑ Algo grave ❑ Muy grave

10a. ¿Alguna vez se ha recomendado a su hijo(a) a tener una evaluación de educación especial? ❑ **No** ❑ **Sí*** ****Por favor, llene 10b.***

10b. *<u>*Si se le ha recomendado alguna vez una evaluación,*</u> ¿ha <u>recibido</u> su hijo(a) alguna vez alguna forma de educación especial?

❑ **No** ❑ **Sí – Explique, que forma o formas de educación especial recibió:** _____

Edad en la que recibió la intervención o forma de educación especial *(favor de marcar todas las opciones que sean aplicables):*

❑ **De nacimiento a 3 años (Intervención Temprana)** ❑ **3 a 5 años (Educación Especial)** ❑ **6 años o mayor (Educación Especial)**

10c. ¿Tiene su hijo(a) un Programa de Educación Individualizada (Individualized Education Program - IEP)? ❑ **No** ❑ **Sí**

11. ¿Considera que hay alguna otra información importante que la escuela deba saber sobre su hijo(a)? *(Por ejemplo, talentos especiales, problemas de salud, etc.)*

12. ¿En qué idioma(s) quiere usted recibir la información de la escuela? _____

_____ Mes: Día: Año: _____

Firma de un padre o de la persona en relación paternal ***Fecha***

Relación con el estudiante: ❑ **Padre** ❑ **Otra:** _____

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

2019-20 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

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 11, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. 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 grade 12 except for interval between measles vaccine doses. 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, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**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)[3]	**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**3 doses**
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**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[7]	**1 dose**	**2 doses**		**1 dose**
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9 and 10: 1 dose**	**2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or 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 grade 12 in the 2019-20 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 grade 12. Two doses are required for grades kindergarten through 11.

   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, 9 and 10.

   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

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

HEALTH OFFICE INFORMATION
Haldane Central School District
265-9254 ext. 125

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**.**

***** Please note that as of July 2019, exemption from immunization compliance for religious reasons no longer applies in NY State.*****

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 "Emergency Authorization Form" 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 Authorization Form on file.

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.

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 to 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 your child experiences any changes in health, or you have any questions or concerns, please call the office at 265-9254, ext. 125 or email kohara@haldaneschool.org. By working together, we can promote optimum health for all Haldane students.

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 ALLERGINS**	**TYPE OF REACTION**	**MEDICATION**
Food	_____	_____	_____
Environmental	_____	_____	_____
Drugs	_____	_____	_____
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.

STUDENT'S NAME	DATE OF BIRTH
ADDRESS	HOME PHONE NUMBER
PARENT/GUARDIAN	BUSINESS PHONE NUMBER
PARENT/GUARDIAN	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 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: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐Type 1 ☐ Type 2 ☐ 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):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

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

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

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

☐ 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
_____	_____
_____	_____
_____	_____
_____	_____

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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

SAMPLE

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: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

Section 2. To be completed by the Dentist

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. ☐

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):_____

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

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

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 _____ Grade _____

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____