MEDINA CENTRAL SCHOOL DISTRICT

Student Name: _____ ID#: _____

Grade: _____ Date/Entry to 9th Grade: _____

Medina Central School District Registration:

****You must make an appointment with the school principal and have ALL required documents on hand at the appointment before student is allowed to start****

Office Location:
One Mustang Drive
Medina, New York 14103
Telephone: 585-798-2700
Fax: 585-798-3108

Following required documents MUST be provided at time of registration:

- ☐ **Original birth certificate or passport**
- ☐ **Release of Information**
- ☐ **Proof of Medina Central School District Residency**
  - ☐ Rental/lease agreement/mortgage statement
  - ☐ Medina Central School District tax bill
  - ☐ Current utility bill
  - ☐ Notarized dual residency affidavit
  - ***Personal mail and driver's license cannot be accepted.**
- ☐ Copy of current **immunization record** and a copy of child's **LAST physical**
- ☐ Dental Health Certificate
- ☐ Adoption/guardian ship/custody documents if applicable

Failure to provide proof of any of the above will delay the entrance of your child into the Medina Central School District.

A physical dated on or after September 1st of the prior year, may be used as an entrance physical. A new physical will need to be provided prior to entrance if the physical is over one year old. Physical and immunization forms are provided for your convenience. Please take the form to your physician and ask him/her to fill it/them out. Please ensure the building nurse at the school your child will be attending receives the completed forms. Call your child's building nurse for any questions.

Medina Central School District
Central Registration Office
One Mustang Drive, Medina, NY 14103
(585) 798-2700
Oak Orchard Elementary School (Grades K–3) (585) 798-2352
Clifford Wise Intermediate School (Grades4-7) (585) 798-6917
Medina High School (Grades 8-12) (585) 318-1280

AUTHORIZATION FOR RELEASE OF INFORMATION

(Please fax or mail the student record to the address above)

Date: _____

NAME OF SCHOOL: _____

ADDRESS: _____ CITY _____

STATE: _____ ZIP: _____ FAX: _____

I/ We authorize the release of information between the Medina Central School District and the above agency for the following student(s):

Last Name	First Name	MI	Date of Birth	Grade

Permanent Records Information

Including, but not limited to birth certificate, most recent report card, all standardized testing, any state testing, high school transcript.

Health Record Information

Including, but not limited to, Hepatitis B verification, most recent immunization testing, and last physical exam.

Confidential Reports

Including, but not limited to CPSE/ CSE records, 504 records, psychological testing, all/any related service information (OT, PT, Speech), outside evaluations

Signature of Legal Guardian/ Parent:

_____

Relationship to Student: _____ **Date Signed** _____

Witness & Requesting Officer: _____

Registration Date: _____ Starting Date:_____

Assigned School:_____ Grade:_____

Student ID#_____

MEDINA CENTRAL SCHOOL DISTRICT REGISTRATION FORM

Student Name:_____ ☐Male ☐Female
Last First MI

Address:_____
Street City State Zip

Home Phone: (____)_____ Date of Birth:___/___/___ Place of Birth:_____

Parent/Guardian
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other
Name:_____
Last First MI
Address:_____
Street
_____
City State Zip
Home Phone: (_____)_____-_____
Cell Phone: (_____)_____-_____
Work Phone: (____)_____-_____
Employer: _____
Relationship to student: ☐ Mother ☐ Father
☐ Foster Parent ☐ Step Mother ☐ Step Father ☐ Legal Guardian
☐ Other _____

Parent/Guardian
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other
Name:_____
Last First MI
Address:_____
Street
_____
City State Zip
Home Phone: (_____)_____-_____
Cell Phone: (_____)_____-_____
Work Phone: (____)_____-_____
Employer: _____
Relationship to student: ☐ Mother ☐ Father
☐ Foster Parent ☐ Step Mother ☐ Step Father ☐ Legal Guardian
☐ Other _____

Emergency Contacts

Name	Address	Phone #	Relationship to Student

Siblings residing in home

Last Name	First Name	Gender	Date of Birth	Grade	School

Students Physician:
Address: Phone #:
Health Concerns/Allergies:
Required Medications:

Registration completed by: _____
Relationship to student: _____
Does the student have an IEP or 504 Plan ☐ Yes ☐ No Special Needs: _____

Primary Language in home: _____ ESL Services: _____ Date entry into US _____
Date entry into US School: _____

Has student ever attended Medina Central Schools: Yes _____ No _____
If yes, what school _____

CONFIDENTIAL INFORMATION: Complete this section if: (1) It reflects your child's current living situation (2) Your living situation if you are a youth not living with a parent or guardian. Please check applicable boxes.

- ☐ Share the housing of other persons due to loss of housing, economic hardship or similar reasons.
- ☐ Living in a motel, hotel, temporary residence, trailer park or camping ground.
- ☐ Living in an emergency or transitional shelter awaiting DSS placement.
- ☐ Living in an abandoned building or similar substandard housing.
- ☐ Other, please specify _____

Are you homeless? ☐ yes ☐ no Are you a migrant? ☐ yes ☐ no Are you an immigrant? ☐ yes ☐ no

Are you Neglected or Delinquent? ☐ yes ☐ no Are parents/parent in the Armed Forces (active duty)? ☐ yes ☐ no

Is there a custody order in place? ☐ yes ☐ no **A copy of court documents designation custodial and or residential custody is required.**

Is there any special legal concerns regarding the child that the school should be aware of? ☐ yes ☐ no

_____
_____
_____
_____

NOTICE

Please be advised that the provision of false information on these registration documents could constitute a crime. In addition, the District reserves its rights to recover from parents, legal guardians or other responsible parties the entire actual cost of education a student, plus related costs, for the entire period that any non-resident student is enrolled in the District's schools without authorization and or false pretenses. This includes costs for students receiving special education services, which are considerably higher and vary depending upon the specific program(s).

CERTIFICATION

I hereby certify that the student(s) listed on this registration form actually resides at the address specified on page 2, within the Medina Central School District boundaries. I further certify that all information I provided on this document is true and correct. I understand that I must immediately notify the District if the residency of the student changes from the address listed on this registration form.

Signature of Registrar: _____ **Date:** ____/____/_____

Signature of Parent/Guardian:_____ **Date:** ____/____/_____

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:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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:

MEDINA CENTRAL SCHOOL DISTRICT

STUDENT RACIAL AND ETHNIC IDENTIFICATION

To the Parent/ Guardian: The Medina Central School District has adopted a policy which requires the collection and recording of the ethnic identity of students in the Medina Central School District in accordance with federal categories and definitions. The information will be used to:

*Report information to the State and federal Education Departments.
*Plan educational programs and make sure they are readily available to all students.
*Analyze differences in academic performance, attendance and completion of school.

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

CONFIDENTIALITY PRODEDURES AND REGULATIONS

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

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

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

Please complete the form on the next page

MEDINA CENTRAL SCHOOL DISTRICT

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

Name of School:	
School District Student Identification Number:	Date of Birth (Month/Day/Year)
Student Name: (Last, First, Middle)	Grade Level:

Directions to Parent/Guardian:
PLEASE ANSWER QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) check (√) the box that best describes your child.]
Check (√) only ONE box.

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.
   - ☐ YES, Hispanic
   - ☐ NO, not Hispanic

2. Select one or more races from the following five racial groups [For question (2) Check (√) all groups that apply to your child; check (√) at least ONE box:

- ☐ **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- ☐ **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **Black or African American:** A person having origins in any of the Black racial groups of Africa.
- ☐ **White:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

_____ _____
Signature of Parent/Guardian/Other Date

Relationship to Student (please check one box below):
☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify):_____

MEDINA CENTRAL SCHOOL DISTRICT

SPECIAL PROGRAMS/CSE/CPSE
335 West Oak Orchard Street
Medina, New York 14103-1845
(585) 798-4032 □ Fax: (585) 798-0935

www.medinacsd.org

Mrs. Alexandra DiLaura
Director of Special Programs

Dear Parents and Families,

Welcome to Medina Central School District. In accordance with Chapter 434 of New York State Education Law, section 4402, we would like to take this opportunity to inform you of your rights in relation to referral and evaluation of your child for the purposes of Special Education services or programs pursuant to applicable federal and state laws. As a parent/guardian, you reserve the right to make a referral to the committee on special education of behalf of your child when you suspect the presence of a disability.

The "Special Education in New York State for Children Ages 3-12: A Parent's Guide", that can be found on the New York State Education website, outlines all aspects of Special Education that a parent or guardian may need to know, including: referral, evaluation, timelines, the individual education program and much more. Please take the time to review this document, provided in English and Spanish, by visiting: http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm

Should you have any questions regarding Medina Central School District's policy, procedures and/or practices, would like clarification regarding the Special Education Referral, classification determination, or other items relating to Special Education, or if you would like to request a hard copy of this guide, please contact the Office of Special Programs Director, Mrs. Alexandra DiLaura at 585-798-4032.

Sincerely,

Alexandra DiLaura

Mrs. Alexandra DiLaura
Director of Special Programs

MEDINA CENTRAL SCHOOL DISTRICT

ANNUAL TRANSPORTATION REQUEST

585-798-0351

School Year: **2018-2019**

(One Form Per Student Please)

School: _____ **Grade:** _____ **Start Date:** _____

Student's Name: _____ ☐**Male** ☐**Female**

Date of Birth: _____

Parent/Guardian Name: _____

Student Home Address:

Address:_____

City:_____ State:_____ Zip:_____

1st Contact Phone #:_____

2nd Contact Phone #:_____

Office use only

Daycare/ Babysitter:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Site Phone #:_____

Office use only

Place a check (√) in a Box to Select Morning pick-up and Afternoon Drop-off Locations for Monday through Friday. You must make a selection for each day of the week.

A.M. Pick-up	Home	Daycare/ Babysitter	No Transport Walker/Drop-off	
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				

P.M. Drop-off	Home	Daycare/ Babysitter	No Transport Walker/Pick-up	
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				

***** Transportation Requests Can Take Up to 30 Days to Take Effect As Per School Policy #5721 *****

My signature certifies that I am the parent/legal guardian of the above student and authorized to request transportation to/from the location(s) above.

_____ _____

Date Signature

	POLICY Medina Central School District Board of Education	5721 Non-Instructional Business Operations

SUBJECT: TRANSPORTATION OF STUDENTS TO AND FROM HOME FOR CHILD CARE

New York State Education Law obligates the District to transport students to and from their residence in accordance with defined limits. Often the District extends its transportation of students beyond the minimum requirements of the law. One instance is the transportation of student to and from locations other than their residence, but only within the confines of the school district boundaries.

Request for a student to be transported to or from a location other than the student's residence must be made according to the following:

Request for transportation to an alternative location on a regular basis shall be made to the transportation department and received by August **1st** prior to the start of each new school year. If a change in location occurs during the school year, the request must be made 30 days in advance. The district shall respond to the request within 5 business days.

Request for transportation to an alternative location on an irregular basis or emergency situation shall be made to the building principal. The building principal along with the transportation department shall determine if the request can be accommodated and shall notify the requester in a timely manner.

The District shall not approve any request for transportation solely for the purpose of an after-school activity such as scouts, 4-H, dance lessons, music lessons and so on.

The Superintendent shall implement and maintain the appropriate regulations and procedures for adherence to this policy.

Adopted: 7/16/13

MEDINA CENTRAL SCHOOL DISTRICT
BOARD OF EDUCATION OFFICE
One Mustang Drive
Medina, New York 14103-1845
(585) 798-2700 • Fax: (585) 798-5676

www.medinacsd.org

Mark B. Kruzynski
Superintendent of Schools

MEDINA CENTRAL SCHOOL DISTRICT INTERNET USE POLICY

The Medina Central School District's Board of Education provides access to computing resources and digital information as a normal function of the schools' instructional and administrative process.

Such access is governed by published District policies and is considered a privilege that can be restricted or revoked if deemed necessary. All authorized users are personally responsible for their proper and ethical use of these resources.

Below is an abstract of the District policies that apply to the fair and proper use of these district-provided resources. The policies are available on-line at www.medinacsd.org or may be reviewed by appointment by contacting any school office or the Superintendent's office (585-798-2700).

Policy	Abstract
3120	The District's website shall be used for timely communication of educationally appropriate information. Guidelines to safeguard personal and student privacy are outlined.
6410	Provides guidelines for staff access to computerized information resources, the expectation for professional use thereof, penalties for guideline violation and a statement of privacy rights.
7315	Provides guidelines for student access to computerized information resources, describes potential risks involved in providing students with access to off-site information sources, and states the expectation for proper use by the student, penalties for guideline violation and a statement of privacy rights.
8270	Describes and frames the District's Computer Assisted Instruction (CAI) focus with regard to enhancing academic performance; including goals and staff training.
8271	Children's Internet Protection Act (CIPA): Internet Content Filtering Safety Policy.

The Medina Central School District shall act fully and professionally within the District policies that are referenced above.

Even with these protections and guidelines in place, some parents/guardians may wish to exclude their students from these District-provided programs and resources. To do so, a parent/guardian must complete the form below and return it to their child's classroom teacher.

☐ I do ***not*** want my child to have access to District computerized information resources of any type.

☐ I do ***not*** want my child's image, name or work to be displayed in the media (web, print, news, etc. **This does not pertain to yearbook pictures.**

☐ I ***do*** want my child to have access to District computerized information.

☐ I ***do*** want my child's image, name or work to be displayed in the media (web, print, news, etc.).

Student's Name _____ Grade _____

Signature of Legal Guardian _____ Date _____

Relationship to Student _____

NEW YORK STATE MIGRANT EDUCATION PROGRAM

IDENTIFICATION & RECRUITMENT OFFICE

PARENT SURVEY

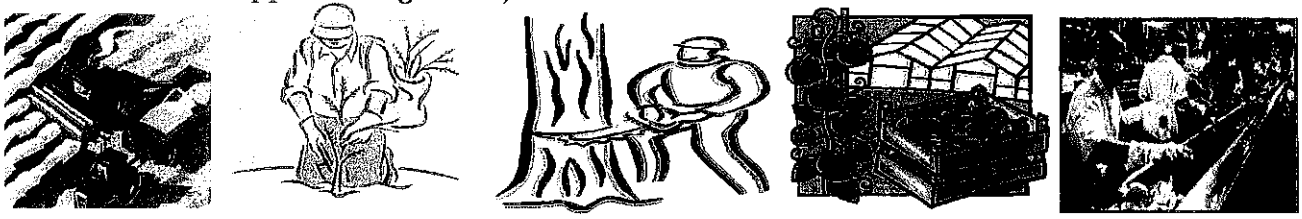
The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture. This program is **free of charge** to all eligible families and may include tutoring, free 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 within the last three (3) years?

☐ Any agricultural or farm work (such as hay, dairy, fruit or vegetable crops, poultry, fish farming, nursery/greenhouse, other)?

☐ Work related to logging, timber growing or harvesting? Work at food processing plant, (such as vegetable or poultry processing plants packing apples or vegetables)?



If you answer YES, please provide contact information below

Parent/Guardian/Eligible Person's 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 contact Irene Sanchez (Recruiter) 585-694-1460 or fax to 585-395-5731 or by mail to Brockport Migrant Education Tutorial and Support Services Program, The College at Brockport, 350 New Campus Drive B-9 Brockport, NY 14420

STUDENT NAME:_____ GRADE:_____ HOMEROOM:_____

HEALTH INFORMATION: List all health conditions which require special handling in an emergency, which may affect your child's performance in school, or that would be important for the nurse to know:

_____

_____

ALLERGIES:_____ASTHMA/INHALER_____

MEDICATIONS:_____

PHYSICIAN'S NAME:_____ PHONE:( )_____

Are there any family circumstances which might have an impact on you child's school performance?

CONSENT FOR EMERGENCY TREATMENT

In case of serious illness or the accident injury of my child, I request school personnel to contact me. If the school is unable to reach me or the emergency persons listed above, I hereby authorize officials of the Medina Central School District to make any arrangements deemed necessary for the emergency care of my child. All information is kept in your child's confidential medical file and is shared only with appropriate members of the teaching team. Also, I give consent that this information may be shared with his/her physician, and the Emergency Care Facility treating my child.

I also authorize the School Nurse to use the following First Aid products on my child as deemed necessary during the school day (please circle any product you do NOT want used on your child):

TRIPLE ANTIOBIOTIC OINTMENT	NEOSPORIN	VASELINE	LOTRIMIN
HYDROCORTISONE CREAM	BENADRYL CREAM	CALADRYL LOTION	A & D OINTMENT
CHLORASEPTIC THROAT SPRAY	STING RELIEF WIPES	ORAGEL	ANBESOL
HALLS COUGH DROPS			

_____ _____ _____ _____

Mother's (Legal Guardian's) signature Date Father's (Legal Guardian's) signature Date

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

I request that my child _____DOB _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

PLEASE CHECK ONE:

- ☐ I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips to my **self directed child**
- ☐ I understand that administration of oral, topical or inhalant medications to my **non self-directed child** and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Signature(Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by physician:

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

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Physician's Signature _____ Date:_____

Address: _____ Phone:_____

* **Medication must be in original pharmacy labeled container with specific orders and name of Medication.**

* **Medication and refills must be brought to school by parent, guardian or responsible adult.**

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE 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:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No	☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type	☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental
Asthma ☐ No	☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : _____
Seizures ☐ No	☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Yes, indicate type	☐ Type: _____ Date of last seizure: _____
Diabetes ☐ No	☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type	☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

MEDINA CENTRAL SCHOOL DISTRICT

Rev 10/30/07

NY State Consolidated Law Article 19 § 903 has been amended. Beginning 9/1/2008, a Dental Health Certificate is requested to be furnished by the student at the same time that a Health certificate is required (K,2,4,7,10 and all new entrants).

- Must be signed by a licensed Dentist.
- Must be no older than the 12 months prior to the beginning of the current school year; therefore the certificate must be dated after September 1, previous school year.
- Must describe the Dental Health Condition at the time of the exam.
- Must state whether student is in fit condition of dental health to permit attendance in school.

SCHOOL: _____ GRADE_____

TO BE FILLED IN BY PARENT/GUARDIAN BEFORE EXAMINATION BY DENTIST:

Student Name_____Birthdate___/___/___Gender_____
Last First

Address:_____
Street Town Zip

Parent/Guardian _____ _____ _____/_____
Name Home Address if different from above Home Phone Work Phone

Physician's Name_____Physician's Phone_____

Dentist's Name_____Dentist's Phone_____

DENTAL HEALTH INFORMATION (TO BE COMPLETED BY DENTIST)

Assessment Date: _____

Visible fillings and/or restoration(s) present: ____Yes____No

Untreated caries present: ____Yes ____No

Treatment Urgency: ____No obvious problem found
____Dental care recommended
____Urgent care needed

Student is in fit condition of dental health to attend school: ____Yes ____No
If No, Plan of Action:

_____ _____
Dental Professional Signature Date

_____
Print Name OR Office Stamp

RETURN THIS FORM TO THE SCHOOL
ORIGINAL TO BE RETAINED IN STUDENT'S SCHOOL RECORD

Residency Form

_____
Date

_____

is/are the owner(s)/renter(s) of the property at:

_____

The following people reside at the above address:

_____

_____

_____

As the owner(s)/renter(s) of the above property, I attest that the people listed above do reside at the above address.

_____

State of New York)
County of Orleans) ss:

Sworn to before me this

_____ of _____, 20____

_____
Notary Public