



CATSKILL

CENTRAL SCHOOL DISTRICT

Integrity / Perseverance / Compassion

Welcome to the Catskill Central School District

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

343 West Main Street Catskill, NY 12414

Hours of Registration are by appointment ONLY

Monday through Friday

Please call for appointment.

518-943-2300 EXT 1401

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: 518-943-7116

Registrar Email: kvela@catskillcsd.org

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 _____

Date child first entered 9th grade: ____/____/____ Has the student ever attended Catskill? [] Yes [] No Last Grade ____

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: _____
- ❖ Has the Student had Academic Intervention Services (**AIS**)/RTI [] Yes [] No,
If yes what subject/s _____

- ❖ Has the Student attended: Universal Pre-K ____ Private Pre-K ____ None ____ Name-_____

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:

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

Integrity / Perseverance / Compassion

Request for Transportation

This form should be filled out for all students, including special education and students transported outside of the Catskill School District.

Today's Date _____

Student's Name _____
First name Last Name

Student's Grade _____ Check if this is a new student

School Attending (*circle one*) CES / CMS / CHS / Other _____

Parent/Guardian Name _____

Home Phone# (____) _____ Work # (____) _____ Cell# (____) _____

Physical Street Address _____
(911 Assigned Address) House Number Street Address

Home [] Childcare [] Days of the week: (Circle all that apply) Mon Tue Wed Thu Fri

Pick up Location (Address) _____

Home [] Childcare [] Days of the week: (Circle all that apply) Mon Tue Wed Thu Fri

Drop Off Location (Address) _____

**** please note the Catskill Central School District maintains a 1 mile walk zone policy for grades 6-12 ****

Emergency Dismissal (ie inclement weather) transportation will be to the Drop Off location on record unless otherwise instructed.

There must be an authorized adult present at stop for students in grades K & 1 to be released from bus.

Alternate temporary transportation requests should be submitted to school in writing by 12 noon.

Permanent changes in transportation must be submitted four days prior to when transportation is to begin.

This form must be submitted to Transportation Office or any CCSD Main Office at least four days prior to when transportation is to begin. Requests for out of district transportation should be received by April 1st each year to establish transportation for the following school year.

 (parent signature)

 (date)

Office Use Only			
Student Grade:		Bus Route:	
Start Date:		Add'tnl Accom:	

Catskill Central School District

AUTHORIZATION FOR RELEASE OF INFORMATION

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Enrollment (start date ___/___/___) | <input type="checkbox"/> Special Education Referral | |
| <input type="checkbox"/> Academic/ Official Transcripts | <input type="checkbox"/> Attendance Records | <input type="checkbox"/> Birth Certificate |
| <input type="checkbox"/> Health/ Medical Records | <input type="checkbox"/> Current IEP | <input type="checkbox"/> Discipline Records |
| <input type="checkbox"/> Section 504 Plans | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Psychological Reports |
| <input type="checkbox"/> Community Service Hours | <input type="checkbox"/> Standardized Test Scores | <input type="checkbox"/> NYSITELL Score |
| <input type="checkbox"/> Home Language Questionnaire (NYS) | <input type="checkbox"/> NYS Science Investigations (3-8) | <input type="checkbox"/> NYSESLAT Score(s) |
| | | <input type="checkbox"/> Other _____ |

Please send records to:

Catskill Elementary School
770 Embought Rd. Catskill, NY 12414
(518) 943-0574/ (518) 943-5396 (fax)
Email: smcculloch@catskillcsd.org

Catskill Middle School Guidance Office
345 West Main St. Catskill, NY 12414
(518) 943-5665/ (518) 943-3001 (fax)
Email: bdaly@catskillcsd.org

Catskill High School Guidance Office
341 West Main St. Catskill, NY 12414
(518) 943-2345/ (518) 943-7470 (fax)
Email: bmaggio@catskillcsd.org

Catskill Special Education Department
770 Embought Rd. Catskill, NY 12414
(518) 943-0574 EXT 3307 / (518) 943-5397 (fax)
Email: cbrust@catskillcsd.org

Office of the Registrar 343 West Main St. Catskill, NY 12414 (518) 943-2300 EXT 1401/ (518) 943-7116 (fax)
Email: kvela@catskillcsd.org

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:

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 send by mail to NYS Migrant Education Program- Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.

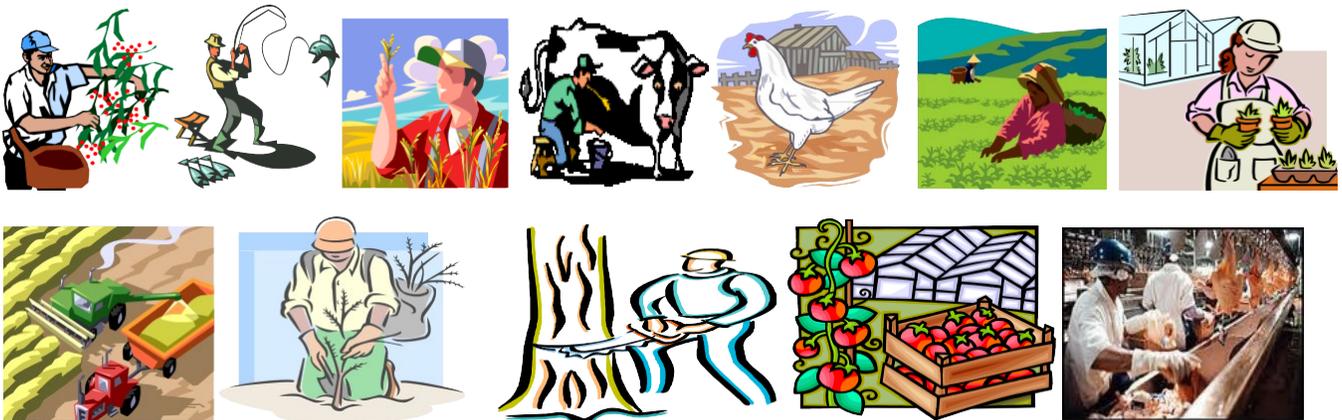
OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Acta de Educación Elemental y Secundaria (ESEA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, **sin importar su nacionalidad o estado legal**. Este programa **es gratuito** para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito en la escuela, excursiones, programa de verano, actividades de involucramiento para padres, programa de emergencias y referidos a otras organizaciones o agencias.

Por favor tome unos minutos para completar este cuestionario.

¿Usted o algún miembro de su familia ha trabajado o buscado trabajo en algunas de las siguientes ocupaciones en los pasados 3 años?

- Cualquier trabajo agrícola (como plantando, seleccionando, o cosechando frutas o vegetales, cultivando o cortando flores o árboles, trabajo en lechería u otro rancho de animales, pescando, etc.)
- Trabajando en la cultivación o procesamiento de los árboles.
- Trabajando en una planta de procesamiento, empacando, lavando o cortando vegetales, frutas o carnes.



Si usted contestó que sí, por favor complete la siguiente información:

Nombre del Padre/Encargado: _____

Dirección Física: _____

Teléfono: (____)-____-____ Mejor tiempo para ser contactado _____ AM/PM

Dirección anterior: _____

Nombre del estudiante: _____ Edad _____ Grado _____

Nombre del estudiante: _____ Edad _____ Grado _____

Para someter este referido, por favor envíelo por fax a 607-436-3606, o por correo a NYS Migrant Education Program- Identification & Recruitment Office 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020



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:		

<i>First</i>	<i>Middle</i>	<i>Last</i>
DATE OF BIRTH:		GENDER:
_____		<input type="checkbox"/> Male
<i>Month</i>	<i>Day</i>	<i>Year</i>
_____		<input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		

<i>Last Name</i>	<i>First Name</i>	<i>Relation to Student</i>
_____	_____	_____

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____	<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____	<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	_____	<input type="checkbox"/> Father	_____
	<input type="checkbox"/> Guardian(s)	_____		<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____	<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____	<input type="checkbox"/> Does not speak
			<i>specify</i>	
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____	<input type="checkbox"/> Does not read
			<i>specify</i>	
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____	<input type="checkbox"/> Does not write
			<i>specify</i>	

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* <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/> *If yes, please explain: _____
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____
Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ Mo. DAY YR.	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> 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: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> 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)



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.

- 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.

<input type="checkbox"/> Ms. Wager, RN High School 518-943-2300 ext. 2111	<input type="checkbox"/> Ms. Ashley, RN - Middle School 518-943-5665 ext. 2321	<input type="checkbox"/> Ms. Murphy, RN - Elementary School 518-943-0574 ext. 3233 <input type="checkbox"/> Ms. Jenkins, RN - Elementary School 518-943-0574 ext. 3189
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**Catskill Central School District
School Entry Health Requirements
2025-2026**

Good Student Health Is Vital to Successful Learning

<p>Pre-K</p> <p>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</p>

<p style="text-align: center;">Kindergarten through Grade 4</p> <p>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)</p>	<p style="text-align: center;">Grade 5</p> <p>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)</p>
<p style="text-align: center;">Grades 6 through 10</p> <p>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</p>	<p style="text-align: center;">Grades 11 & 12</p> <p>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</p>

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 2024 – 2025 school year, a physical done on or after September 1, 2023 by a New York State licensed practitioner (Medical Doctor, Physician Assistant, NursePractitioner) is acceptable.

**CATSKILL CENTRAL SCHOOL DISTRICT
NEW STUDENT HEALTH HISTORY – Two Page Form
TO BE COMPLETED BY PARENT**

-SN -SP -R

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: _____ Telephone #: _____
 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 <input type="checkbox"/> - Type 1 <input type="checkbox"/> - Type 2		
Does your child have sickle cell trait or disease?		
Does s/he have a bleeding disorder?		
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: <input type="checkbox"/> Medication <input type="checkbox"/> Food <input type="checkbox"/> Insect bites <input type="checkbox"/> Pollen <input type="checkbox"/> Latex <input type="checkbox"/> Other		
Has s/he ever had surgery?		
Has s/he been 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 <input type="checkbox"/> near seeing, <input type="checkbox"/> distance or <input type="checkbox"/> both?		
Has s/he ever had a hernia?		
Does s/he have only 1 functioning kidney?		
Does s/he 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?		

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

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

BMI _____ kg/m²

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

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

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K
TB-PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g}/\text{dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

System Review Within Normal Limits

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid	

Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision Screening	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
Notes					
Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done
Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	Negative	Positive	Referral	Not Done	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	
FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> Other Restrictions:					
Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.					
Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> Other Accommodations*: Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
MEDICATIONS					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

Dental Health Certificate

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.