# Northeastern Clinton Central School

## DOCUMENTATION REQUIRED FOR REGISTRATION

### *Kindergarten through 5th Grade*

The following documents are required for registration:

- ☐ **Completed Registration Packet**
- ☐ **Birth Certificate (Copy)**
- ☐ **Health Records** (Current Physical & Immunization Records)
- ☐ **Proof of Residence** – You must provide **two** forms of proof of residency from the list below:

  **(Choose One)**
  - ☐ Current Tax Bill
  - ☐ Mortgage Agreement/Closing Statement showing address and name of parent or legal guardian
  - ☐ Rental Agreement showing name, address, and telephone number of landlord as well as name and address of lessee
  - ☐ A dated/notarized letter from landlord/homeowner stating the address of the residence and the name(s) of people living at that address

  **AND**

  **(Choose One)**
  - ☐ Telephone Bill
  - ☐ Cable Bill
  - ☐ Utility Bill
  - ☐ Bank Account Statement (with financial information redacted)
  - ☐ Credit Card Bill (with financial information redacted)
  - ☐ Valid New York State Driver's License (with current address)
- ☐ **Court Documents** (if applicable)
  **If the student is living with a legal guardian, the guardian must provide the court document granting legal custody of the student.

***Completed registration packets can be emailed to kwright@nccscougar.org. If you are unable to email the registration packet, please contact Kim Wright at 518-298-8242 (Ext. 1009) to set up an appointment prior to arriving to submit paperwork.***

# Northeastern Clinton Central School

## AUTHORIZATION FOR RELEASE OF SCHOOL RECORDS

I, the parent/guardian of _____ entering grade _____ whose birth date
**(Students Full Name)**
is _____/_____/_____ do hereby authorize the school listed below to release all cumulative school records

including:

- Grades/Evaluations
- Health/Immunization Records
- Copy of Birth Certificate
- Psychological/Educational Evaluation Report (if applicable)
- Testing Results
- Confidential & Disciplinary Records
- Individualized Education Program (if applicable)
- Other pertinent data not listed above

**Please check appropriate box:**

☐ My child receives Special Education services
☐ My child **does not** receive Special Education services

_____
Name of School Last Attended

_____
Street Address

_____
City State Zip Code

_____ _____
School Phone Number School Fax Number

**Please send complete records to:**

☐ **Mooers Elementary**
16 School St.
Mooers, NY 12958
Phone: 518-236-7373
Fax: 518-957-4151

☐ **Rouses Point Elementary**
80 Maple St.
Rouses Point, NY 12979
Phone: 518-297-7211
Fax: 518-957-4154

☐ **NCCS High School Guidance Office**
103 Route 276
Champlain, NY 12919
Phone: 518-298-8669
Fax: 518-957-4149

☐ **NCCS Middle School Guidance Office**
103 Route 276
Champlain, NY 12919
Phone: 518-298-8681
Fax: 518-957-4150

_____
Parent/Guardian Signature

_____
Relationship to Child

_____
Date

# Northeastern Clinton Central School

103 Route 276
Champlain, NY 12919
518-298-8242

**Date Form Completed:** _____

**Last Name:** _____ **First Name:** _____ **Middle Name:** _____
(According to Birth Certificate)

**Grade:** _____ **Sex:** Male ____ Female ____ **Name of Last School Attended:** _____

**Date of Birth** _____ / _____ / _____ **Birthplace (City & State):** _____
Month Day Year

(Please check)

| **Ethnic Background:** | **Student Lives With:** | **Parents are:** |
|---|---|---|
| ☐ American Indian | ☐ Mother & Father | ☐ Married |
| ☐ Asian | ☐ Mother Only | ☐ Separated |
| ☐ Black/African American | ☐ Mother/Stepfather | ☐ Divorced |
| ☐ Hispanic/Latino | ☐ Father Only | ☐ Other |
| ☐ Pacific Islander | ☐ Father/Stepmother | _____ |
| ☐ White | ☐ Other _____ | _____ |

| | |
|---|---|
| **Father's Name:** _____ | **Mother's Name:** _____ |
| **Physical Address:** _____ (Street, Village, State) | **Physical Address:** _____ (Street, Village, State) |
| **Mailing Address:** _____ | **Mailing Address:** _____ |
| **Father's Home Number:** _____ | **Mother's Home Number:** _____ |
| **Father's Cell Number:** _____ | **Mother's Cell Number:** _____ |
| **Father's Work Number:** _____ | **Mother's Work Number:** _____ |
| **Work Place:** _____ | **Work Place:** _____ |
| **Email Address:** _____ | **Email Address:** _____ |

***If student is not living with mother or father, please complete this section**

**Legal Guardian Name:** _____ **Relationship to student:** _____

**Physical Address:** _____
(Street, Village, State)

**Mailing Address:** _____

**Guardian's Home Number:** _____ **Cell Number:** _____

**Guardian's Work Place:** _____ **Work Number:** _____

**Guardian's E-Mail Address** _____

Persons who may **NOT** pick student up from school or any additional information you would like kept on file regarding your child:

_____

Is there a custody order or order of protection for this student? **Yes** ____ **No** ____ (If **Yes**, please provide a copy)

| **Alternate Emergency Contacts:** (Please list in order, person(s) to contact if you you are not available) | | |
|---|---|---|
| **Emergency Number** | **Name of Person Being Called** | **Relationship to Student** |
| | | |
| | | |
| | | |
| | | |

**Student Educational Information** - Complete the questions below regarding your child

1. Did this child have a current IEP (Individualized Education Plan) through the committee on Special Education at his/her previous school? **Yes** _____ **No**_____
2. Did this child have a Section 504 Plan at his/her previous school? **Yes**_____ **No**_____
3. If yes, indicate which services your child was receiving:

   **Speech Therapy** _____ **Special Instruction** _____ **Physical Therapy**_____

   **Occupational Therapy**_____ **Other (specify)**_____

| **Student's Primary Language** | **English** | **Other (Specify)** |
|---|---|---|
| What language(s) is (are) spoken in the student's home or residence? | | |
| What was the first language your child learned? | | |
| What is the home language of each parent/guardian? | | |
| What language(s) does your child understand? | | |
| What language(s) does your child speak? | | |
| What language(s) does your child read? | | |
| What language(s) does your child write? | | |

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

Is your current address a temporary living arrangement? Yes_____ No_____

If you answered Yes, please check the following that apply:

- ☐ The Student is an unaccompanied minor. (Not in physical custody of parent or guardian)
- ☐ We are living in temporary housing.
- ☐ We are living in a motel/hotel/RV Park.
- ☐ We are living in a car, camper or on the street.
- ☐ We are living with relatives due to economic hardship.
- ☐ We are living in a shelter.

| **ALL other children under 18 years of age in the home (include children under 5)** | | |
|---|---|---|
| **First & Last Name** | **Date of Birth** | **Grade/School** |
| | | |
| | | |
| | | |
| | | |

I verify that the information contained in this document is true and correct to the best of my knowledge.

Parent/Guardian Signature: _____ Date:_____

# Northeastern Clinton Central School District
## 2023-2024
## Transportation Form

- Students may have ***ONE*** approved pick-up (A.M.) location and ***ONE*** Approved drop-off location (P.M). Example: pick-up at home and drop-off at daycare.
- The PLAN must be CONSISTENT for 10 WEEKS (Quarterly Basis)
- Changes may be made on a quarterly basis. Dates are listed on the Transportation Change Form (located on the school website).
- Bus notes or daily changes **WILL NOT** be accepted
- A parent or guardian MUST be visible for drop off for Elementary Students
- Students will be assigned seats
- Cellphones or electronic devices are not permitted on the elementary buses

_____ **Transportation Needed (Please fill out information below)**
_____ **No Transportation Needed**
_____ **Student Driver**

Student(s) Name(s): _____

_____

_____

Student(s) Bus Stop Address (A.M.): ___ Home ___Other

_____

_____

Student(s) Bus Stop Address (P.M.): ___ Home ___Other ____ Same as above

_____

_____

Parent/Guardian Name: _____

Phone Guardian Phone Number: _____

# Northeastern Clinton Central School

## AUTHORIZATION TO RELEASE STUDENT MEDICAL RECORDS & HEALTH INFORMATION

I, _____, hereby authorize

Doctor's Office: _____

Phone: _____

To release all medical records and confidential information from the health record(s) of:

| Name of child/children | Date of birth | Grade |
|---|---|---|
| | | |
| | | |
| | | |

I also consent for Northeastern Clinton Central School, including the Middle and High Schools, Mooers Elementary School & Rouses Point Elementary School to share information with the physician's office listed. I further understand that this release shall remain in effect until a request to rescind it is received or when the student leaves the NCCS District.

**Please send health records to:**

☐ NCCS Middle/High School
Attn: Kim Letourneau, RN & Alexis Parrotte, RN — Fax Number: **518-957-4153**

☐ Mooers Elementary School
Attn: Connie Poupore, RN — Fax Number: **518-957-4152**

☐ Rouses Point Elementary School
Attn: Donna Marks, RN — Fax Number: **518-957-4155**

_____ _____

**Parent/Guardian Signature** **Date**

**Northeastern Clinton Central School**
**Elementary School Health Office**

| Name: | DOB: | Grade/Teacher: |
|---|---|---|

| Has your child ever: | YES | NO | If Yes, please explain below or on back of sheet if needed: |
|---|---|---|---|
| Had an ongoing medical condition | ☐ | ☐ | |
| Seen a medical specialist | ☐ | ☐ | |
| Had allergies: | ☐ | ☐ | ☐food ☐environmental ☐insect ☐medication ☐other |
| If yes, please list: | ☐ | ☐ | |
| If yes, were Epipen and/or Benadryl ordered | ☐ | ☐ | |
| Been hospitalized | ☐ | ☐ | |
| Had an operation | ☐ | ☐ | |
| Had an injury requiring an E.R. visit | ☐ | ☐ | |
| Had a broken bone | ☐ | ☐ | |
| Had a concussion or serious head injury | ☐ | ☐ | |
| Had vision problems or condition | ☐ | ☐ | ☐glasses ☐contacts |
| Had hearing problems or condition | ☐ | ☐ | ☐tubes; # of times _____ ☐hearing aid |
| **Has any family member under age of 50 ever:** | **YES** | **NO** | **If Yes, please explain:** |
| Had a heart attack: | | | |
| Had other serious health problems | | | |

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

☐ADD/ADHD
☐Asthma/trouble breathing
☐Autism/Asperger's
☐Diabetes
☐Ear Infections
☐GI conditions (ulcer, reflux, IBS)
☐Headaches/migraines
☐Heart Condition, _____
☐High Blood Pressure
☐Mental Health Condition:_____
☐Scoliosis
☐Skin Condition
☐Speech Condition
☐Urinary Condition
☐Other:_____

| CURRENT MEDICATIONS | YES | NO | Please list name, dose, time(s) |
|---|---|---|---|
| **Given at home:** | ☐ | ☐ | |
| | ☐ | ☐ | |
| | ☐ | ☐ | |
| | ☐ | ☐ | |
| | ☐ | ☐ | |
| **Given at school:** | ☐ | ☐ | |
| | ☐ | ☐ | |
| **ASSISTIVE EQUIPMENT** | **YES** | **NO** | **Please check all that apply** |
| | ☐ | ☐ | ☐crutches ☐ walker ☐wheelchair ☐other: |
| **TREATMENTS** | **YES** | **NO** | |
| | ☐ | ☐ | ☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow ☐special diet: |

Is there any condition that would prevent your child from participating in physical education or sports?
☐No ☐Yes:_____

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

I, _____, authorize the school nurse to share any pertinent information regarding
(Parent/Guardian name—please print)
my child's health with the involved staff of Northeastern Clinton Central School and with his/her primary care provider. This authorization shall remain in effect for as long as he/she attends school in the N.C.C.S. district.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

The goal of the health office is to maintain the health and safety of each student so that he/she can meet their full academic potential. Thank you for completing the MANDATORY Health

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

**Note:** NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

### STUDENT INFORMATION

| Name | Sex: ☐ M ☐ F | DOB: |
|---|---|---|
| School: | Grade: | Exam Date: |

### HEALTH HISTORY

| | |
|---|---|
| **Allergies** ☐ No<br>☐ Yes, indicate type | Type:<br>☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached |
| **Asthma** ☐ No<br>☐ Yes, indicate type | ☐ Intermittent ☐ Persistent ☐ Other:<br>☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached |
| **Seizures** ☐ No<br>☐ Yes, indicate type | Type: Date of last seizure:<br>☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached |
| **Diabetes** ☐ No<br>☐ Yes, indicate type | Type: ☐ 1 ☐ 2<br>☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached |

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

**BMI**_____kg/m2

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

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

### PHYSICAL EXAMINATION/ASSESSMENT

**Height:** **Weight:** **BP:** **Pulse:** **Respirations:**

| Laboratory Testing | Positive | Negative | Date | List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ) |
|---|---|---|---|---|
| TB- PRN | ☐ | ☐ | | |
| Sickle Cell Screen-PRN | ☐ | ☐ | | |
| **Lead Level Required Grades Pre-K & K** | | | **Date** | |
| ☐ Test Done ☐ Lead Elevated ≥5 µg/dL | | | | |

☐ **System Review and Abnormal Findings Listed Below**

| | | | | |
|---|---|---|---|---|
| ☐ HEENT | ☐ Lymph nodes | ☐ Abdomen | ☐ Extremities | ☐ Speech |
| ☐ Dental | ☐ Cardiovascular | ☐ Back/Spine | ☐ Skin | ☐ Social Emotional |
| ☐ Neck | ☐ Lungs | ☐ Genitourinary | ☐ Neurological | ☐ Musculoskeletal |

| ☐ Assessment/Abnormalities Noted/Recommendations: | Diagnoses/Problems (list) ICD-10 Code* |
|---|---|
| ☐ Additional Information Attached | *Required only for students with an IEP receiving Medicaid |

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

**SCREENINGS**

| **Vision** (w/correction if prescribed) | **Right** | **Left** | **Referral** | **Not Done** |
|---|---|---|---|---|
| Distance Acuity | 20/ | 20/ | ☐ Yes ☐ No | ☐ |
| Near Vision Acuity | 20/ | 20/ | | ☐ |
| Color Perception Screening ☐ Pass ☐ Fail | | | | ☐ |
| Notes | | | | |

| **Hearing** Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz. | | | | **Not Done** |
|---|---|---|---|---|
| Pure Tone Screening | **Right** ☐ Pass ☐ Fail | **Left** ☐ Pass ☐ Fail | **Referral** ☐ Yes ☐ No | ☐ |
| Notes | | | | |

| **Scoliosis** Screen Boys in grade 9; and Girls in grades 5 & 7 | **Negative** | **Positive** | **Referral** | **Not Done** |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ Yes ☐ No | ☐ |

**RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK**

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

**Developmental Stage for Athletic Placement Process ONLY required** for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

**Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

**MEDICATIONS**

☐ **Order Form for Medication(s) Needed at School Attached**

**IMMUNIZATIONS**

☐ Record Attached ☐ Reported in NYSIIS

**HEALTH CARE PROVIDER**

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

**Please Return This Form To Your Child's School When Completed.**

SAMPLE

# Dental Health Certificate- Optional

**Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.**

## Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

## Section 2. To be completed by the Dentist/ Dental Hygienist

**I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:**

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means, that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

**Dentist's/ Dental Hygienist's name and address**

**(please print or stamp)** **Dentist's/Dental Hygienist's Signature**

***Optional Sections - If you agree to release this information to your child's school, please initial here.*** ☐

### II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

### III. Treatment Needs (check all that apply)

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

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

(3/2018)

# Nurse Notes

K-5 Entry

Dear Parent/Guardian,

Please review the following requirements for school attendance in kindergarten through fifth in New York State.

## ✓ Health Appraisals (Physical Exams)

**New York State Education Law, Section 903**, requires students in the pre-K or kindergarten, 1st, 3rd, 5th, 7th, 9th and 11th grades, special education students, and new students to our district to receive physical examinations.

If your child has already received a physical exam in the current school year, please ask your child's health care provider to complete the enclosed exam form & submit it to the health office. You may also ask your child's health care provider to fax a copy of your child's exam directly to the school. ****As of February 2021, your child's doctor MUST submit his/her exam on the New York State (NYS) School Health Examination Form, enclosed, or an electronic equivalent. ****

If your child has not had a physical exam this year and you would prefer your own family doctor to complete your child's exam, please schedule an appointment and submit a copy of the exam to the school as soon as the exam has been completed. If you prefer, these examinations may be completed by the school physician at no cost to the parent. Our school physicians are from Hudson Headwaters: Champlain Family Health.

School physical examinations will be scheduled beginning in the fall. Please ensure that you have submitted your child's completed physical exam form if you do not wish your child to receive his/her exam at school.

Vision and hearing screenings will be completed on each student during the school year. You will be notified only if a problem is identified.

## ✓ Immunizations

**New York State Public Health Law, Section 2164(7)(a)** mandates that schools shall not permit a child to be admitted unless the parent provides the school with a certificate of immunization, or proof from a physician, nurse practitioner, or physician's assistant that the child is in the process of receiving the required immunizations.

***The required immunizations for school entry in K-5th grade in New York State are:***

- 4-5 doses of diphtheria containing toxoid (DTP, DTaP)
- 4-5 doses of poliovirus vaccine (IPV)
- 3 doses of hepatitis B vaccine.
- 2 doses of measles, mumps, rubella vaccine (MMR), administered after 12 months of age.
- 2 doses of varicella (chicken pox) vaccine administered after 12 months of age.

## ✓ Dental Health Certificates

New York State Education Law 903 requires all public schools to *request* that students entering pre-K provide a dental health certificate to their school health office. A certificate has been provided for you to take to your child's dentist for completion. Currently this is a request, it is not mandatory for school entry.

## ✓ Medications

If it is necessary for your child to receive medication during school hours, the following is required:

1. A written order from the physician including the name, dosage, time of administration and the anticipated effect of the medication.
2. A note from the parent/guardian, giving the school nurse permission to administer the medication.
3. The medication must be provided in the original labeled container from the pharmacy. This procedure must be followed for over-the-counter medications (OTC), as well as prescription medication. Tylenol, Motrin, cough drops, etc. **cannot** be given by the school nurse without an order from the physician and written parental consent. OTC medications must remain in the original manufacturer's package and be labeled with the student's name.
4. All medication must be brought to the school office by the parent/guardian and **NOT** carried by a student on the bus. The student **may not** carry any medication in school except in certain cases such as asthma (inhaler) or life-threatening allergies (EpiPen). In these cases, both the child's doctor and parent or guardian must complete a self-medication form indicating that the student can appropriately administer their medications and is responsible enough to do so in a safe manner.

If your child will require medications to be administered during the school day, please discuss the completion of the necessary forms with your child's physician and the school nurse prior to the first day of school.

## ✓ First Aid


The principal and/or the school nurse must be able to contact students' parent/guardian should an accident or illness occur in school. Therefore, it is imperative that parents ensure the school always has a current telephone number and the name and telephone number of a relative, friend, or neighbor who lives nearby and can pick up your child and assume responsibility for the child in case of illness or emergency. **PLEASE NOTIFY THE SCHOOL IMMEDIATELY OF ANY CHANGES IN YOUR CONTACT INFORMATION.**

**If you have any questions, contact the school nurse:**

Connie Poupore, RN
518-236-7373 ext. 4441

Mooers Elementary School
Fax: 518-957-4152

Donna Marks, RN
518-297-7211 ext. 5411

Rouses Point Elementary School
Fax: 518-957-4155

NYSTEACHS.org

**The New York State Technical and Educational Assistance Center for Homeless Students**

# Is Your Housing Uncertain?

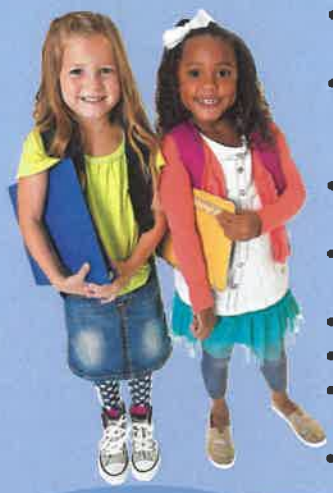
## Are you living...

- with relatives, friends, or others because you lost your housing or because of economic hardship?
- In a shelter?
- In a motel or hotel because you have nowhere else to go?
- In inadequate housing?

**DO YOU LIVE AT A TEMPORARY ADDRESS?**

## Then you may be protected under the McKinney-Vento Act.

**Children and youth in temporary housing have the right to:**



- stay in the same school, including pre-k and get free transportation even if it is across district lines;
- immediately enroll in school without records (school records, medical records, vaccination records, proof of residency);
- get special education services immediately if the student has a current individualized Education Program (IEP);
- Participate fully in any school activities, including before- or after-school activities;
- get support services and help with things like school supplies through Title I;
- get free school meals without filling out an application;
- get help enrolling in pre-k, Head Start, or other preschool programs, and Early Intervention; and
- get help preparing and applying for college.

**YOU HAVE IMPORTANT SCHOOL RIGHTS!**

## ASK YOUR MCKINNEY-VENTO LIAISON FOR HELP!

**For more information, call**

**NYS-TEACHS 800-388-2014**

**www.nysteachs.org**

## Did you know?

**Every school district must have a McKinney-Vento liaison to help students in temporary housing.**

**FOR HELP:**

- McKinney-Vento Liaison

Tom Brandell

If blank, contact NYS-TEACHS for liaison information at 800-388-2014 or visit www.nysteachs.com/liaisons

New York State Coordinator for Homeless Education
**Melanie Faby**
**Email:** melanie.faby@nysed.gov
**Web:**
http://www.nysed.gov/essa/mckinney-vento-homeless-education

MEASUREMENT INCORPORATED

New York State EDUCATION DEPARTMENT
Knowledge > Skill > Opportunity

English