

Checklist of Registration Paperwork:

Please contact the central registrar with any questions regarding registration at 845-446-9575 x 1600.

Name:

Date:

Forms:	Check if given:
Required Registration Forms: Student/Parent Information Form, Request to Transfer Records Form, Home Language Form, Military Affiliation Form, Residency Questionnaire, Health History Form, Parent Portal Form	
Three Valid Forms of Proof of Residency	
Proof of Age (ex: birth certificate, passport, etc.)	
Immunization record	
Health Exam-Dated within 12 months	
Last Report Card	
Copy of IEP, if applicable	
Parent/Guardian Photo ID	
Proof of Custody/Guardianship, if applicable	

NOTES:



Highland Falls-Fort Montgomery Central School District Central Registration

845-446-9575 x-1600

Welcome to the Highland Falls-Fort Montgomery Central School District!

We are pleased to assist you in registering your child in our schools. The HFFMCSD website, www.hffmcsd.org has an overview of our programs, policies, and the forms you will need to enroll your child in our school district.

There are two parts to our registration process. In order to register your child, you will need to provide **three** forms of proof of residency (listed below) a proof of age for your child, last report card, release of records form for the last school your child attended and the most recent physical and immunizations. If applicable, evidence of custody of the child, including but not limited to judicial custody orders or guardianship documents. Only a parent/legal guardian is able to enroll a child into school.

DOCUMENTS REQUIRED AT TIME OF REGISTRATION:

ONE OF THE FOLLOWING:

- CURRENT MORTGAGE STATEMENT or TAX BILL**
- CURRENT LEASE**
- A statement by a third-party landlord, owner, or tenant from whom the parent(s)/
- Such other statement(s) by a third party establishing the physical presence of the parents/guardian(s) in the school district.
- Current utility bill ie, gas/heating oil, water, electricity, cable/phone/internet. (no cell phones)

IN ADDITION TO THE ABOVE LIST - TWO OF THE FOLLOWING MAY BE ACCEPTED:

- Pay stub-must show name and physical address of parent/guardian
- Voter registration document(s)
- State or other government issued identification
- Documents issued by federal, state, or local agencies
- Utility bills i.e. electric, gas, heating oil, cable, water, Internet

Documents must be current and original - Originals will be copied and returned to you immediately. Print-outs from online accounts will be accepted if they show the name and address of the resident and have a current date.

Documentation necessary to establish student's age - In addition to the foregoing documentation, the School District requires appropriate documentation sufficient to establish the age of the child(ren) being registered. The following documentation will be required at the time of registration:

- Certified transcript of a birth certificate or record of baptism;
- Passport (including foreign passport)

If the foregoing documentation is not available, the School District will consider other documentary evidence, including but not limited to:

- State or other government issued identification
- School photo identification with date of birth
- Consulate identification card
- Hospital or health records
- Military dependent identification card
- Documents issued by federal, state, or local agencies
- Court orders or other court-issued documents
- Records from non-profit international aid agencies and voluntary agencies
- Native American tribal documents

If relevant, additional documentation needed for school information:

- IEP (Individualized Education Plan) from previous school district
- Section 504 documentation from previous school district
- Last report card for placement purpose

ADDITIONAL INFORMATION: The child's most recent immunization records are required at the time of registration. All new students are required to have a health physical completed in **New York State** in order to attend school. The exam must be performed within 12 months prior to the child's start date. If a physical has not been performed, you are allowed 14 days from the start of school to obtain one. Exception for military families: A physical done on a military base by a military doctor is acceptable by NYS.

KINDERGARTEN & PRE-KINDERGARTEN: Your child must turn 5 years of age on or before December 1 of the school year in order to enroll in kindergarten. For pre-kindergarten, your child must turn 4 years of age on or before December 1. **There are absolutely no exceptions.** If you have any questions or concerns, please call 845-446-9575 x-1600.

CHANGE IN RESIDENCE AND/OR MAILING ADDRESS: If your living situation changes at any time during the year, you must contact the Central Registration office. Proof of residency documents are required when you change your address and/or change your mailing address. The Central Registrar will update our systems and notify the Transportation Coordinator of the change. Your child's transportation will be arranged when proof of residency is received by the Central Registration office.

The second step of this process is to make an appointment to meet with the child's guidance counselor or building administrator. At the secondary level they will help with course selection, and at the primary and intermediate schools a formal screening will assist us in meeting your child's individual needs. Additionally, you will need to complete the following forms included in this packet:

- Release of Records Form
- Student Information & Registration Form
- Student Residence Questionnaire
- Home Language Questionnaire
- Military Affiliation Questionnaire
- School Transportation Request Form
- Parent Portal Access Form

Optional Forms:

- Internet Opt-Out Form
- District Publication and News Media Opt-Out Form

Additional Required Forms:

- NYS School Health Examination Form, including proof of immunization
- Student Health History Update Form

Request for Transfer of Records

Top Section for Office Personnel Only

Date of Request: _____

Student Name: _____

Date of Birth: _____ Grade: _____

School Fax Number: _____

Email Address: _____

The above named student has enrolled in the Highland Falls-Fort Montgomery Central School District. Please forward the required information to us as soon as possible. For high school students, please also fax the latest transcript directly to the guidance office noted below to expedite registration.

- | | |
|---|---|
| <input type="checkbox"/> Transcript | <input type="checkbox"/> Results of Achievement Tests |
| <input type="checkbox"/> Latest Report Card | <input type="checkbox"/> Results and date of NYSESLAT for ELL Students |
| <input type="checkbox"/> Attendance Record | <input type="checkbox"/> Health Records |
| <input type="checkbox"/> Discipline Record | <input type="checkbox"/> Pupil Services Records including, IEP, 504, psychological testing and social history |

Note: If your district participates in Frontline IEP (formerly IEP Direct), please transfer the student's IEP via Frontline IEP.

Parent/Guardian Authorization

To Parent or Legal Guardian

Please complete and sign below. We will forward this request for records form to your student's previous school.

To: _____ Attention: _____
Name and Location of School School Contact Person

I hereby authorize the transfer of all school records regarding the above named student to Highland Falls - Fort Montgomery Central School District.

Print Name Signature Date

Please fax high school transcripts to:
James I. O'Neill High School, Guidance: Fax: 845-446-2138 Ph. 845-446-4914 x2600

Please fax all education records to the appropriate buildings/departments;
Highland Falls Intermediate School, Gr. 3-8 Office: Fax: 845-446-0858 Ph. 845-446-4761 x3500
Fort Montgomery Elementary School, Gr. PK-2 Office: Fax: 845-446-6608 Ph. 845-446-1008 x4500
Pupil Personnel Office, Fax: 845-446-2141 Ph. 845-446-4083 x 3611

Mail records to the attention of the appropriate office listed above at:
PO Box 287
Highland Falls, NY 10928

Highland Falls-Fort Montgomery CSD

Student Information and Registration Form

Date: _____

Student Information

Name: _____
Last
First
Middle

Date of Birth: _____ Gender: _____

Student Ethnicity (per NYSED):

- American Indian/Alaska Native
 Asian/Pacific Islander
 Hispanic
 Black
 White

PRIMARY HOUSEHOLD (Address Information)

Students' Residence Address: Street: _____ City _____ State _____ Zip _____ Home Phone Number: _____	Student's mailing address, if different Street: _____ City _____ State _____ Zip _____
---	--

Present grade level or grade level just completed: _____

Has your child been retained? (Repeated a grade.) Yes No If yes, what grade? _____

Name of previous school: _____

Address of previous school: _____

Phone # _____ Fax #: _____

Has the student previously attended HFFMCSD? _____ If yes, list dates attended: _____

Primary language spoken at home: _____ Secondary language spoken: _____

Has student received additional educational services: _____ If yes, please indicate:

- Special education
 Speech therapy
 Physical therapy
 Occupational therapy
 English Language Learner Services
 AIS/RtI
 Other _____

Sibling Information-please include first and last names:

Name	M/F	Date of Birth	Current School and Grade

Custody Information

With whom is the student living? (check all that apply)

- Mother Father Stepmother Stepfather Grandparent Guardian
- Other-Please explain _____

If the parents are divorced, who has custody? _____

In addition to student's residence, to whom should mail be sent? _____

Are there any safety concerns the District should be aware of? _____

If yes, please explain: _____

Order of Protection: Yes No

If an order of protection exists, please submit a copy at time of student enrollment.

Parent/Guardian Information: RESIDING IN PRIMARY HOUSEHOLD

Relationship	Name	Cell Phone	Place of Employment	Work Phone
email address: _____				

Parent/Guardian Information: RESIDING IN PRIMARY HOUSEHOLD

Relationship	Name	Cell Phone	Place of Employment	Work Phone
email address: _____				

Parent/Guardian Information: NOT RESIDING IN PRIMARY HOUSEHOLD

Relationship	Name	Cell Phone	Place of Employment	Work Phone
Mailing address: _____				
email address: _____				

Parent/Guardian Signature: _____

Date: _____

Highland Falls-Fort Montgomery Central School District

Student Residence Questionnaire

Name of School: _____

Name of Student: _____ Male ___ Female
Last First Middle

Birth Date: ___/___/___ Age: ___ Student ID #: _____
Month Day Year

This questionnaire is intended to address the McKinney-Vento Act 32 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1. Is your current address a temporary living environment? Yes No
2. Is this temporary living arrangement due to loss of Housing or economic hardship? Yes No

- If you answered **YES** to the above questions, please complete the remainder of this form.
- If you answered **NO**, you may stop here.

Where is the student presently living? (*Check one*)

- In a motel
- In a shelter
- With more than one family in a house or apartment
- Moving from place to place
- In a place not designed for ordinary sleeping accommodations such as a car, park or campsite

Name of Parent(s)/Legal Guardian(s) _____

Address _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Presenting a false record or falsifying records is an offense and enrollment of the child under false documents subjects the person to liability for tuition or other costs.

Signature of Parent/Legal Guardian: _____ Date: _____

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the State.

Date

Liaison Signature



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

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

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

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section.

STUDENT NAME:		

First	Middle	Last
_____	_____	_____
DATE OF BIRTH:		GENDER:
Month	Day	Year
_____	_____	_____
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	_____	<input type="checkbox"/> Father
		<i>specify</i>	<i>specify</i>
	<input type="checkbox"/> Guardian(s)	_____	
		<i>specify</i>	
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<input type="checkbox"/> Does not write
			<i>specify</i>

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* <input type="checkbox"/>	No <input type="checkbox"/> Not sure <input type="checkbox"/> *If yes, please explain: _____
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe	
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below	
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past?	
<input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____	
Age at which services received (Please check all that apply):	
<input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)	
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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? _____	

_____ <i>Signature of Parent or of Person in Parental Relation</i>	Month: _____	Day: _____	Year: _____
_____ <i>Date</i>			
Relationship to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <small>MO. DAY YR.</small>	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <small>MO. DAY YR.</small>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:	

Highland Falls - Fort Montgomery CSD

PO Box 287
Highland Falls, NY 10928
845-446-9575, ext. 1600

Military Affiliation Questionnaire

(To Be Filled Out By Parent/Guardian)

Answers to these questions help determine the eligibility of funds for the school district.

Name of Student: _____

Date of Birth: _____/_____/_____
Month Day Year

Grade: _____

Name of Parent/Guardian: _____ Title: _____

1. Does either parent have any military affiliation? _____ YES _____ NO

2. If yes to the above question, please describe your military affiliation:

- _____ Active military, assigned to West Point, living ON POST
- _____ Active military, assigned to West Point, living OFF POST
- _____ Active military, not assigned to West Point
- _____ Retired military
- _____ Active reservist
- _____ Inactive reservist
- _____ NYS National Guard

3. Is any family member employed at West Point? _____ Yes (Please continue)
_____ No (If No, STOP here)

4. If "YES", please indicate who is employed at West Point and in what capacity.

Signature of Parent/Guardian _____

Date _____

Highland Falls-Fort Montgomery Central School District

Parent Portal Access Form for Parents

Note: If both parents/legal guardian want individual accounts, each must complete a separate form.

Parent/Legal Guardian

Please Print

Name of Parent/Legal Guardian: _____

Student Name(s): _____ Grade: _____

_____ Grade: _____

_____ Grade: _____

Email Address: _____

Each account requires a separate email address. Your signature affirms that you are the **legal guardian for the student(s) named**, and are therefore entitled to access their educational records. It also gives consent for the Highland Falls-Fort Montgomery Central School District to establish an individualized password so that you may gain access to our Parent Portal. You will receive an email from SchoolTool with your log in information. Please note that to protect the privacy of student data, parents/guardians will be required to provide identification in order to be issued their password.

Parent/Guardian Signature: _____ Date: _____

If the parent/legal guardian of the above named student(s) requests permission for a non parent/non legal guardian residing in the household to access the Parent Portal, please fill out and sign the section below. Both parties are required to provide a valid photo ID.

Name of individual to receive access to parent portal: _____

Relationship to student(s): _____

Name of parent/legal guardian: _____

Signature of parent/legal guardian: _____ Date: _____

Parent/legal guardian ID attached _____
School Personnel Initials _____

Non parent/legal guardian ID attached _____
School Personnel Initials _____

Medical Information

1. Student Health History Form (next page) must be filled out and signed by a parent/guardian and submitted with this packet at the time of registration
2. Up to date immunization records
3. The required NYS Health Examination Form must be filled out and signed by the doctor.

Thank you.



Highland Falls-Fort Montgomery Central School District STUDENT HEALTH OFFICES

High School
845-446-9575 x 2700

Intermediate School
845-446-4761 x 3700

Elementary School
845-446-1008 x 4700

Student Name: _____ Gender: _____ Grade: _____

Date of Birth: _____

Parent/Guardian: _____ Phone #: _____

Parent email: _____

Student Health History

Has your child ever had the following Communicable Diseases:

Chicken Pox	Yes__No__Date_____	Scarlet Fever	Yes__No__Date_____
Mumps	Yes__No__Date_____	Whooping Cough	Yes__No__Date_____
German Measles	Yes__No__Date_____		

1. Is your child currently under treatment for any physical problem? Yes_____No_____

If so, explain:

2. Does your child take medication on a regular basis? Yes_____No_____

If so, name of medication and reason.

Name of Medication: _____ Reason: _____

Name of Medication: _____ Reason: _____

Name of Medication: _____ Reason: _____

If your child needs to take medication during the day, you must contact the Health Office in person. Specific forms must be filled out and signed by your Physician before ANY medication can be administered.

3. Has your child ever had surgery? Yes__No__ Explain: _____

4. Has your child had any serious medical problems? Explain _____

5. Has your child has a serious accident or injury? Yes_____No_____ Explain _____

6. Has your child ever been hospitalized? Yes_____No_____

Explain: _____

7. Does your child have any allergies to food, medication or insects/bee stings? Yes _____ No _____
If yes, please list:

8. Does your child wear glasses or contact lenses? Yes ___ No ___ Other visual difficulties, please
explain _____

9. Does your child have any: (circle all that apply)

Ear problems?

Hearing loss?

Frequent ear infections?

Tubes in ears? If so, at what age?

Explain: _____

10. Does your child have any speech difficulties? Yes ___ No ___ If yes, please explain

11. Does your family have a history of diabetes or tuberculosis? Yes ___ No ___

Family

Physician: _____

—

Name

Phone number

In emergency situations, Administration will take any action it deems necessary and appropriate.

Parent/Guardian

Signature: _____ Date: _____

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g}/\text{dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

System Review Within Normal Limits

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

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

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> 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	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominic Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
MEDICATIONS					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					



Proceed to the next two pages only if you wish to:

- **Opt-out** your child from having access to the internet for the purposes of learning, research and communication.
- **Opt-out** your child from having their name, photo, school work, awards, recognition, participation, etc. published.



Highland Falls-Fort Montgomery Central School District

INTERNET OPT-OUT FORM

SIGN AND RETURN THIS FORM **ONLY** IF YOU

DO **NOT** WISH YOUR CHILD TO USE THE INTERNET

Each HFFMCS D student will be assigned a computer network login that will provide the student with access to district approved software and the Internet. Unless a parent has signed this “Internet Opt-Out” form, each student will be given access to the Internet.

The proper use of the Internet provides opportunities for research, learning and communication. Some programs that support district curriculum are accessed *only* through the Internet:

- specific intervention, enrichment and curriculum resources (i.e.,i-Ready, Google Classroom) are only via Internet access
- library catalogs for each of our school libraries are available only via Internet access
- subscription-based research databases are available only via Internet access

The student and his/her parents(s) should read and discuss the district policies regarding computer network and Internet use. While HFFMCS D makes every possible effort to limit improper use and used proxy/filtering software to shield users from access to inappropriate materials, it is not possible to absolutely prevent such access. All Network/Internet users are expected to use all network resources for purposes appropriate to the educational environment at all times. Users must refrain from any use that is not consistent with the policies, purposes or objectives of the Highland Falls-Fort Montgomery Central School District.

Internet Opt-Out

Student Name (please print) _____

As the parent or guardian of this student, I request that my child NOT be given access to the Internet through his/her school network login.

I understand that also means my child will NOT have access to the library catalogs, online research database resources, and online intervention, enrichment and curriculum resources such as i-Ready or Google Classroom. .

Parent signature

Parent name (please print)

Date



Highland Falls-Fort Montgomery Central School District

DISTRICT PUBLICATION AND NEWS MEDIA OPT-OUT

This form should be completed **ONLY** if you do **NOT** want your child to be shown in district media.

Each year the HFFMCSD requests that each parent or guardian receive an “opt-out form regarding the use of their child’s name or image for media purposes. The District takes pictures and videos of students involved in school activities throughout the year. Student work may also be copied for use in newsletter and on District or school websites. The District may use the images on the District website and on individual school websites, in email, in print and electronic publications, individual school newsletter, or on the District’ Cable Channel.

Additionally, the District allows outside media, including newspapers, television and radio, to cover various school events. Images may be published in print, on a web site or on television. Information release with these pictures and/or video may include:

- Student's name
- Student’s grade in school
- Degrees, honors and awards received
- Participation in officially recognized activities and sports.

If, for any reason, you do not want to have your child included in images used in any outside media or by the District, please complete the form below and return it to you child’s building by the second week of September of the current school year. If you are a new resident please return the form within 30 days of your child’s registration.

Student Name: _____

Date: _____

Parent/Legal Guardian

Name: _____

Signature: _____

Relationship to child: _____