CASSADAGA VALLEY CENTRAL SCHOOLS

5935 Route 60, Sinclairville , New York 14782

(716)962-8581 ♦ Fax (716)962-5976 ♦ www.cvcougars.org

ENROLLING NEW STUDENTS

Welcome to Cassadaga Valley Central School District

The following information will help make the school registration process efficient.

You (the parent or guardian) have to show that the youth is living with you and that you have total and permanent custody. To do this, you can show the school district:

- If you are the child's biological parent - Your photo ID and the child's birth certificate

  Or
- Proof of custody or guardianship – court documents

  Or
- Other poof such as documentation that the child has been placed with you by an agency, such as Foster Parent form DSS-2999

Documents required for new student registration, please bring with you when you register your child/children:

- Birth Certificate
- Up-to-date Immunization Record
- Photo Identification of Parent/Guardian registering the student
- Proof of Residency - The following are ways you can show residency:
  - Driver's license, or permit, or non-driver ID
  - State or other government issued ID
  - Documents from government agencies such as a social service agency
  - Custody or guardianship papers
  - Lease or deed
  - Landlord's Affidavit you pay rent to, saying you live there or rent receipt
  - Pay stub showing your address
  - Income tax form that shows your address
  - Utility bill or other bill in your name that shows your address
- Proof of custody/guardianship – Court documents if applicable
- Foster family documentation (DSS-2999) if applicable
- Name, address & phone number of previous school

Optional but not required:

- Report card from previous school
- Transcript
- IEP/504 plan (Special Education Students) if applicable

Notice of Parent/Guardian Rights Related to Special Education Services

Please visit http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm for further information on your rights regarding potential referral and evaluation of your child for purposes of special education. If you have any questions about the guide or special education services please contact the Director of Special Education- Rebecca Donnelly, 716-962-8581

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New Student Registration School (circle one): Elementary Middle High

Student ____
Last First Middle

Has this student ever attended a Cassadaga Valley School before? Yes / No

Previous School- Name, Address, Phone number :

____

Type of School Program- Special Education: ______________________________

Date of Birth ____________ Place of Birth (City, State) ________________ Gender: Male / Female

Race: Circle **ALL** that apply: Asian Black Native American/Alaskan Native Hawaiian/Pacific Islander White

Is Student Hispanic, Latino, or of Spanish origin? _____Yes _____No Student Cell #: ______________

Student Resides at:____
Street Address City State Zip County

Mailing Address (if different): P.O. Box ______________________________________

Home/Main Phone # ________________ Is this a Cell # ____Yes ____No

Student Resides With: Mother Father Both Step-Parent Guardian Foster Other __________
Circle all that apply

If Student is living with someone other than a Custodial Parent, Legal Guardianship papers must be furnished.

Circle: Married Single Separated Divorced Guardian Step

Father/Guardian Name ______________________________ Child Pick Up Allowed: YES NO
If Guardian, please provide relationship to student

Address ____________________________ Home Phone ______________Cell # ______________

Mailing Address_______________________________Email Address___________________

Employer __________________ Job Title _______________ Work Phone_ _____________

Employer Address____

Circle: Married Single Separated Divorced Guardian Step

Mother/Guardian Name ______________________________Child Pick Up Allowed: YES NO
If Guardian, please provide relationship to student

Mother's Address ________________________ Home Phone______________ Cell #______________

Mailing Address_______________________________Email Address___________________

Employer ___________________Job Title _______________ Work Phone _____________

Employer Address____

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CUSTODY (if applicable) ____ (Legal documents required)

Are there any custody issues the school needs to be made aware of?____________________________________

If the student is in a Foster Home, Please list the name of the Caseworker and the Agency involved and provide the phone number and address:

➡ Does this student have a parent on active duty in the Armed Forces? ______Yes ______No

Emergency Contact Information in the event a Parent/Guardian is unavailable

1) Name__________________________________Relationship_____________ Child Pick Up Allowed: YES NO

Address:______________________ Home Phone__________Work Phone___________Cell Phone__________

2 Name__________________________________Relationship_____________ Child Pick Up Allowed: YES NO

Address:______________________ Home Phone__________Work Phone___________Cell Phone__________

3) Name__________________________________Relationship_____________ Child Pick Up Allowed: YES NO

Address:______________________ Home Phone__________Work Phone___________Cell Phone__________

PLEASE LIST THE MEMBERS OF YOUR HOUSEHOLD (ie: Brothers, sisters):

	NAME	RELATIONSHIP TO CHILD	DATE OF BIRTH
1.			
2.			
3.			

Please provide information on alternate drops-off sites for the transportation department to use in case of an early or unplanned school closing. Please discuss this type of emergency situation with your child in the event that the alternative site is not available/not home. Please complete the following to signify the emergency drop-off site:

____Ride the usual bus

____Ride the bus to (Name/address/phone)____

____For MS/HS – Walk to (Name/address/phone)____

____Other (please specify)____

I,____, have read the foregoing and have fully, truthfully and accurately answered the questions.

____ ____

Signature of Parent/Guardian Print Parent/Guardian Name

****

Office Use – Checklist

Photo ID Presented _____Driver's License ____Other- List type______________________

____Birth Certificate ____**IMMUNIZATIONS RECORDS** Must be from Doctor's office** **Parent/Guardian MUST REQUEST from Physician**

____ Proof of Guardianship, Custody Papers, Foster Family documentation (DSS-2999) attach copy

____Proof of Residency – List type________________________________ ____Homeless ____IEP

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Custody Disclosure Form

Cassadaga Valley Central School District is responsible for registration, but is **not** responsible for determining which parent or guardian may check a child in/out of school, etc. If custodial or guardianship issues exist when you register your child, it is your responsibility to provide custodial documentation to the District.

Note: a current complete legal court document must be provided to ensure District compliance with custody orders.

Please inform your child's school of changes in custodial arrangements.

Information on Rights of Parents from the Family Education Rights and Privacy Act (FERPA):

An educational agency or institution shall give full rights under the Act to either parent, unless the agency or institution has been provided with evidence that there is a court order, State statute, or legally binding document relating to such matters as divorce, separation, or custody that **specifically revokes these rights**. (Authority:20 U.S.C. 1232g)

Parent/Guardian Name:____

Child(ren) Name(s):____

☐ Parent/guardians are together residing at the same residence

☐ Parents/guardians divorced/separated – **Joint Custody**
Court ordered or legally agreed upon physical placement is:______________________

☐ Parents/guardians divorced/separated – **Sole Custody**
Status of other Parent/guardian:____

☐ Restricted pickup – Legal documentation must be provided:______________________

☐ Single parent (father or mother is not listed on the birth certificate)

☐ Other Guardian circumstances (please explain):_____________________________

Please initial all that apply

_____ I have attached a copy of those pages of the legal court documents that describe custody arrangements.
_____ I have disclosed my current custody/guardianship arrangement.
_____ I understand that it is my responsibility to update my child's school of changes in custody.

Family Name:________________________________

Address:___________________________________

City, State, Zip:______________________________

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Household Income Form

Community Eligibility Provision (CEP)/Provision 2 non-base year
Household Income Eligibility Form Cassadaga Valley Central School District

Cassadaga Valley Central School District is participating in the Community Eligibility Provision (CEP) or Provision 2 in a non-base year. All children in the school will receive meals/milk at no charge regardless of household income or completion of this form. This form is to determine eligibility for additional State and federal program benefits that your child(ren) may qualify for. Read the instructions on the back, complete **only one** form for your household, sign your name and return it to the school named above. Call Marcy Sweetman at (716)962-8581 x1255, if you need help.

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	No Income
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. Skip to Part 5, and sign the application.

Name: ____ CASE #________________________________

3. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box. If you have listed a foster child above, you must report their personal income.

Name of household member	Earnings from work before deductions ***Amount / How Often***	Child Support, Alimony ***Amount / How Often***	Pensions, Retirement Payments ***Amount / How Often***	Other Income, Social Security ***Amount / How Often***	No Income
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ________	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ________	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ________	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ________	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ________	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ________	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ________	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ________	☐

4. Signature: An adult household member must sign this application.

I certify (promise) that all information on this application is true and that all income is reported. I understand that the information is being given so the school may receive federal funds. The school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Signature: ________________________________ **Date:** _________

Email Address: ____

Home Phone ____

Work Phone ____

Home Address____

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

SNAP/TANF/Foster Income   Total Household Income/How Often: Household Size:

Free Eligibility   Reduced Eligibility   Denied Eligibility

Signature of Reviewing Official

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CEP/Provision 2 Non-Base Year Household Income Form INSTRUCTIONS

PART 1 — **ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE FORM FOR YOUR HOUSEHOLD.**

(1) Print the names of the children, including foster children, for whom you are applying on one form.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, and check the box for each child with no income.

PART 2 — **HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.**

(1) List a current SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families) or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. Do not use the 16-digit number on your benefit card. The case number is provided on your benefit letter.
(2) An adult household member must sign the form in PART 4**. SKIP PART 3** - Do not list names of household members or income if you list a SNAP, TANF or FDPIR number.

PARTS 3 & 4 — **ALL OTHER HOUSEHOLDS MUST COMPLETE ALL OF PARTS 3 AND 4.**

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box.** The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.

PRIVACY ACT STATEMENT

Privacy Notice: The New York State Department of Education is requiring schools to collect the information on this form. You do not have to give this information, but if you do not, we cannot determine your child's eligibility for additional benefits under state and federal programs. We will hold the information you provide us as private and confidential to the extent required by law. However, we will share your socioeconomic status with various state and federal programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules. Regardless, all students enrolled in a Community Eligibility Provision school will receive a meal at no charge.

Non-Discrimination Statement: In accordance with Federal Law and U.S. Department of Education policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write U.S. Dept. of Education, Office for Civil Rights, The Wanamaker Building, 100 Penn Square East, Suite 515, Philadelphia, Pa. 19107-3323 or call (215)656-8541 (Voice). Individuals who are hearing impaired or have speech disabilities may contact U.S. DOE through the Federal Relay Service at (800)877-8339; or (800)845-6136(Spanish). The U.S. Dept. of Education is an equal opportunity provider and employer.

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Student Residency Questionnaire

Name of School: ____

Name of Student: ____

Last First Middle

Address: ____

____

Birth Date: ____/____/____ Age: __________ Sex: ☐ Male ☐ Female

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C.11435. This residency information will 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.

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:______________________________ Zip:__________ Phone:__________________

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:______________________________

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Student Information

Authorization for Release of Information

Student's Last Name:______________________ First Name:____________________ Middle:________________

Date of Birth:______________________ Entering Grade:____________

Former School Information

Name & Address of Former School: ____

____

____

Telephone #:_____________________Fax #_______________________

Reason for Request: **Transfer** Anticipated Start Date:_________________

Return Information to: Cassadaga Valley Central School District to the school checked below

- ☐ Grades PK – 5 — Sinclairville Elementary School Main Office
- ☐ Grades 6 – 8 — Cassadaga Valley Middle School Counseling Department
- ☐ Grades 9 – 12 — Cassadaga Valley High School Counseling Department

<u>Please fax</u> **or** <u>mail the following copies of school records</u> for the above named student.
Your Prompt attention will assure an efficient and easier transition for the student.

- ☐ **Complete Transcript**
- ☐ **Current Report Card**
- ☐ **Attendance Record**
- ☐ **Birth certificate**
- ☐ **Completed Science Labs**
- ☐ **Discipline**
- ☐ **Withdrawal Grades to Date**
- ☐ **CSE Information, IEP, 504 Plan**
- ☐ **Psychological Reports**
- ☐ **Immunization Records (must be from physician or NYSIIS)**
- ☐ **Custodial/Guardianship papers**
- ☐ **Assessment scores**
- ☐ **Other ___________________________________**

I do hereby authorize permission for you to release all of the above records to Cassadaga Valley Central School District.

____ ____________________________

Signature of Parent/Guardian or Student over 18 Date

Parental permission is no longer required when authorized school personnel request records. (FERPA, Final Rule on Education Records, Federal Register, June 17, 1976 Vol. 41, No. 118, Page 24673.)

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Withholding of Consent for the Release of Information

This form is for Students in Grades 11 - 12

Federal regulations allow military recruiters and institutions of higher learning to have access to students' names, addresses and telephone numbers, subj ect to the right of parents to refuse the release of such information. This requirement is part of the "Family Educational Rights and Privacy Act (FERPA)" and the "National Defense Authorization Act."

Parents, or students who are at least 18 years old, wishing to exercise their option to withhold their consent to release the referenced information to military recruiters and institutions of higher learning must sign and return to the school district's attendance secretary.

NOTIFICATION TO SCHOOL DISTRICT

TO: The School Counseling Office, Cassadaga Valley Central School District, Sinclairville, NY

RE: Withholding of Consent for the Release of Certain Student Information

Please DO NOT release the name, address or telephone number of

__________________________________ to military recruiters or institutions of higher learning.

(print name of student on line)

____

Parent Name (Print)

___________________________ ________________

Parent Signature Date

_________________________ ________________

Student Signature (if 18 years old or older) Date

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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:		**GENDER:**
		❑ Male ❑ Female ❑ Non-Binary
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? ❑ English ❑ Other *specify* ____________
2. What was the first language your child learned? ❑ English ❑ Other *specify* ____________
3. What is the Home Language of each parent/guardian? ❑ Mother *specify*____________ ❑ Father *specify*____________ ❑ Guardian(s) *specify*____________
4. What language(s) does your child understand? ❑ English❑ Other) *specify*____________
5. What language(s) does your child speak?❑ English ❑ Other *specify*____________ ❑ Does not speak
6. What language(s) does your child read?❑ English ❑ Other *specify*____________ ❑ Does not read
7. What language(s) does your child write?❑ English ❑ Other *specify*____________ ❑ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:		
SCHOOL DISTRICT INFORMATION:		STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School	*Address*	

 ENGLISH

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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 (PreSchool 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?

Date: Month: Day: Year:

____

Signature of Parent or of Person in Parental Relation

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:

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CVCSD User Agreement

Cassadaga Valley Central School District students will be using devices as an integral part of their educational program. They will be responsible for all of the items that are assigned to them. It is expected that your child will adhere to the expectations outlined in the CVCS User Agreement to use the instructional device in a safe, appropriate manner as a learning tool to better their learning experience. These devices are to be used to access students' educational content, to complete teacher designed learning activities, and to appropriately communicate about learning with peers and teachers. Students are expected to remain diligent in the appropriate care and use of The assigned device.

Read the User Agreement that pertains to your child and sign and return the form.

Agreements can be found on the CVCSD Website www.cvcougars.org.

- Click on **Departments**
- Click on **Curriculum/Technology** tab
- Scroll down to **User Agreements**

Please sign this consent form stating that you have read and understand the User Agreement located on CVCSD Website and that you agree to the guidelines that have been presented and outlined.

Name of Child for Whom this Applies: ______________________________
(Please Print)

Student Signature: ______________________________

Current Grade Level of Child: ________

Name of Parent/Guardian: ______________________________
(Please Print)

Parent/Guardian Signature: ______________________________

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Cassadaga Valley Central School District

IMPORTANT Parent Permission / Student Responsible Use Form

Federal and New York State laws and regulations require parents/guardians to grant or deny permission for a variety of school services. These are the laws and policies that help to protect our students online:

Child Internet Protection Act (CIPA)	**http://fcc.gov/cgb/consumerfacts/cipa.html**
Children's Online Privacy Protection Act (COPPA)	**http://www.ftc.gov/privacy/coppafaqs.shtm**
Family Educational Rights and Privacy Act (FERPA)	**http://www2.ed.gov/policy/gen/guid/fpco/ferpa**

1. The Cassadaga Valley Central School District **has my permission** to create a Google Apps For Education account for my child. Google Apps for Education is a set of free online tools used by teachers and students to better communicate, share, and collaborate. I understand that my child may utilize the account while in school or on another device that has an Internet connection.

    a. ❏ I agree ❏ I disagree

2. The Cassadaga Valley Central School District **has my permission** to create a Schoology account for my child. Schoology is a web-based learning management system that allows teachers to design and share lessons with students and parents. I understand that my child may utilize the account while in school or on another device that has an Internet connection.

    a. ❏ I agree ❏ I disagree

Name of Parent or Guardian:________________________________Date:_______________

Signature of Parent or Guardian: ____

Child for Whom This Permission Applies: ____

Grade: ______

Signature of Child : ____________________________________Date: _______________

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Cassadaga Valley Central School District

IMPORTANT Annual Photo Permission Form

Federal and New York State laws and regulations require parents/guardians to grant or deny permission for a variety of school services. These are the laws and policies that help to protect our students:

Family Educational Rights and Privacy Act (FERPA) http://www2.ed.gov/policy/gen/guid/fpco/ferpa

The Cassadaga Valley Central School District has my permission to use my child's photograph/image for public relations, educational or other purposes consistent with the purpose and mission of the Cassadaga Valley Central School District, including publication on the Cassadaga Valley Central School District website, Facebook™ page and Twitter™ page.

❏ I agree ❏ I disagree

Name of Parent or Guardian: ______________________________ Date: ________________

Signature of Parent or Guardian: ____

Child for Whom This Permission Applies: ____________________________________

Grade: ______

****failure to return the completed form will indicate that student pictures and/or work can be published until appropriate notice is given.**

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Cassadaga Valley Central School District

Student Health Information

STUDENT NAME:____**BIRTH DATE**:___________**GRADE:**________

CHILD'S DOCTOR: ____ **Phone**: ______________

STUDENT'S HEALTH INSURANCE: ____

DOES NOT HAVE HEALTH INSURANCE [ ]

CHILDHOOD ILLNESSES: Has your child had any of the following diseases? Please check all that apply.

Chicken Pox	___________	Pneumonia	_____________
3-Day Measles (German)	___________	Rheumatic Fever	_____________
9-Day Measles	___________	Polio	_____________
Mumps	___________	Diphtheria	_____________
Whooping Cough	___________	Scarlet Fever	_____________

Explanation of the above, if needed: ____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING? Please explain:

Asthma____
Frequent Colds ____
Heart Disease ____
Diabetes____
Seizures/Epilepsy ____
Hemophilia____
Tuberculosis____
Ear Conditions ____
Other____

ALLERGIES: (Please list the agent to which your child is allergic and any treatment needed and severity of allergy.)

____
____

Does the allergy require an epi-pen?____

HAS YOUR CHILD HAD ANY OF THE OF THE FOLLOWING: (Please explain fully.)

Operations : ____
____

Serious Injuries: ____
____

Unusual Illnesses: ____
____

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IS YOUR CHILD ON MEDICATION? YES [ ] NO [ ] **NAME & DOSAGE** : ______________________________

If medication is needed in school you must have a doctor's order and parent permission on file with the nurse

IS THERE ANYTHING SPECIAL ABOUT YOUR CHILD THAT WE SHOULD KNOW? ________________________
____

Speech Problems	__________	Emotional Problems	__________
Hearing Problems	__________	Temper Tantrums	__________
Vision Problems	__________	Aggressiveness	__________
Hyperactivity	__________	Shyness	__________

Any Fears? ____

Is there any language spoken at home besides English? ____

SCREENINGS: The new **vision and hearing screening** guidelines recommend near and distance visual acuity once within six months of admission to school and in grades Pre-K, Kindergarten, 1, 3, 5, 7, and 11. **Scoliosis screening** is required for girls in grades 5 and 7 and for boys in grade 9. If you would prefer your child to have his/her vision, hearing, and scoliosis exams performed by his/her own private physician please notify the nurse in your child's building in writing prior to the start of the school year and provide a copy of the exam when complete.

PHYSICALS: Students in special education classes, pre-k, kindergarten,1st, 3rd, 5th, 7th, 9th & 11th grades and all new students, regardless of grade level, will have a physical in school unless you prefer to have it done by your private physician. If you choose to have a private physical a copy must be provided to the building Nurse or a school physical will be done.

A Dental Certificate and BMI Weight Status Category are also required of students in these grades.

Please indicate your preference:

____School Physical ____Private Physician Physical (a copy must be provided)

I, ________________________________, have read the foregoing and have fully, truthfully and accurately answered the questions.

____ __________
Signature of Parent/Guardian **Date**

Print Parent/Guardian Name: ____

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IMMUNIZATIONS REQUIRED FOR SCHOOL ENTRY:

We must have a copy of your Child's immunization record *FROM A DOCTOR* on or before the first day of school attendance in order for your child to attend school.

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 ☐ NB	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental
Asthma ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached ☐ Intermittent ☐ Persistent ☐ Other : ____________________________
Seizures ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached ☐ Type: ___________________________ Date of last seizure: ______________
Diabetes ☐ No	☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

☐ Yes, indicate type ☐Type 1 ☐ Type 2 ☐ HgbA1c 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	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle ☐ Concussion – Last Occurrence: ______________________
Sickle Cell Screen/PRN	☐	☐		☐ Mental Health: ___________________________ ☐ Other:
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL				

☐ **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:	Diagnoses/Problems (list)	ICD-10 Code
☐ Additional Information Attached	______________________	____________
	______________________	____________
	______________________	____________
	______________________	____________

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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 9-12 to play at high school level **OR** Grades 7-8 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.

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Cassadaga Valley Central School: Dental Health Certificate **MUST BE SIGNED BY DENTIST**

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 1, 3, 5, 7, 9 & 11. 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/Teacher:

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 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/Guardian Signature____ Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of ______________________________ on ________________ (date of exam) The date of the exam 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 a fit condition of dental health to permit his/her attendance at the public schools.
- No, The student listed above is not in a fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in a 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 a 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 your child's 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.

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HIPAA (Health Insurance Portability and Accountability Act) --Compliant Authorization for Release of Health Information

Student Name____ **Date of Birth**_____________

Grade/Teacher____

I hereby authorize the Cassadaga Valley Central School's School Nurse to release my child's health information to appropriate school staff as needed. This information will be used to alert CVCS staff of a student's medical issues and to allow accommodations as needed. This includes such things as bee sting allergies, food allergies, need for Epipen, asthma, diabetes, etc. If this form is not returned NO health information will be shared with staff.

Description of Purpose:
The following health information may be shared with appropriate Cassadaga Valley Central School staff as needed—please include any diagnoses, emergency care, medications, etc:

Authorization

This authorization is valid for the 20___- 20___ school year. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights & Privacy Act. I also understand that if I refuse to sign, such refusal will **NOT** interfere with my child's ability to obtain health care **but that no health information will be shared with Cassadaga Valley Central School staff without your written permission.**

Parent/Guardian Signature Date

Print Name

* If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization

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PROCEDURE FOR MEDICATION TAKEN IN SCHOOL
Form must be signed by a Doctor, Nurse Practitioner or Physician's Assistant

No medication may be given to a student during school hours without following the procedure outlined by the New York State Education Department. Following is the Cassadaga Valley Central School District Policy for administering medication:

1. A **Written Order** from the prescribing provider is required stating:
   a. Students name
   b. Diagnosis
   c. Name of Medication
   d. Dosage and route of administration
   e. Frequency and time of administration
   f. Date written
   g. For PRN (as necessary) medications-conditions under which medication should be administered
2. Over the counter medications require the **SAME** procedures as prescription medications. Over the counter medications must be in the original manufacturer's container with the student's name affixed to the container. (Ex: Tylenol, Advil, cough medicine)
3. A written request from the parent to administer the prescribed medication.
4. The parent must deliver the medication to the nurse and not send it with the student.

Do NOT send pills or medication of any kind with your daughter/son because they will **not** be administered. These procedures must be followed for the safety of the students.

5. If your child's medical provider has deemed him/her competent to carry and self-administer their rescue medications please have the provider complete and submit the "Independent Medication Use and Carry" form.

(A New Order and Medication re-fill are needed each year)

PARENT/GUARDIAN PERMISSION

Name of Student ____ Grade ______ DOB ______________

I hereby give my permission for the School Nurse to administer medication during the school day to my child.

Date _______________ Signature of Parent/Guardian ____

PHYSICIAN'S INSTRUCTIONS FOR MEDICATION ADMINISTRATION IN SCHOOL

Student's Name ____ DOB __________________________

Medication ____ Route ______________________________

Dosage ___________________________________ Frequency and Time _____________________________

Reason for Administration ____

Special Instructions ____

Health Care Provider Signature and Stamp____

Date _________________________________ Phone ____

RETURN THIS FORM TO YOUR CHILD'S BUILDING NURSE

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PROVIDER AND PARENT PERMISSIONS REQUIRED FOR INDEPENDENT MEDICATION USE AND CARRY

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently use and carry their medication as required by NYS law. A **provider order** and **parent/guardian permission** is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: ________________________ DOB: ___________

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications checked below:

This student is diagnosed with:

- ❑ Allergy and requires Epinephrine Auto-injector
- ❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies ❑ ________________________ (state diagnosis) which requires rapid

administration of ________________________ (state medication)

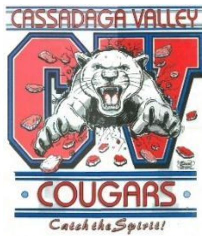
Signature: ________________________ Date:__________________

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may use and carry this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: ____________________________________ Date: ____________ **Please return to School Nurse:**

School Nurse: RN		School:
Phone #:	Fax:	Email:



Please, take a moment to complete this technology survey and have your child/children return it to their homeroom teacher. Thank you for your assistance, your input is valuable to us.

Student Name (Last, First) ____

Did the school district give your student a device for home use in the **2022-2023** school year?

◯ Yes ◯ No

What device does your student use **most often (choose only 1)** to complete their school work while away from school?

◯ Desktop ◯ Laptop ◯ Tablet

◯ Chromebook ◯ Smart Phone ◯ None

Who provides/owns the device that your student uses most often to complete schoolwork at home or the place you are currently living?

◯ Personal ◯ School ◯ No device

Does anyone else use the device that your student uses most often to complete schoolwork at home or the place you are currently living?

◯ Shared ◯ Not shared ◯ No device

Is the primary learning device sufficient for your student to fully participate in all learning activities away from school?

◯ Yes ◯ No

Do you have internet access in your home or the place you are living?

◯ Yes ◯ No

What is the primary type of internet service used in your child's primary place of residence?

◯ Cellular ◯ Community WiFi ◯ Dial Up ◯ DSL

◯ Mobile HotSpot ◯ Satellite ◯ None ◯ Other

Can the student complete the full range of learning activities, including video streaming and assignment upload, without interruptions caused by slow or poor internet performance?

◯ Yes ◯ No

If you do not have sufficient internet access in your place of residence, what is the main reason?

◯ Availability ◯ Cost ◯ None ◯ Other:_____________

____ ________________________

Print parent/Guardian name Date

Updated February 2022