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

STUDENT REGISTRATION PACKET

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

Retain This Page For Your Records

Summary of Forms and Procedures

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

- Required Forms of Proof of Residency

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

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

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

- Required Forms of Proof of Date of Birth

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

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

- Required Physical Examination

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

- Proof of Required Immunizations

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

- Parent/ Legal Guardian Oath

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

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

Please Be Advised

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

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

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

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

NEWSTUDENT REGISTRATION

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

PART I

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

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

PARENT/GUARDIAN INFORMATION:

Student resides with:

_____Both Parents _____Mother Only _____Father Only _____Mother/Stepparent

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

FOR DISTRICT USE ONLY

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

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

Section A: Parent/Guardian Information

Parent/Guardians Residing With Student:

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

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

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

Parent/Guardian Not Residing With Student:

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

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

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

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

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

List any restrictions other parent has regarding child _____.

List type and date of legal document provided _____.

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

Name: _____

Address: _____

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

Name of child's birth parent(s) _____

Address or whereabouts of birth parent(s) _____

Phone number of the birth parent_____

Provide document indicating custody and restrictions, etc.

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

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

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

Section D: Temporary Living Arrangement/Loss of Housing

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

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

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

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

_____In a shelter

_____In a motel or hotel

_____In a transitional housing program

_____In a car, trailer or campsite

_____In a rented trailer/motor home on private property

_____In a rented garage due to loss of housing

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

_____In a single room occupancy building

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

_____Awaiting foster placement

_____Other place unfit for human habitation

_____NONE OF THESE CHOICES APPLY

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

OPTIONAL

FAXED BY _____ DISTRICT_____

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 Every Student Succeeds Act (ESSA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. 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.

Have you or has someone in your family worked on a farm?
Have you moved during the past three years?

- ☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- ☐ Work related to logging, harvesting, or initial processing of trees.
- ☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



If you answer YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____City/Town_____

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

Previous Address: _____

Student name: _____ Age _____Grade_____

Student name: _____ Age _____Grade_____

To submit this referral please fax to 845-257-2953 or mail to Mid-Hudson Migrant Education Program-353 VH Annex 1 Hawk Drive New Paltz, NY 12561

OPTIONAL

FAXED BY _____ **DISTRICT** _____

PROGRAMA DE EDUCACIÓN PARA MIGRANTES DEL ESTADO DE NEW YORK

OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Ley Cada Estudiante Triunfa (ESSA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, **sin importar su nacionalidad o estado legal**. Este programa **es gratuito** para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito, excursiones, programa de verano, actividades de envolvimiento para padres, programa de emergencias y referidos a otras organizaciones o agencias.

Por favor tome unos minutos para completar este cuestionario.

¿Usted o alguien en su familia ha trabajado en la agricultura?
¿Se han mudado durante los últimos 3 años?

- ☐ Cualquier trabajo agrícola (como plantando, seleccionando, o cosechando frutas o vegetales, cultivando o cortando flores o árboles, trabajo en lechería u otro rancho de animales, pescando, etc.)
- ☐ Trabajando en la cultivación o procesamiento de los árboles.
- ☐ Trabajando en una planta de procesamiento, empacando, lavando o cortando vegetales, frutas o carnes.





Si usted contestó que sí, por favor complete la siguiente información:

Nombre del Padre/Encargado: _____

Dirección Física: _____ Ciudad_____

Teléfono: (_____)-_____-_____ Mejor tiempo para ser contactado _____ AM/PM

Dirección anterior: _____

Nombre del estudiante: _____ Edad_____ Grado_____

Nombre del estudiante: _____ Edad_____ Grado_____

Para someter este referido, por favor envíelo por fax a 845-257-2953, o por correo a Mid-Hudson Migrant Education Program- 353 VH Annex – 1 Hawk Drive New Paltz, NY 12561

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

PART II

PREVIOUS ADDRESS INFORMATION

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

PREVIOUS SCHOOL INFORMATION

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

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

Name	Age	School

DOCTOR/DENTIST INFORMATION

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

EMERGENCY CONTACTS (Please list three)

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

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

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

PARENT OR LEGAL GUARDIAN OATH

I, _____, am the parent/guardian of

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

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

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

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

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

_____

Signature *Date*

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

PART III

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

SPECIAL SERVICES SURVEY

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

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

A. What district developed the most recent IEP? _____

B. Most recent year of IEP: _____

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

If yes, please describe. _____
_____
_____

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

If yes, please describe. _____
_____
_____

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

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

FOR DISTRICT USE ONLY

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

_____ _____
Signature *Date Forwarded*

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

PART IV

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

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

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

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

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH: **GENDER:**

Month *Day* *Year* ☐ Male ☐ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE _____

Language Background
(Please check all that apply.)

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

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

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

Home Language Questionnaire (HLQ)-Page Two

Educational History

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

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

*Yes** *No* *Not sure*

☐ ☐ ☐ *If yes, please explain: _____

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

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 ONL Y - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: POSITION: _____

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

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

NAME: POSITION: _____

ORAL INTERVIEW NECESSARY: **0** No **O** YES

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

OUTCOME OF INDIVIDUAL INTERVIEW: **0** ADMINISTER NYSITELL 0 ENGLISH PROFICIENT ☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF **QUALIFIED PERSONNEL ADMINISTERING NYSITELL**

NAME: POSITION:

DATE OF NYSITELL ADMINISTRATION: _____ MO. DAY YR.

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: 0 ENTERING 0 EMERGING 0 TRANSITIONING 0 EXPANDING 0 COMMANDING

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

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

PART V

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

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

AUTHORIZATION FOR THE RELEASE OF STUDENT RECORDS

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

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

Last School Attended	Last Day
Address	
Telephone	Fax

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

_____
Signature of Parent/Guardian

Student's Name: _____

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

Date of Enrollment at Harrison: _____

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

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

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

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

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

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

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

PART VI

HARRISON CENTRAL SCHOOL DISTRICT

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

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

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

PROOF OF IMMUNIZATIONS

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

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

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

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

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

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

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

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

Revised 1/30/15

HARRISON CENTRAL SCHOOL DISTRICT
PROOF OF IMMUNIZATION

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

IMMUNIZATION HISTORY

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

TUBERCULIN SKIN TEST

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

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

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

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

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

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

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

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

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

Physician's Signature: _____ Phone: _____ (Physician's Stamp below)

Physician's Name/Address: _____ Fax: _____

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

HARRISON CENTRAL SCHOOL DISTRICT

STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)

Note: NYSED requires an annual physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers

Name:	DOB:	Gender: ☐ M ☐ F
School:	Grade: ☐NA	Exam Date:

HEALTH HISTORY

Specify Current Diseases

☐Asthma (☐Intermittent or ☐Persistent)
Quick relief inhaler: ☐Yes ☐No
Asthma Action Plan: ☐Yes ☐No
☐Type 1 Diabetes ☐Type 2 Diabetes
☐Hyperlipidemia ☐Hypertension
☐Other:

Sickle Cell Screen:	☐Positive	☐Negative	☐Not Done	Date:
PPD:	☐Positive	☐Negative	☐Not Done	Date:
Elevated Lead:	☐Yes	☐No	☐Not Done	Date:
Dental Referral:	☐Yes	☐No	☐Not Done	Date:

☐ Allergies - See page 2 for details.

Significant Medical/Surgical Information:

PHYSICAL EXAMINATION

Height: Weight: BP: Pulse: Respirations:

Scoliosis: ☐Negative ☐Positive
Degree of deviation: _____
Angle of trunk rotation via scoliometer: _____

Body Mass Index:
Weight Status Category (BMI Percentile):
☐ <5th ☐ 85th- 94th
☐ 5th- 49th ☐ 95th- 98th
☐ 50th-84th ☐ 99th & higher

Vision	**Right**	**Left**	***Referral***
Distance acuity			☐Yes ☐No
Distance acuity with lenses			
Vision - near vision			
Vision - color perception	☐ Pass	☐ Fail	

Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes ☐No

Circle developmental stage (ONLY for selection classification for 7th & 8th graders): Tanner: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ See attached
Specify any abnormalities:

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

☐ Free from contagions and physically qualified for all activities (phys ed, athletics, playground, work, school)
☐ Expected Body Contact (full or limited): football, wrestling, basketball, ice/field/floor hockey, baseball, softball,
☐ Strenuous: cross-country, gymnastics, track & field, swim, diving, crew, ski, cheering, tennis, badminton, fencing,
☐ Non-contact/Non-strenuous: bowling, golfing, table tennis, archery, riflery, shuffleboard, walking
☐ Protective Equipment: ☐Athletic Cup ☐Sport/safety goggles ☐Other:
☐ Medical/prosthetic device:
☐ Recommendations/restrictions:

Name: DOB:

MEDICATIONS

To be completed by Health Care Provider

Diagnosis	ICD Code	Medication Name	Dose	Route	Time	Self Directed*	Self Admin/ Self Carry**

***Self Directed**: I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately, and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently

****Self Admin/Self-Carry**: I have determined this student is consistent and responsible in taking their own medication (self-directed), and in addition, give them permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

To be completed by Parent/Guardian if medication is prescribed

☐ I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/package with my child's name on it.

Parent/Guardian Signature: Date: Phone: ( )

☐ Parent permission & provider consent is required for students to self-administer & self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below.

Parent/Guardian Signature: Date: Phone: ( )

ALLERGIES

☐ **None** ☐ **Non Life-Threatening** ☐ **Life-Threatening**

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Specify allergen(s):

Specify previous symptoms: ☐History of anaphylaxis; last occurrence:

Emergency Care Plan for anaphylaxis: ☐ Yes ☐ No

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

IMMUNIZATIONS

☐ Immunization record attached

☐ Immunizations reported on NYSIIS

☐ No immunizations received today

☐ Immunizations received today:

☐ Will return on: to receive:

Provider / Parental Authorization

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: Date:

Provider Name: (please print) Phone #:

Provider Address: Fax #:

Parent/Guardian Signature: _____ Date:

Medical Provider Email:

Return to:

School Nurse: School:

Phone #: ( ) Fax: ( ) Date:

HARRISON CENTRAL SCHOOL DISTRICT

NEW STUDENT HEALTH HISTORY QUESTIONNAIRE

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

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

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

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

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

HEALTH HISTORY

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

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

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Parent/Guardian Signature *Date*

HARRISON CENTRAL SCHOOL DISTRICT

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

DENTIST CERTIFICATE

TO BE COMPLETED BY PARENT/GUARDIAN

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

Home Address: _____

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

****

TO BE COMPLETED BY DENTIST

Date of Last Examination: _____

Check work that was completed at the last examination:

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

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

_____

_____

_____

_____

_____

_____

_____

_____

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

Dentist Signature: _____ **Date:** _____

Dentist Stamp Required

HARRISON CENTRAL SCHOOL DISTRICT

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

HEALTH REFERENCE SHEET

ILLNESS

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

INTERNAL MEDICATIONS

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

HEALTH SCREENINGS-VISION, HEARING, SCOLIOSIS

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

PHYSICAL EDUCATION-MODIFIED ACTIVITY/EXCUSE

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