Northeastern Clinton Central School

DOCUMENTATION REQUIRED FOR REGISTRATION

UPK Registration

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 <u>two</u> 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

  <u>AND</u>

  (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 <u>kwright@nccscougar.org</u>. 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
UPK Request Form

Name of UPK Student: _____

Date of Birth: _____ Age: _____

Parent(s)/Guardian(s): Name _____

Address _____

Phone Number _____

Indicate Preferred Choice: (Check One)

☐ **Morning Program** 8:00 a.m.-10:30 a.m.

☐ **Afternoon Program** 11:45 a.m.-2:20 p.m.

☐ **Either**

Transportation is needed: (Circle One) ***Transportation will be provided only one way.*

☐ **Yes** ☐ **No**

Transportation For <u>Morning Program</u>:

***Transportation will pick up and bring student to school - you are responsible for picking up your child at 10:30 a.m.*

Indicate address of bus pick-up:

☐ Pick up student at home address

(or)

Home of: _____

Address: _____

Phone: _____

Transportation For <u>Afternoon Program</u>:

***Transportation will bring student home from school - you are responsible for getting your child to school for 11:45 a.m.*

Indicate address of bus pick-up:

☐ Pick up student at home address

(or)

Home of: _____

Address: _____

Phone: _____

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:
- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Pacific Islander
- ☐ White

Student Lives With:
- ☐ Mother & Father
- ☐ Mother Only
- ☐ Mother/Stepfather
- ☐ Father Only
- ☐ Father/Stepmother
- ☐ Other _____

Parents are:
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Other

_____
_____

Father's Name: _____

Physical Address: _____
(Street, Village, State)

Mailing Address: _____

Father's Home Number: _____

Father's Cell Number: _____

Father's Work Number: _____

Work Place: _____

Email Address: _____

Mother's Name: _____

Physical Address: _____
(Street, Village, State)

Mailing Address: _____

Mother's Home Number: _____

Mother's Cell Number: _____

Mother's Work Number: _____

Work Place: _____

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

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 ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ 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
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥5 µg/dL			

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **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:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*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):_____

II. 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

UPK Entry

Dear Parent/Guardian,

Please review the following requirements & guidelines for UPK attendance 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 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 provider MUST submit his/her exam on the New York State (NYS) School Health Examination Form 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 exams may be completed by the district's health care providers at no cost to the parent. Our providers 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.

Public Health Law requires that public schools *request* **lead screening results** of their pre-K students. If available, please submit your child's most recent lead screening results to the health office. At this time, this is not a mandatory requirement.

✓ **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 preschool entry in New York State are:

- 4 doses of diphtheria containing toxoid (DTP, DTaP)
- 3 doses of poliovirus vaccine (IPV)
- 3 doses of hepatitis B vaccine
- 1 dose of measles, mumps, rubella vaccine (MMR), administered after 12 months of age
- 1 dose of varicella (chicken pox) vaccine administered after 12 months of age
- 1 to 4 doses of Haemophilus influenza type b conjugate vaccine (Hib)
- 1 to 4 doses of Pneumococcal Conjugate vaccine (PCV)

✓ 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 health care provider 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 provider and written parental consent. OTC medications must remain in the original manufacturer's package and labeled with the student's name.
4. All medication must be transported to the school 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 instances such as asthma (inhaler) or life-threatening allergies (EpiPen). In these cases, both the child's health care provider and parent/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 medication(s) 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 student's parent/guardian should an accident or illness occur in school. Therefore, it is imperative that parents ensure the school always has a current home 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 OFFICE 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

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