Catskill CENTRAL SCHOOL DISTRICT
reflecting educational excellence

Pre-K
2020-2021

Welcome to the Catskill Central School District

Registration for all new students will take place at the District's Registrar's Office located at:

770 Embought Road, Catskill, New York 12414

Hours of Registration are by appointment
Monday through Friday

Please call for appointment.

518-943-0574 EXT 3335

The following documentation is required in order to enroll your child for school in the Catskill Central School District:

- **Proof of Residency:** Three (3) proofs of residency within the school district that include the name and address of a parent or guardian and are dated within the previous 30 days.
  Documents accepted: executed lease agreement, executed purchase offer agreement, tax bill, rental agreement, mortgage statements, utility bill-{gas, oil, electric, telephone, cable, etc}, income tax return,)

- **Proof of Date of Birth:** Your child's original birth certificate, passport, or other proof of age.

- **Immunization Record / Physician Health Form / Dental Form:**
  (Public Health Law 2164 requires immunizations be received prior to a child being allowed to enter school.)
  **Please see sheet in this packet for age specific requirements.

- **Picture I.D. of the Parent/Guardian:** Driver's License or Non Driver I.D.

- **Custody Papers: if applicable are required**

- **Academic Records:** Including transcripts, recent report cards and any **Special Education Plan** should be presented at registration. If your child has received special education services or accommodation through an Individualized Education Program (IEP) or a Section 504, please sign consent for the release of special education records so that special education services can begin as soon as possible.

Registrar Fax 518-719-8345

Catskill Central School District

STUDENT REGISTRATION FORM

The information on this form is very important. ***PLEASE PRINT CLEARLY***

STUDENT'S NAME: _____ _____/___/_____ _____
LAST FIRST MIDDLE DATE OF BIRTH SEX: M / F

Student Cell # (_____)_____-_____ Student Email: _____ **Grade**_____

PHYSICAL ADDRESS: _____
(911 Address) # STREET CITY STATE ZIP

MAILING ADDRESS: **(IF DIFFERENT)**_____
STREET/PO BOX CITY STATE ZIP

***Former Address*:** _____
STREET CITY STATE ZIP

Household Telephone# (_____)_____-_____ E-MAIL_____

Has the child ever repeated a grade? ( ) Yes ( ) No Grade ____ **Child's place of birth**: _____
City State

LAST SCHOOL ATTENDED:_____LAST DATE OF ATTENDANCE ____/____/____
SCHOOL ADDRESS: _____

Your answers to the following questions are not used for determining eligibility to attend. Your answers to these questions are necessary for certain programming and data collection purposes.

RACE (choose all that apply): [ ] White [ ] Black [ ] Asian [ ] Pacific Islander [ ] American Indian/Alaskan Native

ETHNICITY: Is the child of Hispanic origin? [ ] Yes [ ] No Home Language: ___ English ___ Other*(specify): _____

Is student an Immigrant? [ ] Yes [ ] No, if Yes, date of entry to U.S. _____/_____/_____ Country of Origin _____

- Has student been identified to receive **Section 504** services? [ ] Yes [ ] No
- Does the Student have a Special Education/Individualized Education Plan (**IEP**) [ ] Yes [ ] No
- Please explain any handicapping condition or disability of which we should be aware:_____

FOSTER CHILD? [ ] YES [ ] NO If yes, additional documentation will be required. **DSS 2999 Form Submitted** [ ] Yes [ ] No

FAMILY STATUS: ____ Married, ____ Separated, ____ Divorced, ____ Single parent

***If living apart, who has legal custody of child? _____ (**Copy of Court Custody required**)

PARENT/GUARDIAN INFORMATION

Parent /Guardian 1 Name: Dr./Mr./Ms._____
(Last First Middle initial)

Lives with Student [ ] Has Custody of Student [ ] Should Receive Student Mailings [ ] Can Pick-Up Student [ ] Parent Portal [ ]

Relationship to student: _____

Address (if different from student)_____

Telephones:

Home: _____ Work: _____ Cell: _____ E-mail:_____

Employer's Name/Address:_____

Parent/Guardian 2 Name: Dr./Mr./Ms._____
(Last First Middle initial)

Lives with Student [ ] Has Custody of Student [ ] Should Receive Student Mailings [ ] Can Pick-Up Student [ ] Parent Portal [ ]

Relationship to student:_____ **(Please indicate step-parent/guardian relationship)**

Address (if different from student):_____

Telephones:

Home:_____ Work: _____ Cell:_____ E-mail:_____

Employer's Name/Address:_____

OTHER CHILDREN IN HOME:

____
Name Date of Birth Grade Handicapping Condition? Relationship to Parent/Guardian
RACE (choose all that apply): [ ] White [ ] Black [ ] Asian [ ] Pacific Islander [ ] American Indian/Alaskan Native ETHNICITY: Is the child of Hispanic origin? [ ] Yes [ ] No

____
Name Date of Birth Grade Handicapping Condition? Relationship to Parent/Guardian
RACE (choose all that apply: [ ] White [ ] Black [ ] Asian [ ] Pacific Islander [ ] American Indian/Alaskan Native ETHNICITY: Is the child of Hispanic origin? [ ] Yes [ ] No

____
Name Date of Birth Grade Handicapping Condition? Relationship to Parent/Guardian
RACE (choose all that apply): [ ] White [ ] Black [ ] Asian [ ] Pacific Islander [ ] American Indian/Alaskan Native ETHNICITY: Is the child of Hispanic origin? [ ] Yes [ ] No

____
Name Date of Birth Grade Handicapping Condition? Relationship to Parent/Guardian
RACE (choose all that apply): [ ] White [ ] Black [ ] Asian [ ] Pacific Islander [ ] American Indian/Alaskan Native ETHNICITY: Is the child of Hispanic origin? [ ] Yes [ ] No

EMERGENCY CONTACT INFORMATION ***If you are unavailable, we will contact the individuals below in the order listed in the event of an illness or emergency involving your child. The people listed should be available during school hours. Your child may also be released to these individuals under other circumstances at your request or the school's request. Suitable identification (driver's license) will be necessary before the child is released. These are the only people authorized to pick up your child from school. Please complete this section as accurately as possible.***

Emergency Contact 1 Name: Dr./Mr./Ms.____
(Last name, First name, Middle initial)
Address:____

Relationship to student:_________________________ Employer:_______________________________

Telephones: Home: _____________ Work:________________ Cell:_______________ Email ______________________

Emergency Contact 2 Name: Dr./Mr./Ms.____
(Last name, First name, Middle initial)
Address:____

Relationship to student:_________________________ Employer:_______________________________

Telephones: Home: _____________ Work:________________ Cell:_______________ Email ______________________

CHILD CARE INFORMATION (IF APPLICABLE, FOR TRANSPORTATION PURPOSES)

NAME: ____
ADDRESS: ____
PHONE: ______________________ CELL:____________________ Relationship:_______________________________

MCKINNEY-VENTO Questionnaire: CHECK WHICH OF THE FOLLOWING DESCRIBES YOUR CURRENT LIVING SITUATION

___ In Permanent Housing - ___Rent, ___Lease, ___Own physical residence

___ Shelter; ___Motel/Hotel; ___Car; ___Campground; ___Abandoned Apartment or building;
___ With relatives/others due to lack of housing; ___Temp. housed in shelter awaiting OFCS permanent foster care placement.
(Additional Paperwork to be completed when one of the above are checked)

__ With Relatives by Choice

I declare under penalty of perjury under the laws of the State of New York that I have read and understand the information contained in this registration application and that my responses and any accompanying attachments are true and correct.

Sign **Parent/Guardian Signature**____ **Date**:_____________

Please return all forms to the Registrar's Office 770 Embought RD Catskill, NY 12414 Fax 518-719-8345 Phone: 518-943-0574

TO BE COMPLETED BY SCHOOL **

[ ] Elementary ***[ ] Middle School*** ***[ ] High School*** Student ID # ______________________

GRADE__________ ROOM _____________ TEACHER ________________________________ DATE ENTERING______/______/________

BUS ROUTE (am) _______(pm) _______ 9th/L Period______ WALKER _____ SS#______________________

RESIDENCY ______ CUSTODY______ CSE ______ BIRTH _______ IMMUN _____ PHYSICAL _____ CODE CONDUCT ____ H/L___ LUNCH FORM______
__________ NON-RESIDENT/TUITION STUDENT

Consent for release of special education records signed? Y N Application Received Date: ____/_____/______ Registrar's Initials:__________

Catskill Central School District

AUTHORIZATION FOR RELEASE OF INFORMATION

Student's Full Name:	Date of Birth:	Entering Grade:

In order to coordinate educational plans for the above named student, I authorize the following accredited school or authorized agency to release the requested information to Catskill Central School District:

Previous School _____

Street Address _____

City _____**State** _____ **Zip**_____

School Phone _____**School Fax**_____

I understand that such information will be treated as confidential and privileged and used only for the purpose of giving help and guidance to persons working with my son/daughter.

_____ _____

Signature of Parent/Guardian or Authorized School Representative Date

Do not write below this line (for office use only):

I hereby authorize the following checked information, contained in the record of the above named student, to be released for the purpose of :

☐ Enrollment (start date ___/___/_____) ☐ Special Education Referral

☐ Academic/ Official Transcripts ☐ Attendance Records ☐ Birth Certificate
☐ Health/ Medical Records ☐ Current IEP ☐ Discipline Records
☐ Section 504 Plans ☐ Immunizations ☐ Psychological Reports
☐ Community Service Hours ☐ Standardized Test Scores ☐ Other_____

Please send records to:

☐ Catskill Elementary School
770 Embought Rd. Catskill, NY 12414
(518) 943-0574/ (518) 943-5396 (fax)

☐ Catskill Middle School Guidance Office
345 West Main St. Catskill, NY 12414
(518) 943-5665/ (518) 943-3001 (fax)

☐ Catskill High School Guidance Office
341 West Main St. Catskill, NY 12414
(518) 943-2345/ (518) 943-7470 (fax)

☐ Catskill Special Education Department
770 Embought Rd. Catskill, NY 12414
(518) 943-0574 EXT 3307 / (518) 943-5397 (fax)

☐ Office of the Registrar 770 Embought Rd. Catskill, NY 12414 (518) 943-0574 EXT 3335/ (518) 719-8345 (fax)

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

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

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

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

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:

❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

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?	❑ Mother	*specify*	❑ Father	*specify*
	❑ Guardian(s)	*specify*		
4. What language(s) does your child understand?	❑ English	❑ Other	*specify*	
5. What language(s) does your child speak?	❑ English	❑ Other	*specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other	*specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other	*specify*	❑ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	**STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:**
District Name (Number) & School *Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

*Yes**	*No*	*Not sure*	
❑	❑	❑	***If yes,** please explain:_____

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

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

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

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

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

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

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

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ Mother ❑ Father ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

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

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

NAME: _____ **POSITION:** _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

****DATE OF INDIVIDUAL INTERVIEW:** _____ MO DAY YR.

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:** _____

DATE OF NYSITELL ADMINISTRATION: _____ MO. DAY YR.

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

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

Catskill Central School District
Code of Conduct Summary

The Catskill Central School District is committed to maintaining high standards of education for students in the schools. Because the District believes that order and discipline are essential to being educated effectively, the District is also committed to creating and maintaining high behavioral standards and expectations. An orderly educational environment requires that everyone in the school community play a role in contributing to an effective environment. It also requires the development and implementation of a code of discipline that clearly defines individual responsibilities, describes unacceptable behavior, and provides for appropriate disciplinary options and responses.

Essential Partners: The District believes that order and discipline must be a shared responsibility between "Essential Partners" those individuals who contribute directly to a student's success. The partners include parents, teachers, guidance counselors, other school personnel, principals, the superintendent, and the Board of Education.

Dress Code: Students are expected to dress and groom themselves in an appropriate manner. Student must be dressed in appropriate clothing and protective equipment as required for physical education classes, participation in athletics, science laboratories and home and careers skills classes. Any dress or appearance which constitutes a disruption to the educational process is not acceptable.

Prohibited Student Conduct: The Code of Conduct outlines in detail areas of prohibited student conduct. These include disorderly conduct, insubordination; disruptive behavior, violent conduct, or any other behavior with endangers the safety, morals, health or welfare of others. This includes student behavior on a school bus as well as academic misconduct, (e.g. plagiarism, cheating). The code also provides detail information to incidents involving weapons, students who commit violent acts and students who are repeatedly and substantially disruptive to the educational process.

Penalties: When penalties are imposed, administrators must take into account various issues, which include the age of the student, the circumstances surrounding the offense, prior disciplinary record, information received from other sources, as well as any extenuating circumstances. Penalties include verbal warnings, counseling/mediation, detention, class removal, suspension from activities or privileges, in school suspension, out of school suspension, referrals to family court or other agencies may also be part of the disciplinary action.

Student Searches and Interrogations. Students may be questioned by school officials regarding alleged violations of law or the Code of Conduct. Furthermore, searches of students and their belongings according to specific guidelines are also authorized where there is reasonable suspicion that the student violated the law or the code of conduct, or where safety may be threatened. Students have no reasonable expectation of privacy with respect to computer files, student lockers, desks, and other school storage places and student vehicles while on school property. These may be searched at any time without prior notice or consent. The Board of Education has also authorized the intermittent use of a drug-sniffing dog.

Public Conduct on School Property: All persons on school property or at school functions are expected to conduct themselves in a respectful and orderly manner. Specifically prohibited conduct includes intentional injury or threat; damaging school property; disruptive conduct; wearing materials or objects that are obscene, libelous, advocate illegal action or obstruct the rights of others; smoking or use of tobacco products on school property; possession, consumption, sale or distribution of alcoholic beverages or controlled substances or being under the influence of either; possession of weapons; loitering, or refusing to comply with any reasonable request of recognizable school officials while performing their duties.

(A full copy of the Catskill District Code of Conduct is available at www.catskillcsd.org)

CATSKILL CENTRAL SCHOOL DISTRICT
Community / Achievement / Talent / Success

Code of Conduct Acknowledgement

Please read, sign and return this acknowledgement.

I have received and reviewed the information contained in the Catskill Central School District's plain language version of the Code of Conduct.

Student Name (Print) _____

Student Signature _____

Parent/Guardian Signature _____

Day-time Contact Phone Number _____

Email address _____

Date _____

Student ID # _____

Registrars Initials: _____
Building Principal Initials: _____

Health Information Packet

For New Student Registration

Information to be submitted at the time of Registration

❑ - Health History Form

A copy of the student's complete immunization record signed by the student's health care provider is required at the time of registration.

Medical Exemptions may be issued if immunization is detrimental to a child's health. Medical exemptions must be from a NYS licensed practitioner and include the medical contraindication and the length of time the exemption is valid for. Medical exemptions must be reissued annually to remain valid.
Religious Exemptions may be granted by the district upon a signed and completed Request for Religious Exemption form. This form is available from the student's building nurse.

❑ - Health Appraisal form - (In order to enroll in school a student must submit a health certificate/physical examination within 30 calendar days after entering school. The examination, which must conform to New York State requirements, must have been conducted no more than 12 months before the first day of the current school year. It must be done by a New York State licensed practitioner (Medical Doctor, Nurse Practitioner, or Physician Assistant.)

❑ - Dental Certificate – Please have your child's dentist or dental hygienist complete the attached form.

If you have any questions about these forms or other medical questions please call the nurse in your student's building.

❑Mrs. Hebb, BSN, RN High - School 518-943-2300 ext 2111	❑Mrs. Weber, RN - Middle School 518-943-5665 ext. 2109	❑ Mrs. Ashley, RN - Elementary School 518-943-0574 ext. 3189

Catskill Central School District

School Entry Health Requirements

2020-2021

Good Student Health Is Vital to Successful Learning

Pre-K

4 - DTaP/DTP/Tdap/Td
3 – Polio (IPV/OPV)
1 – MMR (Measles, Mumps, Rubella)
3 – Hepatitis B
1 – Varicella (Chickenpox)
1 to 4 – HIB
1 to 4 - Pneumococcal

Kindergarten through Grade 4

5 - DTaP/DTP/Tdap/Td
Or 4 doses if 4th dose is received after age 4.
Or 3 doses if 7 years or older & the series was started after age 1
4 – Polio (IPV/OPV)
Or 3 doses if 3rd dose received after age 4.
2 – MMR (Measles, Mumps, Rubella)
3 – Hepatitis B
2 – Varicella (Chickenpox)

Grade 5

5 - DTaP/DTP/Tdap/Td
Or 4 doses if 4th dose is received after age 4.
Or 3 doses if 7 years or older & the series was started after age 1
3 – Polio (IPV/OPV)
2 – MMR (Measles, Mumps, Rubella)
3 – Hepatitis B
1 – Varicella (Chickenpox)

Grades 6 through 10

3 - DTaP/DTP/Tdap/Td
1 – Tdap
4 – Polio (IPV/OPV)
Or 3 doses if 3rd dose received after age 4.
2 – MMR (Measles, Mumps, Rubella)
3 – Hepatitis B **or** 2 doses of Adult vaccine for children who received the vaccine at least 4 months apart between the ages of 11 and 15 years of age.
2 – Varicella (Chickenpox)
1 – Meningococcal (MenACWY) **For grades 7, 8 & 9 only**

Grades 11 & 12

3 - DTaP/DTP/Tdap/Td
1 – Tdap
3 – Polio (IPV/OPV)
2 – MMR (Measles, Mumps, Rubella)
3 – Hepatitis B **or** 2 doses of Adult vaccine for children who received the vaccine at least 4 months apart between the ages of 11 and 15 years of age.
1 – Varicella (Chickenpox)
Grade 12 only: 2 doses of Meningococcal (MenACWY) with **1 dose to be received after age 16**
OR **1 dose** if received after age 16

Immunization Exemptions

Medical Exemptions may be used if immunization is detrimental to a child's health. Medical exemptions must be from a New York State licensed practitioner and include the medical contraindication and the length of time the exemption is valid for. Medical exemptions must be reissued annually to remain valid.

Physical Examination Requirements

In order to enroll in school a student must submit a health certificate/physical examination form within 30 calendar days after entering school. The examination, which must conform to New York State requirements, must have been conducted no more than 12 months before the 1st day of the current school year. For the 2020 – 2021 school year, a physical done on or after September 1, 2019 by a New York State licensed practitioner (Medical Doctor, Physician Assistant, Nurse Practitioner) is acceptable.

❑-SN ❑-SP ❑-R

CATSKILL CENTRAL SCHOOL DISTRICT
NEW STUDENT HEALTH HISTORY – Two Page Form
TO BE COMPLETED BY <u>PARENT</u>

Student: _____ Birthdate: _____ Grade: _____

Parent/guardian Name: Father_____ Mother: _____

Address:_____ Address: _____

_____ _____

Home Phone #: _____ Home Phone #:_____

Day time phone #: ❒work ❒cell _____ Day time phone #:❒work ❒cell_____

Who does student live with? ❒ - Both Parents ❒ - Mother ❒ - Father ❒ - Shared ❒ - Guardian

Health Care Provider Name:_____ <u>Telephone #:</u> _____

Does your child have health insurance? _____ Name of Insurance Company: _____

Health History to be completed by parent/guardian

Please answer the questions below and provide details to any yes answer on back:

Question	Yes	No
Does your child have asthma?		
Does s/he use or carry an inhaler or nebulizer?		
Does s/he wheeze or cough frequently during or after exercise?		
Has s/he ever complained of chest pain, tightness or pressure during or after exercise?		
Has s/he ever become ill while exercising in hot weather?		
Does your child have Diabetes ❑ - Type I ❑ - Type 2		
Does your child have sickle cell trait or disease?		
Does s/he have a bleeding d□□□□der?		
Does s/he get frequent nose bleeds□		
Has□/he ever□spent the night in a hospital?		
Has your child ever had a life threatening reaction to any of the below? Please check: ❑ Medication ❑ Food ❑Insect bites ❑Pollen ❑ Latex ❑Other		
Has s/he ever had surgery?		
Has s/he□een told□s/he has□a heart condition or problem?		
Has s/he ever passed out or complained of dizziness during or after exercise?		
Has a health care provider ever ordered a test for his/her heart? (ex. EKG, echocardiogram, stress test)		
Does your child have scoliosis?		
Does your child have ADD/ADHD?		
Does your child have an anxiety disorder?		
Does your child have an Autism Spectrum Disorder?		
Does your child have depression?		
Has s/he had Mononucleosis?		
Has s/he had Lyme disease?		
Has s/he had chicken pox?		
Is s/he on a special diet or have to avoid certain foods?		
Has s/he ever had an eating disorder?		
Does s/he have stomach problems?		
Does s/he have high blood pressure or high cholesterol?		
Does s/he have Cystic Fibrosis?		
Does s/he have any other congenital disease?		

Question	Yes	No
Has s/he ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told s/he had a concussion?		
Does s/he ever have headaches with exercise?		
Has s/he ever had a seizure?		
Does s/he get migraine or frequent headaches?		
Is s/he currently being treated for a seizure disorder or epilepsy?		
Has s/he ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
Has your child ever fainted?		
Has s/he ever an injury, pain, or swelling of a joint ? Please include fractures & sprains.		
Does s/he use a brace, orthotic or other device?		
Does s/he have any problems with his/her hearing or wear hearing aids?		
Does s/he have any problems with his/her vision or have vision in one eye only?		
Does s/he wear glasses or contacts? For ❑ near seeing, ❑ distance or ❑both?		
Has s/he ever had a h□□□a?		
Does s/he have only 1 functioning k□dney?		
Does s/h□ have orthodontic appliances or capped teeth?		
Females Only	**Yes**	**No**
Has she had her period? At what age did it begin? _____		
Males Only	**Yes**	**No**
Does he have only one testicle?		
Family History	**Yes**	**No**
Has any relative had hypertrophic cardiomyopathy, Marfan Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Has any relative died suddenly before the age of 50 from unknown or heart related cause?		

Please explain fully any question you answered yes to in the space below (Please print clearly, and provide dates if known):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ What prescribed or over the counter medication (s) is your child currently taking? _____

_____

Please list any medications that your child must take in school or school sponsored events not during the school day. Include time, dose, frequency of the medication & the condition that it is prescribed for.

_____

_____

_____

New York State law requires that a physician's written prescription and a written permission from the parent/guardian be filed in the health office before your child will be permitted to take medication during school & at all school related activities. Medications must be in the original container with the pharmacy label attached. This also applies to all over the counter medications. Medication must be taken in the health office except in special circumstances specified, in writing, by the health care provider and parent. Please contact the health office for further information and forms to be completed.

PART E - PARENTAL PERMISSION

I, the undersigned, clearly understand these questions are asked in order for the school to determine my child's medical needs & adaptations to the school program, when necessary. I also understand that if my child will be participating in sports, the school physician may review this form to determine if my child can safely participate on athletic teams in the Catskill School District. To the best of my knowledge the answers are correct as of this date.

❑ **- Yes** ❑ **- No** I give permission for this information to be shared with appropriate school personnel involved with my child to insure their health & safety

❑ **- Yes** ❑ **- No** I give permission for the school nurse to discuss necessary information regarding my child's medical care with his/her health care provider.

PARENT SIGNATURE: _____ Print Name: _____ DATE: _____

Catskill Central School District

❑-SN ❑-SP ❑-R

STUDENT HEALTH EXAMINATION FORM – 2 Pages

(To be completed by private health care provider or school medical director)

Note: NYSED requires an annual physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers

Name: _____ DOB: _____ Gender: _____

School: ❑ - CHS ❑ - CMS ❑ - CES Grade: _____ **Exam Date:** _____

HEALTH HISTORY

Specify Current Diseases

☐Asthma (☐Intermittent or ☐Persistent)

Quick relief inhaler: ☐Yes ☐No

Asthma Action Plan: ☐Yes ☐No

☐Type 1 Diabetes ☐Type 2 Diabetes

☐Hyperlipidemia ☐Hypertension

☐Other:

Sickle Cell Screen:	☐Positive	☐Negative	☐Not Done	Date:
PPD:	☐Positive	☐Negative	☐Not Done	Date:
Elevated Lead:	☐Yes	☐No	☐Not Done	Date:
Dental Referral:	☐Yes	☐No	☐Not Done	Date:

☐ Allergies - See page 2 for details.

Significant Medical/Surgical Information:_____

PHYSICAL EXAMINATION

Height: Weight: BP: Pulse: Respirations:

Scoliosis: ☐Negative ☐Positive

Degree of deviation: _____

Angle of trunk rotation via scoliometer: _____

Body Mass Index:

Weight Status Category (BMI Percentile):

☐ <5th ☐ 85th- 94th

☐ 5th- 49th ☐ 95th- 98th

☐ 50th-84th ☐ 99th & higher

Vision	**Right**	**Left**	***Referral***
Distance acuity			☐Yes ☐No
Distance acuity with lenses			
Vision - near vision			
Vision - color perception	☐ Pass	☐ Fail	

Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes ☐No

Check developmental stage (ONLY for selection classification for 7th & 8th graders): Tanner: ☐I ☐ II ☐III ☐IV ☐ V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL

Specify any abnormalities:_____

☐ See attached

RECOMMENDATIONS OR RESTRICTIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ Free from contagion and physically qualified for all activities (physical education, athletics, playground, work, school) **or** only as checked below

☐ May participate in Expected Body Contact (full or limited): football, wrestling, basketball, ice/field/floor hockey, baseball, softball, lacrosse, team handball, volleyball, soccer

☐ May participate in strenuous activities: cross-country, gymnastics, track & field, swim, diving, crew, ski, cheering, tennis, badminton, fencing, weight train, dance, run, jump

☐ May participate in Non-contact/Non-strenuous: bowling, golfing, table tennis, shuffleboard, walking

☐ Protective Equipment: ☐Athletic Cup ☐Sport/safety goggles ☐Other:

☐ Medical/prosthetic device: _____

☐ Recommendations/restrictions: _____

MEDICATIONS

Diagnosis	ICD Code	Medication Name	Dose	Route	Time	Self Directed*	Self Admin/ Self Carry Inhaler**
						❑	❑
						❑	❑
						❑	❑
						❑	❑
						❑	❑

***Self Directed**: I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately, and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently

****Self Admin/Self-Carry**: I have determined this student is consistent and responsible in taking their own medication (self-directed), and in addition, give them permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

To be completed by Parent/Guardian if medication is prescribed

☐ I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/package with my child's name on it.

Parent/Guardian Signature: Date: Phone: ( )

☐ Parent permission & provider consent is required for students to self-administer & self-carry medication (inhalers). Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below.

Parent/Guardian Signature: Date: Phone: ( )

ALLERGIES

☐ **None** ☐ **Non Life-Threatening** ☐ **Life-Threatening**

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Specify allergen(s):

Specify previous symptoms: _____ ☐History of anaphylaxis; last occurrence:_____

Emergency Care Plan for anaphylaxis: ☐ Yes ☐ No

Treatment prescribed: ☐None ☐Antihistamine ☐Epinephrine Auto-injector

IMMUNIZATIONS

☐ Immunization record attached ☐ Immunizations reported on NYSIIS	☐ Immunizations received today:
☐ No immunizations received today	☐ Will return on _____/_____/_____ to receive:

Provider Authorization

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: _____ Date: _____

Provider Name: (please print) _____ Phone #: _____

Provider Address: _____ Fax #: _____

_____

Please Return to the School Nurse

❑Mrs. Hebb, BSN, RN High School
Fax#: 518-943-4899

❑Mrs. Weber, RN Middle School
Fax#: 518-943-4899

❑Mrs. Ashley, RN Elementary School
Fax #: 518-943-5396

❑-SN ❑-SP ❑-R

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school nurse as soon as possible.

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

Child's Name

Birth Date Month Day Year	Sex:	Is this your child's first visit to a dentist? ❑ Yes ❑No

School: ❑ Catskill Elementary School ❑ Catskill Middle School ❑ Catskill High School Grade:

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

Parent's Signature: _____ Print Name: _____ Date: _____

Section 2. To be completed by the Dentist/Dental Hygienist

The dental health assessment of _____ completed on _____ (date of assessment needs to be within 12 months of the start of the school year in which it is requested) indicates that:

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**

If you agree to release this information to your child's school, please initial here. _____

Optional Sections to be completed by Dentist/Dental Hygienist

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):_____

II. 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.