# ALICE E. GRADY PRIMARY SCHOOL

## SCHOOL PACKET

After your registration packet has been accepted by the District Registrar, you can come to the Alice E. Grady main office with your completed packet.

Please make sure all of the enclosed forms are completed and have the following items ready for your visit:

1. Proof of immunization
2. Physical Exam

Your child's registration will be DELAYED if any of the above items are missing.

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THE MAIN OFFICE NUMBER FOR ALICE E. GRADY IS

NUMERO DE LAOFICINA PRINCIPAL DEL COLEGIO

(914) 592-8962

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## FORMAS PARA EL

## COLEGIO DE PRIMARIA DE ALICE E. GRADY

Una vez que su aplicación sea aceptada por la oficina de Registro del distrito llevar este folder.

Asegúrese de que antes de venir todos los documentos adjuntos estén completos:

1. Registro de inmunización-vacunas
2. Registro de Examen físico

Si no tiene todos los papeles requeridos la matrícula de su hijo se RETRASARA.

## ELMSFORD UNION FREE SCHOOL DISTRICT ALICE E. GRADY SCHOOL PACKET PART II

Please bring:

- School records
- Signed "Request for School Records," current report card, transcript, test results, IEP, Section 504 Plan
- Current and up to date Immunization and Health Records with Physician's signature and/or stamp of health facility AND documentation of month, day, and year for each vaccine

The New York State Education Department mandates that school districts enforce public health law's requirements for immunization of children attending schools.

- Physical Examination: Required for all new entrants and for students entering grades:
  Pre-K or kindergarten, 2nd, 4th, 7th and 10th

- Physical Examination must be given to school nurse within 30 days of entering school
- Acceptable Use Policy- Must be signed by both parents /guardians of student
- Parents/Guardians are responsible for payment of tuition if the parent's residency is not with in the Elmsford Union Free School District. If children move out of district, the parents/guardians are responsible for withdrawing them in accordance with the district policy or for paying tuition. The Elmsford Union Free School District will seek restitution for tuition if it is deemed that the student is not a resident of the district

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## PARTE DOS DEL FOLDER DE ALICE E.GRADY DE ELMSFORD UNION FREE SCHOOL DISTRICT

Por favor traiga consigo:

- Historial académico
- Firmar la forma titulada "Request for Records", calificaciones más recientes, resultados de exámenes, IEP (Programa de Educación Individual), Plan de Sección 504 (modificaciones educativas)
- Inmunizaciones actualizadas firmadas por el medico con sello de la oficina y la verificación de cada vacuna con día mes y año

Las leyes de Salud Pública requieren que los colegios públicos ratifiquen inmunizaciones para todos los niños, estos mandatos son del Departamento de Educación del Estado de Nueva York.

- Examen físico: Necesario para todos los estudiantes y los que ingresan a:
  Pre-K o Kindergarten, 2do, 4to, 7moy 10avo grado

- El examen Físico se entrega a la enfermera dentro de 30 días de comenzar el colegio
- Póliza de Uso de Tecnología debe ser firmada por ambos padres o tutores
- Los padres son responsables del pago de matrícula si no viven dentro de los límites geográficos de Elmsford Union Free School District. Si el estudiante no reside en el distrito, los padres o tutores son responsables de retirarlo de acuerdo a las pólizas del distrito o pagar la matricula. El distrito de Elmsford Union Free buscara ser compensado por matricula si encuentra que el estudiante no reside dentro del distrito de Elmsford

**ALICE E. GRADY ELEMENTARY SCHOOL**
45 COBB LANE
ELMSFORD NEW YORK 10523
914-592-8962 (phone) 914-592-5439 (fax)
www.eufsd.org

## E-MAIL REGISTRY

Dear Parent/ Guardian:
In order to keep you better informed of events/happenings, a list of parent email addresses are being compiled. The email address will also be utilized as a means to contact you regarding your child. If you would like to be added to our list, please provide the information requested below. This information can be submitted via e-mail at registration@eufsd.org or by returning this form to the school. Please print the requested information on the lines below. This form only needs to be completed once per family. Please print the requested information on the lines below.

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Estimado Padre/Tutor:

Para mantenerles informados de todos los eventos y acontecimientos el colegio recopila el correo electrónico de los padres. Este también se utiliza como medio de comunicación entre nosotros y usted acerca de su hijo. Si desea ser añadido a la lista por favor provea la información solicitada a continuación por correo electrónico a registration@eufsd.org o por medio de este formulario devolviéndole al colegio. Este formulario es uno por familia. Por favor escriba legible la información solicitada en las siguientes líneas.

| STUDENT NAME (S):<br>NOMBRE DEL ESTUDIANTE (S): | GRADE LEVEL<br>GRADO |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

PARENT/GUARDIAN NAME:
PADRE/TUTOR:
_____

PARENT/GUARDIAN EMAIL ADDRESS: CORREO ELECTRÓNICO DEL PADRE/TUTOR

_____@_____

ELMSFORD UNION FREE SCHOOL DISTRICT
Parent/Guardian Consent & Acknowledgement Form
Student Use of the District's Computer Network and Technology

Student Name:_____

I have read and agree to assist my child in understanding and abiding by the District's Acceptable Use Policy for Students' Use of the District's Computer Network and Technology. I understand that access to the District's Computer Network and Technology, which includes, but is not limited to, the District's hardware, software, computer, networks and systems, is designed solely for educational purposes. I understand the use of the District's Computer Network and Technology is a privilege and not a right. I recognize responsibility for appropriate conduct when using the District's Computer Network and Technology rests with the individual student. I understand my child will be asked to sign an agreement to abide by the rules and guidelines in the District's Acceptable Use Policy for Students' Use of the District's Computer Network and Technology. By signing this Consent & Acknowledgement Form, I give permission for my child to be afforded access to the District's Computer Network and Technology.

I recognize that some materials accessed through the District's Computer Network and Technology may be controversial and objectionable, and that while filtering software is utilized, the District cannot guarantee that using District Technology will not result in access to information which may be upsetting, objectionable or controversial. I will not hold the District responsible for the accuracy or quality of any materials acquired or viewed by my child on or through the District's Computer Network and/or Technology.

I understand that the District may access my child's data, files and material generated on, stored on or transmitted through the District's Computer Network and/or Technology and may monitor my child's use of the District's Computer Network and/or Technology, including but not limited to his/her use of the Internet and his/her electronic communications. I also understand it is impossible for the District to monitor all usages. I have determined the benefits of my child having access to the District's Computer Network and/or Technology outweigh the potential risks and I will not hold the District responsible for materials acquired or contacts made through the District's computer Network and/or Technology.

I understand that improper or inappropriate use of the District's Computer Network and/or Technology by my child may result in revocation of his/her privileges to access and/or use the District's Computer Network and/or Technology and the imposition of school discipline, criminal penalties, or civil penalties. I accept all financial and legal liabilities that may result from my child's misuse of the District's Computer Network and/or Technology.

Parent/Guardian Name (print):_____

Parent/Guardian Signature: _____Date: _____

DISTRITO ESCOLAR LIBRE DE ELMSFORD UNIÓN
Formulario de consentimiento y reconocimiento del padre / tutor
Uso de la tecnología y la red informática del distrito por parte de los estudiantes

Nombre del Estudiante:_____

He leído y acepto ayudar a mi hijo a comprender y cumplir la Póliza de uso aceptable del distrito para el uso de la tecnología y la red informática del distrito por parte de los estudiantes. Entiendo que el acceso a la Red de Computadoras y Tecnología del Distrito, que incluye, pero no se limita a, el hardware, software, computadora, redes y sistemas del Distrito, está diseñado únicamente para propósitos educativos. Entiendo que el uso de la tecnología y la red informática del distrito es un privilegio y no un derecho. Reconozco la responsabilidad de la conducta apropiada cuando el uso de la tecnología y la red informática del distrito recae en el estudiante individual. Entiendo que se le pedirá a mi hijo que firme un acuerdo para cumplir con las reglas y pautas de la Póliza de uso aceptable del distrito para el uso de la tecnología y la red informática del distrito por parte de los estudiantes. Al firmar este formulario de consentimiento y reconocimiento, doy permiso para que mi hijo tenga acceso a la tecnología y la red informática del distrito.

Reconozco que algunos materiales a los que se accede a través de la Red de Computadoras y Tecnología del Distrito pueden ser controvertidos y objetables, y que si bien se utiliza software de filtrado, el Distrito no puede garantizar que el uso de la Tecnología del Distrito no resulte en acceso a información que pueda ser molesta, objetable o controvertida . No haré responsable al Distrito por la precisión o calidad de cualquier material adquirido o visto por mi hijo a través de la Red de Computadoras y / o Tecnología del Distrito.

Entiendo que el Distrito puede acceder a los datos, archivos y material de mi hijo generados, almacenados o transmitidos a través de la Red de Computadoras y / o Tecnología del Distrito y puede monitorear el uso de la Red de Computadoras y / o Tecnología de mi hijo, incluyendo pero no limitado a su uso de Internet y sus comunicaciones electrónicas. También entiendo que es imposible que el Distrito controle todos los usos. He determinado que los beneficios de que mi hijo tenga acceso a la Red de Computadoras y / o Tecnología del Distrito superan los riesgos potenciales y no haré responsable al Distrito por los materiales adquiridos o contactos hechos a través de la Red de Computadoras y / o Tecnología del Distrito.

Entiendo que el uso indebido o inapropiado de la Red de Computadoras y / o Tecnología del Distrito por parte de mi hijo puede resultar en la revocación de sus privilegios para acceder y / o usar la Red de Computadoras y / o Tecnología del Distrito y la imposición de disciplina escolar, criminal sanciones o sanciones civiles. Acepto todas las responsabilidades financieras y legales que puedan resultar del mal uso por parte de mi hijo de la Red de Computadoras y / o Tecnología del Distrito.

Nombre del padre / tutor (en letra de imprenta):_____
Firma del Padre / Tutor: _____ Fecha:_____

ELMSFORD PUBLIC SCHOOLS
45 South Goodwin Avenue
Elmsford, New York 10523

## FIELD TRIP RELEASE

Dear Parent or Guardians:

From time to time during the school year, it is advantageous or necessary to send children during school hours to some point in Elmsford or points beyond. If you wish your child to have the advantage of these trips, please give consent and release of any responsibility in case of accident, not due to our negligence, by signing below.

I give my son/daughter_____permission to attend school field trips.

Parent/Guardian Signature_____ Date:_____

**********

## PERMISO DE PASEO

Estimados Padres o Tutores:

De vez en cuando durante el año escolar, es conveniente que los niños tomen una excursión durante las horas de clase dentro o fuera de Elmsford. Si usted desea que su hijo/a tenga la ventaja de estos viajes, por favor firme a continuación dando el consentimiento y de liberar de toda responsabilidad en caso de accidente no debido a nuestra negligencia.

Doy permiso a mi hijo/hija _____ para que asista a las excursiones escolares.

Firma del padre/tutor _____ Fecha:_____

# ELMSFORD PUBLIC SCHOOLS
# HEALTH HISTORY REGISTRATION FORM

**KINDLY COMPLETE THIS FORM AND RETURN TO SCHOOL WITH REGISTRATION PACKET**

Child's name _____ Sex M ____ F ____
Last Name First Name

Date of Birth _____ Place of Birth _____
City, State, Country

Mother's Name _____ Father's Name _____

BIRTH HISTORY

| | | |
|---|---|---|
| Was mother ill during pregnancy? | YES ____ | NO ____ |
| Was birth normal? | YES ____ | NO ____ |
| Was child premature? | YES ____ | NO ____ |
| Child's weight at birth? | ____ Lbs. | ____ Oz. |

HEALTH HISTORY AND DEVELOPMENT

Does your child have any speech difficulty? YES ____ NO ____

If YES please specify difficulty

_____

Are there any special habits your child has such as:

| | | | | | |
|---|---|---|---|---|---|
| Thumb sucking | YES ____ | NO ____ | Head banging | YES ____ | NO ____ |
| Fears | YES ____ | NO ____ | Rocking | YES ____ | NO ____ |
| Nail biting | YES ____ | NO ____ | Emotional problems | YES ____ | NO ____ |

If YES explain _____

Does your child have frequent ear infections? YES ____ NO ____
If YES which ear _____
Does your child have hearing loss? YES ____ NO ____
If YES which ear _____
Is he/she presently under care for this? YES ____ NO ____

Does your child have a vision problem?
If YES, explain _____

When were eyes last examined professionally? Date _____

Does your child wear glasses? YES ____ NO ____

Has your child ever been to a dentist? YES ____ NO ____

If YES, has dental care been completed? YES ____ NO ____

Does your child have asthma? YES ____ NO ____

Does your child have allergies? YES ____ NO ____
Including medications, bee and insect bites

If YES, what are they? _____

Is your child allergic to peanuts, peanut products, nuts of any kind? YES ____ NO ____

Does your child take medication treatments, either on a part-time or regular basis? YES ____ NO ____
If YES, what are they? _____

Has your child had the following:

| | | | | | |
|---|---|---|---|---|---|
| Operations | YES ____ | NO ____ | Serious Accident | YES ____ | NO ____ |
| Fractures | YES ____ | NO ____ | Head Injuries | YES ____ | NO ____ |

If YES, give details: _____

Has your child been hospitalized for any condition? YES ____ NO ____
Name of condition or disease _____
Hospital _____ Date _____

Please check any ofthe following conditions that your child might have or have had:

| | | | | | |
|---|---|---|---|---|---|
| seizures | ____ | diabetes | ____ | chicken pox | ____ |
| chronic rashes | ____ | headache | ____ | cerebral palsy | ____ |
| rheumatic fever | ____ | frequent nosebleeds | ____ | frequent sore throats | ____ |
| scarlet fever | ____ | tuberculosis | ____ | pneumonia | ____ |

Other illness (specify) _____

Please check any conditions that immediate family have had:

| | | | | | |
|---|---|---|---|---|---|
| asthma | ____ | anemia | ____ | diabetis | ____ |
| hypertension | ____ | tuberculosis | ____ | nervous problem | ____ |
| convulsion | ____ | heart attack under the age of 45 | | | ____ |

Are there any health conditions in your family that are a problem to you and your child? YES ____ NO ____

Are there any health problem NOT already mentioned? YES ____ NO ____

If YES, explain _____

Parent's Signature _____ Date _____

Family Physician _____
Phone Number _____

# ELMSFORD PUBLIC SCHOOLS
# HISTORIAL MEDICO

Nombre del estudiante _____ Sexo M ____ F ____
Apellido Primer Nombre

Fecha de Nacimiento _____ Lugar de Nacimiento _____
Ciudad, Departament, Pais

Nombre de la Madre _____ Nombre del Papa _____

HISTORIAL DE PARTO

| | | |
|---|---|---|
| Hubo problemas durante el embarazo? | SI ____ | NO ____ |
| Fue un parto normal? | SI ____ | NO ____ |
| Fue el bebé prematuro? | SI ____ | NO ____ |
| Cuanto peso el bebé al nacer? | ____Lbs. | _____Oz. |

HISTORIAL MEDICO Y DESARROLLO

Tiene su hijo dificultad para hablar? SI ____ NO ____

Si respondió SÍ, por favor explique _____

Tiene su hijo alguno de estos hábitos?

| | | | | | |
|---|---|---|---|---|---|
| chupar el dedo | SI ____ | NO ____ | golpear la cabeza | SI ____ | NO ____ |
| tener miedo | SI ____ | NO ____ | mecerse | SI ____ | NO ____ |
| morderse las unas | SI ____ | NO ____ | problemas emocionales | SI ____ | NO ____ |

Si respondió SÍ, explique _____

| | | |
|---|---|---|
| Ha tenido su hijo infecciones de oído frecuentes? | SI ____ | NO ____ |
| Si respondió SÍ, en cuál oído? _____ | SI ____ | NO ____ |
| Tiene su hijo pérdida de audición? | SI ____ | NO ____ |
| Si respondió SÍ, en cuál oído? _____ | SI ____ | NO ____ |
| En el presente, está bajo cuidado médico? | SI ____ | NO ____ |

Tiene su hijo problemas de visión?
Si respondió SÍ, explique _____

Cuando fue el último examen de ojos con un profesional? Fecha _____

Usa su hijo espejuelos-anteojos? SI ____ NO ____

Ha visto su hijo al dentista? SI ____ NO ____

Si respondió SÍ, Ha terminado el tratamiento? SI ____ NO ____

Tiene su hijo asma? SI ____ NO ____

Tiene su hijo alergias? SI ____ NO ____
Incluyendo medicinas, abejas o picaduras de insectos

Si respondió SÍ, cuales son _____

Tiene su hijo alergias al maní, productos de maní y todo tipo de nueces? SI ____ NO ____

Toma su hijo medicamento regularmente SI ____ NO ____
o de vez en cuando?
Si respondió SÍ, cuales son _____

Ha tenido su hijo alguno de los siguientes:

| | | | | | |
|---|---|---|---|---|---|
| Operaciones | SI ____ NO ____ | | Un accidente serio | SI ____ | NO ____ |
| Fractura | SI ____ NO ____ | | Trauma a la cabeza | SI ____ | NO ____ |

Si respondió SÍ, de detalles _____

Ha sido hospitalizado su hijo por alguna enfermedad? SI ____ NO ____
Nombre de la enfermedad _____
Hospital _____ Fecha _____

Indique cuál de las siguientes tiene o ha tenido su hijo:

| | | | | | |
|---|---|---|---|---|---|
| convulsiones | ____ | diabetes | ____ | varicela | ____ |
| sarpullido | ____ | parálisis cerebral | ____ | sarpullido | ____ |
| fiebre reumática | ____ | hemorragia nasal | ____ | tuberculosis | ____ |
| escarlatina | ____ | infección frecuente de la garganta | ____ | pulmonía | ____ |

Especifique si hay otra enfermedad _____

Indique condiciones que su familia tenga o que haya tenido:

| | | | | | |
|---|---|---|---|---|---|
| asma | ____ | problemas de nervios | ____ | diabetes | ____ |
| hipertension | ____ | tuberculosis | ____ | convulsiones | ____ |
| anemia | ____ | ataque cardiaco antes de los 45 años | | | ____ |

Hay alguna enfermedad o condición médica que causen problema a usted o su familia?
SI ____ NO ____

Hay algún otro problema de salud que no está mencionado?
Si respondió SÍ, explique _____

Firma del Padre_____ Fecha _____

Medico de la Familia_____
Numero de teléfono _____

ALICE E. GRADY ELEMENTARY SCHOOL
45 South Goodwin Avenue
Elmsford, New York 10523
Andrea Hamilton, Principal

Dear Parents and Guardians:

As you know, there are many exciting activities constantly taking place in our schools as well as celebrations of our students' accomplishments. We are often approached by the media (newspapers, radio, television and our own webmaster) for permission to photograph and publish our students' work. Our productions are regularly transmitted on local cable stations.

Although the district will carefully monitor what information is disseminated to the media, we do not want any child's name, photograph or likeness, voice or creative work(s) on television, radio, motion pictures or any other electronic/digital or print media without parental consent.

Student's name:_____

_____I give permission for my child to be photographed, voice or creative work(s) on television, radio, motion pictures or any other electronic/digital or print media be used.

_____I DO NOT give permission for my child to be photographed, voice or creative work(s) on television, radio, motion pictures or any other electronic/digital or print media.

Parent signature _____ Date:_____

**********

Queridos padres y guardianes:

Como saben, hay muchas actividades emocionantes que se llevan a cabo constantemente en nuestras escuelas, así como celebraciones de los logros de nuestros estudiantes. Los medios de comunicación (periódicos, radio, televisión y nuestro propio webmaster) se acercan a nosotros para pedir permiso para fotografiar y publicar el trabajo de nuestros estudiantes. Nuestras producciones se transmiten regularmente en las estaciones de cable locales.

Aunque el distrito supervisará cuidadosamente qué información se difunde a los medios de comunicación, no queremos el nombre, fotografía o semejanza, voz o trabajo creativo de ningún niño/a en televisión, radio, películas o cualquier otro medio electrónico/digital o impreso sin consentimiento paterno.

El nombre del estudiante:_____

_____ Doy permiso para que mi hijo/a sea fotografiado/a, su voz o trabajo(s) creativo(s) en televisión, radio, películas o cualquier otro medio electrónico/digital o impreso sea utilizado.

_____NO doy permiso para que mi hijo/a sea fotografiado/a, con voz o trabajo(s) creativo(s) en televisión, radio, películas o cualquier otro medio electrónico/digital o impreso.

Firma del padre _____ Fecha: _____

ALICE E. GRADY ELEMENTARY SCHOOL
45 South Goodwin Avenue
Elmsford, New York 10523
914-592-8962 (phone) 914-592-5439 (fax)
Andrea Hamilton, Principal

## PARENT RELEASE OF RECORDS

_____ (Student) has been enrolled in our school.

We would appreciate your forwarding to us all data concerning this pupil, including cumulative, academic and health records. Also, please forward any special information of a psychological nature if available on this child. Below you will find a parent signed release to cover the above information. Thank you for your cooperation.

I authorize _____(former school) to send all data concerning my son/daughter, I realize this may include, but not be limited to, cumulative, academic, psychological and health records.

Parent/Guardian Signature _____ Date:_____

**********

## DIVULGACIÓN DE REGISTROS DE LOS PADRES

_____ (Estudiante) se ha inscrito en nuestra escuela.

Le agradeceríamos que nos envíe todos los datos relacionados con este alumno/a, incluidos los registros acumulativos, académicos y de salud. Además, envíe cualquier información especial de naturaleza psicológica si está disponible sobre este niño/a. A continuación, encontrará un comunicado firmado por los padres para cubrir la información anterior. Gracias por su cooperación.

Autorizo a _____ (escuela anterior) a enviar todos los datos relacionados con mi hijo/hija, entiendo que esto puede incluir, entre otros, expedientes acumulativos, académicos, psicológicos y de salud.

Firma del padre/tutor _____ Fecha: _____

ALICE E. GRADY ELEMENTARY SCHOOL
45 South Goodwin Avenue
Elmsford, New York 10523
914-592-8962 (phone) 914-592-5439 (fax)
www.eufsd.org

Dear Parent/Guardian:

The New York State Department of education has requested that all school districts conduct a district wide screening of all new students entering our district for the purpose of identifying those students who may have possible handicapping conditions or who may be identified as gifted.

In accordance with that regulation, we shall be conducting a screening of _____ which will cover the following areas of development:

**Physical**
**Gross and Fine Motor Skills**
**Language Abilities**
**Memorial Abilities**
**Cognitive Abilities**

Any parent may request information concerning his/her child's screening by contacting the principal of the school at the elementary level.

I have read the above letter regarding the District Screening Plan and understand that my child will be screened in the near future.

**********

El estado de Nueva York requiere que todos los distritos escolares hagan un examen a todos los estudiantes nuevos con el propósito de identificar aquellos que posiblemente tengan una discapacidad o sean dotados.

De acuerdo con la regulación haremos un examen a _____ en las siguientes áreas:

**Fisico**
**Habilidades Motoras: Finas y Gruesas**
**Habilidad Lingüística**
**Agilidad Mental**
**Funciones Cognitivas**

Todos los padres pueden obtener información del examen por medio del director de primaria de su colegio.

Afirmo que he leído la anterior y entiendo que mi hijo se le harán pruebas en el futuro.

Sincerely-Sinceramente,
Sincerely, Principal , Andrea Hamilton

_____ _____
Signature Parent/Guardia (Firma del Padre o Tutor) Date (Fecha)

ALICE E. GRADY ELEMENTARY SCHOOL
45 South Goodwin Avenue
Elmsford, New York 10523
Andrea Hamilton, Principal

**STUDENT AGREEMENT FOR USE of
THE DISTRICT'S NETWORK AND TECHNOLOGY**

Student's Name: _____

I have read and understand the District's Acceptable Use Policy for Students' Use of the District's Computer Network and Technology and I agree to abide by its rules and guidelines.

I understand that I have no right to privacy when I use the District's Computer Network and Technology. I understand the District's staff may monitor all use I make of the District's Computer Network and Technology, including but not limited to all network and Internet communications and activities. I consent to the District's staff monitoring my use of the District's Computer Network and Technology.

I further understand that my violation of the rules and guidelines in District's Acceptable Use Policy for Students' Use of the District's Computer Network and Technology may result in suspension or revocation of my access to the District's Computer Network and Technology, other school disciplinary actions, and possible legal action.

Student Signature: _____

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____ Date: _____

ALICE E. GRADY ELEMENTARY SCHOOL
45 South Goodwin Avenue
Elmsford, New York 10523
Andrea Hamilton, Principal

**ACUERDO ESTUDIANTIL PARA EL USO DE LA RED Y LA TECNOLOGÍA DEL DISTRITO**

Nombre del Estudiante: _____

He leído y entiendo la Póliza de Uso Aceptable del Distrito para el Uso de la Tecnología y la Red de Computadoras del Distrito por parte de los Estudiantes y acepto cumplir con sus reglas y pautas.

Entiendo que no tengo derecho a la privacidad cuando uso la Red de Computadoras y la Tecnología del Distrito. Entiendo que el personal del Distrito puede monitorear todo el uso que hago de la Red de Computadoras y Tecnología del Distrito, incluyendo pero no limitado a todas las comunicaciones y actividades de la red e Internet. Doy mi consentimiento para que el personal del distrito supervise mi uso de la tecnología y la red informática del distrito.

Además, entiendo que mi violación de las reglas y pautas en la Política de Uso Aceptable del Distrito para el Uso de la Red de Computadoras y Tecnología del Distrito por parte de los Estudiantes puede resultar en la suspensión o revocación de mi acceso a la Red de Computadoras y Tecnología del Distrito, otras acciones disciplinarias de la escuela, y posible acción legal.

Firma del Estudiante: _____

Nombre del padre / tutor (en letra de imprenta): _____

Firma del Padre / Tutor: _____ Fecha: _____

# REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

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

IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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

## STUDENT INFORMATION

| | | | |
|---|---|---|---|
| Name | | Sex: ☐ M ☐ F | DOB: |
| School: | Elmsford UFSD | Grade: | Exam Date: |

## HEALTH HISTORY

| | | |
|---|---|---|
| **Allergies** ☐ No ☐ Yes, indicate type | Type: ☐ Medication/Treatment Order Attached | ☐ Anaphylaxis Care Plan Attached |
| **Asthma** ☐ No ☐ Yes, indicate type | ☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached | ☐ Asthma Care Plan Attached |
| **Seizures** ☐ No ☐ Yes, indicate type | Type: ☐ Medication/Treatment Order Attached | Date of last seizure: ☐ Seizure Care Plan Attached |
| **Diabetes** ☐ No ☐ Yes, indicate type | Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached | ☐ Diabetes Medical Mgmt. Plan Attached |

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

**BMI**_____kg/m2

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

**Hyperlipidemia:** ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

## PHYSICAL EXAMINATION/ASSESSMENT

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

| Laboratory Testing | Positive | Negative | Date |
|---|---|---|---|
| TB- PRN | ☐ | ☐ | |
| Sickle Cell Screen-PRN | ☐ | ☐ | |

| Lead Level Required Grades Pre- K & K | Date |
|---|---|
| ☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL | |

**List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)**

☐ **System Review and Abnormal Findings Listed Below**

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*Required only for students with an IEP receiving Medicaid

| Name: | DOB: |
|---|---|

## SCREENINGS

| **Vision** (w/correction if prescribed) | Right | Left | Referral | Not Done |
|---|---|---|---|---|
| Distance Acuity | 20/ | 20/ | ☐ Yes ☐ No | ☐ |
| Near Vision Acuity | 20/ | 20/ | | ☐ |
| Color Perception Screening ☐ Pass ☐ Fail | | | | ☐ |

Notes

| **Hearing** Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz. | | | | Not Done |
|---|---|---|---|---|
| Pure Tone Screening | **Right** ☐ Pass ☐ Fail | **Left** ☐ Pass ☐ Fail | **Referral** ☐ Yes ☐ No | ☐ |
| Notes | | | | |

| **Scoliosis** Screen Boys in grade 9, and Girls in grades 5 & 7 | Negative | Positive | Referral | Not Done |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ Yes ☐ No | ☐ |

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

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

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

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

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

**Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

## MEDICATIONS

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

## IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

## HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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

# Dental Health Certificate-

# Elmsford UFSD

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

## Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: 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/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means, that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

**Dentist's/ Dental Hygienist's name and address**

**(please print or stamp)**

**Dentist's/Dental Hygienist's Signature**

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

### II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained roct, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

### II. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

# ELMSFORD PUBLIC SCHOOLS
## HEALTH SERVICES
### AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Student name_____ Birthdate_____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

| | |
|---|---|
| ☐ School Nurse | ☐ Immunizations/physical exams to comply with NYS regulations |
| ☐ Physical Therapist | ☐ Social History |
| ☐ Occupational Therapist | ☐ Psychological evaluations/report |
| ☐ Speech Therapist | ☐ Medical clearances as needed following an injury or change in condition |
| ☐ Audiologist | ☐ Medical orders required for therapy needs;evaluations |
| ☐ Vision Department | ☐ Authorization for medications during the school day or on school trips |
| ☐ Admissions Officer | ☐ Medical condition/treatment plans that may have an impact in the school environment |
| ☐ School Social Worker | ☐ Physician referral for services (OT,PT) |
| ☐ | ☐ Other |

I hereby authorize my child's physician(s) listed above to exchange the following information with

This information will be used to provide a safe and healthful environment and develop appropriate program for this student at school. Enrollment is not contingent up on obtaining this release, however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment. This release expires on the last day of enrollment of the above student in school and may be revoked at any time by sending a request to cancel this permission in writing to the address above. Such revocation will not affect made prior to this receipt. Protected health information will not be disclosed without consent per FERPA regulations. A copy of this release has been provided to me and will be sent to the appropriate provider when requests are made.

☐ I wave my right to receive a copy of this notice.

_____ _____

Signature of student over 18 or Parent/Guardian Date

If a student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is a signing authority to act on student's behalf sign here _____.

This form complies with all HIPPA regulations.

# ELMSFORD UNION FREE SCHOOL DISTRICT ILLNESS GUIDELINES

Dear Parents,

It is our priority to keep all of our students healthy and in school. One way that we can all work together to do this is to prevent the spread of illness. If your child is not feeling his/her best, please use the following guidelines to determine whether or not he/she should be in school.

| | **Child should not be at school or in contact with other children:** | **If child feels well enough, he/she may attend school:** |
|---|---|---|
| Runny nose | Cloudy or yellow/green discharge with congestion, fever | Clear drainage as with allergies |
| Cough | Frequent or uncontrollable, producing mucous or accompanied by fever | Infrequent, no mucous is being coughed up and/or child has been on antibiotics for at least 24 hours before returning to school, no fever |
| Fever | If temperature is above 100$^0$F or if symptoms of headache or cough accompany any elevated temperature. | If temperature is below 100$^0$ for 24 hrs. without taking a fever-reducing medication and there are no other symptoms |
| Diarrhea or vomiting | One episode of vomiting/more than one occurrence of diarrhea | Single incident of diarrhea and no other symptoms (i.e., fever, vomiting); must be 24 hours after the last episode of vomiting |
| Strep throat | Sore throat, headache, nausea, fever (children do not always have fever or complain of a sore throat.)<br>The only way to rule out Strep is with a throat culture. | After 24 hours on antibiotics and fever free for 24 hours |
| "Pink eye" Conjunctivitis | Eye is red with complaint of burning or itching; crusty, white or yellow drainage is occurring | With a note from the doctor |
| Rash/Skin infection | Any child with rash or signs of skin infection not having been evaluated by doctor | Rash free/written release from doctor/after 24 hours on antibiotic for skin infection |
| Flu | Fever/temp above 100$^0$F with accompanying sore throat, cough, runny nose, congestion, body aches, extreme tiredness, vomiting, or diarrhea | After fever free (less than 100$^0$F oral temp) for 24 hours without having been given fever reducing medication or release from physician if diagnosed with any type of flu |

If you think that your child might have a fever, please check his/her temperature before sending him/her to school. Your child should not be sent to school until he/she has been fever free for at least 24 hours without taking a fever reducing medication.

# MEDICATION POLICY

## ELMSFORD PUBLIC SCHOOLS
## HEALTH SERVICE

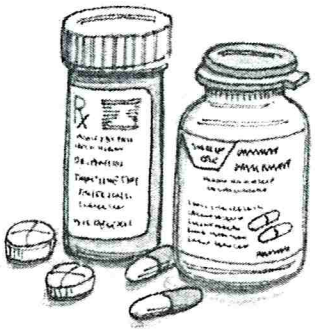
The New York State Education Department requires that all students who must take medication during school hours have the following:

A. A written request to school authorities signed by the parent or legal guardian.
B. A written request from the physician on his prescription form or letterhead stating:
    a. Child's Name
    b. Diagnosis
    c. Name of Medication
    d. Dosage
    e. Mode of Administration
    f. Frequency
    g. Dates of duration.

The medication must be brought to school in the original prescription bottle, properly labeled by a registered pharmacist as prescribed by law.

This procedure must be followed for administering non-prescription drugs also.

Upon receiving the request to give medication, a form will be sent home for the parent or legal guardian to sign and return to school as soon as possible.



**THIS POLICY WILL BE STRICTLY ENFORCED!**

# *ALICE E. GRADY ELEMENTARY SCHOOL*

## Arrival and Dismissal Form

**It is important to have this information for the safety of the children**

Student's Name: _____
Address: _____
Phone Number: _____
Teacher's Name: _____

Please indicate how your child will be traveling to and from school:

**To school** (please check all that apply and circle days of the week that are applicable):

_____ By bus from home address
Bus # & stop: _____
Everyday, Monday, Tuesday, Wednesday, Thursday, Friday

_____ By bus from other location
Bus # & stop: _____
Everyday, Monday, Tuesday, Wednesday, Thursday, Friday
Provide pick-up address _____
Contact name _____ Phone #: _____

_____ Dropped off

**Home from school** (please check all that apply and circle days of the week that are applicable):

_____ By bus to home address
Bus # & stop: _____
Everyday, Monday, Tuesday, Wednesday, Thursday, Friday
Will be met by _____ Phone #: _____

_____ By bus to other location
Bus # & stop: _____
Everyday, Monday, Tuesday, Wednesday, Thursday, Friday
Provide drop-off address _____
Will be met by _____ Phone #: _____

_____ Will Walk

_____ Will be picked up by: (please provide all information of all parties you wish to pick your child up, otherwise your child will not be released to that person if no written permission is given)

1. _____
2. _____
3. _____

Parent's signature _____ Date: _____