

FILLMORE CENTRAL SCHOOL

April 1, 2025

Dear Parents;

Fillmore Central School will provide a Universal Pre-Kindergarten program for eligible students during the 2024-25 school year. Children born between December 2, 2020 and December 1, 2021, are eligible to participate in the Universal Pre-Kindergarten program.

Universal Pre-Kindergarten is a **voluntary** program for parents who desire a Pre-Kindergarten experience for their children. The program

- is a full day session (Times TBD)
- follows the Fillmore Central School calendar,
- is located in the Fillmore Central School building,
- is no cost to parents,
- has a certified teacher and support staff,
- provides transportation if necessary for students who are at least four years of age, and
- provides a developmentally appropriate play-based curriculum focusing on cognitive, social, emotional, and physical skill development.

If you are interested in your child being a member of the 2025-26 Pre-Kindergarten program, please complete and return all of the enclosed Pre-Kindergarten entrance forms. In addition, please submit a copy of your child's ***immunization records and birth certificate***. All paperwork must be submitted before your child may enter the program.

Applications must be received by July 31, 2025. The Universal Pre-Kindergarten program is only permitted to service eighteen students in each of two classes. If more than thirty-six student applications are submitted, Fillmore Central will institute a lottery system to fill the preschool openings. In-District students receive priority fulfillment. In-District students enrolled in the 3-year-old program will also have first rights to the District's UPK program for 4-year-old students the following year. Out of District students must complete and return an Out of District application and await District approval.

If you have any questions, please contact me at 567-4432. Thank you for your interest in Universal Pre-Kindergarten, and we look forward to receiving your child's registration information and working with you and your child.

Sincerely,



Mrs. Sarah Petre
Pre-K-12 Assistant Principal

**Fillmore Central School
Universal Pre-Kindergarten
Entrance Checklist**

Child's Name: _____

Date of Birth: _____

- _____ Entrance Form
- _____ Emergency Form
- _____ Developmental and Social History Form
- _____ Health Form
- _____ Physical (completed by a physician)
- _____ Home Language Questionnaire/ Identification of Homeless Students Form.
- _____ Immunization Records
- _____ Dental Health Certificate
- _____ Birth Certificate
- _____ Transportation Request (Must be at least four years of age)

Please return all forms and the checklist to:

Sarah Petre
PK-12 Assistant Principal
104 Main Street
Fillmore, NY 14735

Office use:

Date Information Received: _____

Preschool applications must be returned before July 31, 2024

Fillmore Central School Entrance Form

Student Number: _____ Grade: _____ Teacher: _____ Bus Number: _____
Date Registered: _____ First Date Attended: _____ SSN: _____

Student Information

Last Name _____ First Name _____ MI _____ DOB: _____ Sex: M F
_____ school-age _____ preschool age child

Place of Birth _____ Circle: New Student Former Student Year(s) Attended: _____

Ethnicity (Check): Is your child Hispanic/Latino or of "Spanish origin" Yes No
Please select one: _____ American Indian or Alaskan American _____ Asian _____ White/ Other
_____ Black or African American _____ Native Hawaiian or Other Pacific Islander

District Resident Non-Resident Placed by DSS/ Agency Agency Name: _____

Address: _____ Telephone: _____

Emergency Number: _____

How many schools has this child attended? _____ Previous School: _____

My child receives or is eligible for _____ free lunches _____ reduced price lunches. (if known)

My child participates in a half day vocational program. _____ yes (program: _____) _____ no

Custodial Parent/ Guardian Information

Name: _____ Active Duty _____ Relationship: _____

Name: _____ Active Duty _____ Relationship: _____

Mailing Address _____

(If different from above): _____

The child's parents are: _____ Married _____ Single Parent _____ Divorced (Custody Papers: _____ received _____ needed)

The child is in foster care: _____

Non-Custodial Parent/ Guardian Information (The following people should receive information about the child.)

Name: _____ Active Duty _____ Relationship: _____

Name: _____ Active Duty _____ Relationship: _____

Mailing Address: _____ Telephone: _____

Census Information: Other Children in the Family

Pre-School Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

In School Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

Special Placement Approval

I agree to the temporary continuation of the classification and programs in which my child, _____, was placed in his/her previous school prior to transferring to Fillmore Central School. My child's program included:

_____ CSE (Resource Room/ Consultant Teacher/ Special Class) _____ Remedial Reading _____ Remedial Math

_____ Academic Intervention Service (Area: _____) _____ Gifted and Talented Program _____ Speech

Route to: _____ CSE _____ Psychologist _____ 5-12 Office _____ District Office _____ Guidance Office

_____ Mrs. Barber _____ Cafeteria _____ Attendance _____ Bus _____ Remedial _____ Speech

Identification of Homeless Students

This questionnaire is intended to address the McKinney-Vento Act. Your answers will help the administrator determine residency documents necessary for enrollment of this student.

1. Presently, where is the student living? *Check one box:*

Section A	Section B
<input type="checkbox"/> With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "double-up") <input type="checkbox"/> In a shelter <input type="checkbox"/> In a hotel/motel, car, park, bus, train or campsite (please specify) <input type="checkbox"/> With friends or family members (other than parent/guardian) <input type="checkbox"/> Other temporary living situation (Please Describe) <input type="checkbox"/> Independently	<input type="checkbox"/> Choices in Section A do not apply <input type="checkbox"/> In permanent housing <input type="checkbox"/> Other (Please specify)
<p><u>CONTINUE:</u> If you checked a box in Section A, complete #2</p>	

2. The student lives with:

- | | |
|---|--|
| <input type="checkbox"/> 1 parent | <input type="checkbox"/> a relative, friend(s) or other adult(s) |
| <input type="checkbox"/> 2 parents | <input type="checkbox"/> alone with no adults |
| <input type="checkbox"/> 1 parent & another adult | <input type="checkbox"/> an adult that is not the parent or the legal guardian |

Home Language Questionnaire (HLQ) CR 154 A-14

<p><i>Dear Parent or Guardian:</i></p> <p><i>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 English. Your assistance in answering these questions is greatly appreciated.</i></p> <p><i>Thank You</i></p>	TO BE COMPLETED BY SCHOOL PERSONNEL
	District/ School: Fillmore Central School
	Student Name _____ Grade _____
	Date of Birth _____ Student Identification Number _____
	Country of Birth/ Ancestry _____
	Number of Years enrolled in school outside the US _____
	Name/ Position of school personnel completing this section _____
	Determination: <input type="checkbox"/> Possible LEP <input type="checkbox"/> English Proficient

(√ boxes that apply)

1. What language(s) is spoken in the student's home or residence? English Other (specify) _____
2. What language(s) is spoken most of the time to the student, in the home or residence? English Other (specify) _____
3. What language(s) does the student understand? English Other (specify) _____
4. What language(s) does the student speak? English Other (specify) _____
5. What language(s) does the student read? English Other (specify) _____ Does Not Read
6. What language(s) does the student write? English Other (specify) _____ Does Not Write
7. In your opinion, how well does the student understand, speak, read, and write English?

	Very Well	Only a little	Not at all
Understands English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reads English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Parent/ Guardian Signature: _____ Date: _____

FILLMORE CENTRAL SCHOOL

Parent Contact Information

Student Name: _____ Grade _____

Home Address: _____

Mailing Address: _____

Parent/Guardian 1: (resides with student)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Parent/Guardian 2: (resides with student)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Parent/Guardian 1: (DOES NOT reside with student)

Name: _____ Relationship: _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Has Custody: _____ Receives Mailings: _____

Parent/Guardian 2: (DOES NOT reside with student)

Name: _____ Relationship: _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Has Custody: _____ Receives Mailings: _____

In the case of a Custody Agreement - Please Circle the appropriate answers:

Do you have a custody agreement: Yes No

If there is a custody agreement, have you provided a copy of the paperwork/court order to the school: Yes No

Emergency Contact Information (these persons may also pick up your student)

Contact 1:

Name: _____ Relationship _____

Phone: _____

Contact 2:

Name: _____ Relationship _____

Phone: _____

Contact 3:

Name: _____ Relationship _____

Phone: _____

After School Program or Care Provider

Name: _____

Student: _____
Last First Grade Teacher

*****physical Conditions Possibly Needing Special Consideration**

Allergies: _____

Other Conditions: _____

In case of an accident or serious illness, I request the school contact me. If the school in unable to reach me, I hereby authorize the school to call the physician below and to follow his/ her instructions. If it is impossible to contact this physician, the school may make whatever arrangements that seem necessary.

Signature Parent/ Guardian _____ Date _____

Physician Name: _____
Telephone Number: _____
Preferred Hospital: _____

*****Early Dismissal Destination** In the event school closes early, my child will go to the indicated destination.

Name _____ Telephone _____ Relationship _____
Address _____

*****Court Papers** Please indicate whether any type of court paper impacts this student (a copy of the court papers must be on file to be enforced by the school).
Are there any court papers impacting this child? Yes ___ No ___
Please identify the type of court papers: _____

Standing Order for Over-The-Counter Medication Permission Form

I give permission for Fillmore Central School to administer the following OTC medication to my child to assist him/her to complete the school day. I understand this is for emergencies only and if my child needs the following medication on a regular basis I will fill out the OTC Medication Permission form and supply the OTC medication for my child.

- Tylenol/Acetaminophen
- Advil/Ibuprofen
- Hydrocortisone Cream
- Triple Antibiotic Cream
- Chloraseptic Throat Spray
- Tums
- Solarcaine
- Sun Screen

Parent/ Guardian Signature _____ Date _____

Consent to Publish Name/ Picture

Fillmore Central School is proud of and enjoys sharing the accomplishments of students of all ages. At the same time, it is important to respect the rights of parents and guardians to not have information shared or publicized about their child. For this reason, the district is collecting parent and guardian consent to publish students' names and/ or pictures across various media.

As the parent/ guardian of _____, I am providing consent to Fillmore Central School to publish my child's picture, name, audio clips, student teaching videos, video clips and other school work in various media sources, **including the school newsletter, yearbook, website, newspapers, etc.**

_____ Yes _____ No _____
Parent/ Guardian Signature _____ Date _____

Fillmore Central School
Transportation 2025-2026

Every student must have a consistent transportation schedule. The only same day change the school will allow is to remove a child from the bus to be picked up from school. **Any other changes must be given to the greeter at 585-567-2252 with at least 24 hours in advance.** Please complete this form with your child's permanent transportation schedule. Your child must be at least age four to ride the bus.

Student Name: _____ Grade: _____ Home Address: _____

Please check all boxes which apply:

I intend to drop my child off at school each day

I will need my child picked up every day at the address listed below.

I will need my child picked up at different addresses throughout the week. (Please provide the address in the appropriate box below)

Monday	Tuesday	Wednesday	Thursday	Friday

I intend to pick my child up from school each day.

I will need my child dropped off every day to the address listed below. Also, please provide the name of the adult the driver will see at drop off (if grade 4 or under)

Adult: _____

I will need my child dropped off at different addresses throughout the week. (Please provide the address in the appropriate box below and the name of the adult the driver will see at drop off if grade 4 or under.)

Monday	Tuesday	Wednesday	Thursday	Friday

Parent/Guardian Signature _____

_____ Date

Fillmore Central School
Pre Kindergarten
Developmental & Social History Form

CHILD NAME: _____ DOB: _____

Person completing the form: _____

Parents: The questions on this form are intended to provide school staff with information which will help us better understand your child's development, experiences and uniqueness. Please feel free to make additional comments in any area. Thank you.

1

Developmental Milestones: Please indicate the age or range when your child performed the following milestones (or indicated "not yet routine")	
Crawled	
Took first steps independently	
Spoke first words	
Spoke in 2-3 word phrases	
Speaks in full sentences	
Fully potty trained	
Ascends/decends stairs confidently	
Drinks from an open cup	
Feeds self with fork/spoon	
Washes own hands at sink	

2

Circle which hand your child prefers for eating, coloring, etc. Right Left Undecided

3

Home Behavior: (check how often the following settings are challenging for your child)			
Getting ready for bed	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Getting ready to leave the house	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Eating at the dinner table	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Playing alone/independently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Playing with siblings or peers	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When with a babysitter	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When asked to pick up toys	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
In public spaces (store, church etc.)	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
In the car	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
When asked to do something they don't prefer	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently

4

Temperament and Tendencies: Check all traits that apply to your child

- | | |
|---|---|
| <input type="checkbox"/> very quiet/reserved | <input type="checkbox"/> has difficulty separating from parent |
| <input type="checkbox"/> generally happy | <input type="checkbox"/> generally sad |
| <input type="checkbox"/> comfortable with change | <input type="checkbox"/> prefers consistency/routines |
| <input type="checkbox"/> usually follows directions | <input type="checkbox"/> easily frustrated/cries easily |
| <input type="checkbox"/> has frequent tantrums/meltdowns | <input type="checkbox"/> easily distracted/short attention span |
| <input type="checkbox"/> trips or falls easily | <input type="checkbox"/> choosy/picky eater |
| <input type="checkbox"/> enjoys conversations with adults | <input type="checkbox"/> avoids physical activity |
| <input type="checkbox"/> seeks movement/always active | <input type="checkbox"/> aggravated by clothing texture, sticky fingers |
| <input type="checkbox"/> bothered by bright lights | <input type="checkbox"/> startles easily/covers ears for loud noise |
| <input type="checkbox"/> touches everything/loves textures | <input type="checkbox"/> dislikes/fears being alone |
| <input type="checkbox"/> very outgoing/social | <input type="checkbox"/> enjoys sitting with adults to read a book |
| <input type="checkbox"/> affectionate/ loves to cuddle | <input type="checkbox"/> enjoys having their own space |
| <input type="checkbox"/> may wander off | <input type="checkbox"/> plays easily with peers |
| <input type="checkbox"/> prefers older children over peers | <input type="checkbox"/> prefers younger children over peers |
| <input type="checkbox"/> prefers adults over other children | |

5

Has your child had any pre-kindergarten or out-of-home daycare? Please indicate below:

	When/What age	Name and Location of Program
Pre-K/Preschool		
Head Start		
Early Intervention		
Day Care		
Other		

6

Please describe who is living in your home at this time: (check appropriate boxes and add ages for children)

- | | | |
|--|---|-------------|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Brother(s) | Ages: _____ |
| <input type="checkbox"/> Father | <input type="checkbox"/> Sister(s) | _____ |
| <input type="checkbox"/> Step-Mother | <input type="checkbox"/> Step/half brother(s) | _____ |
| <input type="checkbox"/> Step-Father | <input type="checkbox"/> Step/half sister(s) | _____ |
| <input type="checkbox"/> Other Adult(s) | <input type="checkbox"/> Foster Children | _____ |
| <input type="checkbox"/> Other Relative(s) | <input type="checkbox"/> Other Children | _____ |
| <input type="checkbox"/> Pets? Types: | | |

7

If parents have joint custody, please describe who is living in the other home: (check appropriate boxes and add ages for children)

- | | | |
|--|---|-------------|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Brother(s) | Ages: _____ |
| <input type="checkbox"/> Father | <input type="checkbox"/> Sister(s) | _____ |
| <input type="checkbox"/> Step-Mother | <input type="checkbox"/> Step/half brother(s) | _____ |
| <input type="checkbox"/> Step-Father | <input type="checkbox"/> Step/half sister(s) | _____ |
| <input type="checkbox"/> Other Adult(s) | <input type="checkbox"/> Foster Children | _____ |
| <input type="checkbox"/> Other Relative(s) | <input type="checkbox"/> Other Children | _____ |
| <input type="checkbox"/> Pets? Types: | | |

8 Are there other adults besides parents who have a significant part in raising your child? Yes No
 If so, provide name, relationship and what does the child call them.

Name	Relationship	What does your child call them

9 Are there any social/family stressors we should be aware of (recent separations, divorce, custody issues, family illness, recent births or deaths, job changes, recent moves, financial struggles) that may be impacting your child at this time?

10 What are you child's current "favorites?" (activities, toys, characters, playmates)

11 Has your child been evaluated by a specialist?

	When?
<input type="checkbox"/> Speech Pathologist	
<input type="checkbox"/> Physical Therapist	
<input type="checkbox"/> Occupational Therapist	
<input type="checkbox"/> Other:	

12 Do you have any developmental concerns for your child? Yes No

Explain:

Fillmore Central School
Pre-Kindergarten Health Form

CHILD NAME: _____ DOB: _____

Custodial Parents/Guardians: _____

Address: _____ Phone #'s Mom home/cell: _____

_____ Mom work: _____

Dad home/cell: _____

Dad work: _____

Name of person completing this form: _____

1

Did your child have a medically normal pre-natal delivery and newborn history?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain:

2

Has your child experienced any of the following? Check all that apply/ please describe / give details, dates or age of onset, treatment/resolution.	
<input type="checkbox"/> Serious Illness	
<input type="checkbox"/> Seizures/convulsions	
<input type="checkbox"/> Head Injury	
<input type="checkbox"/> Surgery/hospitalization	
<input type="checkbox"/> History of ear infections or tubes	
<input type="checkbox"/> Allergies	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Vision problems/glasses	
<input type="checkbox"/> Hearing problems	
<input type="checkbox"/> Swallowing/chewing difficulties	

3

Is your child currently taking any medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please list medications, dosage and condition it's used for:		

4

Has your child been screened for Lead levels in his/her blood?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, what were the results?		

5 Has your child had dental care? Yes No
 Most recent date seen:

6 **Sleep Patterns:**
 Does your child have difficulty:

Falling/staying asleep	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sleeping alone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nightmares/night terrors	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other sleep difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please describe:

What are your child's normal bed/ wake-up times?

7 Does your child typically nap? If yes, how long?
 Yes: No

8 Please list your child's medical professional and address/phone numbers.

	Name	Address	Phone #
Physician			
Eye Doctor			
Dentist			
Specialist and Specialty			
Specialist and Specialty			

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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input checked="" type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Environmental

Asthma <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input checked="" type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: _____	

Seizures <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input checked="" type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input checked="" type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> 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
CPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre-K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

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

<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	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<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
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name: _____ DOB: _____

SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision—Near Vision	20/	20/		
Vision—Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis <small>Required for boys grade 9</small>	Negative	Positive	Referral	
<small>And girls grades 5 & 7</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> 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
- | | | |
|---|---|---|
| <input type="checkbox"/> Brace*/Orthotic | <input type="checkbox"/> Colostomy Appliance* | <input type="checkbox"/> Hearing Aids |
| <input type="checkbox"/> Insulin Pump/Insulin Sensor* | <input type="checkbox"/> Medical/Prosthetic Device* | <input type="checkbox"/> Pacemaker/Defibrillator* |
| <input type="checkbox"/> Protective Equipment | <input type="checkbox"/> Sport Safety Goggles | <input type="checkbox"/> 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 NYSIS Received Today: Yes No

HEALTH CARE PROVIDER

Medical Provider Signature:	Date:
Provider Name: <i>(please print)</i>	Stamp:
Provider Address:	
Phone:	
Fax:	

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

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 1st, 3rd, 5th, 7th, 9th and 11th grade. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school year, ask your dentist to fill out section 2. Return the completed form to the school nurse as soon as possible. (Fillmore Central School, Health Office, PO Box 177, Fillmore, NY 14735)

Section 1. To be completed by Parent or Guardian (please print)

Child's Name: _____			
Birth Date: / /	Sex: <input type="checkbox"/> Male	Will this be your child's first visit to the dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Month Day Year	<input type="checkbox"/> Female		
School: Fillmore Central School Fax# 585-567-2541		Grade: _____	
Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<p>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.</p> <p>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.</p>			
Parent's Signature _____		Date _____	

Section 2. To be completed by the Dentist

I. The Dental Health Condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

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

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

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

Dentist's name and address (please print or stamp)	Dentist's Signature

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

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

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

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

Yes No **Dental Sealants Present**

Other problems (Specify) _____

III. Treatment Needs (check all that apply)

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

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

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

Community Eligibility Provision (CEP)/Provision 2 non-base year Household Income Eligibility Form

_____ (name/school) is participating in the Community Eligibility Provision (CEP) or Provision 2 in a non-base year. All children in the school will receive meals/milk at no charge regardless of household income or completion of this form. This form is to determine eligibility for additional State and federal program benefits that your child(ren) may qualify for. Read the instructions on the back, complete **only one** form for your household, sign your name and return it to the school named above. Call _____ (school phone number), if you need help.

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	No Income
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

2. SNAP/TANF/FDPIR Benefits: if anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. Then skip to Part 4.

Name: _____ CASE # _____

3. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box. If you have listed a foster child above, you must report their personal income.

Name of household member	Earnings from work before deductions Amount / How Often	Child Support, Alimony Amount / How Often	Pensions, Retirement Payments Amount / How Often	Other Income, Social Security Amount / How Often	No Income
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>

4. Signature: An adult household member must sign this application.

I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school may receive federal funds. The school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Signature: _____

Date: _____

Email Address: _____

Home Phone _____

Work Phone _____

Home Address _____

Total Household Income/How Often: _____

Reduced Eligibility _____

Denied Eligibility _____

Household Size: _____

DO NOT WRITE BELOW THIS LINE FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

SNAP/TANF/Foster Income _____

Free Eligibility Signature of Reviewing Official _____