



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.



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

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	



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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:
 - o Parent/Guardian name(s)
 - o Homeowner name & telephone number
 - o Verification of occupancy for current school year
- ☐ Current Rental/Lease Agreement WITH the following:
 - o Parent/Guardian names (s)
 - o Manager or owner name & telephone number
 - o 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.
 - o IRS/Social Security/Child Support/Foster Care
 - o Voter Registration/Polling information
 - o Jury Summons/Subpoena
 - o 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)

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

☐ Parental/Custodial Affidavits (If Applicable)

- o 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
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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:
Street Address:	Phone: () -	From: ____/____/____
City/Town:	State:	To: ____/____/____
	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/YYYY

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

New York State Housing Questionnaire

District or LEA:	School Name:
About this form and your rights Schools are required by federal and state law to identify students living in temporary housing and ensure they can enroll, attend, and succeed in school. The McKinney-Vento Homeless Assistance Act, together with New York State Education Law Section §3209, protects students and families who no longer have a permanent, stable place to live; families who have lost housing; are staying with others temporarily; or are living somewhere that was never meant to be a home. Eligible students have the right to: ✓ Stay in the school they attended when last permanently housed (called the school of origin), for as long as they are in temporary housing. ✓ Immediately enroll in the local school where they are temporarily staying (the school of current location). ✓ Enroll and start school right away, even without a birth certificate, proof of residency, immunization records, or school records. ✓ Receive free transportation to and from the school of attendance, as well as after-school activities (If within 50 miles). ✓ Receive free school meals without income paperwork as well as access to other school services including McKinney-Vento Grant resources, if available. This information is confidential and will be shared only with school staff who have a legitimate educational need to support student access to McKinney-Vento rights and services. Providing this information is voluntary and will be used only to determine eligibility for services under the McKinney-Vento Act and NYS Education Law §3209. Please note that this information will not affect your immigration status, your child's enrollment, or your eligibility for other school services.	

Student Information:		
Student Name (Last, First):		Student Grade Level (PreK-12):
Gender: ☐ Male ☐ Female ☐ X=Nonbinary	Date of Birth: ____ / ____ / ____	
Parent/Legal Guardian Name:	Phone Number:	Email Address:
Address where the student is currently living:		



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Where is the student residing right now?

Under the McKinney-Vento Act, students are protected when their nighttime residence is not **fixed, regular, and adequate**. Check every box that describes where **the student** is residing right now.

- ☐ Permanent housing: you own, rent or lease a fixed, regular, and adequate home
- ☐ Doubled-up: staying with another family or person due to a loss of housing, economic hardship, eviction, or other similar reason
- ☐ In an emergency, transitional, or domestic violence shelter. Shelter or program name: _____
- ☐ In a hotel or motel because there is no other alternative, adequate place to stay
- ☐ In a car, park, campsite, bus/train station, abandoned building, or another place not meant for stable habitation or established dwelling
- ☐ In a place with no heat, running water, or electricity, or that is otherwise structurally unsafe or inadequate to reside in
- ☐ Displaced by a fire, flood, natural disaster, or other emergency
- ☐ Another temporary situation not listed here: _____

Is there anything else you would like to know about your situation (optional)? _____

Is the student an Unaccompanied Homeless Youth (UHY)?

The McKinney-Vento Act identifies students who are not living with a parent or legal guardian, and are not residing in permanent housing, as **Unaccompanied Homeless Youth (UHY)**. UHYs have the right to enroll in school and to complete and sign this form independently, without a parent or adult present. The McKinney-Vento Liaison can assist UHYs with this process.

- ☐ Please check the box if you believe the student identified above may meet the McKinney-Vento eligibility criteria described above.

Additional Children within the Household?

To help us identify and support all eligible children and youth, please list every child who is currently living with you, regardless of age or school enrollment status. This includes infants, preschool-aged children, and school-aged children.

Student Name (Last, First)	Date of Birth	Grade	Current or Recent School	Last School Attended Before Current or Recent



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Accuracy of Information and Signature

The person completing this form certifies that the information provided above is correct and accurate to the best of their ability.

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

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

Date: ____/____/____

MM DD YYYY

Need help? Contact the McKinney-Vento Liaison listed at the top of this form or call the NYS-TEACHS Helpline at 800-388-2014. Visit nysteachs.org for more information.

OFFICIAL USE ONLY (School Staff)

Date received: _____ **Received by:** _____ Eligibility: ☐ Eligible ☐ Not Eligible ☐ Pending

Homeless Primary Nighttime Residence Code (SIRS):

☐ D = Doubled-up ☐ S = Shelter ☐ H = Hotel/Motel ☐ U = Unsheltered ☐ T = Transitional Housing

Unaccompanied Homeless Youth (UHY): ☐ Yes ☐ No

Designation Form: ☐ Yes ☐ N/A ☐ Coded in Student Information System (SIS)

Liaison notified (initials): _____ Date: _____ ☐ Family declined to provide information

Notes:



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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 #:
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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: _____
(signature)

Date: ____/____/____
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.

SECTION I TO BE COMPLETED BY PARENT OR GUARDIAN:

Last Name:	First Name:	Middle Name:
Date of Birth: ____/____/____ MM DD YYYY	Gender: ☐ Male ☐ Female	Will this be your child's first oral health assessment? ☐ Yes ☐ No
School Name:		Grade:
Have you noticed any oral problems that interfere 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/Guardian Name (please print): _____ Parent/Guardian Signature: Date: ____/____/____ MM DD YYYY		

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

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.	
Dentist's Office Name:	_____ Dentist's/Dental Hygienist's Name (please print) _____ Dentist's/Dental Hygienist's Signature
Dentist's Office Address:	



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

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

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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Holland Patent Central High School: 315.865.8154

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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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
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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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Date: ____/____/____
MM DD YYYY

Self-Medication Release Form-Optional

Student Information:

Last Name:	First Name:	Grade:	Date of Birth: ____/____/____ MM DD YYYY
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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 _____/
(Parent's/Guardian's Name) (Parent's/Guardian's Signature) request
that _____
(Student's Name) be permitted to carry the medication on his/her person or to keep
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
☐ 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 ☐ Additional Information Attached	Diagnoses/Problems (list) _____ ICD-10 Code* _____ *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	☐ 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: _____	

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? _____

Signature of Parent or of Person in Parental Relation

Month: Day: Year:

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:



IDENTIFICATION & RECRUITMENT 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, and a representative from NYS Migrant Education Program will contact you:

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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