

Injuries _____ Dental Care _____

— Any other medical problems we should be aware of: _____

Explain above _____

Family History:

	Mother	Father	Siblings	Grandmother	Grandfather
Asthma	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Psychiatric problems	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐
TB	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐
Smokes	☐	☐	☐	☐	☐

Immunizations: Please bring copy of their immunization record.

Need proof of: 3-DTaP / 3-Polio / 1-MMR / 3-Hepatitis B / 1-Hib / 1-Varicella

Family and Social Relations:

This child enjoys doing the following:

Alone: _____

With Others: _____

Please describe this child's personality and activity level: _____

Additional information felt to be relevant: _____

Signature _____

Parent/Guardian's Name

Date _____

I.D. NUMBER _____

HERMON-DEKALB CENTRAL SCHOOL

GRADE _____

BUS # (IN) _____

ENTRY DATE _____

DEKALB JUNCTION, NEW YORK 13630

HOMEROOM # _____

BUS # (OUT) _____

Name of Pupil _____ D.O.B. ____/____/____ Birth Place _____ Sex: M F

Last

First

Middle

Mo Day Year

City

State

Home Address (911 Address) _____

Road or Street Name

Town

State

Zip

Mailing Address (if different) _____

P O Box Number

Town

State

Zip

☐ Check here if you reside in a temporary home that you do **NOT** own, lease, rent, or sublet (*shelter, with relatives or others, abandoned apartment/building, motel/hotel, camping ground, car, train/bus station*).

Home Phone _____ Cell Phone _____ Work Phone _____ Email Address _____

Transferred From: _____

School Name

Town

State

Zip

Previous 911 address: _____

Has the above student ever attended Hermon-DeKalb Central in the past? _____ If so, when? _____ **CSE Services:** Yes or No

Ethnic Origin: [] Asian - [] American Indian/Alaskan Native – [] Black – [] Hispanic – [] Pacific-Islander - [] White

Home Language (Language Spoken in the Home if Not English) _____

Father or Male Guardian _____

Last

First

Middle

(Relationship to Child)

Mother or Female Guardian _____

Last

First

Middle

(Relationship to Child)

Additional Adult(s) in Household _____

Last

First

(Relationship to Child)

Who is the Custodial Parent? _____ Are there any legal custody arrangements? _____

****PLEASE SUBMIT A COPY OF THE CUSTODY AGREEMENT. THE SCHOOL IS BOUND BY LAW TO ADHERE TO THIS DOCUMENT.**

Non-Custodial Parent _____ Address _____

Should the non-custodial parent receive school mailings? _____ May the non-custodial parent pick the child up from school? _____

Siblings or Other Children in the Household:

Last	First	Middle	Birthdate	(Relationship to Child)
Last	First	Middle	Birthdate	(Relationship to Child)
Last	First	Middle	Birthdate	(Relationship to Child)
Last	First	Middle	Birthdate	(Relationship to Child)
Last	First	Middle	Birthdate	(Relationship to Child)
Last	First	Middle	Birthdate	(Relationship to Child)

Emergency Information
(Please fill out any applicable information)

Guardian Work Information: _____
Name Place of Employment Phone Number

Guardian Work Information: _____
Name Place of Employment Phone Number

Other Emergency Contact: _____
Contact Name (Relationship to Child) Phone Number

Other Emergency Contact: _____
Contact Name (Relationship to Child) Phone Number

HEALTH DATA: A COPY OF BIRTH CERTIFICATE AND IMMUNIZATIONS REQUIRED AT TIME OF REGISTRATION
Child’s Doctor _____ Child’s Dentist _____
Childhood Diseases & Dates _____
Serious Injuries _____ Surgery _____

Is there anything concerning vision, hearing, or general health of this child that the school should know about in order to provide special care?

TRIP PERMISSION: THIS CHILD HAS MY PERMISSION TO GO ON FIELD TRIPS TAKEN AS PART OF THE SCHOOL PROGRAM UNDER THE SUPERVISION OF A TEACHER.

Date Signature of Parent or Legal Guardian

EMERGENCY AUTHORIZATION INFORMATION

SCHOOL YEAR: _____ BUS #: _____ HOMEROOM TEACHER: _____ GRADE: _____

STUDENT: _____ BIRTH DATE: _____

MAILING ADDRESS: _____ STUDENT CELL #: _____

911 ADDRESS: _____ HOME PHONE: _____

PARENT/GUARDIAN

NAME: _____
RELATIONSHIP TO CHILD: _____
ADDRESS IF DIFFERENT: _____
CELL PHONE: _____
WORK #/EXT: _____
EMAIL ADDRESS: _____

PARENT/GUARDIAN

NAME: _____
RELATIONSHIP TO CHILD: _____
ADDRESS IF DIFFERENT: _____
CELL PHONE: _____
WORK #/EXT: _____
EMAIL ADDRESS: _____

CUSTODY ARRANGEMENTS (NEED COPY ON FILE): _____

NAME OF SITTER: _____ PHONE: _____

IN CASE OF EARLY DISMISSAL/AFTER SCHOOL CANCELLATION, PLEASE INFORM US WHERE YOUR CHILD SHOULD GO? (HOME/SITTER/OTHER)

NAME: _____ PHONE: _____

NAMES AND PHONE NUMBERS OF 2 PEOPLE WHO COULD GET A MESSAGE TO YOU OR COME TO GET YOUR CHILD IF HE/SHE IS ILL:

NAME: _____ PHONE: _____
NAME: _____ PHONE: _____

DOCTOR: _____ HOSPITAL PREFERENCE: _____

NAMES & GRADES OF BROTHERS & SISTERS IN SCHOOL:

NAME: _____ GRADE: _____ N.Y. STATE REQUIRED PHYSICALS FOR STUDENTS IN GRADES Pre K, K, 1st, 3rd, 5th, 7th, 9th, 11th AND NEW STUDENTS.

NAME: _____ GRADE: _____ ☐ THE SCHOOL DOCTOR

NAME: _____ GRADE: _____

NAME: _____ GRADE: _____ ☐ YOUR OWN PHYSICIAN WITH EXAM FORM FROM SCHOOL.

DOES YOUR CHILD HAVE ANY MEDICAL PROBLEMS THE SCHOOL SHOULD KNOW ABOUT?

THE FORM MUST BE RETURNED
BY NOVEMBER 1st OR THE PHYSICAL
WILL BE SCHEDULED FOR THE
SCHOOL TO COMPLETE.

**PERMISSION TO SHARE HEALTH CONDITION WITH CHILD'S
TEACHER/TEACHERS.**

SIGNATURE OF PARENT/GUARDIAN

SIGNATURE FOR PERMISSION

DATE:

Hermon-DeKalb Central School

STUDENT HEALTH HISTORY UPDATE

Name:	DOB:	Age:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Grade:	Home Phone:	Date:
		Cell Phone:	

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

CHECK ALL THAT APPLY TO YOUR CHILD:

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

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

Is there any condition that would prevent your child from participating in physical education or sports?

☐ No ☐ Yes: _____

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

Parent/Guardian Signature: _____ Date: _____



**HERMON-DEKALB CENTRAL SCHOOL
ENROLLMENT OFFICE**

709 East DeKalb Road
DeKalb Junction, NY 13630

Phone: (315) 347-3442
Fax: (315) 347-3817

HOUSING QUESTIONNAIRE

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth _____ Grade: _____ ID# _____
(PreK – 12)

Address: _____ Phone: _____

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

Where is the student currently living? (please check ONE)

☐ In a shelter

☐ With another family or other person because of loss of housing or as a result of economic hardship
(sometimes referred to as “doubled up”)

☐ In a hotel/motel

☐ In a car, park, bus, train, or campsite

☐ Other temporary living situation (please describe): _____

☐ In permanent housing

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

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

Date

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

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**

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

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Yes, indicate type ☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Yes, indicate type ☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type ☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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 **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
Sickle Cell Screen/PRN	☐	☐		☐ Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	☐ Mental Health: _____
☐ Test Done ☐ Lead Elevated ≥ 10 $\mu\text{g/dL}$				☐ Other: _____

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

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

Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
☐ Additional Information Attached	_____	_____
	_____	_____
	_____	_____
	_____	_____

Name:

DOB:

SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9 And girls grades 5 & 7	Negative ☐	Positive ☐	Referral ☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

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

- ☐ Full Activity without restrictions including Physical Education and Athletics.
- ☐ Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications
- ☐ No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ Other Restrictions:
- ☐ Developmental Stage for Athletic Placement Process ONLY
- Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports
- Student is at Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V
- ☐ Accommodations: Use additional space below to explain
- | | | |
|---|---|---|
| ☐ Brace*/Orthotic | ☐ Colostomy Appliance* | ☐ Hearing Aids |
| ☐ Insulin Pump/Insulin Sensor* | ☐ Medical/Prosthetic Device* | ☐ Pacemaker/Defibrillator* |
| ☐ Protective Equipment | ☐ Sport Safety Goggles | ☐ Other: |

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

Explain: _____

MEDICATIONS

- ☐
- Order Form for Medication(s) Needed at School attached

List medications taken at home:

IMMUNIZATIONS

☐ Record Attached☐ Reported in NYSISReceived Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:

Date:

Provider Name: (please print)

Stamp:

Provider Address:

Phone:

Fax:

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

Lead Poisoning Information

Studies show that no amount of lead exposure is safe for children. Lead is a metal that can harm children when it gets into their bodies. Lead can harm a young child's growth, behavior, and ability to learn. It can also cause anemia, kidney damage, and hearing loss. There are many sources of lead. Lead can be found in dust, air, water, soil, and in some products used in and around our homes.

At each well-child visit, your health care provider should assess children 6 months to 6 years of age for risk of high lead exposure. Your health care providers may use a questionnaire to determine if your child is at higher risk of lead poisoning. If so, they may need a lead test.

Children younger than six years old are more likely to get lead poisoning than any other age group. Most often, children get lead poisoning from breathing in or swallowing dust from old lead paint. It can be found on floors and windowsills, hands, and toys. Lead can also be passed from pregnant person to baby during pregnancy.

How to protect children

- *Keep children away from peeling paint and broken plaster.
- *Wash their hands after play, before meals, and before bed to rinse off any lead dust or dirt.
- *Wash your child's toys often, especially teething toys. Learn more about product recalls including toys.
- *Use cold water - not hot - for infant formula or cooking. Let the cold water tap run for at least a minute before using to flush lead picked up from pipes. Learn more about lead in drinking water.
- *Store food from open cans in glass or plastic containers.
- *Use lead-free dishes. Don't use chipped or cracked dishes to store or serve food.
- *Be careful with your hobbies. Some crafts call for use of paints, glazes and solder may contain lead.
- *Don't bring lead home with you from work. People who work at construction, plumbing, painting, auto repair and certain other jobs can be exposed to lead. Learn more about possible lead dangers while working on a construction site.
- *Wash work clothes separately.
- *Keep children away from remodeling and renovation sites. Old paint can have lead in it.
- *Avoid having children play in soil especially around the foundations of older buildings and near roadways. Use a sandbox instead.
- *When windows are open in warm weather, wash the sills and window wells any time you see dust, but at least once a month.
- *Call your local health department for information about professionals who handle lead-based paint problems.

Foods that get ahead of lead

Foods high in iron, calcium and Vitamin C can help prevent lead poisoning:

Iron – Protects from the harmful effects of lead

Calcium – Makes it hard for lead to enter the body

Vitamin C – Helps the body absorb iron and calcium better

Hermon-DeKalb Central School

Lead Screening Requirements

Public Health Law §1370-d requires childcare providers, public schools, and preschools; to obtain from the parent/guardian- prior to or within three months of initial enrollment- evidence that their child under the age of six years has been screened for lead. If the parent/guardian is unable to provide such evidence, the school must:

- Provide the parent/guardian with information on lead poisoning in children and lead poisoning prevention; and
- Refer the parent/guardian to their primary care provider or local health department for blood lead test.

Note: A student lacking proof of lead screening **may not be excluded**.

☐ Proof of lead screening provided.

☐ Information on lead poisoning and prevention given and referred to health care provider.

Parent Signature

Date

School Nurse: _____

Date received: _____

3/22/24