HARRISON CENTRAL SCHOOL DISTRICT
50 Union Avenue
Harrison, New York 10528
(914) 835-3300

STUDENT REGISTRATION PACKET

TABLE OF CONTENTS

HARRISON CENTRAL SCHOOL DISTRICT
50 Union Avenue
Harrison, New York 10528
(914) 835-3300

Retain This Page For Your Records

Summary of Forms and Procedures

In order to safeguard the health of your child/children, to place your child/children in the most appropriate program, and to conform with New York State law and District policy, the District will need certain information and records. In order to complete the enrollment process, a Student Registration Packet must be completed and submitted to your school's main office. The registration packet can be obtained from the District's website or from the main office of each school. Please direct any questions to the main office of your local school.

- Required Forms of Proof of Residency

Residency documentation must be submitted at the time of registration or within two (2) days of enrollment in order for the District to make a timely determination as to the student's eligibility to attend District schools.

Provide at least one utility bill, one item from Section A, plus one item from Section B.

Section A	Section B
1. Copy of a residential lease or proof of ownership of a house or condominium, such as a deed or mortgage statement 2. A statement by a third-party landlord, owner or tenant from whom the parent(s) or person(s) in parental relation leases or with whom they share property within the district 3. In the absence of the above, the District may consider other forms of documentation and/or information such as a statement by a third-party establishing parent(s) or person(s) in parental relation physical presence in the School District	1. Pay stub 2. Income tax form(s) 3. Additional Utility bills 4. Cell Phone bills 5. Voter registration document(s) 6. Official driver's license, learner's permit or non-driver identification 7. Documents issued by federal, state or local agencies (for instance, local social services agency, Federal Office of Refugee Resettlement) 8. In the absence of the above, the District may consider other forms of documentation and/or information establishing parent(s) or person(s) in parental relation physical presence in the School District

- Required Forms of Proof of Date of Birth

In order to determine the programming needs of your child/children, you must show proof of age by providing one of the following:

- An original birth certificate or record of baptism
- Original passport
- Where the above is not available, the School District may consider certain other documents/records in existence two years or more to determine age.
- A photo ID of parent/guardian when possible

- Required Physical Examination

A physical exam, including Body Mass Index (BMI), is required for all students. A physical exam performed during the calendar year is acceptable (see Part V for complete health requirements).

- Proof of Required Immunizations

Students must provide medical documentation that meets the New York State immunization requirements prior to entry (see Part V for complete health requirements).

- Parent/ Legal Guardian Oath

Parents must complete a parent/ legal guardian oath. If applicable, when guardianship rights for either or both parents is defined by a court determined custody agreement, a copy of the legal agreement that outlines custody is required (See page 7).

Proceed and complete Parts I – VI – All sections must be completed to process student registration.

Please Be Advised

In order for your child/children to attend the Harrison School District, you must be a resident of the School District.

Section 210.45 of the Penal Law of the State of New York prohibits the making of a false written statement. Therefore, statements contained in your registration application must be true and accurate.

If the School District determines that you are not a resident, your child/children will be excluded from attending the Harrison Schools. Further, you will be liable to the School District for payment of tuition from their date of enrollment through their date of exclusion, as well as the costs of collection.

HARRISON CENTRAL SCHOOL DISTRICT
50 Union Avenue
Harrison, New York 10528
(914) 835-3300

NEW STUDENT REGISTRATION

All registrants must complete ALL sections of Part I, II, III, IV, V & VI.

PART I

PARENT/GUARDIAN: Please Complete the Following Student Information**:** The student's legal name is required. (Please Print)

Last Name	Sex: _____M _____F _____X (non binary)
First Name	Date of Birth
Middle Name	Grade Level
Telephone	
Address	
Ethnicity (Choose one) _____Hispanic/Latino _____Not Hispanic/Latino Race (Choose any that apply) _____American Indian/Alaska Native _____Asian _____Black/African American _____Native Hawaiian/Pacific Islander _____White	

PARENT/GUARDIAN INFORMATION:

Student resides with:

_____Both Parents _____Mother Only _____Father Only _____Mother/Stepparent

_____Father/Stepparent _____Foster parent(s) _____Guardian(s)

FOR DISTRICT USE ONLY

- ☐ PROOF OF DATE OF BIRTH
- ☐ IMMUNIZATION RECORDS
- ☐ PROOF OF RESIDENCE
- ☐ PARENT/LEGAL GUARDIAN OATH
- ☐ LANGUAGE SURVEY
- ☐ SPECIAL SERVICES SURVEY
- ☐ REQUEST FOR STUDENT'S RECORDS: Sent: _____
- ☐ SINGLE PARENT, LEGAL GUARDIAN, DIVORCED *(if applicable)*
- ☐ NURSERY SCHOOL QUESTIONNAIRE *(if applicable)*

Date of Entry	ID #	School
Re-entry _____Yes _____No	Class of	Teacher/Counselor

Section A: Parent/Guardian Information

Parent/Guardians Residing With Student:

Please check one: _____Mr./Mrs. _____Mrs. _____Mr. _____Dr./Mrs. _____Dr./Dr. _____Other:

Parent/Guardian Last Name		Relation to Child
Parent/Guardian First Name		Date of Birth
Occupation	Employer Name/Address	
Home Phone	Cell Phone	Work Phone
E-Mail		
Marital Status _____Married _____Divorced _____Separated _____Widowed		

Parent/Guardian Last Name		Relation to Child
Parent/Guardian First Name		Date of Birth
Occupation	Employer Name/Address	
Home Phone	Cell Phone	Work Phone
E-Mail		
Marital Status _____Married _____Divorced _____Separated _____Widowed		

Parent/Guardian Not Residing With Student:

Parent/Guardian Last Name		Relation to Child
Parent/Guardian First Name		
Address		
Occupation	Employer Name/Address	
Home Phone	Cell Phone	Work Phone
E-Mail		
Marital Status _____Married _____Divorced _____Separated _____Widowed		

*****Additional Information Required for Single Parent, Divorced, Separated, Legal Guardian ONLY. If this is not applicable, skip to Section C.**

Section B: Single Parent, Divorced, Separated, Legal Guardian

Complete if you are a Single Parent, Divorced, Separated: If separated or divorced, other parent will have the right to visit student in school and have access to student's records unless a legal document indicating otherwise is provided. If applicable, please indicate any restrictions in the area below and provide a copy of the legal document.

Legal custody of child is with _____. Is there a joint custody arrangement? _____.

List any restrictions other parent has regarding child _____.

List type and date of legal document provided _____.

If separated or divorced, please indicate who is to receive copies of grades and correspondence:

Name: _____

Address: _____

Complete if you are a Legal Guardian: If the student is residing with someone other than a biological parent or a guardian (by way of court order), the District's guardian/parent affidavits will be required. These documents can be obtained through the Superintendent's Office.

Name of child's birth parent(s) _____

Address or whereabouts of birth parent(s) _____

Phone number of the birth parent_____

Provide document indicating custody and restrictions, etc.

Section C: Foster Parent or Foster Care Agency ***Additional Information Required for Foster Parent or Foster Care Agency ONLY. If this is not applicable, skip to Section D.

If you are a Foster Parent or Foster Care Agency you must complete the following or continued enrollment may be at risk. Also, a DSS-2999 Form and a letter verifying information below is required or continued enrollment may be at risk.

Name(s) of Foster Parent(s)		
Name of Agency	Agency Code	
Agency Address		
Type of Agency	Phone Number	
Case Worker	DSS Case #	CIN #
CB#	Date child was placed at current location	

Section D: Temporary Living Arrangement/Loss of Housing

ASSURANCE OF CONFIDENTIALITY:
The Family Educational Rights and Private Act ("FERPA") and the McKinney-Vento Homeless Education Assistance Act require schools and providers to keep all personally identifiable information strictly confidential. The District shall keep all student records and information provided confidential, in accordance with FERPA and McKinney-Vento and not release any such information to non-authorized individuals. Your responses will determine which services your child may be eligible to receive. This questionnaire is intended to address the McKinney-Vento Homeless Assistance Improvement Act. Your responses to this questionnaire will help the District determine which services your child may be eligible to receive.

1. Is your current address a temporary living arrangement? _____Yes _____No
2. If so, is this temporary living arrangement due to loss of house or economic hardship? _____Yes _____No

If you answered **Yes,** please complete the remainder of this form. If you answered **No**, proceed to Part II.

Please check what best describes where this student is <u>currently</u> living:

_____In a shelter

_____In a motel or hotel

_____In a transitional housing program

_____In a car, trailer or campsite

_____In a rented trailer/motor home on private property

_____In a rented garage due to loss of housing

_____Temporarily with an adult that is <u>not</u> the parent/legal guardian of child, due to loss of housing

_____In a single room occupancy building

_____Temporarily in another family's house or apartment due to loss of housing

_____Awaiting foster placement

_____Other place unfit for human habitation

_____NONE OF THESE CHOICES APPLY

These questions are required by the McKinney-Vento Homeless Assistance Improvement Act.

All registrants must complete ALL sections of Part II, III, IV, V & VI.

PART II

PREVIOUS ADDRESS INFORMATION

Dates To/From *(most recent first)*	Address	Location/City/State/Country

PREVIOUS SCHOOL INFORMATION

School Attended	Dates To/From *(most recent first)*	Location/City/State/Country

PLEASE LIST SIBLINGS' NAME(S) AND AGE(S)

Name	Age	School

DOCTOR/DENTIST INFORMATION

Doctor's Name	Phone
Address	
Dentist's Name	Phone
Address	

EMERGENCY CONTACTS (Please list three)

Name		Relationship
Address		
Home Phone	Cell Phone	Work Phone
E-Mail Address		

Name		Relationship
Address		
Home Phone	Cell Phone	Work Phone
E-Mail Address		

Name		Relationship
Address		
Home Phone	Cell Phone	Work Phone
E-Mail Address		

PARENT OR LEGAL GUARDIAN OATH

I, _____, am the parent/guardian of

_____, and I have read the
(Name of Student)

foregoing application and understand its contents. I have provided answers knowing that the Harrison Central School

District will rely upon them in determining whether my child is eligible for admission into the school district.

I understand that in the event that it is discovered that the child registered here is not a resident of the Harrison Central

School District, I will be liable to the School District for payment of tuition from their date of enrollment through their date of exclusion, as well as the costs of collection.

_____

Signature *Date*

All registrants must complete ALL sections of Part III, IV, V & VI.

PART III

ASSURANCE OF CONFIDENTIALITY:
The Family Educational Rights and Private Act ("FERPA") and the Individuals with Disabilities Education Improvement Act ("IDEA") require schools and providers to keep all personally identifiable information strictly confidential. The District shall keep all student records and information provided confidential, in accordance with FERPA and the IDEA and not release any such information to non-authorized individuals. This information is not used in the determination of residency.

SPECIAL SERVICES SURVEY

Does your child have a known or suspected disability that substantially impacts his/her learning? _____Yes_____No
If yes, please describe. If no, proceed to Part IV.

Has your child been evaluated for a disability? _____Yes _____No
If yes, please respond to A and B.

A. What district developed the most recent IEP? _____

B. Most recent year of IEP: _____

Has your child been classified by a Committee on Special Education as a student eligible for Special Education services?
_____Yes _____No

If yes, please describe. _____

_____

_____

Has your child received any special services (i.e. Speech, OT, PT, AIS, ESL, etc.) in a previous school?
_____Yes _____No

If yes, please describe. _____

_____

_____

In accordance with the Individuals with Disabilities Education Act and New York State Education Law §4400 et. Seq., the parent or person in parental relation of any student may refer such student to the District's Committee on Special Education for an evaluation to determine the student's eligibility for special education programs and services. For further information concerning your rights, please refer to the Parent's Guide to Special Education in New York which may be obtained at http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm

In addition, you may contact the Director of Special Education, at (914) 630-3068 to make a referral to the Committee on Special Education, to obtain a copy of the Parent's Guide or to obtain further information concerning the referral process.

FOR DISTRICT USE ONLY

If the registrant has answered 'yes' to any of the questions above, please forward a copy of this form to the Office of Special Education.

_____ _____
Signature *Date Forwarded*

All registrants must complete ALL sections of Part IV, V & VI.

IPARTIV I

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

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

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

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

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:	**GENDER:**
Month _____ *Day* _____ *Year* ____	☐ Male ☐ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name	*First Name*	*Relation to Student*

HOME LANGUAGE CODE _____

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	☐ English	☐ Other	_____ *specify*
2. What was the first language your child learned?	☐ English	☐ Other	_____ *specify*
3. What is the Home Language of each parent/guardian?	Mother _____ *specify*	Father _____ *specify*	☐ Guardian(s) _____ *specify*
4. What language(s) does your child understand?	☐ English	☐ Other	_____ *specify*
5. What language(s) does your child speak?	☐ English	☐ Other _____ *specify*	☐ Does not speak
6. What language(s) does your child read?	☐ English	☐ Other _____ *specify*	☐ Does not read
7. What language(s) does your child write?	☐ English	☐ Other _____ *specify*	☐ Does not write

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

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

Home Language Questionnaire (HLQ)-Page Two

Educational History

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

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

*Yes** *No* *Not sure*

☐ ☐ ☐ *If yes, please explain: _____

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

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

1 Ob. **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)

1 Oc. Does your child have an Individualized Education Program (IEP)? ☐No ☐Yes

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

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

_____ Month: _____ Day: _____ Year: _____

Signature of Parent or of Person in Parental Relation *Date*

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

OFFICIAL ENTRY ONL Y - 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: **0** No **O** YES

**DATE OF INDIVIDUAL INTERVIEW: _____ Mo DAY YR.	OUTCOME OF INDIVIDUAL INTERVIEW: **0** ADMINISTER NYSITELL 0 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: 0 ENTERING 0 EMERGING 0 TRANSITIONING 0 EXPANDING 0 COMMANDING

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

All registrants must complete ALL sections of Part V & VI.

PART V

HARRISON CENTRAL SCHOOL DISTRICT
50 Union Avenue
Harrison, New York 10528
(914) 835-3300

This Section Must be Completed for All Students Except Those Entering Kindergarten

AUTHORIZATION FOR THE RELEASE OF STUDENT RECORDS

Written consent from a parent or legal guardian is required before another school can release student records. In the case of eighteen year old students, permission of the student must be obtained.

The form provided below will authorize your last school to provide us with transcripts and records. Please complete the required information and sign this form.

Last School Attended	Last Day
Address	
Telephone	Fax

Dear Principal or Registrar: In accordance with the Family Educational Rights and Privacy Act of 1974 (PL 93-390), I do hereby authorize you to release all records and transcript on the below-named student to Harrison Central School District. Please provide all health records, semester grades, withdrawal grades, discipline records, dates of attendance, and psychological evaluations.

_____
Signature of Parent/Guardian

Student's Name: _____

Age: _____ **Date of Birth:** _____ **Grade Level:** _____

Date of Enrollment at Harrison: _____

PLEASE FORWARD ALL INFORMATION TO ONE OF THE SCHOOLS LISTED BELOW:

Harrison High School
255 Union Avenue
Harrison, NY 10528
Attention: Records
Fax No. : 835-5471

Harrison Avenue School
480 Harrison Avenue
Harrison, NY 10528
Attention Records
Fax No.: 835-4311

Samuel J. Preston Elementary School
50 Taylor Avenue
West Harrison, NY 10604
Attention Records
Fax No.: 914-761-7166

Louis M. Klein Middle School
50 Union Avenue
Harrison, NY 10528
Attention: Records
Fax No.: 835-0904

Parsons Memorial Elementary School
200 Halstead Avenue
Harrison, NY 10528
Attention Records
Fax No.: 835-4657

Purchase Elementary School
2995 Purchase Street
Purchase, NY 10577
Attention Records
Fax No.: 946-0286

PART VI

HARRISON CENTRAL SCHOOL DISTRICT

50 Union Avenue
Harrison, New York 10528
(914) 835-3300

New York State Public Health Law Requirements for Entrance & Required Health Forms

In order to enroll a new student, New York State requires that the parent or guardian of each new entrant provide the following medical documentation. Bring this packet to your child's physician and use this cover page as a checklist of the forms that you need to complete and return.

PROOF OF IMMUNIZATIONS

The Harrison Central School District is required by New York State Public Health Law to have on file acceptable proof of immunizations for each student upon entering school, and to identify and exclude from school any child that is not in compliance with current and applicable New York State immunization requirements.

☐ **PROOF OF IMMUNIZATION must be fil!Y.-1 of the 3 items listed below:**

- An immunization certificate signed by your health care provider
- Immunization Registry Report (NYSIIS or CIR from NYC) from your health care provider or your county health department
- A blood test (titer) lab report that proves your child is immune to the diseases*
  ** For Varicel/a (Chickenpox), a note from your health care provider that states your child had the disease is also acceptable.*

All new students must be screened for Tuberculosis by their physician. Students who fall into the high risk category must have a negative PPD within 12 months of entry. BCG does not preclude testing. Any positive PPD requires a follow-up chest x-ray or QuantiFERON-TB Gold blood test. Students who do not require Tuberculosis testing must submit a waiver, signed by their physician, stating that they are not at risk for Tuberculosis.

☐ **STUDENT HEALTH EXAMINATION FORM,** including Body Mass Index (BMI), is required for all new students. The form must be completed by your child's physician. Examinations performed within the 12 month period prior to entry are acceptable.

☐ **HEALTH HISTORY QUESTIONNAIRE** is to be completed by the parent or guardian of an entering student. The questionnaire provides important health related information about your child.

D **DENTAL EXAM FORM** is requested and must be completed by your child's dentist. This form is not required for entry and can be returned during the school year.

Also included in this packet is a Health Reference Sheet, which provides important information regarding health procedures in our schools. Parents and students are urged to fully acquaint themselves with these procedures. It is our goal to provide a healthy and safe environment for your child. Your attention to these forms is appreciated.

Revised 1/30/15

HARRISON CENTRAL SCHOOL DISTRICT
PROOF OF IMMUNIZATION

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

IMMUNIZATION HISTORY

DTaP/DT/Td					
Tdap					
Polio – IPV					
Live Measles Vaccine	#1	#2	Disease		
Live Mumps Vaccine	#1	#2	Disease		
Live Rubella Vaccine	#1	#2	Disease		
Varicella	#1	#2			
Hepatitis B Vaccine	#1	#2	#3		
Hepatitis A	#1	#2	#3		

TUBERCULIN SKIN TEST

*** If the student has had a medically documented, positive TST in the past, the test need not be repeated. Go to Section B below.

A. Tuberculin Skin Test (Mantoux/Intermediate PPD) – WITHIN 12 MONTHS OF ENTRY

Test must be read by a health care provider 48-72 hours after administration. If there is no induration, indicate "0" under results. Tine or Mono-Vac tests are not accepted.

Date test administered: ____/____/____ Date test read: ____/____/____ Result: _____mm induration

Test interpretation (refer to table below): ☐ Negative ☐ Positive

Risk Factor	Positive Result
Close contact with case of TB/is immunocompromised	5 mm or more
Born in country with a high rate of tuberculosis	10 mm or more
Traveled or lived for a month or more in a country with a high rate of tuberculosis	10 mm or more
No risk factors (PPD should not be performed)	15 mm or more (if PPD done)

B. If Tuberculin Skin Test is Positive, now or previously, the following are required:

1. Date of Positive PPD: ____/____/____
2. Chest X-ray: (please attach copy of report) ____/____/____ ☐ Normal ☐ Abnormal
   If Abnormal, describe: _____
3. Clinical Evaluation: ☐ Normal ☐ Abnormal
   If Abnormal, describe: _____
4. Treatment: ☐ No (please explain): _____
   ☐ Yes (Drug, Dose, Frequency, Dates): _____
   _____

C. Tuberculin Skin Test screening not indicated (Student has none of the above risk factors): _____
(Physician's Signature Required)

Physician's Signature: _____ Phone: _____

(Physician's Stamp below)

Physician's Name/Address: _____ Fax: _____

This health appraisal complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school physician.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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

BMI_____kg/m2

Percentile (Weight Status Category): ☐ < 5th ☐ 5th- 49th ☐ 50th- 84th ☐ 85th- 94th ☐ 95th- 98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

<u>If Restrictions Apply</u> – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

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

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

HARRISON CENTRAL SCHOOL DISTRICT

NEW STUDENT HEALTH HISTORY QUESTIONNAIRE

This New Student Health History Questionnaire is to be completed by the parent or guardian of an entering student who is new to the Harrison Central School District. The information provided in this questionnaire will provide the school nurse with important health-related information about your child.

Student Name: _____ **Date of Birth:** _/_/_ **Gender:** ☐ **M** ☐ **F** **Grade:** _____

Father's Name: _____ **Mother's Name:** _____

Family Physician: _____ **Physician Phone #:** _____

Dentist: _____ **Dentist Phone #:** _____

HEALTH HISTORY

Please provide the following information about your child's health history.
If you answer "Yes" to any of the questions, ***please explain below.***

	Yes	No		Yes	No
Allergies to food or bee stings	☐	☐	Asthma	☐	☐
Allergies to medication	☐	☐	Any hospitalizations or ER visits (past 1 year)	☐	☐
Allergy to latex	☐	☐	Chronic illnesses	☐	☐
Allergies to animals	☐	☐	Diabetes	☐	☐
Seasonal allergies	☐	☐	Takes daily insulin or uses an insulin pump	☐	☐
Eczema or skin rashes	☐	☐	Bleeding disorders or frequent nosebleeds	☐	☐
Any daily medications	☐	☐	Chicken Pox	☐	☐
Any problems with vision	☐	☐	Mononucleosis (past 1 year)	☐	☐
Wears glasses or contact lenses	☐	☐	Measles	☐	☐
Dental braces, caps or bridges	☐	☐	Mumps	☐	☐
Any problems with hearing	☐	☐	Rubella	☐	☐
Wears a hearing aid	☐	☐	Whooping Cough	☐	☐
Frequent ear infections	☐	☐	Heart Disease	☐	☐
Any growth or developmental delays	☐	☐	Kidney Disease	☐	☐
Any prior concussions or head injuries	☐	☐	Lyme Disease	☐	☐
Any broken bones or dislocations	☐	☐	Migraine headaches	☐	☐
Any muscle or joint injuries	☐	☐	Pneumonia	☐	☐
Any neck or back injuries	☐	☐	Seizure Disorder	☐	☐
Any mobility limitations	☐	☐	Tuberculosis	☐	☐

Please explain all "Yes" answers below and include any other physical or mental health concerns not identified above.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Parent/Guardian Signature *Date*

HARRISON CENTRAL SCHOOL DISTRICT

50 Union Avenue
Harrison, New York 10528
(914) 835-3300

DENTIST CERTIFICATE

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: _____ **Date of Birth:** _____

Home Address: _____

School: _____ **Grade Level:** _____ **Teacher** _____

****

TO BE COMPLETED BY DENTIST

Date of Last Examination: _____

Check work that was completed at the last examination:

☐ **Inspection** ☐ **Cleaning** ☐ **Repair** ☐ **No Treatment Needed**

Please provide any comments about the child's dental health that the school nurse should be aware of:

_____

_____

_____

_____

_____

_____

_____

_____

Name of Dentist (please print): _____ **Phone:** _____

Dentist Signatu e: _____ **Date:** _____

Dentist Stamp Required

HARRISON CENTRAL SCHOOL DISTRICT

50 Union Avenue
Harrison, New York 10528
(914) 835-3300

HEALTH REFERENCE SHEET

ILLNESS

Please consult with your doctor for evaluation, diagnosis and treatment if illness is suspected. Students should be fever free (without medication to control fever) and without vomiting or diarrhea for twenty-four hours before returning to school. It is important for to let your school nurse know if your child has been recently diagnosed with a communicable illness, such as Strep throat, Conjunctivitis (Pink Eye), Flu or Fifth Disease. Students with rashes and skin lesions can be excluded from school pending diagnosis and a written statement from the doctor is required upon return to school. Students who are absent for a period of more than two weeks are required to present a doctor's statement regarding the nature of illness and any necessary modifications in the school program.

INTERNAL MEDICATIONS

To ensure the safety of students and to comply with applicable regulations associated with the administration of medications to students in the school setting please note the following information. All medications, including over-the-counter (Tylenol, Advil, Benadryl, etc.) are administered only with written parental permission and written physician's orders. Parents/Guardians must provide the medication as ordered in a clearly labeled bottle. All medications must be dropped off to or picked up from the Health Office by an adult. If a medication is considered a controlled substance, the medication must be counted and signed for by both the school nurse and the adult providing the medication. Medications on field trips are managed according to district procedure.

HEALTH SCREENINGS-VISION, HEARING, SCOLIOSIS

The district's School Health Services program supports your student's academic success by promoting health in the school setting. One way that we provide care for your student is by performing health screenings as mandated by the State of New York. Parents/Guardians are notified if the results of the screening require further evaluation.

PHYSICAL EDUCATION-MODIFIED ACTIVITY/EXCUSE

A note from a parent or guardian will excuse a student from Physical Education and/or related physical activities for no more than two consecutive classes. A physician's note may be requested for repeated absence from Physical Education and related activities at the discretion of the school physician. If a student is excused from physical activities following treatment by a physician, a note is required from that physician to resume physical activities. Any student that sustains a concussion must be managed in accordance with the *HCSD Concussion Management Protocol.*