

2026-2027 Rush-Henrietta UPK Registration Checklist – Parents

Please bring the following to your registration intake appointment.

Please complete:

- _____ 1. Pupil Registration Form
- _____ 2. UPK Developmental History Guide
- _____ 3. Custody Disclosure Form (provide copy of agreement, if applicable)
- _____ 4. Confidential Information Form (Blue Card)
- _____ 5. Student Racial and Ethnic Identification Form
- _____ 6. NYSED Emergent Multilingual Learners Language Profile for Prekindergarten Students
- _____ 7. Supplemental Information Form
- _____ 8. RHCS D Authorization for Use or Disclosure of Protected Health Information (HIPAA Compliant) *(Preferred; Not Required)*
- _____ 9. UPK Parent Contract
- _____ 10. Parent Report – Self-Help and Social-Emotional Scales
- _____ 11. Consent Form for The Children’s Institute
- _____ 12. Student Health History Form *(Winslow & Fyle)*
- _____ 13. UPK 2026-2027 Student Pick-Up Form *(Winslow & Fyle)*

Please provide copies:

- _____ 14. NYS School Health Examination Form* *(No Other Physical Form Accepted)*
- _____ 15. Immunizations
- _____ 16. NYS Dental Certificate - Optional* *(Preferred; Not Required)*
- _____ 17. Birth Certificate
- _____ 18. Proof of Residency (Please provide one of the following documents.)
 - Property Tax Document, Mortgage, or Deed
 - Lease Agreement (Signed)
 - Notarized Shared Housing Agreement

Please contact the UPK Office by phone at 585-359-7913 or 585-359-7814 or by email at dwood@rhnet.org or kklubek@rhnet.org if you have any questions.

Thank you and welcome to UPK!

* Sample Form Included in Packet

Student #	Proof of residency	Birth Record Y or N	Date Reg mm/dd/yy / /	Time	Custody Doc	Immunizations	First Polio (m/d/y)	Imm checked by	Yr ent Gr 9
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Rush-Henrietta Central School District ~ Pupil Registration Form

Student Information (Use Legal Name) Please print clearly in black ink.

Last name	First name	Middle name	Gender	Telephone #
Birth Date	Birth City/State/Country	Name and Address of the last school attended/last grade completed		

Has the student ever lived in the Rush-Henrietta school district? (even if school was never attended)	Lived in RH (y or n) Y or N	School attended	Last date in district
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Home Address Information

Street Address	Apt.	City	State	Zip
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Mailing Address (only if different from home address)

PO Box	City	State	Zip
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These questions are intended to address the McKinney-Vento Act 42 U.S.C. 11435.

The answers to this residency information help to determine the services the student may be eligible to receive.

Do you believe that you are living in Permanent Housing? Yes No If you answered NO, where is the student presently living? (Check one box)

In a shelter In a hotel/motel (Days Inn) In a car, park, bus, train, or campsite Other temporary living situation

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

Is this temporary living arrangement due to loss of housing or economic hardship? (for example, eviction or foreclosure) Yes No

Please explain: _____

NOTE: If the student is **not** living in permanent housing, **proof of residency** and other documents normally needed for enrollment **are not required**.

Family Information

Legal Parent(s) Guardian(s):

Siblings

	Legal Parent/Guardian 1		Legal Parent/Guardian 2	
Full Name				
Title(Mr/Mrs)				
Relationship				
Has Custody	Yes	No	Yes	No
Lives w/student	Yes	No	Yes	No
Receives Mailings	Yes	No	Yes	No
Mailing Address				
City,State,Zip				
Home Phone				
Employer				
Work Phone				
Needs Interpreter				
Email				

List student's siblings to age 18, living at same address as student.		
Name	Gender	Birth Date
School Entering	Grade Entering	
Name	Gender	Birth Date
School Entering	Grade Entering	
Name	Gender	Birth Date
School Entering	Grade Entering	
Name	Gender	Birth Date
School Entering	Grade Entering	

Signature: _____

Legal Parent/Guardian or Student (for unaccompanied homeless youth)



By signing your name electronically, you are agreeing that your electronic signature is the legal equivalent of your manual signature on this form.

Date _____

Date Rec'ds Req	Date Rec'ds Rec	Home School	Placement School	Entry Grade	Entry Date mm/dd/yy	Room/Team	Bus In	Bus Out
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UPK Developmental History Guide

2026-2027

Parent/Guardian: _____ Date: _____

Child's Name: Last _____ First _____

List languages other than English spoken in the home: _____

List any preschool, daycare or nursery school attended: _____

What was the experience like?

What are you and your child looking forward to in UPK?

Developmental History:

1. Please describe any unusual problems or difficulties as an infant/toddler.
2. List the approximate ages of the following milestones:
Walking: _____ Speaking: _____ Independent in the bathroom: _____
3. Please describe any frequent illness or medical problems experienced by your child.
4. List allergies that your child has.
5. Has your child ever been hospitalized/had an operation? If so, for what?

6. Has your child ever had a serious injury or head injury? If so, what and when?
7. Does your child (please check if appropriate)
- wear glasses?
 - have difficulty hearing?
 - have speech difficulties?
 - problems with eating?
 - problems with sleeping?
 - difficulty with gross motor activities (running and jumping)?
 - difficulty with fine motor activities (cutting, coloring, drawing, fastening, buttoning)?
8. Does your child currently have an Individualized Education Program (IEP)? If so, what services does your child receive?
- speech Occupational therapy Physical therapy
 - special education itinerant teacher (SEIT)
 - my child has been recommended for a special class placement
9. Are there concerns regarding your child's peer relationships? If so, explain:
10. Briefly describe your child's personality (likes, dislikes, fears, good qualities, reactions when frustrated, etc.)
11. What kind of interest does your child display in reading, writing and numbers?
12. What have you found effective in managing your child's behavior and setting limits?

13. How does your child react to these kinds of situations?

Please mark the appropriate boxes:

	Never	Sometimes	Often	Always
Follows rules				
Handles disappointment				
Gets along with others				
Tries new things				
Controls temper				
Accepts the word "no"				
Asks Questions				
Remains attentive				

Thank you for taking the time to share this valuable information.

Parent/Guardian signature: _____

Central Registration
Phone: (585) 359-7957
Fax: (585) 359-7959
www.rhnet.org



Rush-Henrietta Central School District
Webster Learning Center
2000 Lehigh Station Road
Henrietta, NY 14467

Custody Disclosure Form

The Central Registration Office is responsible for registration, **not** responsible for determining custody. If custodial or guardianship issues exist when you register your child in the Rush-Henrietta Central School District, it is your responsibility to provide custodial documentation to the Central Registration Office and a copy will be forwarded to your child's school principal. **NOTE:** A copy of the current court order as to custody is required to ensure compliance.

Information on Rights of parents from the Family Education Rights and Privacy Act (FERPA) An educational agency or institution shall give **full rights** under the Act of both parents, unless the agency or institution has been provided with evidence that there is a court order, state statute, or legally binding document relating to such matters as divorce, separation or custody that **specifically revokes these rights.**

(Authority: 20 U.S.C. 1232g)

Please check all that apply:

- Both parents are residing at the same residence
- Single parent (father and mother **are** listed on the birth certificate)
- Single parent (father is **not listed** on the birth certificate)
- Parent/guardians divorced/separated
- Parents have never been married and have no legal custody papers
- Parent is remarried with a step-parent in the house
- Custody/Guardianship was granted by the courts (date _____, copy attached)
- Custody/Guardianship proved by affidavit (date _____, copy attached)
- Restricted pickup (legal documentation must be provided)** _____
- Foster Care arrangement
- Parent deceased
- Student is emancipated (legal documentation must be provided)

Child's primary residence is with _____

I understand as guardian that it is my responsibility to update my child's school principal of changes in custody.

Student Name (please print): _____

Signature of Parent/Guardian _____ Date _____

By signing your name electronically, you are agreeing that your electronic signature is the legal equivalent of your manual signature on this form.

Rush-Henrietta Central School District

Confidential Information

Student Information						
Student #	Last Name	First Name	Telephone #	Teacher	Grade	
Address			City	State	Zip	
Birthdate	Gender	Student's Physician		Physician's Phone #		
Contact Information						
The student's Custodial Parents/Guardians are listed below and will be contacted in case of emergency (Call Order: Evaluate all phone numbers and indicate the order in which you want them called, starting with #1.)						
Title	Contact Name	Relationship	Allowed to Pick Up	Preferred Language for Communication	Phone Information	
					Call Order	Phone Number
E-mail:						Home
						Cell
						Work
						Other
					Call Order	Phone Number
E-mail:						Home
						Cell
						Work
						Other
The following people may also be contacted in case of an emergency involving this student:						
Title	Contact Name	Relationship	Allowed to Pick Up	Preferred Language for Communication	Phone Information	
					Call Order	Phone Number
						Home
						Cell
						Work
						Other
					Call Order	Phone Number
						Home
						Cell
						Work
						Other

Family Information

Please list siblings below:

Name	Birthdate	Building	Grade

If I can not be reached the persons named above are authorized to assume responsibility in the event of a serious illness or injury. This responsibility includes signing out/removing the student from school should the need arise. I give the school nurse, teacher, or designee permission to exchange pertinent medical information with my child's physician and emergency medical personnel.

By signing your name electronically, you are agreeing that your electronic signature is the legal equivalent of your manual signature on this form.

Parent/Guardian Signature

Date



Student Racial and Ethnic Identification

To the Parent/Guardian:

School districts are required to follow Federal standards for collecting and reporting race and ethnicity of students. This information will be used to:

- Report information to the New York State and Federal education departments.
- Plan educational programs and make sure that they are readily available to all students.
- Analyze differences in academic performance, attendance, and completion of school.

We need your help in order to accomplish this task. Please review the racial/ethnic definitions on the back of this page. Put a check (✓) in the box for the category or categories which best describes your child. The Rush-Henrietta Central School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all New York State and Federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging.

Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff: This form will be filed in the student's permanent record as confidential information.

To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

Please complete the form on the reverse side of this page.



Rush-Henrietta Central School District

Student Racial and Ethnic Identification

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Student ID Number Student Name (Last, First, Middle)

Name of School Date of Birth (mm/dd/yyyy) Grade Level

DIRECTIONS TO THE PARENT/GUARDIAN: PLEASE ANSWER QUESTIONS (1) AND (2) BELOW. PLEASE READ BOTH QUESTIONS BEFORE YOU RESPOND.

QUESTION 1

For Question 1, check (✓) the box that best describes your child.

Check (✓) only ONE box.

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

QUESTION 2

Select one or more races from the following five racial groups.

For Question 2, 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 attachments.

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 peoples of Europe, North Africa, or the Middle East.

Signature of Parent/Guardian/Other

Date

By signing your name electronically, you are agreeing that your electronic signature is the legal equivalent of your manual signature on this form.

Relationship to Student (please check one box below):

Mother Father Guardian Other (Specify): _____

See reverse side for important message to Parents/Guardians and Confidentiality Procedures and Regulations.



**NEW YORK STATE EDUCATION DEPARTMENT
Emergent Multilingual Learners Language Profile for
Prekindergarten Students¹**

*Dear Parent or Guardian,
Thank you for completing the Emergent Multilingual Learners Language Profile. This survey will assist your new school with valuable information about your child's experience with languages. Information gathered will assist Prekindergarten educators in delivering academically and linguistically relevant instruction that strengthens the language and literacy of all students.*

THIS SECTION TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY AND MAINTAINED ON FILE
Date Profile Completed:
Student Name:
Gender:
Date of Birth:
District or Community Based Organization Name:
Student ID (if applicable):
Name of Person Administering Profile:
Title:

Parent or Person in Parental Relation Information

Name of parent or person in parental relation:

Relationship (to student) of person providing information for this profile:

mother father other: _____

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

English other home language: _____

Language in the Home

1. In what language(s) do you (parents or guardians) speak to your child at home?

2. What is/are the primary language(s) of each parent/guardian in your home? (List all that apply.)

3. Is there a caretaker in the home? yes no

If yes, what language(s) does the caretaker speak most frequently?

4. What language(s) does your child understand?

5. In what language(s) does your child speak with other people?

6. Does your child have siblings? yes no

If yes, in what language(s) do the children speak with each other most of the time?

7a. At what age did your child begin to speak in short sentences?

In what language?

7b. At what age did your child begin to speak in full sentences?

In what language?

8. In what language does your child pretend play?

9. How has your child learned English so far (television shows, siblings, childcare, etc.)?

Language Outside the Home/Family

10. Has your child attended any nursery, Head Start or childcare program? yes no

If yes, in what language was the program conducted?

In what language does your child interact with other people in the nursery or childcare setting?

11. How would you describe your child's language use with friends?

Language Goals

12. What are your language goals for your child? For example, do you want child to become proficient in more than one language?

13. Have you exposed your child to more than one language to ensure that he or she is bilingual or multilingual?
 yes no

14. Does your child need to speak a language other than English in order to communicate with your relatives or extended family?
 yes no

If yes, in what language(s)?

Emergent Literacy

15. Does your child have books at home or does he or she read books from the library?

In what language(s) are these books read to him or her?

16a. Can your child name any letters or sounds in English? yes no

16b. Can your child recognize letters or symbols in another language? yes no

If yes, in what language(s)?

17a. Does your child pretend to read? yes no unsure

If yes, in what language(s)?

17b. Does your child pretend to write? yes no unsure

If yes, in what language(s)?

18. Does your child tell the stories from his/her favorite books or videos? yes no

If yes, in what language(s)?

19. Does your child's childcare or nursery program describe goals for his or her learning? yes no

If so, what goals do they describe?

20. Please describe anything special you did to prepare your child to begin Prekindergarten.

ⁱ For more information contact: the New York State Education Department Office of Early Learning at (518) 474-5807 or email OEL@nysed.gov or the New York State Education Department Office of Bilingual Education and World Languages at (518) 474-8775 or (718) 722-2445 or email OBEWL@nysed.gov.



Supplemental Information Form

Has your child been referred to the Committee for Special Education (CSE)?

*see note below

Yes No

Does your child have an Individual Education Plan (IEP) or 504 Plan?

Yes No

Has your child received additional services for:

Speech	ESL	Reading	Math
Occupational Therapy	Physical Education	BOCES	

Other: _____

Has your child ever had an out of school suspension?	Yes	No
Is your child currently suspended?	Yes	No

Are there any legal restraints, pertaining to your child, of which we should be aware? Yes No

Student Name

Parent/Guardian Signature

Date

By signing your name electronically, you are agreeing that your electronic signature is the legal equivalent of your manual signature on this form.

Note: Every Rush-Henrietta parent or person in parental relation has a right to the referral and evaluation of their child for the purposes of special education services or programs. Please visit the district website www.rhnet.org for more Special Education information.

**RUSH-HENRIETTA CENTRAL SCHOOL DISTRICT
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(HIPAA compliant)**

I, _____, authorize my child’s healthcare provider(s) listed below to release my child’s medical records to the district’s medical officer, school nurse, psychologist, counselor and/or social worker.

Child’s Name _____ Date of Birth _____

Physician _____ Phone _____ Fax _____

Physician _____ Phone _____ Fax _____

Physician _____ Phone _____ Fax _____

The healthcare provider may disclose the following protected health information and the district may exchange the following school information:

- Immunizations
- Health Appraisals
- Past/Current Medical Conditions and Its Impact on Attendance or School Programming
- Other _____

The Protected Health Information may be used, disclosed or received for the following purpose(s):

- To develop care plans for routine and emergent school management
- To design appropriate educational programs
- To assess the impact of the medical condition(s) on school programming and/or attendance
- To share school observations/concerns surrounding behavior
- To assess a medical basis for modification of transportation and/or home tutoring
- Medication delivery
- At patient’s request with no specified purpose
- Other _____

Please select one:

- This authorization is valid throughout my child’s enrollment in the school district
- This authorization is valid for the entire academic school year 2026-2027
- This authorization shall expire on _____ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider’s office and to the District Administration Building.

I understand that the revocation of this authorization is not effective if the healthcare provider or district has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice.

I understand that any Protected Health Information disclosed as a result of this authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that my child’s treatment is not dependent on my agreement to release or withhold information.

Date Signature of Patient (over 18), Parent or Guardian Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A signed copy of this authorization must be given to the adult patient or parent of the minor child.



Rush-Henrietta Central School District

www.rhnet.org

Universal Pre-K Program (UPK)
Parent Contract 2026-2027

Child's Name: _____

Please read and respond by checking below and signing your name in agreement:

It is my responsibility to take an active role in my child's education. I commit to working with my child's teacher in a cooperative relationship and I will participate in the opportunities provided for family engagement on a monthly basis. Examples of how I can participate are by attending Rush-Henrietta's parenting programs, exploring take-home literacy kits, and participating in family fun nights provided by the Rush-Henrietta Family Center.

I understand my child must attend regularly and maintain consistent attendance in order to remain in the UPK program. If my child is going to be absent from school, I will inform the school via a phone call or email prior to the start of class that day. I understand that if my child misses twenty (20) consecutive days or more, they may be disenrolled from UPK.

It is my responsibility to arrange for transportation to and from the UPK program as well as being on time for drop off and pick up. **I understand that my child must be at school at the class start time.** I understand that a late fee may be charged if my child is not picked up on time.

It is my responsibility to comply with all requirements set forth by my UPK site. I am responsible for all payments for before- and after-school childcare services my child participates in. My child's UPK site has the right and responsibility to communicate with the Rush-Henrietta Central School District regarding my child's medical information, attendance, and academic progress while in the program.

I understand that if my child is consistently demonstrating excessive disruptive behavior or behavior that could cause harm to his or herself, peers or teachers/staff, my child may be removed from the UPK program.

I will speak to the site program director first if I have a concern or an issue with my UPK classroom. If the concern cannot be resolved, I will then speak with the Rush-Henrietta UPK Coordinator.

_____ **I agree with the above statements.**

Signature of Parent

Date

Parent Report—Self-help and Social-Emotional Scales

Child's Name _____ Child's Date of Birth _____ Today's Date _____

Parent's/Caregiver's Name _____ Teacher's Name _____

Directions: Read each item and circle the response or description that best reflects your child's behavior or skill level.

SELF-HELP SKILLS					
A. Eating Skills					
1.	Does your child ask for food when he/she is hungry?	Rarely/No	Sometimes	Most of the time	
	2.	Can your child hold a cup in one hand and drink from it without much spilling?	Rarely/No	Sometimes	Most of the time
	3.	Does your child use a spoon? If yes, does your child place the spoon in his/her mouth without turning the spoon upside down and without spilling a lot of food?	Rarely/No	Sometimes	Most of the time
B. Dressing Skills					
4.	Does your child take off his/her coat, shirt, or pants on his/her own if the article of clothing is left unbuttoned or unzipped?	Rarely/No	Sometimes	Most of the time	
	5.	Does your child put on his/her shirt, coat, shorts, or pants on his/her own? (Buttons, snaps, or zippers may be left undone.)	Rarely/No	Sometimes	Most of the time
C. Toileting Skills					
6.	Does your child get on the toilet or potty by himself/herself (even if he/she needs help with clothing)?	Rarely/No	Sometimes	Most of the time	

SOCIAL AND EMOTIONAL SKILLS				
D. Relationships with Adults				
7.	Does your child give you affection by kissing, hugging, or patting you?	Rarely/No	Sometimes	Often
	8.	Does your child look back at you or come back to you often when in a new place?	Rarely/No	Sometimes
9.	Does your child respond with feelings of pride and enthusiasm when he/she earns positive feedback?	Rarely/No	Sometimes	Most of the time
	10.	Does your child watch the faces of other people for clues about how they are feeling?	Rarely/No	Sometimes
E. Play and Relationships with Peers				
11.	Does your child pretend to do things that you or other adults do, such as driving a car, cleaning the house, or talking on the phone?	Rarely/No	Sometimes	Often
	12.	Does your child watch other children play and then join the play briefly?	Rarely/No	Sometimes
13.	Does your child watch other children do something and then try to copy them?	Rarely/No	Sometimes	Often
	F. Motivation and Self-Confidence			
14.	Does your child show signs of being curious about the things around him/her through exploring and wanting to do things, such as pulling pans from the cupboard or pulling toilet paper from the roll?	No	Yes	
	15.	Does your child exhibit signs of pushing for independence by insisting that he/she do things for himself/herself?	Rarely/No	Sometimes
G. Prosocial Skills and Behaviors				
16.	Does your child help put away things, such as his/her books, toys, or clothes?	Rarely/No	Sometimes	Most of the time
	17.	Does your child like to perform or show off for you? Does he/she sing, perform acts, or do funny things to get you to smile or laugh?	Rarely/No	Sometimes
18.	Does your child give as well as take to avoid or resolve conflicts with other children?	Rarely/No	Sometimes	Most of the time



Rush-Henrietta Central School District
www.rhnet.org

CONSENT TO RELEASE/RECEIVE INFORMATION

STUDENT NAME: _____ DOB: _____

I hereby give permission to UPK Program & Office of Special Education at
Rush-Henrietta Central School District to:

Receive information from: -or- Release information to:

AGENCY: The Children's Institute

ADDRESS: 205 Saint Paul Street, Rochester, NY 14604

TELEPHONE: 585-295-1000

INFORMATION REQUESTED

- | | |
|---|--|
| <input checked="" type="checkbox"/> Intake/Screening Evaluation | <input checked="" type="checkbox"/> Psychiatric Evaluation |
| <input checked="" type="checkbox"/> Psychological Evaluation | <input checked="" type="checkbox"/> Social Work Reports |
| <input checked="" type="checkbox"/> Academic Performance/ Classroom Behavior | <input checked="" type="checkbox"/> Medication Record |
| <input checked="" type="checkbox"/> Medical History/Physical Findings/Lab Reports | <input checked="" type="checkbox"/> Treatment Plan |
| <input checked="" type="checkbox"/> Therapeutic Intervention | <input checked="" type="checkbox"/> Treatment Summary |
| <input checked="" type="checkbox"/> Other: All information as needed/requested for educational planning | |

"This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulation (42 CFR Part 2) prohibits you from making and further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulation."

- This authorization is valid throughout my child's enrollment in the school district.
- This authorization is valid for the entire academic school year 2026-2027.
- This authorization will expire on ____ / ____ / ____.

Client or Parent/Guardian Signature

Date:



Rush Henrietta Central School District

STUDENT HEALTH HISTORY FORM

To be completed by parent or guardian and returned to the School Health Office

Child's Name _____ Birthdate _____ Gender _____

Physician's Name _____ Phone _____

Dentist's Name _____ Phone _____

Born in U.S.? Yes No(if no, where?) _____ Date of last physical exam _____

Traveled outside the U.S. in the last six (6) months? Yes No (if yes, where?) _____

Health History (check all that apply and explain below)

- ADD/ADHD
- Anemia
- Arthritis
- Asthma/trouble breathing
- Autism/Asperger's/etc.
- Bleeding Disorder
- Cancer
- Vision Deficit
 - Wears Glasses
 - Contacts
- Color Vision Deficiency
- Allergies (specify type of allergy; environmental, food, insects, latex, medication and previous reactions)
- Chicken Pox
- Dental Injuries
- Diabetes
- Ear Infections
- Gastrointestinal Condition (ulcer, reflux, IBS)
- Headaches/Migraines
- Heart Condition
- Hernia Repair
- Hypertension
- Behavioral/Mental Health (depression, eating disorder, anxiety, OCD, ODD, Etc.)
- Orthopedic Condition
- Hearing Deficit
 - Hearing Aid
 - Cochlear Implant
- Other _____
- Scoliosis
- Seizure Disorder
- Single Organ
- Skin Condition
- Speech Condition
- Urinary/Kidney Problem

Is any emergency medication required? _____

- Congenital Condition
- Concussion with or without loss of consciousness (list dates injuries occurred)

Please list any hospitalizations or surgeries.

Please list any injuries requiring medical care.

Does your child receive treatments or use assistive equipment during or outside the school day?

- Insulin/blood glucose monitoring Inhaler/nebulizer/peak flow monitoring Special diet
 Crutches Walker Wheelchair Other

Does your child take medication either at home or at school?

(list name, dose, and time(s) of administration)

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

No Yes

Has your child recently traveled outside of the country?

No Yes

If so, when and where and for how long did they stay?

Additional Information:

Completed by: _____

Date: _____

By signing your name electronically, you are agreeing that your electronic signature is the legal equivalent of your manual signature on this form.

UPK 2026-2027 Student Pick-Up Form – Winslow & Fyle

Child's Name: _____

Child's Gender: _____ Child's Date of Birth: _____

Parent(s)/Guardian(s) Name(s) and Phone Number(s):

Name: _____ Relationship: _____

Phone Number(s): _____

Name: _____ Relationship: _____

Phone Number(s): _____

Pick-Up Designee(s)

I give permission for only the following people to pick up my child from the Rush-Henrietta UPK program. I am aware that:

- I may not list anyone under the age of 18; and
- My child will not be released to anyone who is not listed below.

Name: _____ Relationship: _____

Phone Number(s): _____

Name: _____ Relationship: _____

Phone Number(s): _____

Name: _____ Relationship: _____

Phone Number(s): _____

Name: _____ Relationship: _____

Phone Number(s): _____

**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: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g}/\text{dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

System Review Within Normal Limits

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

<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/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<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	*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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominic Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> 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					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

Dental Health Certificate - Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first oral health assessment? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 / Dental Hygienist

I. The dental health condition of _____ on _____ (date of assessment). The date of the assessment 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/Dental Hygienist's Name and Address (please print or stamp)

Dentist's/Dental Hygienist'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.

Parker Administration Building
2034 Lehigh Station Road
Henrietta, NY 14467
Fax: 585-359-5045



Dr. Barbara A. Mullen
Superintendent of Schools
bmullen@rhnet.org
Phone: 585-359-5000

Parental Rights Regarding Student Information & Educational Records

Dear Parent/Guardian or Student:

This is to advise you of your rights with respect to the school's records relating to (your son) (your daughter) (you) pursuant to the Federal "Family Educational Rights and Privacy Act (FERPA) of 1974."

Parents/guardians of a student under 18, or a student 18 or older, have a right to inspect and review any and all official records, files, and data directly related to the student, including all material that is incorporated into each student's cumulative record folder, and intended for school use or to be available to parties outside the school or school system, and specifically including, but not necessarily limited to, identifying data, academic work completed, level of achievement (grades, standardized achievement test scores), attendance data, scores on standardized intelligence, aptitude, and psychological tests, interest inventory results, health data, family background information, teacher or counselor ratings and observations, and verified reports of serious behavior patterns.

A parent/guardian of a student under 18 years of age or a student 18 years of age or older shall make a request for access to a child's (his/her own) school records, in writing, to the principal of the building to which such student is assigned. Upon receipt of such request, arrangements shall be made to provide access to such records within a reasonable period of time, but no more than 30 days after the request has been received.

If information contained in the student's record is believed to be inaccurate or misleading, that parent or eligible student should write the principal, clearly identify the part of the record they want changed, and specify why it is inaccurate or misleading. If the district decides not to amend the record as requested, the parent or eligible student will be notified of the decision and advised of their right to a hearing regarding the request for amendment. Additional information regarding the hearing procedures will be provided to the parent/guardian or eligible student when notified of the right to a hearing.

Student records, and any material contained therein which is personally identifiable, are confidential and may not be released or made available to persons other than parents/guardians or students without the written consent of such parents/guardians or student. There are a number of exceptions to this rule, such as other school employees and officials, and certain State and Federal officials, who have a legitimate educational need for access to such records in the course of their employment. In addition, the district will disclose, upon request, education records to officials of another school district in which a student seeks or intends to enroll.

Further, under the provisions of FERPA, directory information may be released by the district without parental consent. Directory information includes a student's name, parents' names, address, telephone number, date and place of birth, e-mail address, photograph, grade, participation in school activities or sports, weight and height if a member of an athletic team, dates of attendance, degrees and awards received, and most recent previous school attended. It is the practice of the district to release such information only to colleges and other post-secondary education institutions, and military recruiters. The release of directory information to the media shall be for the sole purpose of reporting upon or promoting a district activity and shall not include addresses and telephone numbers. If a parent/guardian does not wish to have some or all of the directory information released by the district, he/she must notify the building principal in writing within 10 school days of the time this letter was issued.

Sincerely yours,

A handwritten signature in black ink that reads 'Barbara Mullen'. The signature is fluid and cursive.

Superintendent of Schools