

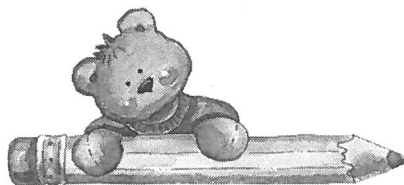
We will need the following

information to register your child for PreK:



_____ Residency Questionnaire

_____ Registration Form



_____ Student User Agreement & Parent Permission Form

_____ Copy of Birth Certificate

_____ Social Security Card (or write No. on Registration) (Optional)

_____ Copy of Shot Records (Dr. can faxed to the office at 315-389-5245)

_____ Proof of Residency (Driver's License, Rental Agreement or Utility bill with 911 address on it)

_____ Any Court Orders regarding this child (if applicable)

_____ Physical form filled out by your doctor (before September 1st).

Copies can be made at your scheduled appointment.

Please call our office to schedule an appointment to bring in all documents.



If you have any questions, or want to schedule an appointment, please call Mrs. Delisle at 315-389-5131, Ext. 29108.

BRASHER FALLS CENTRAL SCHOOL STUDENT REGISTRATION FORM

(PLEASE FILL IN ALL WHITE AREAS)

A. STUDENT INFORMATION

First Name:		Middle Name:		Last Name:	
Date of Birth ____ / ____ / ____		Male Female <i>(Please circle)</i>	Grade:	Returning Student: Y or N <i>(Please circle)</i>	
SSN: ____ - ____ - ____ <i>(optional)</i>		Race:		Student ID #	Bus #
City of Birth:	State of Birth:		Country of Birth:		If no US, date of entry into US: ____

B. PRIMARY GUARDIAN INFORMATION

Mr. Mrs. Miss Ms. <i>(Please circle)</i>	First Name:	Last Name:		Relationship:
Mr. Mrs. Miss Ms. <i>(Please circle)</i>	First Name:	Last Name:		Relationship:
Parents are: Married Separated Divorced Other <i>(Please circle)</i>			Active Duty? Y or N <i>(Please circle)</i>	Child Lives With:
Father Occupation:		Father Employer:		Last Grade Completed:
Mother Occupation:		Mother Employer:		Last Grade Completed:
Email Address:			Cell Phone: ____ - ____ - ____	

C. PRIMARY GUARDIAN RESIDENCE

Physical Address:			Home Phone: ____ - ____ - ____	
Mailing Address:			Work Phone: ____ - ____ - ____	
City:	State:		ZIP Code:	

The answer to this residency question helps determine services the student may be eligible to receive under the McKinney-Vento Act.

Is your current address a temporary living arrangement? YES NO *(Please circle)*

If you answered YES, you must complete Residency Enrollment Form

D. SECONDARY GUARDIAN INFORMATION IF SEPARATED/DIVORCED

Mr. Mrs. Miss Ms. <i>(Please circle)</i>	First Name:	Last Name:		Relationship:
Physical Address:			Home Phone: ____ - ____ - ____	
Mailing Address:			Work Phone: ____ - ____ - ____	
City:	State:		ZIP Code:	
Email Address:		Permission to Pick Up? Y or N <i>(Please circle)</i>	Cell Phone: ____ - ____ - ____	

E. EVERYONE LIVING IN THE PRIMARY HOME

Name	Relationship	Date of Birth	Grade/Occupation

F. STUDENT PRIOR EDUCATION

Name of Previous School:	Address:
Date of Attendance:	Has Either Parent Ever Worked on a Farm Y or N <i>(Please circle)</i>

G. MEDICAL INFORMATION

Date of Last Physical:	Family Doctor:	Date of Last Eye Exam:
Findings of Last Eye Exam:	Date of Last Hearing Exam:	Findings of Last Hearing Exam:

Does your child have a health problem? Check where appropriate.

<input type="checkbox"/> Hearing	<input type="checkbox"/> High Temperature	<input type="checkbox"/> Difficulty Swallowing/Chewing	<input type="checkbox"/> Injury	<input type="checkbox"/> Stomach complaints	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Vision	<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Allergies	<input type="checkbox"/> Anemia
<input type="checkbox"/> Seizures	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart	<input type="checkbox"/> Surgeries	<input type="checkbox"/> Headaches	<input type="checkbox"/> Fainting
<input type="checkbox"/> Coordination problems	<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Bee sting allergy	Other _____		

Does your child take medication? Y or N <i>(Please circle)</i>	Name of medication(s):
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Does any close relative in your family have a history of: Check where appropriate.

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Learning Problems	<input type="checkbox"/> Mental Retardation	Other _____					

Are there any problems in the home that might affect your child's learning? ? Y or N *(Please circle)*
 If yes, explain:

Is there anything more about this child's health that you think is important for us to know? (i.e.: surgeries, illnesses, or disorders that have been difficult for this child (dates if available))

H. SIGNATURE

I authorize the verification of the information provided and understand it will be treated confidentially.

X	X
<i>Signature of Parent/Guardian</i>	<i>Date</i>

I. Additional Information Needed

Birth Certificate	Date Received:	Immunization Records	Date Received:
Social Security Card (optional)	Date Received:	Proof of Residency If the student is NOT living in permanent housing-proof is not required	Date Received:

For Office Use Only : Routing

Elementary School		Middle School		HS / Guidance	
Official Date of Entry		Official Date of Entry		Official Date of Entry	
AM Bus #		AM Bus #		AM Bus #	
PM Bus #		PM Bus #		PM Bus #	
All Transcript Received		All Transcript Received		All Transcript Received	
OSS Eligible		OSS Eligible		OSS Eligible	
Free/Reduce Eligible		Free/Reduce Eligible		Free/Reduce Eligible	
Classroom Teacher		Locker# / Agenda		Locker# / Agenda / COC	
Court Order		Court Order		Court Order	

STUDENT USER AGREEMENT AND PARENT PERMISSION FORM



This form must be completely filled out for your network and email accounts to be activated. If you don't know how to respond to any item, please ask for assistance. **PLEASE PRINT!** Illegible responses will be considered incomplete.

To be completed by all new PreK-4th grade students to the district.

Office Use Only:
Username:
Password:
Date of Completion:

Student LAST Name: _____

Student FIRST Name: _____

Year of Graduation: 20__ Date of Birth: __/__/__ Home Phone: _____

Student ID Number: _____ Homeroom Teacher or #: _____

Parent/Guardian Name: _____

Home Street Address & Town: _____

Parent: Please read and respond in the appropriate place(s) below.

As a parent or guardian of a Brasher Falls Central School student, I have read the Computer Use Policy regarding student use of the computer network. I have discussed the rules and procedures with my son/daughter and agree to allow him/her to utilize the districts network, Internet and personal e-mail as long as he/she upholds those rules. I understand that computer network privileges can and will be suspended or revoked for a student who does not comply. I agree to release the Brasher Falls Central 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 District's Computer System (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: _____

COMPUTER USE POLICY

The Board of Education considers computers to be a valuable tool for education and encourages the use of computer-related technology in district classrooms.

Through software applications, online databases, and electronic mail, computer use will significantly enhance educational experiences and provide statewide, national, and global communications opportunities for students and staff.

The Superintendent shall establish rules and regulations governing the use and security of the district's computer network. Failure to comply with district policy and regulations for use of the computers may result in disciplinary actions as well as suspension and/or revocation of computer access privileges.

The following rules and regulations apply to students using the district computer system:

1. Each student will be granted a network account.
2. Each student will be issued a network login name and password. The username/login is comprised of the last two digits of the year of graduation + first three letters of last name + 3 digit student ID. (i.e. 04smi990)
3. Each student shall sign an acceptable use agreement to abide by district policy and regulations concerning the use of computers. These agreements shall be kept on file in the technology office and are active for the duration of student's educational career. Parental permission is required.
4. The district prohibits the use of any computer hardware/software in any inappropriate, fraudulent, or destructive manner including but not limited to
 - o Accessing inappropriate sites
 - o Sending of unauthorized messages
 - o Entering a code-protected file
 - o Plagiarism
 - o Altering a software program
 - o Vandalizing hardware or software components
 - o Using others username and/or password

Users are expected to follow these rules for network etiquette:

1. I will be polite and use appropriate language. Abusive and/or vulgar messages are not allowed.
2. I will not reveal anyone else's address, phone number, or personal information out over the Internet.
3. I will not use the network in any way that will disrupt others' use of the network.
4. I will not access, alter, or destroy another user's files.
5. I will not use another person's password, nor will I give my password to anyone.
6. I will treat the district computer equipment with care and not abuse it.
7. I will use the network with educational intent. I will not play or investigate games or use chat rooms.
8. I will credit all materials in my work in keeping with copyright laws.
9. I will not employ the network for commercial purposes.
10. I understand that a user's files are *not* guaranteed to be private. System Operators may have access to all files.
11. I will not engage in illegal activities. Any evidence of or incidents relating to or in support of illegal activities may be reported to authorities.
12. I will not hold the District responsible for materials acquired on the network.
13. I will not download any programs, games, or other inappropriate files from the Internet to the hard drive or to my network storage space.
14. I will not tamper with network system or computer desktop security passwords or programs.
15. I will report any misuse of the system according to these rules to the administration.

SANCTIONS FOR VIOLATIONS:

First Offense - loss of privileges for **30 school days**, at the discretion of the administration.

Second Offense - loss of privileges for **60 school days**, or the remainder of the semester, at the discretion of the administration.

Third Offense - loss of privileges for **90 school days**, or the remainder of the school year, at the discretion of the administration.

The Technology Coordinator may remove students from the network system for inappropriate use of the network/Internet. Faculty/staff will file a referral to report violations. Additional disciplinary action may be determined at the building level for infractions that may violate existing practices (i.e. inappropriate language). When applicable, law enforcement agencies may become involved. A student whose account has been suspended for a third offense must appear before the technology committee to discuss the infraction(s) prior to reinstatement.

Internet Safety Policy:

The Children's Internet Protection Act (CIPA) was signed into law on December 21, 2000. In compliance with the FCC regulations, Brasher Falls Central School has employed software and hardware technologies to ensure Internet safety for all computers in the district. This Internet Safety Policy protects against access, through computers with Internet access, to visual depictions that are obscene, child pornography, or (in the case of use by minors) harmful to minors.

Internet harassment that occurs outside of school may be referred to law enforcement.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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 <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: Date of last seizure: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

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

BMI _____ kg/m²

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

Hyperlipidemia: No Yes Not Done **Hypertension:** No Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Lead Level Required Grades Pre- K & K			Date	
<input type="checkbox"/> Test Done	<input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$			

System Review and Abnormal Findings Listed Below

<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: <input type="checkbox"/> Additional Information Attached	Diagnoses/Problems (list) ICD-10 Code* *Required only for students with an IEP receiving Medicaid
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Name:				DOB:	
SCREENINGS					
Vision (w/correction if prescribed)		Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening		<input type="checkbox"/> Pass <input type="checkbox"/> Fail			<input type="checkbox"/>
Notes					
Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done
Pure Tone Screening		Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Notes					
Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK					
<input type="checkbox"/> Student may participate in all activities without restrictions. <input type="checkbox"/> Student is restricted from participation in: <input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. <input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball. <input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. <input type="checkbox"/> Other Restrictions:					
Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level. Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V Age of First Menses (if applicable) : _____					
<input type="checkbox"/> Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.					
MEDICATIONS					
<input type="checkbox"/> Order Form for Medication(s) Needed at School Attached					
IMMUNIZATIONS					
		<input type="checkbox"/> Record Attached	<input type="checkbox"/> Reported in NYSIIS		
HEALTH CARE PROVIDER					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form To Your Child's School When Completed.					