

MARYVALE SCHOOL DISTRICT
REGISTRATION PROCESS

Registrar: Michelle Pilley 716-631-7460

1. Call the Registrar (above) for a registration appointment.
2. Fill out the Enrollment Form and Registration Form.
3. Bring with you all of the following to the appointment:
 - a. **Proof of Residency**
 - i. Two proofs required - (If using an Owner's Affidavit- three proofs of residency are required)
**First proof must be a copy of a residential lease or proof of ownership of a house or condominium; a notarized statement by a landlord or owner from whom the parent/guardian leases or with whom the parent/guardian shares property within the district
 - ii. *See a list of acceptable Second proofs on this page below
 - b. **Parent/Legal Guardian Identification**
 - i. One proof required - Valid Driver's License, Non-Driver's Identification Card, Passport or other photo identification
 - c. **Proof of Student(s) Age**
 - i. One proof required - Birth Certificate, Record of Baptism, or Passport. If these are not available one of the following may be used: official driver's license; state or other government issued identification; school photo identification with date of birth; consulate identification card; hospital or health records; military dependent identification card; documents issued by federal, state or local agencies; court orders or court-issued documents; native American tribal document; or records from non-profit international aid agencies and voluntary agencies.
 - d. **Previous School Information** (name of school, address, phone number, copy of report card)
 - e. **Copy of Immunization Records and most current Physical. Immunization Records must be submitted within 14 days of this application.**
 - f. **Enrollment and Registration Forms**
 - g. **If child(ren) is not/are not living with both parents, evidence of custody of the child, including judicial custody orders or Court notarized guardianship paperwork**
4. At your appointment
 - a. Staff will review your Registration/Enrollment Forms and have you sign consent to retrieve your child's records from his/her previous school, if applicable.

Additional Forms (Acceptable as the Second of Proof of Residency):

- Current pay stub
- Income tax form
- Current utility or other bills
- Voter registration document
- Official driver's license, learner's permit or non-driver identification
- State or other government issued identification
- Documents issued by federal, state or local agencies (such as a social service agency or the federal Office of refugee Resettlement)
- Evidence of custody of the child, including judicial custody orders or Court notarized Guardianship paperwork

Enrollment Form

Local Educational Agency (LEA): **Maryvale Union Free School District**

Name of Student: _____

School: <input type="checkbox"/> Maryvale Primary School (Pre-K - 2nd) <input type="checkbox"/> Maryvale Intermediate School (3rd - 5th Grade) <input type="checkbox"/> Maryvale Middle School (6th - 8th Grade) <input type="checkbox"/> Maryvale High School (9th- 12th Grade)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth: _____	Grade: _____
Address: _____ _____	Phone: _____

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

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

Print name of Parent, Guardian or Student
(for unaccompanied homeless youth)

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

Date

MARYVALE SCHOOL DISTRICT
REGISTRATION FORM

STUDENT INFORMATION

STUDENT'S LEGAL NAME _____
Last First Middle

BIRTHDATE _____ SEX: M F DATE ENTERED GRADE: _____ Has student attended Maryvale Schools before? YES NO

STUDENT'S LEGAL RESIDENCE: _____
No. & Street Apt. No. City/Town Zip Code

Student is living with (Check only one): Both Parents Mother Only Father only Foster Parent (DSS-2999)
 Lives with relatives/friends Foreign Exchange student Other (Shelter: Motel, Hotel, Car)

Parents divorced or separated? Yes No If yes, please list contact information in **ADULT #3 BOX** and if applicable, **ADULT #4**

HOME TELEPHONE: _____ E-MAIL ADDRESS: (if any) _____

PREVIOUS ADDRESS: _____ PHONE: _____
No. & Street Apt. No. City/Town Zip Code Date of Anticipated Move to Maryvale Residence: _____

PREVIOUS DISTRICT & SCHOOL: _____ PREVIOUS GRADE _____

PREVIOUS SCHOOL PHONE NUMBER: _____ FAX NUMBER: _____

SCHOOL'S ADDRESS (to request records) _____
No. & Street City/Town State Zip

HAS STUDENT EVER REPEATED A GRADE? YES If yes, which grade? _____ NO

SPECIAL PROGRAMMING

HAS CHILD EVER RECEIVED ANY SPECIAL SERVICES? YES (check below) NO
 Special Education Services 504 Accommodation Plan Academic Intervention Services (AIS) Speech Therapy
 English as a Second Language Physical Therapy Occupational Therapy Gifted / Talented Program
 Counseling Other

HAS CHILD EVER BEEN REVIEWED BY A COMMITTEE ON SPECIAL EDUCATION (CSE): YES (If yes, please see below) NO

DOES CHILD HAVE A CURRENT INDIVIDUALIZED EDUCATION PLAN (IEP)? YES, (if yes, please provide a copy) NO

PLEASE PROVIDE CURRENT COUNSELOR AND/OR PROBATION OFFICER IF APPLICABLE: _____

For a Parent/Guardian's legal rights regarding referral and evaluation for purposes of special education services/programs please visit <http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm> or you can contact Director of Special Education, Joelle Burke, at 716-631-7476.

STUDENT RACIAL AND ETHNIC IDENTIFICATION

To the Parent/Guardian: The Maryvale School District has adopted a policy which requires the collection and recording of the ethnic identity of students in the Maryvale School District in accordance with the 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 that 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 below. Put a check (✓) in the box for the category or categories which best describes your child. The Maryvale School District understands the 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 officer 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. Thank you for your cooperation.

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.

<p>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.</p> <p><input type="checkbox"/> YES, Hispanic</p> <p><input type="checkbox"/> NO, not Hispanic</p>
<p>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.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: A person having origins in any of the original peoples of Hawaii, Guan, Samoa, or other Pacific Islands.</p> <p><input type="checkbox"/> BLACK OR AFRICAN AMERICAN: A person having origins in any of the Black racial groups of Africa.</p> <p><input type="checkbox"/> WHITE: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.</p>

MEMBERS OF THE STUDENT'S PRIMARY RESIDENCE

ADULT #1 Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <i>Sal Last First MI</i> COMPANY /BUSINESS NAME _____ WORK PHONE: _____ CELL PHONE _____ E-MAIL ADDRESS: _____ RELATIONSHIP TO CHILD: <i>Check one</i> <input type="checkbox"/> Natural Parent <input type="checkbox"/> Step-Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster _____ Other: _____		ADULT #2 Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <i>Sal Last First MI</i> COMPANY /BUSINESS NAME _____ WORK PHONE: _____ CELL PHONE _____ E-MAIL ADDRESS: _____ RELATIONSHIP TO CHILD: <i>Check one</i> <input type="checkbox"/> Natural Parent <input type="checkbox"/> Step-Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster _____ Other: _____	
NAME OF CHILD'S BROTHERS	DATE OF BIRTH	NAME OF CHILD'S SISTERS	DATE OF BIRTH

SECONDARY PARENT / GUARDIAN INFORMATION

ADULT #3 Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <i>Sal Last First MI</i> ADDRESS: _____ CITY/STATE/ZIP: _____ HOME PHONE : _____ CELL PHONE: _____ E-MAIL ADDRESS: _____ RELATIONSHIP TO CHILD: <i>Check one</i> <input type="checkbox"/> Natural Parent <input type="checkbox"/> Step-Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Other _____ ARE THEY TO RECEIVE DUPLICATE MAILINGS?: <input type="checkbox"/> YES <input type="checkbox"/> NO		ADULT #4 Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <i>Sal Last First MI</i> ADDRESS: _____ CITY/STATE/ZIP: _____ HOME PHONE : _____ CELL PHONE: _____ E-MAIL ADDRESS: _____ RELATIONSHIP TO CHILD: <i>Check one</i> <input type="checkbox"/> Natural Parent <input type="checkbox"/> Step-Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Other _____ ARE THEY TO RECEIVE DUPLICATE MAILINGS?: <input type="checkbox"/> YES <input type="checkbox"/> NO	
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USE THIS SPACE BELOW FOR ADDITIONAL NOTES/EXPLANATION, IF NECESSARY

EMERGENCY CONTACTS (RELATIVE, FRIEND, PHYSICIAN)

NAME _____	RELATIONSHIP _____	DAY PHONE _____
NAME _____	RELATIONSHIP _____	DAY PHONE _____

NAME AND ADDRESS OF OTHER YOU WOULD WANT TO RECEIVE CORRESPONDENCE AND OR REPORT CARDS: _____

 _____ RELATIONSHIP TO CHILD _____

**NOTICE / CERTIFICATION / AUTHORIZATION
FOR PERSON COMPLETING THIS FORM**

Please be advised that the provision of false information on this registration form could constitute a crime. In addition, the District reserves its right to recover from parents, legal guardians or others responsible parties the entire actual cost of educating 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 under false pretenses.

I hereby certify that the student listed on this registration form actually resides at the address specified on page 1, within the Maryvale School District boundaries. I further certify that all the information I provided on this registration form 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.

I authorize the request of student records from previous schools and give permission to the Maryvale School District to verify telephone numbers, addresses and employment. I understand that if the District believes that the information on this form is no longer correct or that the child being registered no longer lives at the address provided by you, the Maryvale School District has the right under New York State Law to investigate and to withdraw the child from the Maryvale School District.

PARENT/GUARDIAN SIGNATURE _____	DATE _____
REGISTRAR'S SIGNATURE _____	DATE _____

OFFICE USE ONLY:	SCHOOL: _____	TODAY'S DATE: _____
START DATE: _____	GRADE _____	STUDENT # _____



Lisette Colon-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:		GENDER:
Month	Day	Year
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	_____ specify
	<input type="checkbox"/> Guardian(s)		_____ specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak _____ specify
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read _____ specify
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write _____ specify

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. <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 30%;"> <p>Yes* <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/></p> </div> <div style="width: 65%;"> <p>*If yes, please explain: _____</p> </div> </div> <p>How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe</p>	
10a. Has your child ever been referred for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* <i>*Please complete 10b below</i>	
10b. <i>*If referred for an evaluation</i> , has your child ever received 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 QUALIFIED 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: _____ <small>Mo. DAY YR.</small>	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: _____ <small>Mo. DAY YR.</small>	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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:	



MARYVALE

Cheektowaga-Maryvale Union Free School District

Joseph D'Angelo
Superintendent of Schools

PARENT/GUARDIAN CONSENT FOR DISPLAY OF STUDENT PICTURES AND STUDENT WORK

At various times during the school year, your child may be involved in a number of activities in which pictures and/or work may be used. These pictures and work could be used in the yearbook, at awards assemblies, displayed on the district website, bulletin boards, submitted to "Inside Your Maryvale Schools" and/or other media to promote our school! Therefore, we are asking you to verify your intention to have your child's pictures or school work displayed.

PLEASE SIGN AND RETURN TO YOUR CHILD'S SCHOOL IMMEDIATELY

_____ Yes, I give the Cheektowaga-Maryvale UFSD permission to display my child's picture and their school work.

_____ No, I do **NOT** give the Cheektowaga-Maryvale UFSD permission to display my child's picture and their school work.

_____ Date

_____ Student's Name

_____ Grade/School

_____ Parent/Guardian Signature



MARYVALE

Cheektowaga-Maryvale Union Free School District

Joseph D'Angelo
Superintendent of Schools

STUDENT AGREEMENT FOR USE OF COMPUTERIZED INFORMATION RESOURCES

In consideration for the opportunity to use the Cheektowaga-Maryvale Union Free District's Computer System (DCS), I agree that I have been provided with a copy of the District's policy regarding student use of computerized information resources (Policy #7315). I agree to adhere to the policy and to any changes or additions later adopted by the District. I also agree to adhere to related policies published in the Student Handbook.

I understand that failure to comply with these policies may result in the loss of my access to the DCS, and in addition may result in the imposition of discipline under the District's School Conduct and Discipline Policy. Further I understand that failure to comply with these policies may constitute a criminal offense which could cause appropriate legal action to be initiated against me.

Date	Student Signature	Grade/School
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PARENT/GUARDIAN CONSENT FOR STUDENT USE OF COMPUTERIZED INFORMATION RESOURCES

I am the parent/guardian of _____, the minor student who has signed the District's Agreement for use of computerized information resources. I have been provided with a copy and I have read the District's Policy concerning use of the DCS.

I also acknowledge receiving notice that, unlike most tradition instructional or library media materials, the DCS will potentially allow my son/daughter access to external computer networks not controlled by the school district. I understand that some materials available through these external computer networks may be inappropriate and objectionable; however, I acknowledge that it is impossible for the District to screen or review all of the available materials. I accept responsibility to set and convey standards for appropriate and acceptable use to my son/daughter when using the DCS or any other electronic media or communications.

I agree to release the Cheektowaga-Maryvale Union Free School District, the Board of Education, its agents and employees from any and all claims of any nature arising from my son/daughter's use of the DCS in any manner whatsoever.

I agree that my son/daughter may have access to the DCS and I agree that this may include remote access from our home.

Date	Student Name
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Grade/School	Parent/Guardian Signature
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REQUEST FOR STUDENT RECORDS FOR NEW ENROLLMENTS

I hereby authorize the release of school records including academic, discipline, standardized testing, cumulative records/transcript, special education and/or 504/ADA information including confidential reports such as a birth certificate, NYSESLAT scores and level, science labs, immunization and health records for my son/daughter from the following school:

Previous School Name: _____

Address: _____

City/State/Zip: _____

School Phone: _____ School Fax: _____

Student Name: _____ DOB: _____

Present Grade Level: _____ Last Grade Completed: _____

Parent/Guardian Signature: _____

Please send records to the following in the Maryvale School District (see checked box):

Maryvale High School
Student Services
1050 Maryvale Dr.
Cheektowaga, NY 14225
Phone: 716-631-7409
Fax: 716-631-7404

Maryvale Middle School
Counseling Center
1050 Maryvale Dr.
Cheektowaga, NY 14225
Phone: 716-631-7439
Fax: 716-631-7499

Maryvale Intermediate School
1050 Maryvale Dr.
Cheektowaga, NY 14225
Phone: 716-631-7423
Fax: 716-631-4858

Maryvale Primary School
1 Nagel Drive
Cheektowaga, NY 14225
Phone: 716-631-7471
Fax: 716-651-0031

Maryvale School District - Special Ed. Records (IEP, Psychological, etc.)
Office of Special Education
1050 Maryvale Dr.
Cheektowaga, NY 14225
Phone: 716-631-7476
Fax: 716-635-4684

Student Health History

Parent/Guardian Please Complete:

Name: _____

(Last)

(First)

(Middle)

Date of Entry: _____ Entering Grade: _____ Birth Date: _____ Male Female Other

Address: _____

(Street)

(Town)

(Zip Code)

Father's Name: _____ Mother's Name: _____

Student's Primary Doctor: _____ Phone: _____

Last School Attended: _____

DOES YOUR CHILD:	PLEASE CHECK:	COMMENT (IF NECESSARY)
1. Have allergies (insect/food/environment)? CHECK What was your child's reaction/ANAPHYLAXIS? _____ How was this treated? 911 Benadryl Epi-Pen Was testing done to confirm the diagnosis? Yes No		1. _____ _____
2. Have Asthma?	Yes No	2. _____
3. Have frequent sore throats/strep throat?	Yes No	3. _____
4. Have frequent stomach aches?	Yes No	4. _____
5. Have ear problems/tubes/loss of hearing?	Yes No	5. _____
6. Wear glasses or contact lenses? (Please circle)	Yes No	6. _____
7. Have an orthopedic/bone/joint problem?	Yes No	7. _____
8. Have frequent headaches?	Yes No	8. _____
9. Have fainting spells?	Yes No	9. _____
10. Have a seizure disorder/staring spells? History of concussion? Yes No	Yes No	10. _____ _____
11. Have diabetes?	Yes No	11. _____
12. Have a heart condition, chest pain? Family history of sudden death (cardiac/heart) Yes No	Yes No	12. _____ _____
13. Have kidney or bladder problems?	Yes No	13. _____
14. Have anemia or other blood disorder?	Yes No	14. _____
15. Have any skin conditions?	Yes No	15. _____
16. Have scoliosis?	Yes No	16. _____
17. Wear dental braces?	Yes No	17. _____

Maryvale School District

Student Health History

Has your child ever been hospitalized for tests, illness, and surgery? If yes, please explain:

Has your child ever been treated for serious injuries or fractures? If yes, please explain:

Does anyone at home have a medical problem? If yes, explain: _____

Are there any special problems or conditions we should know about to better understand your child?

If yes, explain: _____

Does your child take medication at home? _____

Will it be necessary for your child to take medication in school? _____

Please explain: _____ (See Nurse for Medication Regulations)

Students Entering Grades 7 through 12

Does your child know how to swim? Yes No

Does your child have any medical restrictions that would prevent full participation in a swim program? Yes No

If yes, please explain: _____

If you wish to have a conference with the school nurse, please check here: _____

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: <input type="checkbox"/> M <input type="checkbox"/> 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	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g}/\text{dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

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

<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	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<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
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name:			DOB:	
SCREENINGS				
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis Required for boys grade 9	Negative	Positive	Referral	
And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics.				
<input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications				
<input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling				
<input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field				
<input type="checkbox"/> Other Restrictions:				
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> Accommodations: Use additional space below to explain				
<input type="checkbox"/> Brace*/Orthotic				
<input type="checkbox"/> Colostomy Appliance*				
<input type="checkbox"/> Hearing Aids				
<input type="checkbox"/> Insulin Pump/Insulin Sensor*				
<input type="checkbox"/> Medical/Prosthetic Device*				
<input type="checkbox"/> Pacemaker/Defibrillator*				
<input type="checkbox"/> Protective Equipment				
<input type="checkbox"/> Sport Safety Goggles				
<input type="checkbox"/> Other:				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
MEDICATIONS				
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached				
List medications taken at home:				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached				
<input type="checkbox"/> Reported in NYSIS				
Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No				
HEALTH CARE PROVIDER				
Medical Provider Signature:			Date:	
Provider Name: <i>(please print)</i>			Stamp:	
Provider Address:				
Phone:				
Fax:				
Please Return This Form To Your Child's School When Entirely Completed.				