FRANKFORT-SCHUYLER ELEMENTARY
610 REESE ROAD
FRANKFORT, NY 13340
PHONE: 895-7491 FAX: 895-4102

Date: _____

Name of Student: _____
(First) (Middle) (Last)

Date of Birth: _____ **Current Grade:** _____

The above named student has enrolled in our school district. Please forward the following records:

1. Report Card/Current Grades
2. Health Records
3. Standardized Test Results
4. Individual Education Plan/504 Plan
5. Psychological/Confidential Records
6. Cumulative School Records/Transcript
7. Social Records
8. Transition Plan
9. OT/PT Evaluations
10. Speech/Language Evaluation
11. Other Documentation Necessary For Program Placement

PREVIOUS SCHOOL INFORMATION:

_____
(Name of Previous School)

_____
(Address)

_____
(City, State, Zip Code)

_____
(Phone number/Fax number)

I agree to the release of the above named records.

_____ _____
(Parent/Guardian Signature) (Date)

NOTE: Parental permission is no longer required when records are requested by authorized school personnel (Family Educational &Privacy Act Final Rule on Educational Records Federal registrar, June 17, 1976, Vol 41, No. 118. Page 246773).

( ) Faxed ( ) Mailed _____
(Date)

FRANKFORT-SCHUYLER ELEMENTARY SCHOOL
STUDENT INFORMATION UPDATE FORM

CHILD'S LAST NAME:_____ **FIRST:**_____ **MIDDLE:**_____

ADDRESS:_____ **ETHNICITY**_____

HOME TELEPHONE NUMBER:_____ **LANGUAGE SPOKEN AT HOME**_____

E-MAIL ADDRESS:(Mom)_____ **E-MAIL ADDRESS:(Dad)**_____

DATE OF BIRTH:_____ **PLACE OF BIRTH:**_____

NAME OF PARENT(S) / GUARDIAN(S) WITH WHOM CHILD RESIDES:_____

FATHER'S LAST NAME:_____ **FIRST NAME:**_____

ADDRESS OF FATHER:_____ **FATHERS CELL:**_____

PLACE OF EMPLOYMENT:_____ **FATHERS WORK #:**_____

MOTHER'S LAST NAME:_____ **FIRST NAME:**_____

MOTHER'S ADDRESS:_____ **MOTHERS CELL:**_____

PLACE OF EMPLOYMENT:_____ **CELL PHONE NUMBER:**_____

PLEASE LIST WHO MAY PICK UP YOUR CHILD FROM SCHOOL:_____

PLEASE LIST WHO MAY NOT PICK UP YOUR CHILD FROM SCHOOL:_____

PLEASE LIST ANY UNUSUAL CIRCUMSTANCES THAT THE SCHOOL SHOULD BE AWARE OF OR OTHER PERTINENT INFORMATION IN REGARD TO YOUR CHILD:_____

IN CASE OF AN EMERGENCY, PLEASE LIST TWO PEOPLE OTHER THAN PARENTS/GUARDIANS WHO MAY BE CALLED. PLEASE BE SURE THE PEOPLE LISTED CAN BE READILY AVAILABLE WHEN CALLED TO TRANSPORT YOUR CHILD HOME:

1. **NAME/RELATIONSHIP:**_____ **Address**_____

   PHONE NUMBER(S): Home#_____ **Cell #**_____

2. **NAME/RELATIONSHIP:**_____ **Address**_____

   PHONE NUMBER(S):Home phone #_____ **Cell number**_____

   LIST ANY BROTHER(S)/SISTER(S) CURRENTLY IN THE F-S SCHOOL DISTRICT, PLEASE INCLUDE THE SCHOOL AND TEACHER'S NAME:_____

Updated: 3/19/2024

FRANKFORT-SCHUYLER ELEMENTARY SCHOOL

Dear Parents:

Please provide us with the following information so that we may set up your child's bus transportation. You may call or write us a note with any changes after today. Also, if your child needs to be dropped off after school at a different location for 1 day, please send a note with him/her to his/her teacher giving the date, address, name of adult that will be responsible for your child, and the bus (if you know it).

Thank you.
Roe Salvaggio – Secretary

Student name: _____

Home address: _____

Nearest corner: _____

Morning bus pick-up: (Check one)

_____ Home

____ Other

Address:_____

Responsible adult(s):_____

Nearest Corner:_____

Afternoon bus drop-off: (Check one)

_____ Home

_____ Other

Address:_____

Responsible adults(s):_____

Nearest corner:_____

Frankfort-Schuyler Central School District
Student Racial and Ethnic Identification

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

STUDENT ID NUMBER: _____ GRADE LEVEL: _____

STUDENT NAME: _____DATE OF BIRTH: ___/___/____

To Parents/Guardians:

Please complete and return this form to your student's school immediately. Please complete Parts 1 and 2 by completely darkening the circle beside your answers.

Part 1: Ethnicity Designation
Directions: Read the definition below and completely darken the circle that indicates this student's heritage.

Is this student Hispanic or Latino? (Select one answer)
Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race, are considered Hispanic or Latino.

O Yes O No

Part 2: Race Designation
Directions: Read the descriptions below and completely darken the circle or circles that indicate this student's race. You must select at least one race, regardless of ethnicity designation. More than one response can be selected. Indicate this student's race. (Select all that apply.)

O American Indian or Alaskan Native: A person having origins in any of the original peoples of North or South America (including Central America) and who maintains a tribal affiliation or community attachment.

O Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand , and Vietnam.

O Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

O Black or African American: A person having origins in any of the black racial groups of Africa.

OWhite: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

_____ ____/____/____
Signature of Parent/ Guardian **Date**

Relationship to Student: Check one O Mother O Father O Guardian O Other (Specify)

FRANKFORT-SCHUYLER ELEMENTARY SCHOOL PERMISSION FORM

Please indicate your permission and/or understanding for the following:

YES	NO	Child's Name:_____
_____	_____	**Field Trips: I give permission for my child to take part in field trips and school activities. I understand that transportation will be provided by Birnie Bus or other tour busses such as High Adventure Tours. Parents will be notified of all field trips ahead of time.**
_____	_____	**Photos: I give permission for my child to take part in picture-taking activities which may be released to the news media or used for public relations.**
_____	_____	**Telephone and Address Release: I authorize the school to give out my address and/or telephone number to other parents in regards to birthday parties, etc.**
_____	_____	**I give my son/daughter permission to watch PG or PG13 movies where appropriate.**

_____ _____

Signature of Parent/Guardian **Date**

Computer Network and Internet Access:

Parental Notification / Student Agreement Form

Dear Students, Parents and Guardians:

(I) We are pleased to offer students of the District access to the District computer network, the BOCES regional network and the Internet.

(II) Access to these resources will enable students to explore thousands of libraries, databases, Google Apps for Education, and bulletin boards while exchanging messages with Internet users around the world. The district does have a firewall and strict filtering on all web content, however, families should be warned that some material accessible via the internet may contain items that are illegal defamatory, inaccurate or potentially offensive to some people. While our intent is to make this access available to further educational goals and objective, students may find ways to access other material as well. We believe that the benefits to students from this access, in the form of information resources and opportunities for collaboration, exceed any disadvantages.

(III) Network and Google Storage areas may be treated like school lockers. Network administrators and district administrators may review files and communications to maintain system integrity, to ensure that users are using the system responsibly and to check their content. Users should not expect that files stored on the district and google servers will be private.

(IV) As outlined in Board Policy and procedures on students' rights and responsibilities, copies of which are available in school offices, the following are not permitted:

a. Sending or displaying offensive messages or pictures
b. Using obscene language
c. Harassing, insulting or attacking others
d. Damaging computers, computer systems or networks
e. Violating copyright laws
f. Using another's password
g. Trespassing in another's folders, work or files
h. Intentionally wasting limited resources
i. Employing the network for commercial purposes

Violations may result in the loss of access as well as other disciplinary or legal action

I have read and understand the information presented above and give my permission for my child to participate in this program:

_____ Parent or Legal Guardian Signature

I have read and understand the information as presented above and I hereby agree to abide by the District's policy and guidelines, as well as all directions I receive from District Personnel, regarding the appropriate use of computer resources made available to me by the district.

_____ Student's Signature

Frankfort-Schuyler Central School
Teacher-Parent-Student-Contract

Student Name: _____ Grade: _____ Year: _____

When parents actively participate in their child's education, children do better in school. While neither parent nor schools alone can ensure the educational success of a student, the Frankfort-Schuyler Central School District, working collaboratively with parents and students agree:

For Faculty and Staff:
As a member of the faculty/staff, I will encourage and support student learning by:
Recognizing the believing that all children can learn
Showing respect for each child and his or her family
Coming to class prepared to teach
Providing an environment conducive to learning
Helping each child grow to his or her full potential
Providing meaningful and appropriate school and homework activities
Enforcing school and classroom rules fairly and consistently
Maintaining open lines of communication with each student and his or her parents/guardians
Seeking ways to involve parents in school programs
Demonstrating professional behavior and a positive attitude

For Parent(s) / Guardian(s):
As a parent/guardian, I will encourage and support student learning by:
Seeing that my child attends school regularly and on time
Providing a home environment that encourages my child to learn
Insisting that all homework assignments are completed
Communicating regularly with my child's teacher
Supporting the school in developing positive behaviors
Encouraging my child to read at home and to monitor his/her television viewing
Showing respect and support for my child, his or her teachers and the school

For Students:
As a student, I will encourage and support my learning by:
Always try to do my best in my work and in my behavior
Working cooperatively with my classmates
Showing respect for myself, my school and the other people
Obeying the school rules
Taking pride in my school
Coming to school prepared with my homework done and with my supplies
Believing that I can learn and will learn

Parent's Signature _____ Date _____

Student's Signature _____ Date _____

Principal's Signature Melanie Weber Date _____

Teacher's Signature _____ Date _____

_____ Elementary School _____ Middle School _____ High School

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at the top page of registration materials that the district shares with families. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the **student is not required to submit proof of residency** and other required documents that may be part of the registration packet.

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐Male ☐Female

Date of Birth: ____/____/____ (Month Day Year)

Grade: ____ (preschool-12)

ID#: _____ (optional)

Address: _____

Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (*Please check **one** box.*)

☐In a shelter
☐With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
☐In a hotel/motel
☐In a car, park, bus, train, or campsite
☐Other temporary living situation (Please describe): _____
☐In permanent housing

_____
Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____
Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____
Date

If **ANY box other than "In Permanent Housing" is checked**, then the student/family should be immediately referred to the MV Liaison. In such cases, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled. After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

NEW YORK STATE MIGRANT EDUCATION PROGRAM
IDENTIFICATION & RECRUITMENT OFFICE
PARENT SURVEY

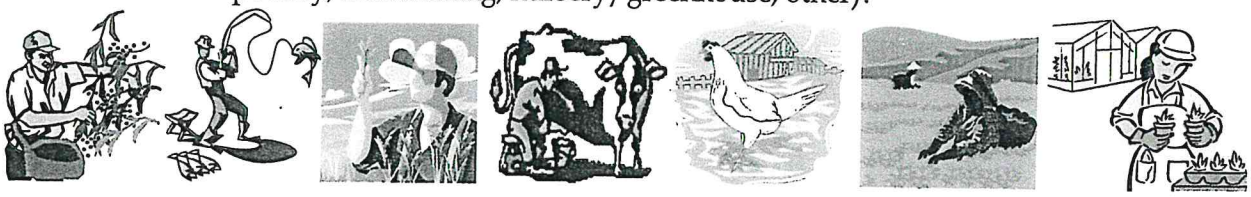
The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture. This program is **free of charge** to all eligible families and may include tutoring, free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

Please take few minutes to complete this questionnaire.

1. **Has anyone in your family moved from another, country, city, town or school district within the past 3 years? _____Yes _____No**

2. **Has anyone in your family worked or looked for work at the following occupations within the last three (3) years? _____Yes _____No**

☐ Any agricultural or farm work (such as hay, dairy, fruit or vegetable crops, poultry, fish farming, nursery/greenhouse, other)?



☐ Work related to logging, timber growing or harvesting? Work at food processing plant, (such as vegetable or poultry processing plants packing apples or vegetables)?

If you answer YES, please provide contact information below

Parent/Guardian/Eligible Person's Name: _____

Home address: _____

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

Previous Address: _____

Student name: _____ Age _____Grade_____

Student name: _____ Age _____Grade_____

To submit this referral please contact 518-289-5618. Send by fax to 518-289-5623 or by mail to Migrant Education Identification & Recruitment Program, 100 Saratoga Village Blvd. #41 Ballston Spa, NY 12020

02/01/15

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

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

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

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

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section.

STUDENT NAME:		
First	*Middle*	*Last*
DATE OF BIRTH:		GENDER:
Month	*Day*	*Year*
		❑ Male ❑ Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

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

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

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

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

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

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

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

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

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

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

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

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

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

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

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

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

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

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ NO ☐ YES

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

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

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

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

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

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

FRANKFORT-SCHUYLER ELEMENTARY SCHOOL HEALTH SERVICES

Dear Parents/Guardians,

The following items are **REQUIRED** at the Nurse's Office when your child begins school:

***Birth certificate**

***Record of immunizations**

Attached is a list of **REQUIRED** immunizations and the contact information for Public Health to schedule an appointment if vaccines are needed/missing.

***Physical Examination Report**

New York State **REQUIRES** physical examinations for **all new students entering the district at any grade upon registration, as well as for those students entering Pre-K or Kindergarten and grades 1,3,5,7,9 and 11. A copy of the exam must be provided to the school within 30 days from when your child starts.** The exam must be completed by a duly licensed physician, physician assistant, or nurse practitioner authorized to practice in NYS. **If a copy is not provided to the school within 30 days, the office will contact you and a physical exam will be scheduled for your child with the school's physician assistant** pursuant to Education Law 903, Commissioners' regulation 136.3. If your child has an appointment scheduled after the first 30 days of school, please inform the office of that date at 315-895-3007 or list date and sign below. If you wish your child to be scheduled with our school physician please check the line and sign below. A dental certificate which states your child has been seen by a dentist/hygienist is also requested at this time. A physical exam form and dental form have been included for you.

Upcoming appointment date:_____

____ **Please schedule an exam with the school physician**

Child's Name:_____

Parent signature:_____

NEW YORK STATE IMMUNIZATION REQUIREMENTS FOR SCHOOL ENTRANCE/ATTENDANCE

Vaccines	Pre-Kindergarten (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 adolescent 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		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**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**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9, 10 and 11: 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

IF YOUR CHILD IS MISSING OR NOT UP TO DATE ON REQURIED IMMUNIZATIONS, YOUR LOCAL HEALTH DEPARTMENT CAN HELP!!

Herkimer County Public Health's Immunization Program supports county residents with access to affordable or no cost vaccinations. We strive to promote health safety and vaccine confidence to all residents through education and vaccination efforts.

Immunization Clinics are held weekly, welcoming all adults and children. Clinics are located at the Prevention Unit at 301 North Washington St. in Herkimer on Tuesdays from 9–11 am & 1–3 pm, and are open to any member of the community. Evening clinics are held intermittently throughout the year.

All clinics are by appointment only. Call 315-867-1176 to schedule an appointment.

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

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.

Frankfort-Schuyler Central School District

HEALTH HISTORY INFORMATION

Students Name:	Date of Birth: Place of Birth:	Grade: New Student? Y or N
Parent/Guardian:	Relationship:	Phone:
Parent/Guardian:	Relationship:	Phone:
Who does student live with:	Doctor's Name: Address:	Phone:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Had allergies (specify):	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
*Epi pen or Benadryl required?	☐	☐	
Had an operation	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Dental Injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
- ☐ Scoliosis
- ☐ Single Organ (☐kidney, ☐testicle)
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Urinary Condition

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?
☐ No ☐ Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

_____

Parent/Guardian Signature: _____ Date: _____

Frankfort-Schuyler Elementary School
610 Reese Road Frankfort, NY 13340 | 315-894-7491 Principal |315-895-4102 Fax

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ _____
Name of Child Child's Date of Birth

I, _____, hereby authorize the following person(s) / organization(s) to provide to, and receive from, Frankfort-Schuyler Central School District:
( ) WRITTEN records and / or ( ) VERBAL information on the above named person

( ) Counseling Agency: _____
( ) Medical Provider: _____
( ) Service Provider: _____
( ) Other: _____

THIS INFORMATION WILL BE UTILIZED TO:

- Provide educational services
- Coordinate medical services
- Coordinate services with my family / concerned person
- Coordinate educational planning programs with school personnel

I understand that I need not consent to the release of information in order to obtain services. I choose to do so willingly and voluntarily for the purposes specified above. The duration of this authorization is for no longer than the school year ending June _____ unless I specify a date, event, or condition upon which is will expire sooner. I understand that I may revoke this consent at any time by notifying school staff in writing, except to the extent that action has been taken in reliance on my consent.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

Specify date, event or condition upon which this agreement will expire sooner:_____

Frankfort-Schuyler Elementary
BMI Release Authorization

As part of a required health examination, a student is weighed and his/her height is measured. These numbers are used to figure out the student's body mass index or "BMI" The BMI helps the doctor or nurse know if the student's weight is in a healthy range or is too high or too low. Recent changes to the New York State Education Law require that BMI and weight status group be included as part of the student's school health examination. A sample of school districts will be selected to take part in a survey, we will be reporting to New York State Department of Health information about your students' weight status groups. Only summary information is sent. No names and no information about individual students are sent. However, you may choose to have your child's information excluded from this survey report.

The information sent to the New York State Department of Health will help health officials develop programs that make it easier for children to be healthier.

If you have any questions please contact your student's building nurse.

PLEASE DO / PLEASE DO NOT (circle one) include my child's weight status information in the School Survey.

Student Name: _____

Name of Parent/Guardian: _____
Please Print

Parent/Guardian Signature: _____ Date: _____

EMERGENCY POWER OF ATTORNEY

In the event of an accident or sudden/unexpected illness of my child, if I cannot be contacted, I authorize the school staff to call the physician named below and to follow his instructions. Should the named physician not be available, I further authorize, in my place and in my stead, the school to seek the services of any qualified physician and to transport my child to the physician's office or hospital for treatment including x-rays, laboratory tests, or whatever medical or surgical treatment and agree to pay the customary fees or charges for such treatment.

Student Name: _____ Grade: _____

Local Physician's Name: _____ Physician's Address: _____ Physician's Phone: _____

Local Dentist's Name: _____ Dentist's Phone: _____

Name of Parent/Guardian: _____
Please Print

Parent/Guardian Signature: _____ Date: _____