HOLLEY CENTRAL SCHOOL NEW STUDENT REGISTRATION FORM

DATE:_____ ENTERING GRADE:_____ GENDER: _____MALE _____FEMALE

(HIGH SCHOOL ONLY)FIRST YEAR IN 9TH GRADE:_____

STUDENT'S NAME:_____
First Middle Last

DATE OF BIRTH:_____ BIRTHPLACE:_____

CHILD LIVES WITH: ___FATHER ___MOTHER ___BOTH ___GUARDIAN

NAME AND ADDRESS OF GUARDIAN (IF APPLICABLE):
NAME: _____
ADDRESS:_____ PHONE:_____
_____ CELL: _____
_____ E-MAIL:_____

ARE THERE ANY CUSTODY ISSUES WE NEED TO BE AWAREOF:_____
(IF YES, YOU MUST PROVIDE ORIGINAL LEGAL DOCUMENTS)

DOES YOUR CHILD RECEIVE ANY SERVICES:_____ IEP ( ) 504 ( )

FATHER'S NAME:_____ MOTHER'S NAME:_____

ADDRESS:_____ ADDRESS:_____
_____ _____
PHONE (If different)_____ PHONE (If different)_____
EMPLOYER:_____ EMPLOYER:_____
WORK PHONE:_____ WORK PHONE:_____

BROTHERS			SISTERS		
NAME	DOB	GRADE	NAME	DOB	GRADE

NAME, ADDRESS, AND PHONE NUMBER OF THE LAST SCHOOL ATTENDED:_____
_____
_____

PRE-K PREFERENCE:
___ Holley AM ___ Holley PM ___ Holley ABCD (Grace's Place) ___ Ready, Set, Grow
(No Transportation Provided)

Holley Central School District

Student Residency Questionnaire

Name of School: _____

Name of Student: _____ Sex: ☐Male ☐Female
Last First Middle

Birth Date: ____/____/____ Age: _____
Month Day Year

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? ____ Yes ____ No

2. Is this temporary living arrangement due to loss of housing or economic hardship?
____ Yes ____ No

If you answered YES to the above questions, please complete the remainder of this form. If you answered NO, you may stop here, but please sign below.

****

Where is the student presently living? (*Check one box.*)

☐In a motel
☐In a shelter
☐With more than one family in a house or apartment
☐Moving from place to place
☐In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite

Name of Parent(s)/Legal Guardian(s) _____
Address _____ Phone _____

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002(3)(d).

_____ _____
Signature of Parent/Legal Guardian **Date**

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

_____ _____
Date McKinney-Vento Liaison Signature

Holley Central School District

Cuestionario de Residencia para Estudiantes

Nombre de la Escuela _____

Nombre del Estudiante _____ Sexo: ☐ Masculino
Apellido Nombre Segundo Nombre ☐ Femenino

Fecha de Nacimiento ____/____/____ Edad: _____ # de Seguro Social: _____
Mes Día Año *(o número de indentificación escolar)*

El propósito de este cuestionario es presentar los objetivos del Acta McKinney-Vento (42 U.S.C.11435). Las respuestas a estas preguntas ayudarán determinar los servicios que el estudiante debe recibir.

1. ¿Es su domicilio actual un arreglo de vivienda temporal (de poca duración)? _____Si _____ No

2. ¿Es este arreglo de vivienda temporal debido a la pérdida de su casa, vivienda o habitación, o debido a algún problema económico (*ejemplo*: desempleo)? _____Si _____ No

Si usted contestó SI a estas preguntas, por favor complete el resto de este formulario.
Si usted contestó NO a estas preguntas, no siga.

¿Dónde se encuentra viviendo el estudiante actualmente? (Marque una opción.)

- ☐ En un motel
- ☐ En un albergue o lugar de refugio
- ☐ Con más de una familia en una casa o apartamento
- ☐ Moviéndose de lugar en lugar
- ☐ En un lugar generalmente no designado para dormir (ejemplo: carro, parque, o campamento)

Nombre del Padre/Madre/Guardián _____

Dirección _____ Zona Postal _____ Teléfono _____

Presentar información falsa o la falsificación de documentos para uso escolar son ofensas bajo la Sección 37.10 del Código Penal, y la inscripción del estudiante usando documentos falsos traerá como consecuencia que los responsables estarán sujetos a pagar los gastos de instrucción u otros cargos. TEC Sec. 25.002(3)(d).

Firma del Padre/Madre/Guardián _____ **Fecha** _____

Yo certifico que el estudiante nombrado en este formulario califica para los programas de nutrición escolares bajo las provisiones del Acta McKinney-Vento.

_____ _____
Fecha Firma del oficial autorizado

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

Lissette 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: *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 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: ☐ 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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

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

Lissette 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

Cuestionario de Idioma del Hogar ("HLQ" por sus siglas en inglés)

Estimados padres o tutores:
Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura, escritura y comprensión en el inglés, así como conocer su educación previa e historial personal. Por favor, llene con su información las secciones "Conocimientos de idiomas" e "Historial educativo". Apreciamos mucho su colaboración respondiendo a estas preguntas.
Gracias.

Por favor escriba con claridad al completar esta sección.

NOMBRE DEL ESTUDIANTE:

Nombre *Segundo nombre* *Apellido*

FECHA DE NACIMIENTO:

Mes *Día* *Año*

GÉNERO:
☐ Masculino
☐ Femenino

INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL

Apellido *Primer Nombre* *Relación con el estudiante*

CÓDIGO DEL IDIOMA DEL HOGAR

Conocimientos de idiomas

(Por favor, marque todas las opciones que sean aplicables)

1. ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante?	☐ Inglés	☐ Otro	*especifique*	
2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?	☐ Inglés	☐ Otro	*especifique*	
3. ¿Cuál es el idioma primario de cada padre / tutor?	☐ Madre *especifique*	☐ Padre *especifique*	☐ Tutor(es) *especifique*	
4. ¿Qué idioma o idiomas entiende su hijo(a)?	☐ Inglés	☐ Otro	*especifique*	
5. ¿Qué idioma o idiomas habla su hijo(a)?	☐ Inglés	☐ Otro	*especifique*	☐ No sabe hablar
6. ¿Qué idioma o idiomas lee su hijo(a)?	☐ Inglés	☐ Otro	*especifique*	☐ No sabe leer
7. ¿Qué idioma o idiomas escribe su hijo(a)?	☐ Inglés	☐ Otro	*especifique*	☐ No sabe escribir

TO BE COMPLETED BY THE DISTRICT IN WHICH THE STUDENT IS REGISTERED

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

PARA LLENAR POR EL DISTRITO EN EL QUE EL ESTUDIANTE SE HA INSCRITO

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

8. Indique con un número el total de años que su hijo(a) lleva inscrito en una escuela: _____

9. ¿Cree usted que su hijo(a) pueda tener dificultades, interferencias o problemas educacionales que le afecten su capacidad para entender, hablar, leer o escribir en inglés o en cualquier otro idioma? En caso afirmativo, por favor describalos.

*Sí** ☐ *No* ☐ *No se sabe* ☐ * En caso afirmativo, por favor explique :_____

¿Qué gravedad considera usted que tienen estas dificultades educacionales? ☐ Poca gravedad ☐ Algo grave ☐ Muy grave

10a. ¿Alguna vez se ha recomendado a su hijo(a) a tener una evaluación de educación especial? ☐ No ☐ Sí* * *Por favor, llene 10b.*

10b. **Si se le ha recomendado alguna vez una evaluación,* ¿ha recibido su hijo(a) alguna vez alguna forma de educación especial?

☐ No ☐ Sí -- Explique, que forma o formas de educación especial recibió:

_____

Edad en la que recibió la intervención o forma de educación especial *(favor de marcar todas las opciones que sean aplicables):*

☐ De nacimiento a 3 años (Intervención Temprana) ☐ 3 a 5 años (Educación Especial) ☐ 6 años o mayor (Educación Especial)

10c. ¿Tiene su hijo(a) un Programa de Educación Individualizada ("IEP" por sus siglas en inglés)? ☐ No ☐ Sí

11. ¿Considera que hay alguna otra información importante que la escuela deba saber sobre su hijo(a)?
(Por ejemplo, talentos especiales, problemas de salud, etc.)

12. ¿En qué idioma(s) quiere usted recibir la información de la escuela? _____

_____ Mes: Día: Año: _____

Firma del padre/madre o de la persona en relación paternal *Date*

Relación con el estudiante: ☐ Madre ☐ Padre ☐ Otra:_____

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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Internet Usage/Permission to Use Computers

The District has taken appropriate precautions to protect students during their use of the District's Computer System (DCS). A "firewall" is in place and the District uses *LightSpeed* to block inappropriate Internet sites. However, new sites are launched every minute, so complete student protection must be a partnership between the District, its students, and their parents/legal guardians.

After you have read the copy of the district's policy from page 2 of the *Holley Elementary School Rules and Expectations for Student Behavior* (white handbook), fill in the forms below and return them to school.

Agreement for Student Use of District Computerized Information Resources (Policy 7000F)

In consideration for the privilege of using the School District's Computer System (DCS), I agree that I have been provided with a copy of the District's policy on student use of computerized information resources and the regulations established in connection with that policy. I agree to adhere to the policy and the regulations 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 and regulations may result in the loss of my access to the DCS, and may in addition result in the imposition of discipline under the District's school conduct and discipline policy and the Student Discipline Code of Conduct. I further understand that the District reserves the right to pursue legal action against me if I willfully, maliciously or unlawfully damage or destroy property of the District. Further, the District may bring suit in civil court pursuant to General Obligations Law Section 3-112 against my parents or legal guardians if I willfully, maliciously or unlawfully damage or destroy District property.

_____

Student Signature Date

Parent/Legal Guardian Consent (Policy 700F.1)

I am the parent/legal guardian of _____, the minor student who has signed the District's agreement for student use of computerized information resources. I have been provided with a copy (above) and I have read the District's policy and regulations concerning the use of the District's Computerized System.

I also acknowledge receiving notice that, unlike traditional instructional or library media materials, the DCS will potentially allow my son/daughter student access to external computer networks (Internet) not controlled by the School District. I understand that some of the materials available through these external computer networks may be inappropriate and objectionable; however, I acknowledge that it is impossible for the District to screen 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 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.

_____

Parent Signature Date

THIS FORM IS TO REMAIN IN THE STUDENT'S CUMULATIVE FOLDER

Holley Central School District

Elementary School

Brian Bartalo, Superintendent bbartalo@holleycsd.org
Karri D. Schiavone, Principal kschiavone@holleycsd.org
Timothy Artessa, Assistant Principal tartessa@holleycsd.org

HOUSEHOLD TECHNOLOGY SURVEY

1. Do you have regular access to a computer? ____Yes ____No
   If yes… ____at home
   ____at work
   ____other_____

2. Do you have internet access? ____Yes ____No
   If yes… ____at home
   ____at work
   ____other_____

3. Do you access the SchoolTool Parent Portal? ____Yes ____No

4. Do you have an email address? ____Yes ____No
   If yes, please list them _____

_____

Please identify the household name and children:
Parents/Guardians _____

Children (include ages) _____

_____

_____

_____

HOLLEY CENTRAL SCHOOL DISTRICT

All students between 3 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.

Student Name: _____

Date of Birth: _____ Name of School: _____

School District Student Identification Number: _____

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): ☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify):_____

Holley Central School District

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Student Name _____ Birthdate _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

I hereby authorize my child's physician(s) listed above to exchange the following information with Holley Central School staff, including:

- ☐ School Nurse
- ☐ Physical Therapist
- ☐ Occupational Therapist
- ☐ Speech Therapist
- ☐ Audiologist
- ☐ Vision Department
- ☐ Admissions Officer
- ☐ School Psychologist
- ☐ School Social Worker
- ☐ _____
- ☐ Immunizations/physical exams to comply with NYS regulations
- ☐ Social History
- ☐ Psychological evaluations/reports
- ☐ Medical clearances as needed following an injury or change in condition
- ☐ Medical orders required for therapy needs; evaluations
- ☐ Authorization for medications during the school day or on school trips
- ☐ Medical condition/treatment plans that may have an impact in the school environment
- ☐ Physician referral for services (OT, PT)
- ☐ Other _____

This information will be used to provide a safe and healthful environment and develop an appropriate program for this student at school. Enrollment is not contingent upon obtaining this release, however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment. This release expires on the last day of the enrollment of the above student in school and may be revoked at any time by sending the request to cancel this permission to the address above. Such revocation will not affect any disclosure made prior to its receipt. Protected health information will not be disclosed without consent per FERPA regulations. **A copy of this release has been provided to me and will be sent to the appropriate provider when requests are made.**

☐ **I waive my right to receive a copy of this notice.**

_____ _____

(Signature of student over 18 or Parent/Guardian)** (Date)

**If a student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is signing, authority to act on student's behalf: _____

This form complies with all HIPPA regulations.

3800 North Main Street • Holley, New York 14470
Phone: (585) 638-6316 • ES Fax: (585) 638-0706 • MS/HS Fax: (585) 638-7925

HOLLEY CENTRAL SCHOOL DISTRICT
STUDENT HEALTH HISTORY

Student's Name _____ Date of Birth _____

Parent's Names _____ Phone _____

Address _____

Physician's Name _____ Phone _____

Address _____

Dentist's Name _____ Phone _____

Address _____

Has your child had any of the following? If yes, describe.

	NO	YES	PLEASE DESCRIBE
Allergies	___	___	_____
Asthma	___	___	_____
Diabetes	___	___	_____
Seizures	___	___	_____
Bleeding Tendencies	___	___	_____
Heart Disease	___	___	_____
Tuberculosis Contact	___	___	_____
Rheumatic Fever	___	___	_____
Severe Headaches	___	___	_____
Frequent Sore Throats	___	___	_____
Frequent Ear Infections	___	___	_____
Pneumonia	___	___	_____
Chicken Pox	___	___	_____
Skin Conditions	___	___	_____
Cancer	___	___	_____
Leukemia	___	___	_____
Vision Problems	___	___	_____
Hearing Problems	___	___	_____
Speech Problems	___	___	_____
Orthopedic Problems Such as scoliosis or club foot	___	___	_____

OVER

Is your child now or has (s)he ever been on any regular medication? Explain.

_____

_____

Has your child had any operation (including tonsillectomy, tubes in ears)? Yes No

When?_____

Explain_____

_____

Has your child had any serious accidents or injuries? _____ When?_____

Describe_____

_____

Has your child ever been hospitalized? _____ For what reason? _____

_____

Does your child have any special problems or inherited family diseases?

_____

Does your child have any dietary restrictions? _____

_____

Does your child have any physical restrictions? _____

_____

Is there anything not covered in the above medical history that you think would be important for us to know about your child? If so, please explain.

_____

_____

_____

_____

Date of last physical _____

HOLLEY CENTRAL SCHOOL, 3800 NORTH MAIN STREET, HOLLEY, NEW YORK 14470

Dental Health Certificate- Optional

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. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. 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's medical director or school nurse as soon as possible.

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

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

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

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health. I understand that I am free to choose my own dentist for further care.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature _____ Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the examination needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit him/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit him/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 name and address (please print or stamp) Dentist's Signature

Optional Sections - If you agree to release this information to school, please initial here. ☐

II. 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):_____

III. 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.

Revised 8.1.09

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH APPRAISAL FORM

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** ☐ M ☐ F **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

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

Significant Medical/Surgical History: ☐ See attached _____

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other: _____

Allergies: ☐ **LIFE THREATENING** ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____
☐ Seasonal ☐ Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Body Mass Index: _____ . _____

Weight Status Category (BMI Percentile):
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ☐ Yes ☐ No Student may self carry and self administer medication ☐ Yes ☐ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school:** _____ ☐ None

☐ **Known or suspected disability:** _____ ☐ Please monitor

☐ **Restrictions:** _____ ☐ Please monitor

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

(Stamp below)

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 10/3/07*