

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 Carley Bearden 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 Date of Birth: ____/____/____ Grade: ____ ID#: ____
 Female 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:** _____

<input type="checkbox"/>	Health Office
<input type="checkbox"/>	CSE Office
<input type="checkbox"/>	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:

<p align="center">GOUVERNEUR CENTRAL SCHOOL DISTRICT CARLEY BEARDEN REGISTRAR TELEPHONE: (315) 287-1949 FAX: (315) 287-4736 EMAIL ADDRESS: bearden.carley@gcsk12.org</p>
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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



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:		
<i>First</i>	<i>Middle</i>	<i>Last</i>
DATE OF BIRTH:		GENDER:
		<input type="checkbox"/> Male
<i>Month</i>	<i>Day</i>	<i>Year</i>
PARENT/PERSON IN PARENTAL RELATION INFO:		
<i>Last Name</i>	<i>First Name</i>	<i>Relation to Student</i>

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____	<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____	<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	_____	<input type="checkbox"/> Father	_____
	<input type="checkbox"/> Guardian(s)	_____		<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____	<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____	<input type="checkbox"/> Does not speak
			<i>specify</i>	
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____	<input type="checkbox"/> Does not read
			<i>specify</i>	
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____	<input type="checkbox"/> Does not write
			<i>specify</i>	

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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *If yes, please explain: _____
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____
Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <small>MO. DAY YR.</small>	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <small>MO. DAY YR.</small>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: _____ _____	

GOUVERNEUR CENTRAL SCHOOL DISTRICT
Delivering the Promise of a Brighter Future

Bev Martin, RN
Head Nurse

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



Melissa Breckenndge, RN
Elementary School

Brittaney Fairbanks, LPN
Elementary School

Christine Sitts, RN
Middle School

Kylynn Stamer, 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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Environmental

Asthma <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	

Seizures <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HgbA1c results: _____	Date Drawn: _____

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

BMI _____ kg/m2 Percentile (Weight Status Category): <5th 5th-49th 50th-84th 85th-94th 95th-98th 99th and<

Hyperlipidemia: No Yes Hypertension: No Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 µg/dL				<input type="checkbox"/> Other: _____
<input type="checkbox"/> System Review and Exam Entirely Normal				

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name:	DOB:
-------	------

SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis	Negative	Positive	Referral	
Required for boys grade 9 And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> 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

<input type="checkbox"/> Brace*/Orthotic	<input type="checkbox"/> Colostomy Appliance*	<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Insulin Pump/Insulin Sensor*	<input type="checkbox"/> Medical/Prosthetic Device*	<input type="checkbox"/> Pacemaker/Defibrillator*
<input type="checkbox"/> Protective Equipment	<input type="checkbox"/> Sport Safety Goggles	<input type="checkbox"/> 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: <i>(please print)</i>	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.

Form with fields for Family Physician (Name, Phone) and Family Dentist (Name, Phone).

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

- Checkboxes for Tuberculosis, Heart Disease, Sore throats, convulsions/seizures, Orthopedic defects, Period of unconsciousness, Speech, Lungs, Asthma, Bronchitis/Pneumonia, Migraine headaches, Nervous system, Head Injury/Concussion, Kidney/urinary problem, Hernia, 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 _____

Mother _____

Address _____

Address _____

E-mail _____

E-mail _____

Home Phone _____ Cell Phone _____

Home Phone _____ Cell Phone _____

Name of Employer _____

Name of Employer _____

Work Phone _____

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
----------------	-------------------------	-------

Name & Address	Relationship to student	Phone
----------------	-------------------------	-------

Name & Address	Relationship to student	Phone
----------------	-------------------------	-------

Signature of Parent/Legal Guardian: _____ Date: _____

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



Melissa Breckenridge, RN
Elementary School

Brittaney Fairbanks, LPN
Elementary School

Christine Sitts, RN
Middle School

Kylynne Stamper, LPN
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 do not wish 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 **do not** 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
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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 elevated 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: _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision - without glasses/contact lenses	R	L	
	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	Hearing <input type="checkbox"/> 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: _____



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: _____

<u>Sports Played in Previous School</u>		<u>Level & Number of Years Played</u>		
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



Melissa Breckenridge, RN
Elementary School

Brittaney Fairbanks, LPN
Elementary School

Christine Sitts, RN
Middle School

Kylynne Stamper, LPN
High School

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**

HEALTH OFFICE
133 East Barney Street
Gouverneur, New York 13642
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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 be 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 toys
- 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. Kimberly Richards, at 315-287-4972

Thank you.

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