Student Registration Packet

Holland Patent Central School District

9601 Main St.
PO Box 306
Holland Patent, NY 13354
(315) 865-7200

Our Mission

The mission of the Holland Patent CSD is to provide a safe learning environment where students become civic minded, resilient critical thinkers and problem solvers who are prepared for the rigorous demands of college and careers in an ever-changing world.

Our Vision

The Holland Patent CSD will be a leading educational organization where all students and staff are excited to be engaged and growing to their full academic potential. We will strive to always meet the comprehensive needs of our students. We will embrace and support a culture of positive collaboration and productive cooperation.

Summary of Forms and Procedures - Registration Checklist

Welcome to the Holland Patent Central School District! In order to complete the registration process, the District needs specific information and records. This Student Registration Packet must be completed and submitted to the main office of your child's school. The packet is available electronically on the District website or from the main office of each school. If you have questions while completing this packet, or require forms in another language, please contact your child's school.

Please note: A current photo identification of the parent/guardian is required to register all students. Parent/Guardian must be a present in order to verify identity. Acceptable forms of identification include a current passport, Driver License, or Military ID.

Where to File	
General William Floyd Elementary Rte 365 Stittville, NY (315) 865-5721 **Grades PreK-2**	**Holland Patent Elementary** 7940 Elm St. Holland Patent, NY 13354 (315) 865-8151 **Grades 3-5**
Holland Patent Middle School 9601 Main St. Holland Patent, NY 13354 (315) 865-8152 **Grades 6-8**	**Holland Patent Central High School** 8079 Thompson Rd, Holland Patent, NY 13354 (315) 865-8154 **Grades 9-12**
Holland Patent CSD District Office PO Box 306 9601 Main St. Holland Patent, NY 13354 (315) 865-7200	

Holland Patent Central School District

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General William Floyd Elementary: 315.865.5721 **Holland Patent Elementary:** 315.865.8151
Holland Patent Middle School: 315.865.8152 **Holland Patent Central High School:** 315.865.8154

REGISTRATION CHECKLIST

A current photo identification of the parent/guardian is required to register all students. Parent/Guardian must be a present in order to verify identity. Acceptable identification includes a current passport, Driver License, or Military ID.

Registration Forms: Any form not noted as optional is required

- Records Release Form (1 page)
- Student Registration Form (4 pages)
- Residency Questionnaire (1 page)
- Student Health History (1 page)
- Parent Portal Access Request (SchoolTool) (2 pages)
- Dental Health Certificate (optional) (2 pages)
- Transportation Request (optional)
- Parent/Health Care Provider's Request for Administration of Medication in School (optional) (1 page)
- Self-Medication Release Form (optional) (1 page)
- NYS Health Exam Form-Physical (can provide copy of current physical) (2 pages)
- NYS Home Language Questionnaire (HLQ) (2 pages)
- NYS Migrant Education Program - Parent Survey (1 page)
- NYS Application for Free and Reduced-Price School Meals/Milk (Separate Enclosure) (3 pages)

Required Documentation

Proof of Residency: Parent(s)/Guardian(s) must supply two (2) types of documentation (ONE from each group)

Group 1:

- Deed or mortgage statement
- Notarized Letter WITH the following:
  - Parent/Guardian name(s)
  - Homeowner name & telephone number
  - Verification of occupancy for current school year
- Current Rental/Lease Agreement WITH the following:
  - Parent/Guardian names (s)
  - Manager or owner name & telephone number
  - Verification of occupancy for current school year
- Current Property Tax Bill (online copies not accepted)
- Current Homeowner's or Renter's Insurance Policy or Declarations (not a bill/statement)

Group 2:

- Current State or Federal Tax Returns WITH W-2 OR 1099 attached
- Current Payroll Check Stub WITH name & address (not a personal check) *within 30 days*
- Current correspondence from an official Government agency not used in group 1.
  - IRS/Social Security/Child Support/Foster Care
  - Voter Registration/Polling information
  - Jury Summons/Subpoena
  - ANY Current Document from Federal, State, or County agency excluding DMV
- Utility Bill

Proof of Age (Date of Birth): One (1) of the following documents must be provided:

- An original birth certificate
- Original passport
- Record of baptism

Proof of Immunizations from Doctor or County Health Department

Educational Records: Most Recent Report Card/Current Grades, Transcript

Confidential Records (If Applicable)

- Examples include Individualized Education Programs (IEPs), 504 Plans, Psychological Testing, etc.

Parental/Custodial Affidavits (If Applicable)

- If the student is residing with someone other than Parent(s)/Guardian(s), you must complete a Parent/Affidavit Form. Forms must be completed and notarized.

Custody Agreements, Separation Agreements, Divorce Decrees, etc. (If Applicable)

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Date: ____ / _____ / _____
MM DD YYYY

Records Release Form

To Whom It May Concern:

I authorize the Holland Patent Central School District to secure a transcript of grades, including grades in progress up to the date of withdrawal, report cards, health records, psychological/psychoeducational evaluations, achievement testing, Individualized Education Plans, 504 Accommodation Plans, and any other pertinent information.

Prior School Information:	
Name of School:	
Street Address	
City, State, Zip Code	
School Phone: ( ) -	School Fax: ( ) -

Student Information:		
Last Name:	First Name:	Date of Birth: _____/_____/_______ MM DD YYYY

Please send the requested records to the following school: check box to indicate which building		
☐ **General William Floyd Elementary** Rte 365 Stittville, NY Ph: (315) 865-5721 **Fax: (315) 865-7284** **Grades PreK-2** **Email: jcarro@hpschools.org**	☐ **Holland Patent Elementary** 7940 Elm St. Holland Patent, NY 13354 Ph: (315) 865-8151 **Fax: (315) 865-7265** **Grades 3-5** **Email: tdibble@hpschools.org**	☐ **Holland Patent Middle School** 9601 Main St. Holland Patent, NY 13354 Ph: (315) 865-8152 **Fax: (315) 865-8978** **Grades 6-8** **Email: jshepard@hpschools.org**
☐ **Holland Patent Central High School** 8079 Thompson Rd, Holland Patent, NY 13354 Ph:(315) 865-8154 **Fax: (315) 865-4069** **Grades 9-12** **Email: acyr@hpschools.org**	☐ **Holland Patent Office of Pupil Personnel Services (CSE)** PO Box 306 9601 Main St. Holland Patent, NY 13354 Ph: (315) 865-4148 **Fax: (315) 865-7243** **Email: jblier@hpschools.org**	

Parent/Guardian: ______________________________ / ______________________________
(print name) (signature)

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Date: ____/____/_______
MM DD YYYY

Student Registration Form

Student Information			
Last Name:	First Name:	Middle Name:	
Date of Birth: ______ / ______ / ______	Place of Birth:	State (country if not US):	
Gender: ☐ Male ☐ Female	Is this student a foster child?	Current Grade:	
Are either or both of the child's parents/guardians active members of the U.S. Armed Forces? **YES / NO**			
Student's Address:			
Street Address:		Apt #	Home Phone: ( ) -
City/Town:	State: **NY**	Zip Code:	Cell Phone: ( ) -

Educational Information:
Student is currently enrolled in (please check all that apply): ☐ Reading ☐ Math ☐ Special Education ☐ Speech ☐ English as a New Language ☐ OT ☐ PT ☐ Counseling
Does the student have an Individualized Education Plan (IEP)? **YES / NO**
Does the student have a 504 plan? **YES / NO**
Has the student ever attended public school in New York State? If yes, please specify most recent: District: ______________________________ School: ______________________________ Grade(s): ____________________ Year(s) Attended: ____________________

Name, Address, and Phone Number of Most Recent School Attended:			
Name of School:		Grades:	Dates Enrolled: From: _____ / _____ / ______ To: _____ / _____ / ______
Street Address:		Phone: ( ) -	
City/Town:	State:	Zip Code	

Ethnicity:
Hispanic/Latino: **YES / NO**

Race *(Choose all that apply regardless of Ethnicity):*		
American Indian or Native American Asian	Black or African American White	Native Hawaiian or Other Pacific Islander

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STUDENT LAST NAME:	STUDENT FIRST NAME:

Parent/Guardian Information

Parent/Guardian #1:

Relation to Student: ___ Mother ____ Father ____ Step-Parent ____ Foster Parent ____ Guardian ____ Other: _________

Last Name:	First Name:	M.I.

Street Address:	Apt. #

City/Town:	State:	Zip Code:

Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -

Email Address:	Employer:

Mailing Address (if different from physical address):	City/Town:	State:	Zip Code:

Parent/Guardian #2:

Relation to Student: ___ Mother ____ Father ____ Step-Parent ____ Foster Parent ____ Guardian ____ Other: _________

Last Name:	First Name:	M.I.

Street Address:	Apt. #

City/Town:	State:	Zip Code:

Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -

Email Address:	Employer:

Mailing Address (if different from physical address):	City/Town:	State:	Zip Code:

Custody Information:

If parents are divorced/separated, is there a custody agreement? Provide a copy of the current order.	YES NO NOT APPLICABLE
If parents are divorced/separated, do you request double mailings?	YES NO NOT APPLICABLE

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STUDENT LAST NAME:	STUDENT FIRST NAME:

Emergency Contacts: Please list at least one emergency contact

First Emergency Contact (other than parent/guardian):		
Last Name:	First Name:	Relationship to Student:
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
In the event of an emergency, such as an illness, does this person have permission to pick your child up from school? **YES / NO**		
Second Emergency Contact (other than parent/guardian):		
Last Name:	First Name:	Relationship to Student:
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
In the event of an emergency, such as an illness, does this person have permission to pick your child up from school? **YES / NO**		
Third Emergency Contact (other than parent/guardian):		
Last Name:	First Name:	Relationship to Student:
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
In the event of an emergency, such as an illness, does this person have permission to pick your child up from school? **YES / NO**		
Fourth Emergency Contact (other than parent/guardian):		
Last Name:	First Name:	Relationship to Student:
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
In the event of an emergency, such as an illness, does this person have permission to pick your child up from school? **YES / NO**		

Physician Information:

Name of Physician:		
Street Address:	Phone: ( ) -	Fax: ( ) -
City/Town:	State:	Zip Code:

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STUDENT LAST NAME:	STUDENT FIRST NAME:

Please indicate which of the following programs/services your child receives and/or participates in, if any.

____ Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps)
____ Family Assistance: Temporary Assistance for Needy Families (TANF)
____ Safety Net Assistance (SNA)
____ Food Distribution Program on Indian Reservations (FDPIR) or BIA
____ Foster Care, Migrant, or McKinney-Vento/Homeless designation, certified by the State or local agency
____ Social Security Insurance/Supplemental Security Income (SSI)
____ Earned Income Tax Credit (EITC)
____ Home Energy Assistance Program (HEAP)
____ Refugee Assistance
____ My child/family is not eligible for any of the programs/services listed above

Children in Household *(Please list all other children in your household birth through grade 12):*

Last Name:	First Name:	Middle Name:	DOB:	Gender
1.			____/____/______ MM DD YYYY	Male Female
2.			____/____/______ MM DD YYYY	Male Female
3.			____/____/______ MM DD YYYY	Male Female
4.			____/____/______ MM DD YYYY	Male Female
5.			____/____/______ MM DD YYYY	Male Female
6.			____/____/______ MM DD YYYY	Male Female
7.			____/____/______ MM DD YYYY	Male Female

Certification:

To the Parent/Guardian: The information asked on the previous pages is needed as a permanent school record of your child and will be used by school personnel. This is to certify the information provided is correct. In the event a parent/guardian cannot be reached, I give my permission for emergency medical treatment to be administered to my child, and for officials of the school to contact the physician named on this form. I will not hold the school district financially responsible for the emergency care and/or transportation of my child.

______________________________ Parent/Guardian Name

______________________________ Parent/Guardian Signature

_____/_____/_________ MM DD YYYYY

Section 4402 of the Education Law of the State of New York requires the District to notify the parents/guardians of all incoming students of their rights regarding referral and evaluation for possible special education services. The state has made available “A Parent’s Guide to Special Education” at: http://www. p12.nysed.gov/specialed/publications/policy/parentsguide.pdf. The guide provides a summary of the special education process and your child’s rights under state and federal law. If you have any questions or would like a paper copy of the above guide, please contact Pupil Personnel Services at (315) 865-4148.

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Date: ____/____/_______
MM DD YYYY

Residency Questionnaire

Student Information:		
Last Name:	First Name:	Middle Name:
Gender: ☐ Male ☐ Female	Grade	Date of Birth: ______ / ______ / ______

Parent/Guardian Information:			
Last Name:	First Name:	M.I.	
Street Address:			Apt. #
City/Town:		State:	Zip Code:
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -	

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

Student Residency:
Where is the student currently living? (Please check one box.)
In a shelter
With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
In a hotel/motel
In a car, park, bus, train, or campsite
In permanent housing
Other temporary living situation (Please describe):

____
Name of Parent, Guardian, or Student *(please print)*:

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

Date: ______/______/________
MM DD YYYY

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Date: ____/____/_______
MM DD YYYY

Student Health History

Student Information:		
Last Name:	First Name:	M.I.
Date of Birth: ____ /____ /_______	Gender: Male Female	Parent Name:

Physician Information	
Name:	Phone #:

Student Health History: Check all that apply and provide any additional relevant information below

Condition	Date	Additional Info	Condition	Date	Additional Info
ADD/ADHD	__/__/____		Mononucleosis	__/__/____	
Anemia	__/__/____		Urinary Problems	__/__/____	
Asthma	__/__/____		Pneumonia	__/__/____	
Chicken Pox	__/__/____		Rheumatic Fever	__/__/____	
Diabetes	__/__/____		Scarlet Fever	__/__/____	
Ear Infections	__/__/____		Scoliosis	__/__/____	
Epilepsy/Seizure Disorder	__/__/____		Serious Head Injury/Concussion	__/__/____	
Fractured Bones	__/__/____		Skin Condition	__/__/____	
Heart Disease/Murmur	__/__/____		Surgeries	__/__/____	
Migraines	__/__/____		Tuberculosis	__/__/____	
Hospitalization(s)	__/__/____				
Hearing Condition	__/__/____	Cochlear Implant Hearing Aid			
Vision Condition	__/__/____	Contacts Glasses Last Exam: Next Exam:			
Other:	__/__/____				
Allergies	__/__/____	List and provide documentation from treating physician: ____________________ ____________________ Does your child require an EpiPen? Yes No			

Current Medications	Dosage	Current Medications	Dosage

Emergency Medical Contact (if parent(s)/guardian(s): not available)		
Last Name:	First Name:	Relation to Student:
Home Phone #: ( ) -	Cell Phone #: ( ) -	Work Phone #: ( ) -

Please provide any additional medical history/information below:

Parent/Guardian: ______________________________ / ______________________________
(print name) (signature)

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Date: ____/____/_______
MM DD YYYY

Parent Portal Access Request

The Parent Portal is a program which is embedded in our SchoolTool software. This software program manages our student data district wide. Parents will have access to their child's daily attendance, report card, discipline and progress reports. Each parent will be able to look online daily to monitor their child's progress, Parents who are interested in applying for access to the Parent Portal will need to complete this form. Once the form is processed parents will be given access to the Portal through our web site.

Parent Information:		
Parent Last Name:	Parent First Name:	Email Address for Parent Portal Access:
Student Information:		
Last Name:	First Name:	Date of Birth:
		____/____/_______ MM DD YYYY
		____/____/_______ MM DD YYYY
		____/____/_______ MM DD YYYY
		____/____/_______ MM DD YYYY
		____/____/_______ MM DD YYYY

I request that the District provide me with a login/password that will allow me to access information about my student's school performance, which could include classes, teacher names, attendance, grades, discipline, and other information housed in the district's Student Management Database. I understand that this information is stored in a database called SchoolTool, which is maintained by the District with support from the Mohawk Regional Information Center of the Madison-Oneida BOCES.

In return for the District providing me with a login/password, I agree to the following Terms of Network Access:	
_______ Initial	I will maintain a valid e-mail address that the District may use to send me the pertinent information concerning my Parent Portal Account.
_______ Initial	I will only attempt to view information about the student(s) listed above. I will not attempt to "hack," manipulate, or otherwise try to evade the security measures to access information regarding any other person.
_______ Initial	I will not intentionally transfer to the SchoolTool system any virus, Trojan horse, or other malicious computer code.
_______ Initial	If granted the ability (at a future time) to enter data into my child's record, I will only enter accurate information.

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_______ Initial	I understand that the District's use of the SchoolTool software is supported by technical assistance from the Mohawk Regional Information Center, SchoolTool, and possibly other consultants, and employees of these entities. They are instructed to keep confidential any personally-identifiable information, including educational records, they may see in the performance of their duties. I consent to the disclosure of information about me or the student(s) listed above under these circumstances.
_______ Initial	I understand that all information stored in the SchoolTool database remains the property of the District, and may be accessed, examined, or modified by the District or its vendors at any time.
_______ Initial	I understand that the SchoolTool database may record and retain information about when and how I use SchoolTool through the Parent Portal, and that this information is the property of the District and subject to review by the District.
_______ Initial	I agree that I will not disclose my login password to any other person, not even other people in my family or household. I accept responsibility for all actions that are performed by anyone gaining access to the SchoolTool database using the login password assigned to me.
_______ Initial	I understand that the District retains the discretion to block my access to SchoolTool whenever it has reasonable suspicion to believe that I have violated one of the foregoing Terms of accessing SchoolTool and other Network resources.

Parent/Guardian Name: ___________________________________
(print name)

Parent/Guardian Signature: ________________________________ Date: ____/____/______
(signature) MM DD YYYY

FOR DISTRICT USE ONLY:	
Received By:	Date:
Processed By:	Date:

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Date: ____/____/_______
MM DD YYYY

Dental Health Certificate-Optional

Parent/Guardian: New York State Law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 1, 3, 5, 7, 9, 11. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section I 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 II.

Return the completed form to your child's school as soon as possible.

<table>
<tr><th colspan="3">SECTION I TO BE COMPLETED BY PARENT OR GUARDIAN:</th></tr>
<tr><td>Last Name:</td><td>First Name:</td><td>Middle Name:</td></tr>
<tr><td>Date of Birth: ____/____/_______
MM DD YYYY</td><td>Gender: ☐ Male ☐ Female</td><td>Will this be your child's first oral health assessment? ☐Yes ☐No</td></tr>
<tr><td colspan="2">School Name:</td><td>Grade:</td></tr>
<tr><td colspan="3">Have you noticed any oral problems that interfere with your child's ability to chew, speak or focus on school activities? YES / NO</td></tr>
<tr><td colspan="3">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/Guardian Name (please print):

_______________________________________ Date: ____/____/_____
Parent/Guardian Signature: MM DD YYYY</td></tr>
<tr><th colspan="3">SECTION II ITEMS 1-3 TO BE COMPLETED BY THE DENTIST/DENTAL HYGIENIST:</th></tr>
<tr><td colspan="3">1. The dental health condition of_____________________________________ on ____/____/______
Name of child MM DD YYYY

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

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 public schools" does not preclude the student from attending school.</td></tr>
<tr><td>Dentist's Office Name:</td><td colspan="2" rowspan="2">_______________________________________
Dentist's/Dental Hygienist's Name (please print)

____
Dentist's/Dental Hygienist's Signature</td></tr>
<tr><td>Dentist's Office Address:</td></tr>
</table>

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STUDENT LAST NAME:	STUDENT FIRST NAME:

SECTION II CONTINUED - ITEMS 1-3 TO BE COMPLETED BY THE DENTIST/DENTAL HYGIENIST:

Optional Information - Parent/Guardian, if you agree to release this information to your child's school, please initial in the box to the right. Initial Here

2. Oral Health Status:

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 Problem (Specify):

OPTIONAL INFORMATION TO BE COMPLETED BY PARENT/GUARDIAN: if you agree to release this information to your child's school, please initial in the box to the right. Initial Here

3. Treatment Needs:

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.

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Date: ____/____/_______
MM DD YYYY

Transportation Request-Optional

If your child will be picked up or dropped off ***regularly*** from a location ***other than his/her primary residence***, please complete the for below.

Student Information:		
Name:	School:	Grade:
Name:	School:	Grade:
Name:	School:	Grade:
Name:	School:	Grade:

Transportation Information:

AM: Will be picked up at:

Name of Sitter: ____

Address of Sitter: ____

Phone # of Sitter: ____

On the following days: ____

PM: Will be picked up at:

Name of Sitter: ____

Address of Sitter: ____

Phone # of Sitter: ____

On the following days: ____

Date: ____/____/_______ (MM DD YYYY)	Parent/Guardian Name: ______________________ (print name) Parent/Guardian Signature: ______________________ (signature)

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Holland Patent Central School District

9601 Main St. PO Box 306 • Holland Patent, NY 13354 • www.hpschools.org

General William Floyd Elementary: 315.865.5721 **Holland Patent Elementary:** 315.865.8151
Holland Patent Middle School: 315.865.8152 **Holland Patent Central High School:** 315.865.8154

Date: ____/____/_______
MM DD YYYY

Parent/Health Care Provider's Request for Administration of Medication in School-Optional

Student Information:		
Last Name:	First Name:	Grade:

Authorization for the Administration of Medication:

A. To be completed by the parent or guardian annually:

I request that my child, ____, receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse or other assigned person will administer the medication.

_______________________________ Parent/Guardian Name (please print):	_______________________________ Parent/Guardian Signature:	
Address:		
Home Phone: ( ) -	Work/Cell Phone: ( ) -	Date: ____/____/_______ MM DD YYYY

B. To be completed by the licensed health care provider:

I request that my patient, as listed below, receive the following medications:

Name of Student:	Date of Birth: ____/____/_______ MM DD YYYY
Diagnosis:	
Name of Medication(s):	
Prescribed Dosage, Frequency and Route of Administration:	
Time to Be Taken During School Hours:	Duration of Treatment:
Possible Side Effects and Adverse Reactions (if any):	
Other Recommendation:	
Name of Licensed Health Care Provider and Title (please print):	
Licensed Health Care Provider's Address:	
Licensed Health Care Provider's Phone:	
_______________________________ Licensed Health Care Provider's Signature:	Date: ____/____/_______ MM DD YYYY

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Holland Patent Middle School: 315.865.8152 **Holland Patent Central High School:** 315.865.8154

Date: ____/____/_______
MM DD YYYY

Self-Medication Release Form-Optional

Student Information:			
Last Name:	First Name:	Grade:	Date of Birth: ____/____/_______ MM DD YYYY

SELF-MEDICATION RELEASE FORM

____ has been instructed in the proper use of the following medication
(Student's Name)

Procedures: ____

____.

We ____/____
(Physician's Name) (Physician's Signature)

and ____/____ request
(Parent's/Guardian's Name) (Parent's/Guardian's Signature)

that ____be permitted to carry the medication on his/her person or to keep
(Student's Name)

same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands

the purpose and appropriate method and frequency or use.

Note:

This form must be completed in addition to routine district medication form for those students who request permission to carry their own medication on campus or keep this medication in a P.E. locker.

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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

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ 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.** If Restrictions Apply – 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 ONLY 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.

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

Elisa Alvarez, Associate 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 Person in Parental Relation:
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.

STUDENT NAME:		
First	*Middle*	*Last*
DATE OF BIRTH:		GENDER:
Month	*Day*	*Year*
		❑ Male ❑ Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

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?	❑ Parent 1 ______ *specify*	❑ Parent 2 ______ *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:*	

ENGLISH

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: ❑ Parent ❑ 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:

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

IDENTIFICATION & RECRUITM ENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, regardless of their nationality or legal status. This program is free of charge to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take a few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)

Work related to logging, harvesting, or initial processing of trees.

Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)

If you answered YES, please provide your contact information below:

Parent/Guardian Name: ____

Home address: ____

Telephone number: (_____)-_______-________ Best time to be reached: _______ AM/PM

Previous Address: ____

Student name: ______________________________ Age _____________Grade_________

Student name: ______________________________ Age _____________Grade_________

To submit this referral please fax to 607-436-3606, or by mail to NYS Migrant Education Program- Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.

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