



# 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 <i>(Please circle)</i>		
<b>If you answered YES, please complete Residency Enrollment Form</b>		

## 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. FAMILY LIVING IN THE 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.

<b>X</b>	<b>X</b>
<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	

**BRASHER FALLS CENTRAL SCHOOL DISTRICT  
ST. LAWRENCE CENTRAL  
1039 STATE HIGHWAY 11C, PO BOX 307  
BRASHER FALLS, NEW YORK 13613  
PHONE: (315) 389-5131**

**FAX NUMBERS**

**ELEMENTARY (GRADES PRE-K - 4) ..... (315) 389-4651**

Danielle Colterman, Elementary School Principal  
Katherine McFarland, Guidance Counselor (PreK, 1 & 3)  
Carey White, Guidance Counselor (Kdg, 2 & 4)

**MIDDLE SCHOOL (GRADES 5 - 8) ..... (315) 389-4185**

Jamie LaBarge, Middle School Principal  
Nathan Niles, Guidance Counselor (A-K)  
Rachel Roldán, Guidance Counselor (L-Z)

**HIGH SCHOOL (GRADES 9 -12) ..... (315) 389-5245**

Kristen Zender, High School Principal  
Michaela Bethel, Guidance Counselor (A-K)  
Rachael Huntley, Guidance Counselor (L-Z)

**OFFICE OF SPECIAL SERVICES (CSE Office) (GRADES K-12).... (315) 389-5194**

**Name of school Student last attended:** (Please provide) \_\_\_\_\_

**TO WHOM IT MAY CONCERN:**

According to the Final Regulations-Family Educational Rights and Privacy Act (Buckley Amendment) dated June 17, 1976, it is no longer necessary to obtain written consent to release records between schools. It states that school officials, including teachers within an educational institution and officials of other schools in school systems in which the student may intend to enroll, may receive a student's record without a written consent for such release.

STUDENT NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

GRADE LEVEL: \_\_\_\_\_

School Device Returned to Previous School?  Y or  N

**Please release the following information to the appropriate address and/or fax number as listed above.**

- Health and Attendance
- Academic Records
- \*Science Labs\*
- Birth Certificate / Social Security Card
- Custody Information / Court Orders
- Free & Reduced Meal Application
- Assessment Scores
- Other \_\_\_\_\_

**CSE/CPSE/Section 504 Records**

- Individualized Education Program
- 504 Accommodation Plan
- Psycho-Educational Evaluation
- Speech & Language Evaluation
- All other Evaluations
- Speech/OT/PT Scripts
- Initial Referral
- Consent for Initial Placement
- Medicaid Consents
- Test Scores
- Vocational I Assessments

\_\_\_\_\_  
Parent/Guardian Signature                      Date



**BRASHER FALLS CENTRAL SCHOOL DISTRICT**

**ST. LAWRENCE CENTRAL**

**1039 STATE HIGHWAY 11C, PO BOX 307**

**BRASHER FALLS, NEW YORK 13613**

**PHONE: (315) 389-5131**

*Special Support Classes/Programs and/or Special Education Programs*

**Name of Student:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Grade:** \_\_\_\_\_

1. Was your child enrolled in any special support classes/programs? If yes, please list the programs. (Examples: remedial reading, remedial math, speech improvement, counseling, special groups, etc.)

\_\_\_\_\_  
\_\_\_\_\_

2. Was your child placed in any special education programs (Have an IEP or 504 Plan)? If yes, please list the programs. (Examples: self-contained class, resource room, consultant teachers, speech therapy, physical therapy, occupational therapy, counseling, etc.)

\_\_\_\_\_  
\_\_\_\_\_

*If the answer to question #2 was YES, please provide your latest copy of the Individualized Educational Program (IEP).*

3. Name, address and phone number of student's Physician.

\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## Community Eligibility Provision (CEP)/Provision 2 non-base year Household Income Eligibility Form

Brasher Falls Central School District is participating in the Community Eligibility Provision (CEP) for the 2023-2024 school 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 Melany Cline School Lunch Manager at (315)389-5131 Ex: 29138, if you need help.

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

Student Name	School	Grade/Teacher	Foster Child	No Income
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

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 <i>Amount / How Often</i>	Child Support, Alimony <i>Amount / How Often</i>	Pensions, Retirement Payments <i>Amount / How Often</i>	Other Income, Social Security <i>Amount / How Often</i>	No Income
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>

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

I certify (promise) that all the 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



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.

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**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.**

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**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.
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PRIVACY ACT STATEMENT

# BRASHER FALLS CENTRAL SCHOOL STUDENT EMERGENCY FORM

This form is to be used for one building only. Please use a separate form for each building: check one

Middle School grades 5-8

High School grades 9-12

**STUDENT INFORMATION: This form should be completed by the custodial parent/guardian of the child(ren) listed.**

<b>STUDENT NAME</b>			
<b>BIRTHDATE</b>			
<b>GRADE</b>			
PRIMARY DOCTOR AND PHONE NUMBER			
HOSPITAL PREFERENCE			
Please list any parent <b>NOT</b> living in the student's home and note if parent is allowed to pick up child. <b>( Court Orders must be on file in the district office)</b>	Name Pick up? Yes or No Phone:	Name Pick up? Yes or No Phone:	Name Pick up? Yes or No Phone:
If this parent <i>is</i> to receive report cards, etc please list their mailing address.			

STUDENT'S 911 ADDRESS	MAILING ADDRESS	HOME PHONE
STREET ADDRESS	PO BOX OR STREET	
CITY / ZIP CODE	CITY / ZIP	EMAIL ADDRESS

PARENTS/ GUARDIANS IN HOME	RELATIONSHIP	EMPLOYER/ WORK NUMBER	CELL NUMBER
<b>Other Adults living in this home:</b>	<b>Relationship</b>	<i>If this person has permission to pick up student please list below in the emergency contacts.</i>	

*Please list three local contact persons who you authorize to pick up your child from school in the event that you cannot be reached.*

EMERGENCY CONTACT NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE OR OTHER

In case of Emergency (serious illness or injury) when I cannot be reached, I hereby authorize BFCSD personnel to obligate me for services of a local doctor/hospital for my child(ren).

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date



## **BRASHER FALLS CENTRAL SCHOOL MIDDLE/ HIGH SCHOOL HEALTH OFFICE NEWS**

Welcome to St. Lawrence Central Middle/High School. I, Carol Hallahan, RN, would like to take this opportunity to acquaint you with our Health Policies. I would like to extend to you an open invitation to call with any questions you may have throughout the year. I can be reached at 389-5131, extension 29104.

### **I. Attendance**

A written excuse is required if your child is absent from school. Phone calls will be made to monitor attendance.

Please notify the Health Office of any major illness, injuries or surgeries so that your child's health record may be kept up to date. In addition, if your child will be absent due to illness for an extended period of time please let me know; it may be possible for home instruction. A note to re-enter school from your physician may be required.

### **II. Immunization Requirements Students Enrolled in Grades 6 & 7**

**Sixth grade students** must receive a Tdap Booster. **Seventh grade students** must receive the first dose of MenACWY (Menactra-Menveo or MCV4) for Meningococcal Disease. *It is imperative that physician documentation of these immunizations must be on file in the health office by the first day of school in September -- students will be excluded from school for non-compliance.*

### **III. Immunization Requirements Students Enrolled in Grade 12**

New York State law mandates twelfth grade students must fully vaccinated against Meningococcal Disease. One dose of MenACWY (Menactra-Menveo or MCV4), if first dose is given on or after sixteenth birthday or two doses of MenACWY (Menactra-Menveo or MCV4) if the first dose was given before sixteenth birthday. *It is imperative that physician documentation of these immunizations must be on file in the health office by the first day of school in September -- students will be excluded from school for non-compliance.*

### **IV. Physicals**

New York State law mandates that the following students receive a physical during the school year:

1. All students in grades 5, 7, 9 and 11;
2. New students entering our school for the first time;
3. Students requiring a triennial review;
4. Students referred for CSE services.

Physicals are scheduled through out the year. If you wish your private physician to complete this physical, please let me know as soon as possible. I do have a form that your private physician must complete and return to me by October 1st. If not, our school physician will do the exam.

**\*\*\*A sport physical completed in June this calendar year satisfies the requirement for mandated physicals.**

### **V. Health History Updates for Students in Grades 5, 7, 9 and 11**

Please complete the Health Questionnaire (provided in the packet of information at the beginning of school) to update my medical files for your child. Please complete and return the questionnaire to your child's homeroom teacher or to my office.

### **VI. Sports Physicals**

Sport Physicals are required for any student who wishes to play school sports. Contact the health office if you wish your private physician to complete the sports physical. I have a form that your private physician must complete. Our school physician may review all physicals for students to be qualified.

## **VII. Screenings**

New York State mandates that the following Screenings be completed:

1. Vision (near and far) - Students in grades 5, 7 and 11;
2. Hearing – Students in grades 5, 7 and 11;
3. Scoliosis (back checks) - for girls in grades 5 and 7; and boys in grade 9;

Written and/or verbal referrals are given if any problems are noted.

## **VIII. Body Mass Index (BMI) Screening and Reporting**

BMI is determined by a student's weight and height which helps the doctor or nurse know if the student's weight is in a healthy range.

Recent changes to the New York States Education Law require that that BMI and weight status group be included as part of the students school health examination. Furthermore, the New York State Department of Health may require us to report a summary of weight status groups for Grades 5, 7, 9 and 11. This is only a summary report, no names or personal information about individual students is sent. However, you may choose not to have your child's information on the report. Please contact my office for this form, which must be completed and in my office by November 1<sup>st</sup>.

## **IX. Dental Health Certificate**

New York State Law (Chapter 281) permits schools to request a dental examination in the following grades: all newly entering students, grades 5, 7, 9 and 11 (form is provided). 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 has had a dental check-up before he/she started the school year, ask your dentist to fill out Section 2. Return to the school nurse as soon as possible. Students in grades 5, 7, 9 and 11, please see form in the packet of information provided at the beginning of the school year.

## **X. Medications**

If medications are needed during school hours, either prescription or over-counter, State Law requires that:

1. A written, signed order form from your health care provider stating the medication, dosage and time to be given.
2. A note from parent or guardian requesting that the medication be given.
3. Medication should be in original pharmacy container, if a prescription medication, and if an over-the-counter medication, please send in a new unopened container with your child's name on it.
4. Medications should be transported to the school nurse's office by an adult.

**Please note: Students must not carry medications on their persons unless they have a doctor's order stating they may do so. Please discuss this with your child, as our goal is to provide our students with a safe and drug free environment.**



If you have received this form, it must be completed and returned to the Health Office.

## BRASHER FALLS CENTRAL SCHOOL DISTRICT STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Grade:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:	

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	<input type="checkbox"/>	<input type="checkbox"/>	
Seen a medical specialist	<input type="checkbox"/>	<input type="checkbox"/>	
Had allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other
Been hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	
Had an operation	<input type="checkbox"/>	<input type="checkbox"/>	
Had an injury requiring an Emergency Room visit	<input type="checkbox"/>	<input type="checkbox"/>	
Missed 5 days of school in a row due to illness/injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a bone/muscle injury	<input type="checkbox"/>	<input type="checkbox"/>	
Passed out, had a concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a convulsion/seizure	<input type="checkbox"/>	<input type="checkbox"/>	
Had a vision problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> glasses <input type="checkbox"/> contacts
Had a hearing problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant
Worn dental bridge, braces or mouthpiece	<input type="checkbox"/>	<input type="checkbox"/>	
Have any family members under the age of 50 ever:	YES	NO	If Yes, please specify:
Had a heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
Had other serious health problems	<input type="checkbox"/>	<input type="checkbox"/>	

**CHECK ALL THAT APPLY TO YOUR CHILD:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> ADHD<br><input type="checkbox"/> Asthma/trouble breathing<br><input type="checkbox"/> Autism/Asperger<br><input type="checkbox"/> Dental Injuries<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Ear Infections | <input type="checkbox"/> GI Conditions (ulcer, reflux, IBS)<br><input type="checkbox"/> Headaches/migraines<br><input type="checkbox"/> Heart Conditions<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Mental Health Condition<br>(depression, eating disorder, anxiety,<br>OCD, ODD, etc.) | <input type="checkbox"/> Scoliosis<br><input type="checkbox"/> Single Organ ( <input type="checkbox"/> kidney, <input type="checkbox"/> testicle)<br><input type="checkbox"/> Skin Condition<br><input type="checkbox"/> Speech Condition<br><input type="checkbox"/> Urinary Condition |
|--|---|---|

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other:
TREATMENTS	YES	NO	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> special diet

Is there any condition that would prevent your child from participating in physical education or sports?

No  Yes: \_\_\_\_\_

Please list any additional concerns: (use back of sheet if necessary) \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Dental Health Certificate

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:	<input type="checkbox"/> Male	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Female			
School:	Brasher Falls Central School			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 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 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 fit condition of dental health to permit his/her attendance at the public schools.

No, The student listed above is not in fit condition of dental health to permit his/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 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)

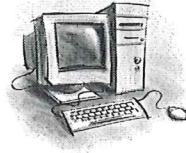
No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

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.



# 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 entering 5<sup>th</sup> graders and new 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: \_\_\_\_\_

*Student:* Please return this full page to your homeroom teacher.

As a user of the Brasher Falls Central School computer network, I have read and hereby agree to comply with the Computer Use Policy. I understand that network privileges can and will be suspended or revoked if I fail to fully comply.

STUDENT SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

*Parent and Student:* 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.**





## schooltool Student Portal Consent Form

The login ID and password issued to you will be your means of access to schooltool. They are to be used solely for you to access your information. You should take all necessary steps to prevent anyone from gaining knowledge of them. The use of your login ID, password and access rights by anyone other than yourself is prohibited and should be reported to the District immediately.

I have read, understand, and agree to comply with the above statement and agree to accept responsibility for my access to the Brasher Falls Central School's schooltool Student Information System.

Student Full Name: \_\_\_\_\_

Student ID# \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom Teacher \_\_\_\_\_

\*Email Address: \_\_\_\_\_

An email address is required. Your schooltool username and password will be sent to this email address.

Please return this form to your homeroom teacher or Ms. Taraska in Computer Lab 107. You may contact Ms. Taraska with further questions at 315-389-5131 ext. 29164 or at [btaraska@bfcsd.org](mailto:btaraska@bfcsd.org).



schooltool

<https://schooltool3.neric.org/schooltool> BRAS/

[btaraska@bfcsd.org](mailto:btaraska@bfcsd.org)

315-389-5131 ext. 29164

## schooltool Parent Portal Consent Form

Brasher Falls Central School's Student Information System (schooltool) is a valuable resource that is used consistently with the District's educational mission. Your child's contact information, schedule, attendance, grades and discipline are stored in the schooltool system. We are making your child's information available to you through a secure website to strengthen the connection between school and home to make your child even more academically successful in school.

The Login ID and password issued to you will be your means of access to schooltool. They are to be used solely for you to access your child's information. You should take all necessary steps to prevent anyone from gaining knowledge of them. The use of your login ID, password and access rights by anyone other than yourself is prohibited and should be reported to the District immediately.

***I have read, understand, and agree to comply with the above statement and agree to accept responsibility for my access to the Brasher Falls Central School's schooltool Student Information System.***

Student's Full Name (printed): \_\_\_\_\_ Grade \_\_\_\_\_

Student's Full Name (printed): \_\_\_\_\_ Grade \_\_\_\_\_

Student's Full Name (printed): \_\_\_\_\_ Grade \_\_\_\_\_

Parent's/Guardian's Full Name (printed): \_\_\_\_\_

Parent's/Guardian's Signature: \_\_\_\_\_

\*Parent's/Guardian's Email Address: \_\_\_\_\_

**\*An email address is required for schooltool access.**

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date: \_\_\_\_\_

**Please return this form to your child's homeroom teacher or the High School Main Office. You may contact Brandie Taraska with further questions at 315-389-5131 ext. 29164 or at [btaraska@bfcsd.org](mailto:btaraska@bfcsd.org).**