INFORMATION REQUEST

Please provide information as requested herein below to establish your student's school district residency:

(a) Child resides with both parents in one household - parents own or rent dwelling.
proof of residency:
- proof of ownership
- original purchase order
- original lease
- other objective proof of residency

(b) Child resides with both parents in one household - parents neither own nor rent
proof of residency:
- original of at least two of the following with home address:
- ♦ tax return
- ♦ payroll stub or unemployment document
- ♦ insurance policy
- ♦ utility bill
- ♦ Social Services documentation
- ♦ Post Office documentation of forwarding address
- ♦ other objective proof of residency

(c) Child resides with one parent
- **proof of residency as above and,**
- **proof of physical custody:**

- ♦ documentation in separation divorce agreement of physical custody arrangements -physical custodian must reside in district
- ♦ all other - paperwork must be reviewed by superintendent
- ♦ affidavit may be requested by superintendent

YOU ALSO NEED TO BRING:

- Birth Certificate for the child you are registering
- Immunization Record for the child you are registering
- Report Card for the child you are registering

Please complete 1 (one) packet per student.

Please call Alicia Porter at 315-287-1949 to make arrangements to drop off your completed registration packet.

HOUSING QUESTIONNAIRE

Name of LEA: Gouverneur Central School District

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____ /____ /____ Grade: ____ ID#: _____
Month Day Year (preschool-12) (optional)

Address: _____ Phone: _____

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

Where is the student currently living? (*Please check **one** box.*)

☐ In a shelter

☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")

☐ In a hotel/motel

☐ In a car, park, bus, train, or campsite

☐ Other temporary living situation (Please describe): _____

☐ In permanent housing

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

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

_____
Date

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

GOUVERNEUR CENTRAL SCHOOL DISTRICT
ENROLLMENT FORM

FOR OFFICE USE ONLY

_____New _____Re-Enter _____ Change of Parent/Guardian _____ Out of District Placement

PLEASE COMPLETE THE INFORMATION BELOW.

Child's Last Name: _____ Child's First Name: _____ Child's Middle Initial: _____

Gender: _____ **HAS YOUR CHILD ATTENDED SCHOOL HERE BEFORE:** _____

Ethnic Description (Please check one of the following):

_____ American Indian OR Alaskan Native **_____ Asian** **_____ Black OR African American**

_____ White **_____ Native Hawaiian OR Other Pacific Islander**

Is the student Hispanic, Latino, or of Spanish Origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, or South American, or other Spanish culture or origin, regardless of race:

Check only ONE BOX: ☐ **YES, Hispanic** ☐ **No, not Hispanic**

PLACE OF BIRTH: _____

Primary Language Spoken in the Home: __ Chinese __ English __ French __ German __ Korean __ Spanish
Check only ONE BOX
Other: _____

****

PLEASE VERIFY THE INFORMATION BELOW.

Relation of where student will be residing *(circle one)*

Father Mother Parents Grandfather Grandmother Grandparents
Legal Female Guardian Legal Male Guardian Foster Care Self Other_____

NAME(S) OF PARENT(S): _____ ***OR***

NAME OF STEP PARENT: _____ ***OR***

FOSTER PARENT: _____

****

If there are others who should receive records on the above child, please list the appropriate information below: use Second Address for this purpose.

Second Address (if someone else needs information)

Relation to the student (circle one)

Father Mother Parents Grandfather Grandmother Grandparents
Legal Female Guardian Legal Male Guardian Foster Care Self
Other_____

Mr.
Mrs. _____
Ms. Last Name First Name MI Suffix

_____ _____
911 Address

_____
Supplemental address ie PO Box

_____ _____ _____
Home Phone Work Phone Cell Phone

_____
E-Mail Address

Check what they receive:
_____ Attendance _____Grading ____Scheduling _____Can pick up student _____Discipline _____Mailing ____Testing

PRESCHOOL CHILDREN: ***IF YOU HAVE PRE-SCHOOL CHILDREN, PLEASE COMPLETE THE INFORMATION BELOW.***

THIS SECTION IS FOR CHILDREN NOT OLD ENOUGH TO ATTEND SCHOOL YET

****

Child's Last Name: ___________________ Child's First Name: _______________ Child's Middle Initial: ______

Gender: ____________ Date of Birth: ________________________________

Ethnic Description (Please check one of the following):

_____ American Indian OR Alaskan Native _____ Asian _____ Black OR African American
_____ White _____ Native Hawaiian OR Other Pacific Islander

Is the student Hispanic, Latino, or of Spanish Origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, or South American, or other Spanish culture or origin, regardless of race:

Check only ONE BOX: ☐ YES, Hispanic ☐ No, not Hispanic

****

Child's Last Name: ___________________ Child's First Name: _______________ Child's Middle Initial: ______

Gender: ________ Date of Birth: ________________________________

Ethnic Description (Please check one of the following):

_____ American Indian OR Alaskan Native _____ Asian _____ Black OR African American
_____ White _____ Native Hawaiian OR Other Pacific Islander

Is the student Hispanic, Latino, or of Spanish Origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, or South American, or other Spanish culture or origin, regardless of race:

Check only ONE BOX: ☐ YES, Hispanic ☐ No, not Hispanic

****

Child's Last Name: ___________________ Child's First Name: _______________ Child's Middle Initial: ______

Gender: _______ Date of Birth: ________________________________

Ethnic Description (Please check one of the following):

_____ American Indian OR Alaskan Native _____ Asian _____ Black OR African American
_____ White _____ Native Hawaiian OR Other Pacific Islander

Is the student Hispanic, Latino, or of Spanish Origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, or South American, or other Spanish culture or origin, regardless of race:

Check only ONE BOX: ☐ YES, Hispanic ☐ No, not Hispanic

****

Parent Signature: ____ Today's Date:__________________________

___ Health Office
___ CSE Office
___ Faxed Previous School

GOUVERNEUR CENTRAL SCHOOL DISTRICT
133 EAST BARNEY STREET
GOUVERNEUR, NEW YORK 13642
PHONE: (315)287-1949
FAX: (315)287-4736

I HERBY AUTHORIZE: _____

(THE SCHOOL LAST _____

ATTENDED) _____

Phone: _____

FAX Number: _____

TO RELEASE ALL CONFIDENTIAL INFORMATION FROM THE THE RECORDS OF:

STUDENT'S NAME: _____

DATE OF BIRTH (month, day, year) _____

GRADE ENTERING: _____

Please send to:

GOUVERNEUR CENTRAL SCHOOL DISTRICT
ALICIA PORTER REGISTRAR TELEPHONE:
(315) 287-1949
FAX: (315) 287-4736
EMAIL ADDRESS: porter.alicia@gcsk12.org

THIS CONFIDENTIAL INFORMATION INCLUDES:

ACADEMIC INFORMATION	GIFTED/TALENTED/ENRICHMENT INFORMATION
HEALTH AND IMMUNIZATION RECORD	BIRTH CERTIFICATE
PHYSICAL EXAM	CUSTODY INFORMATION
ATTENDANCE RECORDS	DISCIPLINE/SUSPENSION RECORDS
TITLE I/AIS REPORTS	CSE/PSYCHOLOGICAL RECORDS

SIGNATURE OF OF PARENT/LEGAL GUARDIAN **DATE**

IN ACCORDANCE WITH PUBLIC LAWS 93-380: FAMILY EDUCATION RIGHTS AND PRIVACY ACT OF 1972, THIS IS AUTHORIZATION TO RELEASE A COPY OF STUDENT RECORDS (INCLUDING COMPLETE TRANSCRIPT OF THE SCHOOL RECORD, STANDARDIZED TEST RESULTS, HEALTH RECORD AND PSYCHOLOGICAL REPORTS).

CHILD'S FULL NAME: _____

In order to best plan for your child's educational program, we are interested in obtaining information which will assist us in making an appropriate placement. We are also interested in knowing if you, as parent(s), have any concerns about your child's educational program.

Previous school(s) attended:

Grade(s) _____ School: _____ Location/State: _____

Grade(s) _____ School: _____ Location/State: _____

Grade(s) _____ School: _____ Location/State: _____

Grade(s) _____ School: _____ Location/State: _____

Grade(s) repeated: _____

Does your child have special needs? Yes or No

Has s/he been identified by the Committee on Special Education? Yes or No
If yes, please explain: _____

_____

Is this child dealing with stress such as: a new baby, illness, death in the family, separation/divorce of parents, loss of a pet, loss of friends because of moving, etc. If so, explain: _____

_____

Are there other agencies and/or people involved with the family? _____

Does the child have any unreasonable fears? (fire, animals, etc.) _____

_____

Has the child had any pre-school experience? If so, what _____

Any other information that will help us understand your child: _____

_____

Significant Other Living in the Home: __ YES ___ NO If so, name: _____

Has either parent worked on a farm, in agriculture or in logging in the last 36 months?(Please check one) _____ Yes _____ No
If yes, date: _____

I have received the following information in the Annual Notification Newsletter that was provided to me at the time of registration:

- Asbestos Notification
- Drug Free Schools
- Disclosure of Student Information to Military and Colleges
- Complaints and Grievances by Students
- Student Use of Computerized Information Resources
- Medications Information/Form
- Code of Conduct Summary
- School Lunch/Breakfast Information and Application
- Dignity for All Students Act (DASA)
- No Child Left Behind
- Notice of Non-Discrimination
- Rights Under FERPA for Elementary and Secondary Schools
- School Insurance
- FERPA Notice for Directory Information
- Protection of Pupil Rights (PPRA)
- Comprehensive Student Attendance Policy Summary
- Potential Pesticide Use
- FORM for Request for Pesticide Application
- School Closing Information
- School Calendar
- AIDS Instruction In Health Education
- Curriculum Areas in Conflict with Religious Beliefs

I would like to speak to a School Nurse Today: _____ Yes _____ No

_____

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

CHILD'S FULL NAME: _____

NAME (S) OF LEGAL PARENT/GUARDIAN: _____

Are there custody issues/agreements we should be aware of? Yes or No **(CIRCLE ONE)**

If yes, are you providing us with a copy of custody papers? Yes or No **(CIRCLE ONE)**

(If not, please be advised if someone arrives in our district and can prove they are the legal parent or guardian, they will be able to take the child with them.)

****

SAFE SCHOOLS REGISTRATION FORM
STUDENT ENROLLMENT

Is your son/daughter currently under suspension or expulsion from another school district? YES NO

Has he/she ever received the following penalties in another school district?

In-school suspension? YES NO

Student dropped from school? YES NO

Expulsion? YES NO

Alternative school placement? YES NO

Out-of-school suspension? YES NO

I am the parent/legal guardian of _____ and I am providing this affidavit in support of the enrollment of my child in school. I understand that it is a criminal offense to give false information concerning prior disciplinary actions taken against my child. I also understand that if this school district admits my child based on false information which I gave, my son/daughter's enrollment will be nullified.

UNDER PENALTY OF PERJURY, I swear (or affirm) that the legal papers submitted and questions answered above for the Gouverneur Central School District on this _____ day of _____, 20_____, with respect to the custody arrangements for _____ are current, valid and still in effect, and that there are no legal documents with any later date that alter the custody arrangement set for in these papers.

_____

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

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
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*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes* ***No*** ***Not sure***
❑ ❑ ❑ ***If yes,** please explain:_____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ No ❑ Yes* **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
❑ No ❑ Yes – Type of services received:_____

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ❑ No ❑ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ Mother ❑ Father ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF 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:

Bev Martin, RN
Head Nurse

GOUVERNEUR CENTRAL SCHOOL DISTRICT

Delivering the Promise of a Brighter Future

HEALTH OFFICE
133 East Barney Street
Gouverneur, New York 13642
FAX: (315) 287-5517
Phone: (315) 287-1902

Melissa Breckenridge, RN
Elementary School

Brittaney Fairbanks, LPN
Elementary School

Christine Sitts, RN
Middle School

Kylynne Stamper, LPN
High School

AUTHORIZATION FOR RELEASE OF RECORDS

Child's Name_____ DOB:_____

This authorization is written permission for my child's Health Care Provider to disclose their protected health information as directed below:

I, _____, hereby authorize Community Health Center and/or_____
(Parent/guardians name) *(Doctor's Name)*

to disclose my child's protected health information to:

Gouverneur Central School District
Health Office
133 East Barney Street
Gouverneur, NY 13642

The specific information to be disclosed includes:

HEALTH and SHOT RECORD and/or PHYSICAL EXAM

The protected health information will be disclosed for the following purposes:

School Requirements and/or other Requirements for student to participate in school related activities and programs.

I understand that this consent is for the duration of my child's enrollment at GCSD.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notice to my child's doctor.

I understand that the revocation is only effective after it is received and recorded by my child's doctor and is not effective to the extent that my child's doctor has already relied upon the authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be disclosed as permitted by federal law (or state law to the extent the state law provides greater access rights)

_____ _____
Signature of Parent or Legal Guardian Date

BEV MARTIN
RN
Head of Health Services
(315) 287-1902

GOUVERNEUR CENTRAL SCHOOL DISTRICT

133 East Barney Street
Gouverneur, New York 13642
PHONE: (315) 287-1902
FAX: (315) 287-5517

Melissa Breckenridge, RN
Elementary School

Brittaney Fairbanks, LPN
Elementary School

Christine Sitts, RN
Middle School

Kylynne Stamper, LPN
High School

Dear Parent or Guardian:

Education Law (Section 903) requires **medical examination** of all students in grades Pre-K, Kindergarten, first, third, fifth, seventh, ninth and eleventh, as well as new entrants into our district. The intent of this requirement is to identify any harmful conditions detrimental to learning. A cumulative health record is kept on all students.

Parents are encouraged to have their children seen by their own physician for their health evaluation/examination. A physical examination form is available upon request from your child's school nurse. For those pupils whose parents do not provide these reports from their family physician the school district is mandated by law (Section 904) to provide an examination by the school physician. The completed physical exam form must be presented to the school nurse of the school your child attends within the next 30 days otherwise, we are required by law to have our School Physician, Dr. Donald Schuessler, do a physical exam.

During the examination, the doctor checks the skin, eyes, ears, nose throat, heart, lungs, checks for structural deformities, abdomen, external genitalia (all males and kindergarten females) and breast exam. Screenings are completed by the nurses prior to Dr. Schuessler's exam: blood pressure screening, pulse, height, weight, vision, hearing and scoliosis (grades 5-9). A letter will be sent home if there are any findings on the screenings or exam done at school that would cause concern or need medical follow-up.

Interscholastic athletics involves students in more rigorous activity. Because of this, Dr. Schuessler examines all these students. If the student has already had an examination by his or her own physician, Dr. Schuessler will review available information and may require a physical examination before clearance for participation. The parents will be notified if this is the case. Dr. Schuessler has the final authority to determine the physical capability of a student to participate in a sport. Urinalysis screening is also required prior to participation and is done in the school health office. These interscholastic physical exams will be scheduled upon receiving written permission from the student's parent/legal guardian.

Additionally, all students entering school in NYS from out of state are required to complete a screening process to determine which students may possibly be gifted or may possibly have a handicapping condition. The screening program is designed to obtain preliminary information regarding a child's development in the following areas:

- ★ Physical development (physical exam)
- ★ Cognitive development (school psychologist)
- ★ Receptive and expressive language development (speech therapist)
- ★ Motor development (physical education teacher)

Parent(s) may be present for any physical examination given at school. Notify the school nurse if you desire to be present or if you have any questions or concerns.

Sincerely,

GOUVERNEUR CENTRAL SCHOOL HEALTH OFFICE

☐ *I will be taking/or have taken my child to their own Medical Doctor for the required school physical. I understand that if I do not provide a physical within 30 days, the school will give my child the required school physical with the School MD.*

☐ *I authorize the School MD—Dr. Schuessler, to give my child the required school physical.*

Information received & read by:_____ _____ _____

Signature Relationship to student Date

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	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 ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ 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
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **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:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

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

GOUVERNEUR CENTRAL SCHOOL DISTRICT

HEALTH DATA SHEET FOR NEW STUDENTS

NAME OF STUDENT:_____ GRADE:_____

Please note→ A copy of your child's birth certificate and immunizations are required at time of registration.

Family Physician		Family Dentist	
Name	Phone	Name	Phone

HISTORY: Please check diseases or illnesses your child has had.

☐ Tuberculosis ☐ Heart Disease ☐ Sore throats, freq. colds

☐ Convulsions/seizures ☐ Orthopedic defects ☐ Period of unconsciousness/fainting spells

☐ Speech ☐ Lungs ☐ Asthma

☐ Bronchitis/Pneumonia ☐ Migraine headaches ☐ Nervous system

☐ Head Injury/Concussion ☐ Kidney/urinary problem ☐ Hernia, actual or potential

☐ Freq. Ear infection ☐ Growths, tumors ☐ Gastrointestinal disorder

☐ Alcoholism/Drug addiction ☐ Fractures or Dislocations ☐ Joint pain/injury

☐ Sinus ☐ Diabetes ☐ Epilepsy

☐ If yes to any of the above, please describe:_____

_____

_____

☐ Allergic to: (medication, food and/or insect bites)_____

☐ Reaction to Allergy and recommended treatment:_____

_____

☐ Is there anything concerning vision, hearing, or general health of your child that the school should know about in order to provide special care?_____

_____

_____

Is your child currently taking medication(s) prescribed by a physician and/or any over the counter medications? ☐ YES ☐ NO

Medications(s) and Dosage(s)_____

Name of doctor who prescribed medication(s)_____

Condition medication is prescribed for_____

Please refer any questions or concerns to Bev Martin, RN; Head of Health Services—287-1902

_____ _____

Parent/Guardian Signature Date

Gouverneur Central School District

Student Emergency Notification and Student Release Information

Student Name:_____ Birth date: _____ Home Phone:_____

School (Circle One): Elementary School Middle School High School Grade:_____ Teacher:_____

Mailing Address:_____

911 Address (if different)_____

IN CASE OF LEGAL CUSTODY: Please furnish our office with a copy of the legal document noting legal custody, otherwise EITHER parent may pick up the child
Custodial Parent/Guardian _____

Father _____

Address_____

E-mail _____

Home Phone _____ Cell Phone_____

Name of Employer _____

Work Phone _____

Mother _____

Address_____

E-mail _____

Home Phone _____ Cell Phone_____

Name of Employer _____

Work Phone _____

Government Information. Is a parent or guardian at the home address employed by the military? No Yes If "yes", circle one: **Mother** or **Father**

_____Active Military-Fort Drum _____Active Military-Other _____ Active Reserves _____Federal Gov't Civilian Employee

If employed by the Military, please provide the name of Brigade you are in_____

Do you share your address with another family? _____No _____Yes, provide the family name _____

Is your child a bus student or a walker?_____ Circle which apply: AM PM
Each child starts out as a walker or bus student depending on the home address. Any changes in these arrangements can ONLY be made in writing. Notes from previous school years do not carry over.

Does your child Walk or Ride a Bus in the morning? _____ Does your student go home after school? Yes or No If No, where does your student go?
Person's name where student goes_____ Phone number_____

Address of where your child will be going_____ If rides a bus.... Bus Name _____

IF SCHOOL CLOSES EARLY, WHERE SHOULD YOUR CHILD GO? (For unplanned, early closings....Please list the Person's Name, Address, Phone# and indicate Bus Name or Walker)

Person's name where child goes _____

Address of Above Person _____

Phone number of above person _____Bus Name or walker_____

In case of an UNPLANNED, early dismissal, the school will follow the instructions you have provided above. This information will override any notes for that day unless the note specifically states that it should be followed in the case of any early dismissal. It is very important to your child's safety that this information is kept current. **Changes cannot be accepted over the phone.**

STUDENT RELEASE INFORMATION and EMERGENCY NOTIFICATION

According to New York State Law (S 7737) schools can only release student to those persons whose name appear on a list provided by the parents.

List three alternate persons (with address & telephone) to be notified in case of emergency, when parents cannot be reached. These persons will also be allowed to pick up your child at school. This signed form will serve as your pre-signed permission for release of your child at any time. IT IS NOT NECESSARY TO LIST PARENTS OR LEGAL GUARDIANS.

REMINDER:
1. Authorized individuals are to pick up children at the school office ONLY (not classroom).
2. Changes in list must be submitted on new forms at the school office.
3. If necessary, we may request identification before releasing your child.
4. We will release your child only to persons who are listed below.

Name & Address	Relationship to student	Phone

Signature of Parent/Legal Guardian:_____ Date: _____

STAC ID

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
STAC & Special Aids Unit
Room 514, Education Building
Albany, NY 12234

STAC-202
HOMELESS DESIGNATION

Designation of School District of Attendance for a Homeless Child

Submitted by: ☐ Local Dept of Social Services (DSS) ☐ Designated School District of Attendance (PSD)

PLEASE READ THE INSTRUCTIONS ON THE REVERSE BEFORE COMPLETING THIS FORM

1. NAME OF CHILD

LAST NAME

FIRST NAME M.I.

2. DATE OF BIRTH MO / DAY/ YR

3. GENDER M F

5. Racial/Ethnic Category of Child (See definitions on reverse side of last page.)

American Ind or Alaskan Native ☐ Asian or Pacific Isl. ☐ Black ☐ Hispanic ☐ White ☐

6. GRADE LEVEL FOR WHICH PLACEMENT IS SOUGHT

7. COMPLETE ADDRESS BEFORE CHILD/FAMILY BECAME HOMELESS

8. COMPLETE ADDRESS OF CURRENT LOCATION

DATE CHILD/FAMILY PLACED IN TEMPORARY HOUSING
MONTH DAY YEAR

9. DATE DISTRICT OF ATTENDANCE CHOSEN
MONTH DAY YEAR

10. DATE PLACED IN PERMANENT HOUSING
MONTH DAY YEAR

7A. NYS SCHOOL DISTRICT OF ATTENDANCE BEFORE BECOMING HOMELESS

7B. NYS SCHOOL DISTRICT WHERE LAST ENROLLED

8A. NYS SCHOOL DISTRICT OF CURRENT LOCATION

9A .NYS DESIGNATED DISTRICT OF ATTENDANCE

One of four school districts may be chosen to provide the education component: the school district of attendance before becoming homeless, the school district where last enrolled, the school district of current location or a school district participating in a Regional Placement Plan. This designation may be changed either prior to the end of the first semester of attendance or within 60 days of making this designation, whichever occurs later.

11. Check the appropriate box if the designated school district of attendance (9A) is different from the district of attendance before becoming homeless (7A) and from the district of current location (8A).

☐ District participating in a Regional Placement Plan OR ☐ District where last enrolled (7B) if it is different from the district where last permanently housed (7A) and the district of current location (8A).

12. ....
NAME OF PARENT OR PERSON IN PARENTAL RELATIONSHIP AREA CODE TELEPHONE NUMBER

13. ....
SIGNATURE OF PERSON IN PARENTAL RELATIONSHIP TO CHILD DATE

IT HAS BEEN REPORTED TO ME THAT THIS CHILD IS UNDER THE AGE OF 21 YEARS AND IS THEREFORE ELIGIBLE FOR EDUCATIONAL SERVICES. THE CHILD HAS BEEN ADVISED OF HIS/HER RIGHT TO DESIGNATE THE SCHOOL DISTRICT OF ATTENDANCE.

14. .....
PRINT NAME OF LOCAL DSS OR SCHOOL DISTRICT REPRESENTATIVE TITLE

15. ....
SIGNATURE OF LOCAL DSS OR SCHOOL DISTRICT REPRESENTATIVE DATE

16. PLACEMENT COUNTY _____ ....
Local DSS use only AREA CODE TELEPHONE NUMBER

WE ASK THAT ALL PARENTS COMPLETE THIS FORM. THANK YOU. ____ Assistant Superintendent's Office

REVISED 05/15

BEV MARTIN, RN
Head of Health Services
(315) 287-1902

GOUVERNEUR CENTRAL SCHOOL DISTRICT

HEALTH OFFICE
133 East Barney Street
Gouverneur, New York 13642
FAX: (315) 287-5517

Melissa Breckenridge, RN
Elementary School

Brittaney Fairbanks, LPN
Elementary School

Christine Sitts, RN
Middle School

Kylynne Stamper, LPN
High School

WELCOME TO GOUVERNEUR CENTRAL SCHOOL

Dear Parent:

The health office staff is pleased to welcome you to the Gouverneur Central School.

Incoming students **are required to have** the following before attending school.

Proof of immunizations

Birth Certificate

Attached to this letter for your convenience is:

1. Student Medical Examination form (Physical Form)
   This is for your use if you choose to have your child go to its own medical doctor for the required physical.

2. (Over the Counter) Medications form
   Before we can administer ANY medications to your child, both you and your child's physician must sign this form.

3. Dental Health Certificate
   A Dental exam is requested by not required, for your child.

4. Lead Poisoning Information—Pre-K only

5. Weight Status Survey Information

Health Office forms may also be obtained from the GCS website, under Health Office or from the Health Office. The health office staff is there to assist you should you have any questions or concerns. Please do not hesitate to call your school nurse.

Sincerely,

Bev Martin, RN
Head of Health Services

BEV MARTIN, RN
Head of Health Services
(315) 287-1902

GOUVERNEUR CENTRAL SCHOOL DISTRICT

HEALTH OFFICE
133 East Barney Street
Gouverneur, New York 13642
FAX: (315) 287-5517

Melissa Breckenridge, RN
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Middle School

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High School

Dear Parent/Guardian:

As part of a required school health examination, a student is weighed and his/her height is measured. These numbers are used to figure out the student's body mass index or "BMI". The BMI helps the doctor or nurse know if the student's weight is in a healthy range or is too high or too low. Recent changes to the New York State Education Law require that BMI and weight status group be included as part of the student's school health examination. A sample of school districts will be selected to take part in a survey by the New York State Department of Health. If your school is selected to be part of the survey, we will be reporting to New York State Department of Health information about our students' weight status groups. Only summary information is sent. No names and no information about individual students are sent. However, you may choose to have your child's information excluded from this survey.

The information sent to the New York State Department of Health will help health officials develop programs that make it easier for children to be healthier.

If you <u>do not wish</u> to have your child's weight status group information included as part of the Health Department's survey this year, please print and sign your name below and return this form to:

Gouverneur Central School
Attention: Health Office
113 East Barney Street
Gouverneur, NY 13642

Please **<u>do not</u>** include my child's weight status information in the BMI School Survey.

_____ _____
Print Child's Name Grade

_____ _____
Print Parent's Name Parent's Signature

_____
Date

Beverly Martin, RN
Head of Health Services
(315) 287-1902

GOUVERNEUR CENTRAL SCHOOL DISTRICT

HEALTH OFFICE
133 East Barney Street
Gouverneur, New York 13642
FAX: (315) 287-5517

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Student Health Appraisal Supplement
For Body Mass Index and Weight Status Reporting

Dear Parent/Guardian:

The American Academy of Pediatrics has recommended guidelines to ensure healthy growth. Your child's height and weight are followed throughout his/her school years and with normal growth, a healthy child is expected to attain and maintain a given percentile in both height and weight. Below you will find an explanation of this measuring tool.

What is BMI: (Body Mass Index)

- A calculation based on height, weight, age and gender. Children's body fat content changes as they grow. Boys and girls differ in their body fat content as they mature. This is why BMI for children is gender and age specific.
- A screening tool- an evaluated BMI does not necessarily mean a child is overweight. For example, a muscular child can have an elevated BMI but a physician is the best judge of accuracy for body weight and health.
- Informative: BMI raises awareness among parents about health risks associated with being overweight. The incidents of Type 2 Diabetes has increased nationally. Overweight children tend to become overweight adults. This puts them at greater risk for heart disease, high blood pressure and stroke.
- BMI Information: Statistically parents who have BMI knowledge will change their child's diet and physical activity levels.

Weight Reduction through dieting is not advised in children who are still growing. The recommendation is to maintain a constant weight as the child grows, while increasing the physical activity to improve fitness. The Academy of Pediatrics recommends that children participate in regular physical activity and decrease passive activities (TV, and video/computer games).

You may contact your school nurse if you have any questions regarding this information.

Sincerely,
Beverly Martin, RN
Head of Health Services

BEV MARTIN, RN
Head of Health Services
(315) 287-1902

GOUVERNEUR CENTRAL SCHOOL DISTRICT

High School Health Department
113 East Barney Street
Gouverneur, New York 13642

Melissa Breckenridge, RN
Elementary School

Brittaney Fairbanks, LPN
Elementary School

Christine Sitts, RN
Middle School

Kylynne Stamper, LPN
High School

Dear Parent/Guardian:

Gouverneur Central School requires that the school have on file permission signed by the parent/guardian **and** the child's physician **before** we can administer **any** medication to your child. This includes both prescription and non-prescription (over-the-counter) medications.

After consultation with our school physician (Dr. Donald C. Schuessler, Jr.), we have decided to have available certain non-prescription medications in our Health Office for use by our nursing staff in the care of our students.

Please mark an "X" on the left of any medication you DO NOT wish your child to receive.

_____ ACETAMINOPHEN: _____mg every 4 hours as needed for mild headache, fever, musculoskeletal complaints, menstrual cramps, minor pain
_____ AMBESOL: for gum discomfort, toothache
_____ BACITRACIN/NEOSPORIN/NEOPOLYCIN: abrasions or superficial wounds after cleaning
_____ BLISTEX: chapped lips or cold sores
_____ CALAMINE: skin irritation /insect bites
_____ CHOLORASEPTIC: spray/gargle: minor sore throats
_____ CINDER SUDS: cleansing of abrasions
_____ CORTAID: minor skin rashes
_____ FIRST AID CREAM: minor cuts, abrasions
_____ FOILLE ointment & spray: floor burns
_____ GLYOXIDE: Minor mouth irritations
_____ IBUPROFEN: ____mg every 6 hours as needed for mild headaches, musculoskeletal complaints, menstrual cramps
_____ SALINE: wash foreign body from eye, contacts
_____ SOLARCAINE: minor sunburn
_____ SUNSCREEN
_____ COUGH DROPS prn sore throat/cough
_____ TUMS
_____ OTHER _____ as provided by parent

I give permission for the use of all the above medications in the treatment of my child **EXCEPT the ones that are marked with an "X"**, as deemed appropriate by the school nurse. This permission will remain in effect until I notify the School in writing.

Please note that both the parent/guardian and the child's physician for your child must sign this form to be able to receive these medications in the Health Office.

STUDENT NAME: _____ GRADE: _____

SCHOOL: *(circle one)* ELEMENTARY MIDDLE SCHOOL HIGH SCHOOL ST. JAMES PAROCHIAL

Both Signatures are required

_____ _____
PARENT/GUARDIAN SIGNATURE Date

_____ _____
PHYSICIAN'S SIGNATURE Date

A NEW form must be signed and on file yearly.

GOUVERNEUR CENTRAL SCHOOL DISTRICT

HEALTH CERTIFICATE / APPRAISAL FORM

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

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

IMMUNIZATIONS / HEALTH HISTORY

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

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

Significant Medical/Surgical History: ❒ See attached _____

Allergies: ❒ **LIFE THREATENING** ❒ Food: _ ❒ Insect: _____ ❒ Other: _____

❒ Seasonal ❒ Medication: _____

PHYSICAL EXAM

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

Urinalysis: Protein _____ Glucose _____

				Referral
Body Mass Index: _____ _____ . _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th	Vision - Near Point	R	L	
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	Hearing ❑ Pass 20 db sc both ears or:	R	L	

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

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

MEDICATIONS

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

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

Students who are capable should be encouraged to carry and self administer emergency medications, such as rescue inhalers, glucagon and epinephrine, under the supervision of an adult.

***Student may self carry and self administer medication** ❒ **Yes** ❒ **No**
* **Student may self administer with adult supervision** ❒ **Yes** ❒ **No**
* **Student will need medication when on field trips** ❒ **Yes** ❒ **No**

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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

❒ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

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

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

❒ **Restrictions:** _____ ❒ Please monitor

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

OPTIONAL INFORMATION, if known

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

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Rev. May 2010

NYSPHSAA
Section X
NORTHERN ATHLETIC CONFERENCE

NEW STUDENT ATHLETIC PARTICIPATION FORM

Student: _____Date: _____

Entering Grade: _____ Male/Female Date of Birth: _____ Age_____

Date of last Health Examination (Physical) _____
Attached documentation

New Address: _____

Parents' Name: _____ Telephone: _____

With Whom Are You Living in This District: _____

********** PREVIOUS SCHOOL INFORMATION **********

Previous School: _____

Sports Played in Previous School	Level & Number of Years Played
Fall Sport _____	_____ Modified ____ JV _____Varsity
Winter Sport _____	_____ Modified ____ JV _____Varsity
Spring Sport _____	_____ Modified ____ JV _____Varsity

Previous Address: _____

With Whom Did You Live: _____

Reason For Leaving Previous School: _____

Were you subject to the APP Process as a 7th or 8th grader? _____ Yes _____ No

********** ACADEMIC INFORMATION **********

Year Entered 9th Grade: _____ Verification: _____
Counselor's Initials

Have You Repeated a Grade in JR High or High School: _____ Yes _____ No
If Yes, which grade: _____

Date of the student's registration accepted: _____

Guidance Department should forward this form to the Director of Athletics when student has been accepted for registration. Please list any other high school attended on back.

THE FOLLOWING PAGES ARE FOR

UPK & KINDERGARTEN

ONLY

BEV MARTIN, RN
Head of Health Services
(315) 287-1902

GOUVERNEUR CENTRAL SCHOOL DISTRICT

HEALTH OFFICE
133 East Barney Street
Gouverneur, New York 13642
FAX: (315) 287-5517

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LEAD SCREENING TESTS FOR PRESCHOOL- AGE CHILDREN

Dear Parent/Guardian:

Enclosed please find an informational flyer regarding lead poisoning.

Preschool-age children are at some risk of getting poisoned by lead. New York State Department of Health (NYSDOH) regulations now require lead screening of *all* children under six years of age and enrolled in a pre-kindergarten program. (Title 10, New York Codes, Rules and Regulations, Part 67, Subpart 67-1)

The purpose of testing, or screening for blood lead levels, is to provide for the early identification of children with elevated blood lead levels and, once identified, coordinate intervention services.

If you have small children in your home, you should be especially concerned about the health risks posed by lead. Even at low levels, exposure to lead can cause serious and permanent damage to the health of young children.

If you have any questions regarding the State-mandated lead screening, please feel free to call me at 287-1902.

Sincerely,

Bev Martin, RN—Head of Health Services

Complying with State-mandated Lead Screening

When your child receives the lead screening, please have the information below completed and return to your child's school so we can record it on his/her cumulative health record.

Students Name:_____ School: _____

Date of Lead Screening:_____ Result:_____

MD/Healthcare Provider Signature:_____

BEV MARTIN, RN
Head of Health Services
(315) 287-1902

GOUVERNEUR CENTRAL SCHOOL DISTRICT
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LEAD POISONING INFORMATION

- Lead is an element that has no useful purpose in the body and is known to cause harmful effects, including, the neurological, hemato-poietic and renal systems. The effects can by insidious or acute.

- The likelihood that lead will cause harmful effects and the nature of these effects is related to the extent and duration of exposure.

RISK FACTORS FOR LEAD POISONING:

- Exposure to contaminated dust, soil, and water.
- Living in housing built prior to 1950.
- Poverty, race and ethnicity.
- Occupational exposure of the parent. Jobs involving exposure to lead are: refinishing furniture, welding, battery recycling, construction & pottery making.
- Exposure to parental hobbies that use leaded products. Loading ammunition stained glass, fishing sinkers etc.
- Exposure to folk remedies such as pay-loo-ah, greta, azarcon, bali gola, coral and several others.

LEAD POISONING PREVENTION TIPS FOR PARENTS:

- Use unleaded paints in the home, on furniture and children's toy
- Wash your child's hands frequently. Dirt tracked into the home may contain lead. Young children do a lot of hand to mouth activity and will decrease exposure with clean hands
- Encourage a diet adequate in calcium, iron and vitamin C. Lead is less likely to absorb if the intake of these vitamins and minerals is adequate.
- Know your child's blood lead level.

Important Phone Numbers for Gouverneur Central School District

Assistant Superintendent – (315) 287-4870

Bus Garage – (315) 287-0650

Central Registration – (315) 287-4914

Committee on Special Education Office – (315) 287-4972

Elementary School – (315) 287-2260

High School Guidance Office – (315) 287-4914

Health & Athletics – (315) 287-1902

High School – (315) 287-1900

Middle School – (315) 287-1903

School Lunch Office – (315) 287-4870

PARENTAL RIGHTS REGARDING THE REFERRAL AND EVALUATION OF CHILDREN FOR THE PURPOSES OF SPECIAL EDUCATION SERVICES OR PROGRAMS

Upon a child's enrollment or attendance at a public school in New York State, the child's parent, guardian, or person in parental relation to that child has the right to refer the child to the school District's Committee on Special Education to have the child evaluated and a determination made whether the student is a student with a disability and therefore eligible for special education and/or related services.

For additional information regarding this process, please visit the State Education Department's website and review "A Parent's Guide to Special Education," http://www.p12.nysed.gov/specialed/publications/policy/parentsguide.pdf

You may also contact the District's Committee on Special Education ("CSE") Chairperson, Mrs. im erly ichards, at 315-287-4972

Thank you.

REF: Chapter 434, Laws of 2014, eff. July 1, 2015