

ALICE E. GRADY PRIMARY SCHOOL

SCHOOL PACKET

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

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

1. Proof of immunization
2. Physical Exam

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

THE MAIN OFFICE NUMBER FOR ALICE E. GRADY IS
NUMERO DE LA OFICINA PRINCIPAL DEL COLEGIO

(914) 592-8962

**FORMAS PARA EL
COLEGIO DE PRIMARIA DE ALICE E. GRADY**

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

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

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

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

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

Please bring:

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

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

- Physical Examination: Required for all new entrants and for students entering grades:
Pre-K or kindergarten, 2nd, 4th, 7th and 10th
- Physical Examination must be given to school nurse within 30 days of entering school
- Acceptable Use Policy- Must be signed by both parents /guardians of student
- Parents/Guardians are responsible for payment of tuition if the parent's residency is not within the Elmsford Union Free School District. If children move out of district, the parents/guardians are responsible for withdrawing them in accordance with the district policy or for paying tuition. The Elmsford Union Free School District will seek restitution for tuition if it is deemed that the student is not a resident of the district

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

Por favor traiga consigo:

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

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

- Examen físico: Necesario para todos los estudiantes y los que ingresan a:
Pre-K o Kindergarten, 2do, 4to, 7mo y 10avo grado
- El examen Físico se entrega a la enfermera dentro de 30 días de comenzar el colegio
- Póliza de Uso de Tecnología debe ser firmada por ambos padres o tutores
- Los padres son responsables del pago de matrícula si no viven dentro de los límites geográficos de Elmsford Union Free School District. Si el estudiante no reside en el distrito, los padres o tutores son responsables de retirarlo de acuerdo a las pólizas del distrito o pagar la matrícula. El distrito de Elmsford Union Free buscara ser compensado por matrícula si encuentra que el estudiante no reside dentro del distrito de Elmsford

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

E-MAIL REGISTRY

Dear Parent/ Guardian:

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

.....
Estimado Padre/Tutor:

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

STUDENT NAME (S):
NOMBRE DEL ESTUDIANTE (S):

GRADE LEVEL
GRADO

PARENT/GUARDIAN NAME:
PADRE/TUTOR:

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

_____@_____

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

Student Name: _____

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

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

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

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

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____ Date: _____

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

FIELD TRIP RELEASE

Dear Parent or Guardians:

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

I give my son/daughter _____ permission to attend school field trips.

Parent/Guardian Signature _____ Date: _____

PERMISO DE PASEO

Estimados Padres o Tutores:

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

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

Firma del padre/tutor _____ Fecha: _____

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

Dear Parents and Guardians:

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

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

Student's name: _____

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

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

Parent signature _____ Date: _____

Queridos padres y guardianes:

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

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

El nombre del estudiante: _____

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

_____ NO doy permiso para que mi hijo/a sea fotografiado/a, con voz o trabajo(s) creativo(s) en televisión, radio, películas o cualquier otro medio electrónico/digital o impreso.

Firma del padre _____ Fecha: _____

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

PARENT RELEASE OF RECORDS

_____ (Student) has been enrolled in our school.

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

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

Parent/Guardian Signature _____ Date: _____

DIVULGACIÓN DE REGISTROS DE LOS PADRES

_____ (Estudiante) se ha inscrito en nuestra escuela.

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

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

Firma del padre/tutor _____ Fecha: _____

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

Dear Parent/Guardian:

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

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

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

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

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

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

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

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

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

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

Sincerely-Sinceramente,
Sincerely, Principal , Andrea Hamilton

Signature Parent/Guardia (Firma del Padre o Tutor)

Date (Fecha)

Does your child have asthma? YES ___ NO ___

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

If YES, what are they? _____

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

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

Has your child had the following:
Operations YES ___ NO ___ Serious Accident YES ___ NO ___
Fractures YES ___ NO ___ Head Injuries YES ___ NO ___

If YES, give details: _____

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

Please check any of the following conditions that your child might have or have had:
seizures ___ diabetes ___ chicken pox ___
chronic rashes ___ headache ___ cerebral palsy ___
rheumatic fever ___ frequent nosebleeds ___ frequent sore throats ___
scarlet fever ___ tuberculosis ___ pneumonia ___

Other illness (specify) _____

Please check any conditions that immediate family have had:
asthma ___ anemia ___ diabetes ___
hypertension ___ tuberculosis ___ nervous problem ___
convulsion ___ heart attack under the age of 45 ___

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

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

If YES, explain _____

Parent's Signature _____ Date _____

Family Physician _____
Phone Number _____

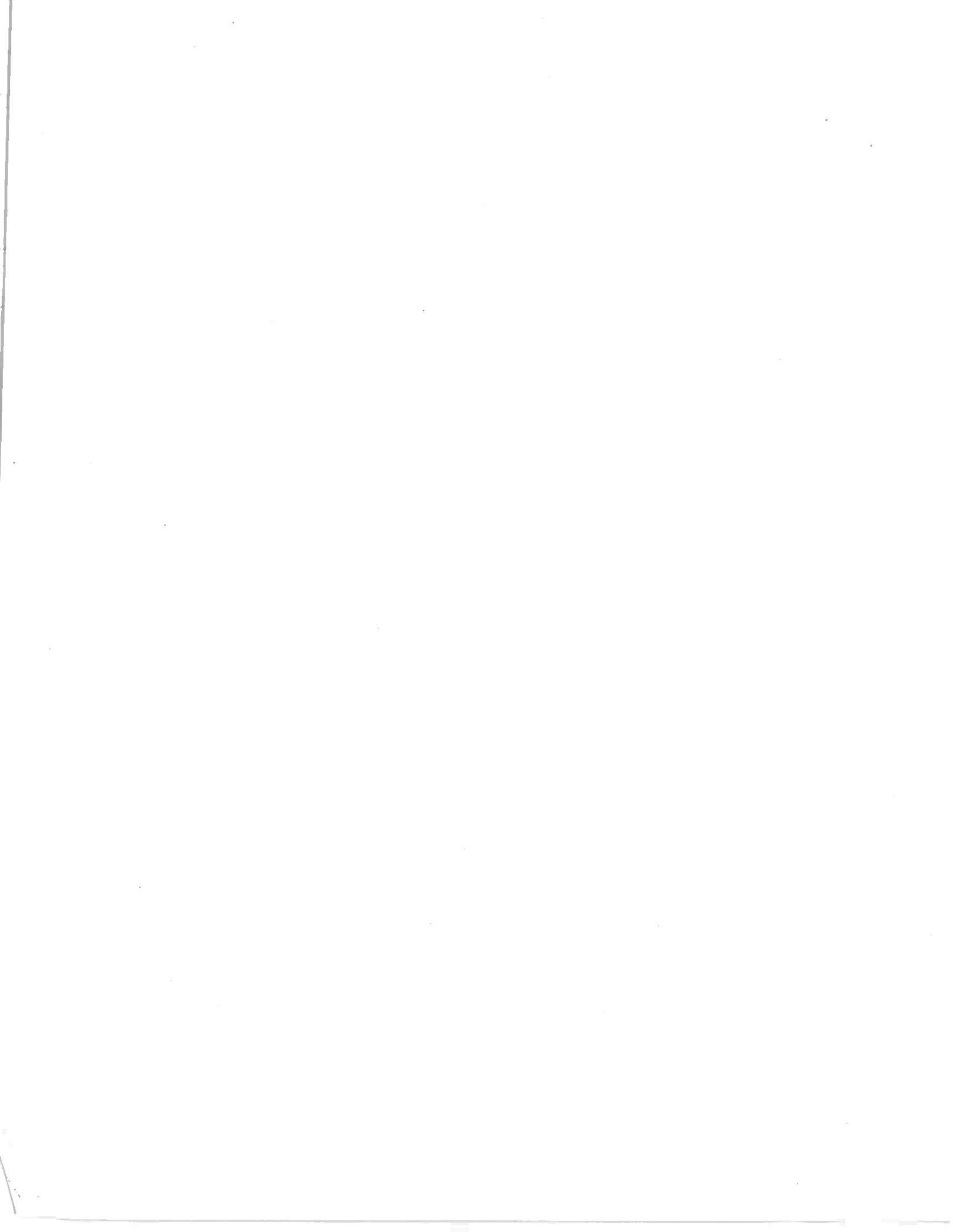
ELMSFORD UNION FREE SCHOOL DISTRICT ILLNESS GUIDELINES

Dear Parents,

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

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

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



MEDICATION POLICY

ELMSFORD PUBLIC SCHOOLS HEALTH SERVICE

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

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

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

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

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



THIS POLICY WILL BE STRICTLY ENFORCED!

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	<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: _____
<input type="checkbox"/> System Review and Exam Entirely Normal				
Check Any Assessment Boxes <u>Outside</u> 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
		_____		_____
		_____		_____
		_____		_____
<input type="checkbox"/> Additional Information Attached				

Name:

DOB:

SCREENINGS

Vision	Right	Left	Referral	Notes
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Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
-----------------	-----	-----	--	--

Distance Acuity With Lenses	20/	20/		
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Vision – Near Vision	20/	20/		
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Vision – Color	<input type="checkbox"/> Pass <input type="checkbox"/> Fail			
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Hearing	Right dB	Left dB	Referral
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No

Scoliosis	Negative	Positive	Referral
Required for boys grade 9 And girls grades 5 & 7	<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 NYSIIS Received 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.

Dental Health Certificate

Elmsford Public Schools

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. 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, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

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

Child's Name: Last First Middle

Birth Date: / / Sex: Male Female Will this be your child's first visit to a dentist? Yes No
Month Day Year

School: Name Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities?
 Yes No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature Date

Section 2. To be completed by the Dentist

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 him/her attendance at the public schools.
- No, The student listed above is not in fit condition of dental health to permit him/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 school, parent 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 1/2 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.

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

Student name _____ Birthdate _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

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

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

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

I waive my right to receive a copy of this notice.

Signature of student over 18 or Parent/Guardian

Date

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

This form complies with all HIPPA regulations.

ARRIVAL AND DISMISSAL FORM

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

Student's Name: _____

Address: _____

Phone Number: _____ Teacher's Name: _____

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

TO SCHOOL

_____ Dropped off at school

_____ By bus from home address: Bus # & Stop _____
(Please circle) EVERYDAY MON TUE WED THU FRI

_____ By bus from other location: Bus # & Stop: _____
(Please circle) EVERYDAY MON TUE WED THU FRI

Include Daycare/Sitter Name: _____

Address: _____

Contact Number: _____

HOME FROM SCHOOL

_____ By bus to home address Bus # & Stop: _____
(Please circle) EVERYDAY MON TUE WED THU FRI

Will be met by _____ Phone #: _____

_____ By bus to another location: Bus # & stop: _____
(Please circle) EVERYDAY MON TUE WED THU FRI

Include Daycare/Sitter Name: _____

Address: _____

Contact Number: _____

PICKED UP AT SCHOOL (Please circle) EVERYDAY MON TUE WED THU FRI

Adults allowed to pick up your child, name, relationship, and phone number.

1. _____

2. _____

3. _____

Parent's signature _____ Date: _____

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

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

Student's Name: _____

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

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

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

Student Signature: _____

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____ Date: _____

Digital Access Survey - Technology Loan Agreement

Email*: _____

Student Last Name*: _____

Student First Name*: _____

Student ID (Available on report cards / transcripts / etc.) Example: 009019998*:

Student Grade*: _____

This section of the form is required by the NYS Education Department.

What device does your student most often use to complete learning activities away from school?

- Desktop Computer
- Laptop Computer
- Tablet
- Chromebook
- Smartphone
- None
- Other:

Is the student's primary learning device shared with anyone else?

- Shared
- Not Shared
- Unknown

Who provided the primary learning device to your student?

- Personal
- School
- Other:

Can your student access the internet in their primary place of residence?

- Yes
- No

If the student is unable to access the internet in their primary place of residence, why not?

- Not available
- Not affordable
- Not Desired

My student has internet access

- Yes
- No

What is the primary type of internet service used in your student's primary place of residence?

- Residential Broadband
- Cellular Network
- Hot Spot
- Community Provided Wi-Fi
- Satellite
- Dial-Up
- Other
- None
- Unknown

Can your student complete learning activities such as streaming a video and uploading assignments without interruptions caused by poor internet performance?

- Yes
- Sometimes
- No

Parent Full Name: _____

Parent Address: _____

Parent Email: _____

Parent Home Phone: _____

Parent Cell Phone: _____

This form must be completed by a student's parent / guardian prior to the loan of a District-owned device such as a Chromebook.

I understand that as the Parent/Guardian, I will be responsible for any cost related to repair or replacement of the borrowed DEVICE and any provided accessories, including protective case and charger. (Details below)

I agree

I understand that I am responsible for the replacement value if the DEVICE is stolen or lost.*

I agree

I understand I am responsible for the repair costs of the DEVICE if damaged during this borrowing period.*

I agree

I understand the DEVICE remains the property of the Elmsford UFSD and can be recalled at any time for any reason.*

I agree

I will not loan the DEVICE to, or allow its use by, others.*

I agree

I will immediately notify the District if the DEVICE is lost, stolen or damaged.*

I agree

I will ensure the DEVICE is used for educational purposes only.*

I agree

I will not modify the DEVICE in any way. This includes repair, maintenance, installing or deleting software or applications.*

I agree

I will obey all Copyright Laws.*

I agree

I understand that all files stored on the DEVICE or the network are property of the district and may be subject to review and monitoring*

I agree

I will notify a staff member immediately if I come across information, images, or messages that are inappropriate, dangerous, threatening, or make me feel uncomfortable.*

I agree

I will not use the DEVICE in any way that violates any local, state or federal laws.*

I agree

I will not use the DEVICE to access any inappropriate websites or materials, including, but not limited to pornographic, obscene, or vulgar content.*

I agree

I will return DEVICE when the Districts requests.*

I agree

I will return the DEVICE in the same condition issued, normal wear and tear excepted.*

I agree

I understand that violation of the above policies will result in immediate termination of the loan.*

I agree

I understand and agree to the replacement costs for Chromebooks and Chromebook related items as follows: Chromebook/iPad (\$350) // Protective Case (\$20) // Charger (\$30)*

I agree

As the Parent/Guardian please sign your full name in the space below to indicate that you explicitly agree to the terms of this loan agreement as stated in the previous sections.

Signature: _____ Date: _____