Universal Pre-Kindergarten Required Form Check List

Name: ______________________________

Date: ______________________________

Registration Form 108	________
Social History Form	________
Health Registration Form	________
Home Language Questionnaire	________
Immunization Record	________
Student Physical Examination Record	________
Dental Health Certificate	Optional
Lead Screening Results	________
Copy of Birth Certificate	________
Copy of Proof of Residency	________
Custody Papers or Affidavit (if applicable)	
Auth. For Release of Confidential Info.	________

Glens Falls City School District
Curriculum Office
15 Quade Street
Glens Falls, New York 12801
Telephone: 518-792-0107/ Email: sdonlon@gfsd.org
Attn: Sara Donlon

Universal Pre-Kindergarten Registration Form

Form 108: Rev: 10/2012

GLENS FALLS CITY SCHOOL DISTRICT

Glens Falls, New York 12801

Student's Name ______________________ ______________ _________ Sex: M / F
Last First Middle Initial

Date of Birth ___________ Place of Birth (City, State, Country) ______________________

Date of 1st POLIO vaccination ______________________

Directions to Parent/Guardian
Please answer questions (1) and (2). Please read them before you respond. For question (1) check (√) the box that best describes your child. Check (√) only ONE box.

1. **Is the student Hispanic, Latino, or of Spanish origin?** Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.
   - □ YES, Hispanic
   - □ NO, Not Hispanic
2. **Select one or more races from the following five racial groups.** Check (√) all groups that apply to your child. Check (√) at least one box.
   - □ **American Indian or Alaska Native**: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
   - □ **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
   - □ **Native Hawaiian or other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
   - □ **Black or African American:** A person having origins in any of the Black racial groups of Africa.
   - □ **White:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Homeless: Yes □ No □ Do you live in a shelter? Yes □ No □

Do you live with relatives/other due to lack of shelter? Yes □ No □

Are you housed in a shelter awaiting an OCFS permanent foster care placement? Yes □ No □

Attach Proof of Residency □ Lease Agreement □ Phone Bill □ Utility or TV Bill □ Closing Papers
(must be dated within 30 days) □ New Drivers License □ Notarized Landlord Affidavit □ Mortgage Statement

Student's address: ______________________________________

Phone Number: ______________________ Is this a listed number? Yes □ No □

Last School attended, Pre-School or Nursery School (include address) ______________________

____

Father's Name: ______________________ **Email:** ______________________

Address: ______________________________________

Does the father reside with student? Yes / No Home phone: ______________ Cell: ____________

Father's place of employment: ______________________ Work # ____________

Mother's Name: ______________________________ **Email:** ______________________

Address: ____

Does the mother reside with student? Yes / No Home phone: ______________ Cell: ______________

Mother's place of employment: ______________________________ Work # ______________

Other Adult with Family: ____

What is this person's relationship to child? ______________________ Cell: ______________

Place of employment: ______________________________________ Work # ______________

Emergency Name: ____

Address: ____

Home phone: ________________ Cell: __________________ Work: ______________

If parents are not available in an emergency, call: (this person should be in the local area)

Relationship to Child: ____

Guardian / Legal Documents? Yes / No *Please describe*

____

Is there anyone to whom the student cannot be released due to court order/order of protection?

Yes / No If yes, please provide a copy of the order(s)

OTHER INFORMATION: (Has your child ever received)

Special Education _____ Physical Therapy _____ Occupational Therapy _____

English as a Second Language _____ Speech _____

What language did the child learn when he/she first began to talk? English _____ Other ______________ (specify)

Are any other languages spoken in the home on a regular basis? If so, specify:

____

Completion of this form does not constitute placement in the program. Students will be selected via a lottery system. All applicants will be contacted to inform you of admission to the program.

______________________________ ______________

Signature of Parent/Guardian Date

Email address: ______________________________

Number to call first in case of emergency: ______________________

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

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

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

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

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section:		
STUDENT NAME:		
First	*Middle*	*Last*
DATE OF BIRTH:		GENDER: ☐ Male ☐ Female
Month	*Day*	*Year*
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to Student*

HOME LANGUAGE CODE ______

Language Background
(Please check all that apply.)

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

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED	
SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School *Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

Yes* ☐ ***No*** ☐ ***Not sure*** ☐ *If yes, please explain:________________________________

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

10a. Has your child ever been *referred* for a special education evaluation in the past? ☐ No ☐ Yes* **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
☐ No ☐ Yes – Type of services received:________________________________

Age at which services received *(Please check all that apply):*
☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ☐ No ☐ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

____

____

12. In what language(s) would you like to receive information from the school? ________________________________

________________________________ Month: Day: Year:

Signature of Parent or of Person in Parental Relation — ***Date***

Relationship to student: ☐ Mother ☐ Father ☐ Other:________________

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: ________________ **POSITION:** ________________

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

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

NAME: ________________ **POSITION:** ________________

ORAL INTERVIEW NECESSARY: ☐ NO ☐ YES

**DATE OF INDIVIDUAL INTERVIEW: ________ MO DAY YR.	OUTCOME OF INDIVIDUAL INTERVIEW: ☐ ADMINISTER NYSITELL ☐ ENGLISH PROFICIENT ☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: ________________ **POSITION:** ________________

DATE OF NYSITELL ADMINISTRATION: ________ MO. DAY YR.	PROFICIENCY LEVEL ACHIEVED ON NYSITELL:	☐ ENTERING	☐ EMERGING	☐ TRANSITIONING	☐ EXPANDING	☐ COMMANDING

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

SOCIAL HISTORY FORM

Child's Name:______________________________ Age:_______ DOB: ___/___/___

Child's Preferred Name:___________________________Gender ___Male___Female

Ethnicity/Race:_____________________ Language(s) Spoken:________________

School Attending:_______________________ Child's Current Grade in School:_____

Current Address:

Street:_____________________ City/State:______________ Zip:__________

Please list the names, gender, ages, and level of education (i.e. high school, college, etc.) of all family members currently residing in your household and their relationship to your child (feel free to use the back.)

Name	Gender	Age	Relationship to Child	Level of Education	Living with Child
					__Y __N
					__Y __N
					__Y __N
					__Y __N
					__Y __N
					__Y __N

Please list any other information that would be important for us to know about your family:

____

ADOPTION

Is your child adopted? ___Yes ___No If yes, at what age was your child adopted?______________

______Domestic ______International (Country:____________________)

Does your child know he/she is adopted? ____Yes ____No If yes, what does your child know about his/her adoption? ____

Does your child have any contact with his/her birth parent(s)? ___Yes ___No

If yes, please describe the nature and extent of the contact:____________________________
____

Have any of the following changes occurred in your child's life? (please check all that apply)

__Parental separation/divorce __Remarriage/new partners __Parent incarcerated

__Death/ loss of a family member __Loss of/ new job for parent __Birth/Adoption

__Serious illness (child/family member) __Traumatic experience __Accident

__Exposure to **and/or** experience abuse **and/or** neglect (please specify the type(s) of abuse):

__Sexual abuse, neglect __Physical abuse, neglect __Emotional abuse, neglect

Please describe the nature of the change and how it has impacted your child's development and/or behavior:

____

____

COMMUNITY SUPPORTS

Is your child currently receiving counseling or psychiatric services? ___Yes ___No If yes, please list:

Name of provider:______________________________ Phone #:__________________________

Do you have any concerns about your child's safety? ___Yes ___No If yes, please explain:__________

____

Please describe any other concerns you may have about your child's psychological health and well being that would be important for us to know:

____

____

Does your child attend school on a daily basis? ___Yes ___No If no, please describe your child's current attendance (i.e. modified day, suspended, expelled, dropped out, GED program, etc.)

____

On average, how many **days per month** is our child absent from school?______________________

For what reason(s)?____

In general, what is your child's attitude toward going to school and receiving an education?

____

Has there been a change in your child's attitude toward attending school? ___Yes ___No
If yes, please describe when and what change(s) you observed:_____________________________

____

Has your child ever repeated a grade: ___Yes ___No If yes, what grade(s)________________________________

Is your child involved in any extracurricular activities at school or in the community? ___Yes ___No

If yes, what activities____

____

Does your child have a history of disciplinary or behavioral issues at school? ___Yes ___No

If yes, please describe the behaviors and what steps have been taken to address these behaviors:

____

____

Has there been involvement with outside law enforcement or probation for school-related problems (i.e. PINS)? ___Yes ___No If yes, please explain:____

____

Does your child have any of the following?

Individualized education plan (IEP) or a 504 plan? ___Yes ___No

Is there any other information that would be important for us to know to meet the educational and personal needs of your child?

____

____

____

Name of person completing this form:____

Relationship to child:_______________________________ **Date:**____________________

Registration Requirements:

*Only children who are at least 5 years old as of December 1st of the year of enrollment, under 21 and do not possess a high school diploma may enroll. In addition, children seeking to enroll must be residents of the district.

**UPK students must be 4 years old as of December 1st of the year of enrollment.

- **Proof of residence** which includes the name and address of the parent(s) or guardian(s) and is dated within 30 days (recent date).
- **Proof of Age** - Original documentation of birth, in the form of an original, state-issued birth certificate, baptismal certificate or passport
- **Immunization Record** signed by a physician or clinic staff
- **Custody Papers or signed and notarized Affidavit** if applicable.

Authorization for Release of Confidential Information

I hereby consent to and authorize Glens Falls City School District to obtain from and/or release to:

____

Name of Child's Pediatrician

____

Address/City/State/Telephone/Fax

The following information pertaining to:

____

Child's Name

____

Child's DOB

<u>The information to be disclosed is:</u>

-Educational Evaluations/Reports
-Medical Evaluations/Reports
-Psychological Evaluations/Reports
-Medical history and physical examination
-Diagnosis, brief description of progress and prognosis
-Immunization Records

<u>This information is needed for the following purposes:</u>

-To provide ongoing treatment/continuing care
-To coordinate treatment efforts with parent/guardian
-To coordinate educational planning
-To coordinate services with authorized school officials and/or community service providers

I understand that I have the right to revoke this authorization at any time by submitting a request in writing. The revocation will not apply to information that has already been released in response to this authorization. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one-time release or a periodic release of information. I understand that disclosure of this information is voluntary. I understand that I have a right to receive a copy of this authorization. The duration of this authorization is for no longer than one (1) year unless I specify a date, event or condition upon which it will expire sooner. Rerelease of this information without written consent is prohibited.

____

Parent/Guardian Signature

____

Date

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name		Date of Birth	Phone Number	
Street Address	**City**		**State**	**Zip Code**

A) I hereby authorize records FROM:

Name: Hudson Headwaters Health Network

Address: 9 Carey Rd

City/State/Zip: Queensbury, NY 12804

Phone: (518) 761-0300 Fax: (518) 745-1378

B) To be released TO:

Name: ____________________

Address: ____________________

City/State/Zip: ____________________

Phone: ____________ Fax: ____________

C) Information disclosed: *(please select one)*

☒ Medical information ☐ Dental information

☐ Entire record set

☐ Date range: ____________ to ____________

☒ Other: School Notes and Physical Forms

D) Special Considerations:

To include the following information, please initial below. If not initialed, this information will not be disclosed.

______ Alcohol/Drug treatment

______ HIV/AIDS-related information

______ Mental health treatment

E) Purpose of requested information: *(please select one)*

☒ At the request of the individual ☐ Transfer of care *(select reason)*

☐ Legal purposes ☐ Patient experience ☐ Other: ____________

☐ Coordination of care ☐ Patient relocation

F) Delivery method: *(please select one)*

☐ US mail (Paper) ☐ US mail (CD) ☐ Pick up at: ____________

☐ Encrypted email: ____________ ☒ Fax to: ____________

G) Authorization Expiration: Unless previously revoked by me in writing, this authorization will expire on the following date or event: ____________ *Please note If left blank, this authorization will expire upon the completion of the release of information outlined in this document.

H) If not the patient, name of person signing authorization:	I) Authority to sign on behalf of patient:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:
This authorization may include disclosure of information relating to **ALCOHOL/DRUG TREATMENT, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and HIV **RELATED INFORMATION** only if I place my initials on the appropriate line in the Special Considerations section. In the event the health information described above includes any of these types of information, and I initial the line in the Special Considerations, I specifically authorize release of such information to the person(s) indicated in Item B.

If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this authorization might be redisclosed by the recipient (except for the Special Considerations as noted above), and this redisclosure may no longer be protected by federal or state law.

HHHN reserves the right to charge the 'medical record stated fee structure' as set forth in the NYS Article 18 Public Health Law. By signing this authorization, I agree to pay HHHN for my records if applicable.

______________________ ______________________ ______________________

Signature of Patient or Representative Authorized by Law   Print Name   Date

Glens Falls City School District

Glens Falls, NY 12801

HEALTH REGISTRATION FORM

Student's Name:______________________________ DOB:________________

If you check yes to any of the following, please provide details below. Include date(s), treatment prescribed, physician's name, and current status of problem.

	YES	NO		YES	NO
ADD/ADHD	___	___	Head Injury/Concussion	___	___
Bee Sting Allergy	___	___	Heart Problem/Murmur	___	___
Asthma	___	___	Fractures/Dislocations	___	___
Arthritis	___	___	Orthodontic Appliance	___	___
Ear Tubes	___	___	Surgery	___	___
Bladder/Kidney Issues	___	___	Migraines	___	___
Convulsions/Seizures	___	___	Glasses/Contacts	___	___
Diabetes/Hypoglycemia	___	___	Other______________________		

____

____

____

____

____

Family Physician or Pediatrician:____

1. Medical information details (Included significant birth history, disabilities, speech difficulties, etc.):____

____

Is your child presently taking medication?_____Yes ____No

If yes: what medication (s) and for what reason (s)?______________________________

____

Is the medication administered during the school day? _____Yes _____No

2. Does your child have allergies?

FOOD:____

MEDICATION:____

ENVIRONMENTAL:____

3. Has your child been evaluated for or received any of the following services: Speech, OT, PT, Counseling? If so, please explain:

____

4. Has your child ever seen a dentist? ____Yes ____No

If so, for what reason: ____

5. Should your child be restricted from participating in school gym or sports? ____Yes ____No

If yes, please provide written recommendations from your child's physician.

6. Additional Comments: ____

____

____

Date:____________ **Parent/Guardian Signature** ______________________________

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors:Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI________kg/m2

Percentile (Weight Status Category): ☐ < 5th ☐ 5th- 49th ☐ 50th- 84th ☐ 85th- 94th ☐ 95th- 98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB-PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 μg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision	**With Correction** ☐ Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/		☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

	Negative	**Positive**	**Referral**	**Not Done**
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed** – required for Dominic Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

<u>If Restrictions Apply</u> – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

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

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

Glens Falls City School District: Dental Health Certificate- Optional

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: / / Month Day Year

Sex: € Male € Female

Will this be your child's first visit to a dentist? € Yes € No

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 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.

Proof of Residency Requirements:

Proof of residence which includes the name and address of the parent(s) or guardian(s) and is dated within 30 days (recent date). Examples of proof of address include the following:

Driver's License: with current physical address of residence, will also require 1 additional document. (see list below)

And/Or (One of the following):

- **Utility Bill** (Gas, Electric, Water, Waste, Cable, Wi-Fi, Landline (non-cell))
- **STAR Exemption**
- **Lease Agreement**
- **Mortgage Statement**
- **Assistance Letter**

Items NOT Accepted:

- Bank account statements
- Rent receipts
- General Mail
- Tax bill
- Payroll checks
- Insurance cards

Glens Falls City School District
District Office ~ 15 Quade Street ~ Glens Falls, New York 12801~ (518) 792-1212 ~ Fax: (518) 792-1538

Dr. Krislynn Dengler
Superintendent

Anthony Cammarata
Assistant Superintendent for Business

Amanda Simmes
Assistant Superintendent for Curriculum & Instruction

AFFIDAVIT - DESIGNATING GLENS FALLS AS DISTRICT OF RESIDENCE

Student: First Name: ______________________ Last Name: ______________________

Date of Birth: ____/____/_____ ☐Male ☐Female Grade: _______

Birth Mother: First Name: ______________________ Last Name: ______________________

Address: ______________________ Cell Phone: ______________

Birth Father: First Name: ______________________ Last Name: ______________________

Address: ______________________ Cell Phone: ______________

______________________(Mother) and ______________________(Father) being duly sworn, depose and say:

1. We are the biological parents/guardians of ______________________ (Student's Name)

2. We state as follows: (choose either A or B)

   A. ____Pursuant to the attached signed **court document**, custody of ______________________ (Student's Name) is as follows:

   Joint Legal Custody to: ______________________

   Primary Physical Custody to: ______________________

   B. ____There are no custody court documents.

3. We agree to designate _____Mother's ______Father's (check one) residence located at ______________________ within the Glens Falls City School District, as ______________________ (Student's Name) residence for purposes of school attendance.

This affidavit is made for the purpose of requesting the Glens Falls City School District to admit ______________________(Student's Name) as a resident student on a tuition-free basis. We agree to notify the Glens Falls City School District in writing if at any time during the above child's attendance there is any change in the facts set forth above. We understand that signing this statement is a representation that the information provided is correct and true and made under penalty of perjury.

Birth Mother's Signature: ______________________

Sworn to before me this ____ day of ______________, 202_

____
Notary Public

Birth Father's Signature:______________________

Sworn to before me this ______ day of ______________,202_

____
Notary Public