Mechanicville City School District

New Student Registration Packet

2022-2023

Karen Higgins, Registrar
518-664-9888 x2008
khiggins@mechanicville.org

Mechanicville City School District

CENTRAL REGISTRAR CHECKLIST

Proof of Residency is required before a student will be registered. (Post Office Box is not acceptable).

Parent/Guardian Form of Identification: ☐Driver's License ☐State or Government Issued ID ☐Passport

Proof of Residency: TWO FROM **LIST A**: ☐ Lease Agreement ☐ Mortgage Statement ☐ Signed Rent Receipt ☐ Utility Bill (NYSERDA) ☐ Landline Phone Bill

OR ONE FROM LIST A + ONE **LIST B**: ☐ Recent Paystub ☐ Driver's License ☐ State or Gov't Issued ID ☐ Passport ☐ Current Income Tax Form ☐ Voter Registration Documents ☐ Documents Issued by federal/state/local agencies ☐ Car/Home/Renter Insurance Documents ☐ Bank/Loan Statements

OR IF LIST A does not apply (**2**) LIST B + **OTHER**: ☐ Notarized statement by third party establishing physical presence of parent/guardian in the school district (i.e. landlord, owner or tenant leased from or live with).

Documents must be from the past 30 days

Determination of Student Age:

☐ Original Birth Certificate ☐ Baptismal Record ☐ Passport ☐ Driver's License (student)

☐ State or other government issued ID ☐ Consulate identification Card ☐ Hospital or Health Records

☐ Military Dependent Identification Card ☐ Court orders or other court issued documents with DOB

☐ Native American Tribal Documents ☐ Records from non-profit international aid agencies and voluntary agencies

Health Records:

To Be Completed by Parent/Guardian

- ☐ o Medical History Form
- ☐ o Health Information Release Form

To Be Completed by Health Care Professional

- ☐ o Health Certificate/Appraisal Form
- ☐ o Authorization to Administer Medication (if applicable)*
- ☐ o Dental Health Certificate
- ☐ o Immunization Records**

*** (Proof of up to date immunizations per NYSED requirements. Temporary enrollment will be considered as needed; parents will be given 14 days upon date of registration to supply school with documents, pending administrative approval.)*

School Records:

- ☐ • Authorization to Request Release of Records
- ☐ • Report Card/ Transcript *
- ☐ • Current Schedule (MS/HS)*
- ☐ • Lab grades for Science Courses (HS)*

Other Required Paperwork:

- ☐ • Free and Reduced Lunch Application*
- ☐ • Student Registration Form
- ☐ • Teacher Data Sheet
- ☐ • Residency Questionnaire
- ☐ • Home Language Questionnaire

Divorce and/or Custodial / Guardianship/Foster Child Documentation:

Individual's attempting to enroll a student must be listed on the child's birth certificate as the natural parent or must provide court documentation proving legal custody. When parents reside in different school districts the child must attend the school in the district of the parent with whom the child lives for a majority of the time, unless court order specifies otherwise. If parents split time equally, parents are given school of choice.

Custodial paperwork is not required only when both natural parents reside in the same household and are both listed on registration paperwork OR if a natural parent is not listed on the child's original birth certificate.

- ☐ • Copy of the most recent divorce decree and/or custodial/visitation paperwork issued by the court
- ☐ • Copy of official Guardianship Paperwork or Foster Placement
- ☐ • No Official Custody Agreement (both natural parents are not involved) – Affidavit of custodial parent voluntarily relinquishing the role of non-custodial parent, other parent receives copies of school correspondence but has no input on day-to-day.

Special Education Services:

- ☐ • Most recent IEP (Individualized Education Program) developed by previous school.
- ☐ • Most recent 504 Education Plan developed by previous school.

Mechanicville City School District

Forms to Return to School

Completed by parent/guardian

MECHANICVILLE CITY SCHOOL DISTRICT
STUDENT REGISTRATION FORM

Student Name: _____ Student #: _____ Grade: _____

Physical Address: _____ Date of Birth: _____ Gender: _____

Street Apt. #

_____ _____ County of Residence: _____

City , State Zip

Mailing Address: _____ Home Phone Number: _____

(if other than above - ex: P.O. Boxes) Street City Zip

Special Accommodations: (please check one)

☐ Student does not have any Special Accommodations

☐ Special Education Classification

☐ Section 504 Classification

Ethnicity: **(Please check all that apply)**

☐ American Indian ☐ Black/African American

☐ Asian ☐ White/Caucasian

☐ Native Hawaiian/Other Pacific Islander

Hispanic/Latino: **(Please check one)**

☐ YES ☐ NO

Has your child(ren) ever attended Mechanicville City School District in the past? ☐ YES ☐ NO (Please check one)

LIST BOTH LEGAL PARENTS AND/OR GUARDIANS *(Step Parent – should be listed as Other Adult Living in Home)*****

Parent/Guardian (1): _____

Address: _____

(if different than student)

Email Address: _____

Place of Employment: _____

Work Phone #: _____ Cell Phone #: _____

☐ Is Primary Contact ☐ Receives Mail ☐ Receives Email ☐ Parent Portal Access ☐ Automated Emergency Notifications ☐ Pick Up Only

Parent/Guardian (2): _____

Address: _____

(if different than student)

Email Address: _____

Place of Employment: _____

Work Phone #: _____ Cell Phone #: _____

☐ Is Primary Contact ☐ Receives Mail ☐ Receives Email ☐ Parent Portal Access ☐ Automated Emergency Notifications ☐ Pick Up Only

Child Lives With: **(Please check <u>one</u> :)** **☐ Both Parents ☐ Mother ☐ Father ☐ Other (Specify) ☐ Foster Parents ☐ Homeless**

Other Adult Living in Home ***with Supervisory Jurisdiction***: _____ Relation to Child: _____

Place of Employment: _____ Work Phone#: _____ Cell Phone#: _____

☐ Receives Mail ☐ Receives Email ☐ Parent Portal Access ☐ Automated Emergency Notifications ☐ Pick Up Only

Any legal custodial restrictions? ☐ YES ☐ NO If yes, court documents required, see below

Important: The school district shall presume that either parent of a student has authority to obtain the child's release from school. However, a student shall not be release to a non-custodial parent if the district is provided with a certified copy of a legally binding instrument, such as a court order, decree of divorce, separation or custody that indicates the non-custodial parent does not have the right to obtain such a release.

PLEASE LIST ALL CHILDREN LIVING IN PRIMARY HOUSEHOLD UNDER THE AGE OF 21

Name: _____ Name: _____ Name: _____

DOB: _____ Age: _____ DOB: _____ Age: _____ DOB: _____ Age: _____

Gender: _____ Gender: _____ Gender: _____

Name: _____ Name: _____ Name: _____

DOB: _____ Age: _____ DOB: _____ Age: _____ DOB: _____ Age: _____

Gender: _____ Gender: _____ Gender: _____

In accordance with Chapter 549 of the Education Law of 1986, I am providing the following list of people to whom my child/children, upon my written authorization, may be released from the Mechanicville City School District. These people may also be contacted in the event of an emergency and I cannot be reached:

Name: _____ Address: _____ City, State Zip _____

Relationship: _____ Daytime Phone #: _____ Alternate #: _____

☐ **Receives Mail** ☐ **Receives Email** ☐**Parent Portal Access** ☐**Emergency Notification** ☐ **Pick Up Only**

Name: _____ Address: _____ City, State Zip _____

Relationship: _____ Daytime Phone #: _____ Alternate #: _____

☐ **Receives Mail** ☐ **Receives Email** ☐**Parent Portal Access** ☐**Emergency Notification** ☐ **Pick Up Only**

Parent in the Armed Forces: ☐ YES ☐ NO If Yes, Parent Name: _____

(Please Check One)

☐ Active Duty ☐ Reserves ☐ Veteran ☐ Civilian

Technology in the Home: ☐ Desktop Computer ☐ Laptop ☐ Chromebook ☐ Tablet ☐ Smart Phone ☐ Other

(Please check all that apply) Access to the Internet: ☐ None ☐ Wifi ☐ Mobile Hot Spot ☐ Cell Phone only

Physician to be called in an Emergency: _____ Phone #: _____

Preferred Hospital Choice: _____

RELEASE

If emergency treatment is required and the parents or legal guardian cannot be reached immediately, your signature in the space provided below empowers the school authorities to exercise their own judgment to transport the child to a hospital emergency room/Allows school physician to complete physical examinations as required by State Law. Likewise, your signature below is not sufficient for the release of confidential information protected by Federal Law.

Parent Statement:

I certify that the above information is true and correct. Any misinformation regarding residency may result in being billed to cover the cost of instruction and/or exclusion from attending the Mechanicville City School District.

Parent/Legal Guardian Signature: _____ **Date:** _____

Mechanicville City School District

25 Kniskern Avenue - Mechanicville, NY 12118
Registrar: 518-664-9888 Ext. 2008

Authorization to Request Release of School Records

I give permission for the exchange of information concerning my child,

Name: _____ Current Grade: _____
who has been registered for school at Mechanicville City School District.

Name of Previous School: _____

Address: _____

Phone Number: _____ Fax Number: _____

_____ _____
Signature of Parent Date

Items Requested *(to be completed by MCSD)*:

- ☐ Birth Certificate
- ☐ Report Cards
- ☐ Student Transcript
- ☐ Standardized Test Scores
- ☐ Science Lab Reports
- ☐ Universal screener used in reading & math (ie. iReady, STAR, AIMSWEB, etc.)
- ☐ Immunizations
- ☐ Last Health Physical
- ☐ Special Education Records (IEP, 504 Plan, psychological, etc.)
  Please send to Kim Dunn - Fax number 518-514-2118 or kdunn@mechanicville.org
- ☐ Latest Custodial Documentation on file
- ☐ Attendance Reports
- ☐ Discipline Reports

Please send to:

Mechanicville Jr/Sr High School
Attn: Karen Higgins
Fax Number: 518-514-2108
khiggins@mechanicville.org

Mechanicville Elementary School
Attn: Jen Topetro
Fax Number: 518-514-2119
jtopetro@mechanicville.org

Mechanicville City School District
TEACHER DATA SHEET

Student Information		
Student's Name:	Grade:	Date:
Student lives with: ☐ Mother & Father ☐ Mother ☐ Father ☐ Guardian/Other:		
Academic Information		
Names and Addresses of Previous Schools Attended (list most recent first):		
Name of School:	Phone Number:	
Address:	Previous Teacher's Name:	
	Month/Year Attended: From to	
Name of School:	Phone Number:	
Address:	Previous Teacher's Name:	
	Month/Year Attended: From to	
Has your child ever been retained: ☐ Yes ☐ No If yes, what grade?		
Does your child presently receive Special Education Services? ☐ Yes ☐ No		
Does your child have an IEP or a 504 plan? ☐ Yes ☐ No		
Have they in the past? ☐ Yes ☐ No		
Does your child presently receive Academic Intervention Services for:		
☐ Reading ☐ Math ☐ Science ☐ Social Studies		
Does your child presently receive:		
☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy		
Have they received these services in the past? ☐ Yes ☐ No		
Comments:		
Has there been a recent change in your family (parent separation, death, birth, hospitalization)? If so, please explain:		
Does your child receive counseling services? ☐ Yes ☐ No		
Comments:		

TURN OVER

General Academic Levels				
	Advanced	Average	Developing	Comments
Reading	○	○	○	
Math	○	○	○	
Writing	○	○	○	

Sibling Information					
Name (first & last)	Sex	D.O.B.	Living in the home?	Grade	School Attending

Parent/Guardian Signature

Date Signed

Parent/Guardian
(Please Print Name)

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:
☐ Male
☐ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

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

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

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

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

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

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

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

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

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

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

_____ _____
Signature of Parent or of Person in Parental Relation *Date*

Relationship to student: ☐ **Mother** ☐ **Father** ☐ **Other:**_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ NO ☐ YES

DATE OF INDIVIDUAL INTERVIEW: _____
MO DAY YR.

OUTCOME OF INDIVIDUAL INTERVIEW:
☐ ADMINISTER NYSITELL
☐ ENGLISH PROFICIENT
☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____
MO. DAY YR.

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Mechanicville City School District

25 Kniskern Avenue Mechanicville, New York 12118
Telephone 518-664-9888 Extension 2416 Fax 518-514-2108

RESIDENCY QUESTIONNAIRE FORM

Name of Student: _____

Address: _____

Phone: _____

Date of Birth: _____ _____ _____ _____ _____
Month Day Year *(preschool-12)*

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.

1. Is your current address a temporary living arrangement? ☐ Yes ☐ No

2. Is this temporary living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No

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 refered 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

Mechanicville City School District

25 Kniskern Avenue Mechanicville, New York 12118
Telephone 518-664-9888 Extension 2416 Fax 518-514-2108

Eligibility Screen for Migrant Education Services

** Migrant Eduaction Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed. ***

1. Has your family moved to a different school district in the last 3 years? ☐ Yes ☐ No

2. In the last three years, has the parent or guardian of the child enrolling done farm work as a paid job? (Did they work on a dairy farm, planting, picking/harvesting fruits or vegetables, food processing or packaging, logging or tree farming?) ☐ Yes ☐ No

3. If yes, what farm did you work on? _____ Where? _____ When? _____

If you can answer YES to BOTH of the above questions, your family MAY qualify for Migrant Education services. To be contacted by a Migrant Education liaison, please complete the information below.

Child's Name _____ **D.O.B.** _____ **Grade**_____

Child's Name _____ **D.O.B.** _____ **Grade**_____

Child's Name _____ **D.O.B.** _____ **Grade**_____

Child's Name _____ **D.O.B.** _____ **Grade**_____

Child's Name _____ **D.O.B.** _____ **Grade**_____

Parents/Guardians

Mother's Name _____ Father's Name _____

Home Street Address _____ Home Phone # _____

City, State Zip _____ Cell Phone # _____

_____ _____

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

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

_____

Date

Any questions regarding the Migrant Education Program can be directed to Mary Alice Hipwell, Director of Student Services @ (518) 664-7336 ext. 2503.

Mechanicville City School District

MEDICAL HISTORY FORM

Student's Name: _____ DOB ___/___/___ Sex: Male
Last First Middle

Address: _____ City _____ Zip _____

Mother's Name (including maiden): _____ Phone: _____

Father's Name: _____ Phone: _____

Physician to be called: _____ Phone: _____

Has your child ever had any of the following? Please complete:

Asthma NO ☐ YES ☐ DATE _____

Chicken Pox NO ☐ YES ☐ DATE _____

Diabetes NO ☐ YES ☐ DATE _____ Specify _____

Ear Illness/Tubes NO ☐ YES ☐ DATE _____

Eye Problems NO ☐ YES ☐ DATE _____ Specify _____
Surgery/ Dysfunction/Glasses

Fifths Disease NO ☐ YES ☐ DATE _____

Frequent Sore Throat/ NO ☐ YES ☐ DATE(s) _____
Scarlet Fever / Rheumatic Fever

Head Injury/Concussion NO ☐ YES ☐ DATE (s) _____

Heart Disease NO ☐ YES ☐ DATE _____ Specify _____

Hepatitis NO ☐ YES ☐ DATE _____ Specify _____

Kidney Disease NO ☐ YES ☐ DATE _____

Measles/Mumps/Rubella NO ☐ YES ☐ DATE _____

Pneumonia NO ☐ YES ☐ DATE _____

Tuberculosis (TB) NO ☐ YES ☐ DATE _____

Whooping Cough NO ☐ YES ☐ DATE _____

Neurological Disorders NO ☐ YES ☐ DATE _____ Specify _____

(Asperger Syndrome, Autism, Cerebral Palsy, Epilepsy, Muscular Dystrophy, Traumatic Brain Injury)

Behavioral/Mental Health NO ☐ YES ☐ DATE _____ Specify _____

(ADD, ADHD, Anxiety, Bi-polar, Depression, OCD, ODD, PTSD, Schizophrenia)

(OVER)

Other (PLEASE SPECIFY) _____

PLEASE COMPLETE IN DETAIL THE FOLLOWING QUESTIONS RELATING TO YOUR CHILD

1) **Does your child have allergies? _____What kind? _____**

   Any allergies to food? _____What food(s)? _____

   Describe allergic reaction: _____

   Is it life threatening? _____ If your child is allergic to any foods, your physician must document it and the cafeteria & teacher will be notified.

2) Has your child had any operations/serious injuries? _____ If yes, what & when _____

   _____

   _____

3) Does your child have any urination/bowel problems that the school should be aware of? _____

   _____

4) Is there anything concerning the eyes, ears or general health of your child which the school should know in order to provide special care? _____

   _____

   _____

5) Does your child have any limitations on activities including recess on playground equipment and Physical Education class? _____

   _____

IF SO, AN ANNUAL PHYSICAL ACTIVITY FORM MUST BE COMPLETED BY YOUR PHYSICIAN AND RETURNED TO THE SCHOOL NURSE.

6) Is your child on any medication? _____ If yes, what medication/reason? _____

   _____

   _____

   Will any need to be administered during school hours? _ _____

- **ALL MEDICATIONS PRESCRIPTIONS AND OVER-THE-COUNTER, REQUIRE A PHYSICIAN'S WRITTEN ORDER (EXAMPLE: LOTIONS, CREAMS, OINTMENTS, COUGH MEDICINES, COUGH DROPS, ANALGESICS, ETC.) AN ADULT MUST BRING THE MEDICINE IN A PHARMACY/ORIGINAL LABELED CONTAINER TO THE NURSE'S OFFICE WHERE IT WILL BE KEPT IN A LOCKED CABINET AND ADMINISTERED ACCORDINGLY.**

Mechanicville City School District

Authorization for Use or Disclosure of Protected Health Information

In order to share protected health information with the school district, your healthcare provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays in care for your child.

I, _____ authorize my child's healthcare provider(s) listed below:
Name_____Phone_____FAX_____
Name_____Phone_____FAX_____
Name_____Phone_____FAX_____

to release the medical records of my child, _____, DOB_____
to the district's: Medical Director, School Nurse, Athletic Trainer (AT), Counselor, Occupational, Therapist (OT), Physical Therapist (PT), Psychologist, Social Worker, Speech Therapist (ST).
❒ Other _____

The healthcare provider may disclose the following information:

Immunizations, Health Appraisals, Past/Current Medical Conditions and impact on attendance, athletics, or school programming or therapy.

The Protected Health Information may be used, disclosed or received for the following purpose(s):

To develop care or therapy plans for routine and emergent school management
To design appropriate educational, school, or athletic programs
To assess the impact of the medical condition(s) on school programming and/or attendance
To share school observations/concerns surrounding behavior
To assess a medical basis for modification of transportation and/or home tutoring
Medication delivery or therapy prescriptions
At patient's request with no specified purpose
Court, Probation or CPS Mandates

PARENT:

This authorization is valid for the duration of attendance within the school district.

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the School Nurse. I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

_____

Signature of Parent/Guardian (or student if over 18) Relationship Date

MECHANICVILLE CITY SCHOOL DISTRICT
Mechanicville, New York

**** Not required - only complete to opt-out***

THIS FORM WILL BE VALID FOR THE DURATION OF THE STUDENT'S ENROLLMENT IN THE MECHANICVILLE CITY SCHOOL DISTRICT.

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 our 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 report.

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, please print and sign your name below and return this form to:

Mrs. Barb Sikamiotis, RN ~ Elementary School Nurse
OR
Mrs. Yvonne LaJeunesse, RN ~ Junior / Senior High Nurse

- -

Please **DO NOT** include my child's weight status information in any BMI school survey for their duration of enrollment in the Mechanicville City Schools.

_____ _____

Print Child's Name Date

_____ _____

Print Parent's Name Parent's Signature

Date Withdrew_____ F____R____D____

2022-2023 Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and **return it to the address listed below.** Call 518-450-4085, if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: **Mechanicville City School District**
25 Kniskern Avenue
Mechanicville, NY 12118

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

Student Name	School	Grade/Teacher	Foster Child	Homeless Migrant, Runaway
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. **Skip to Part 4, and sign the application.**

Name:_____ CASE #:_____

3. Report all income for ALL Household Members (Skip this step if you answered 'yes' to step 2)

All Household Members (including yourself and all children that have income).
List all Household members not listed in Step 1 (including yourself) **even if they do not receive income.** For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any other source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of household member	Earnings from work before deductions *Amount / How Often*	Child Support, Alimony *Amount / How Often*	Pensions, Retirement Payments *Amount / How Often*	Other Income, Social Security *Amount / How Often*	No Income
	$_____ / _____	$_____ / _____	$_____ / _____	$_____ / _____	☐
	$_____ / _____	$_____ / _____	$_____ / _____	$_____ / _____	☐
	$_____ / _____	$_____ / _____	$_____ / _____	$_____ / _____	☐
	$_____ / _____	$_____ / _____	$_____ / _____	$_____ / _____	☐
	$_____ / _____	$_____ / _____	$_____ / _____	$_____ / _____	☐

Total Household Members (Children and Adults) ☐☐

***Last Four Digits of Social Security Number:** XXX-XX-__ __ __ __

I do not have a SS# ☐

*When completing section 3, an adult household member must provide the last four digits of their Social Security Number (SS#) or mark the "I do not have a SS# box" before the application can be approved.

4. Signature: An adult household member must sign this application before it can be approved.
I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school will get federal funds; the school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.
Signature:_____ **Date:**_____
Email Address:_____
Home Phone:_____ Work Phone:_____ Home Address:_____

5. Ethnicity and Race are optional; responding to this section does not affect your children's eligibility for free or reduced price meals.

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
Race (Check one or more): ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Island ☐White.

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

☐ SNAP/TANF/Foster
☐ Income Household: Total Household Income/How Often: _____/_____ Household Size: _____
☐ Free Meals ☐ Reduced Price Meals ☐ Denied/Paid

APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, complete only one application for your household using the instructions below. Sign the application and return the application to _____. If you have a foster child in your household, you may include them on your application. A separate application is not needed. Call the school if you need help: _____. Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

PART 1 ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE APPLICATION FOR YOUR HOUSEHOLD.

(1) Print the names of the children, including foster children, for whom you are applying on one application.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, or if you believe any child meets the description for homeless, migrant, runaway (a school staff will confirm this eligibility).

PART 2 HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.

(1) List a current SNAP, TANF or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. The case number is provided on your benefit letter.
(2) An adult household member must sign the application in PART 4. SKIP PART 3. Do not list names of household members or income if you list a SNAP case number, TANF or FDPIR number.

PART 3 ALL OTHER HOUSEHOLDS MUST COMPLETE THESE PARTS AND ALL OF PART 4.

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box.** The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.
(3) Enter the total number of household members in the box provided. This number should include all adults and children in the household and should reflect the members listed in PART 1 and PART 3.
(4) The application must include the last four digits only of the social security number of the adult who signs **PART 4** if Part 3 is completed. If the adult does not have a social security number, check the box. **If you listed a SNAP, TANF or FDPIR number, a social security number is not needed.**
(5) An adult household member must sign the application in PART 4.

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). To determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

USE OF INFORMATION STATEMENT

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not submit all needed information, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the primary wage earner or other adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs.
We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

DISCRIMINATION COMPLAINTS

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

CONSENT TO RELEASE FREE OR REDUCED PRICE ELIGIBILITY INFORMATION

School officials may release information that shows that my child/children are eligible for free or reduced price meals or free milk to the following programs. I understand that the information will only be provided to the program(s) checked.

(Check the box next to the program area(s) you wish to release information to)

☐ Federal health programs such as Medicaid or Children's Health Insurance Program (CHIP).

☐ State or federal programs such as the Youth Summer Work program or the Educational Talent Search Program.

☐ Local health and education programs and other local programs that provide benefits such as free textbooks or school supplies, free band instruments, or reduced fees for summer school or driver education.

☐ Community programs such as holiday baskets, summer arts and playground programs.

I understand that I will be releasing information that will show that my child/children are eligible for free and reduced price meals or free milk. I give consent to release my confidential information for the above named uses.

Child/Children

_____

_____

_____

I certify that I am the child's parent/guardian for whom the application was made.

Signature of Parent/Guardian: _____

Print Name: _____

Address: _____

Phone Number: _____

Date: _____

MECHANICVILLE PUBLIC SCHOOL DISTRICT
25 Kniskern Avenue
Mechanicville, NY 12118

TRANSPORTATION REQUEST FORM FOR CHILD CARE

DIRECTIONS: *Complete the form below and return to the Elementary School Office. Please call (518) 664-7336, ext. 2501, if you have any questions regarding the form. Submit one form for each child.*

Student's Name_____

2020-2021 Grade_____ **2020-2021 Teacher** _____

Home Address_____

I hereby request a change in bus transportation FIVE (5) DAYS PER WEEK effective:

_____ **(Beginning Date)**

Caregiver's Name_____

Address_____

Phone _____

Circle as Appropriate: **AM only** **PM only** **AM and PM**

Comments:

_____

_____

_____

_____ _____

Parent Signature **Date**

_____ _____

Home Phone **Work Phone**

* *

FOR SCHOOL USE ONLY: **Approved** _____ **Denied** _____

Date: _____

Home Bus # _____ **Babysitter Bus #** _____

Comments: _____

_____

Principal's Signature: _____

Date Parent Contacted: _____ **Phone Call / Letter**

cc: - Bus Garage

[c:\mydoumentcs\forms\babysitterrequestform]

Mechanicville City School District

Medical documents to be Completed by physician

Mechanicville City School District
HEALTH SERVICES

Education law is very strict in the control of over the counter and prescription drugs; therefore, we ask all families involved to follow this outline. Most medications can be given outside of the school hours. Please ask your doctor to schedule as such.

If however during the school year it becomes necessary for your child to take medication ordered by a doctor while in school, please adhere to the following rules:

1. Doctors must fill out and sign a written order.

2. Parents must fill out and sign a written request.

3. Medication must be properly labeled from your pharmacy with the patient's name, dose, name of drug and date.

4. Parent is to bring the medication into the nurse. Any medications brought in by the student will not be administered.

5. No student is to have ANY medication with them at school without a prescription on file in the nurses office that states "may carry".

On the reverse side is a medication order/request form to be used should your child need it.

Thank you for your attention in this matter

Yvonne Lajeunesse, R.N.
Barbara Sikamiotis, R.N.

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

I request that my child _____DOB _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature (Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

PLEASE CHECK ONE:

- ☐ Student may carry benedryl / inhaler / epi-pen with them in school and any sporting event they participate in.
- ☐ Student may not carry benedryl / inhaler/ epi-pen with them in school
- ☐ Student no longer requires _____(Medication)

Physician's Signature _____ Date:_____

Address: _____ Phone:_____

* Students with "may carry" orders must have appropriate meds with them at all times, but only the meds specifically ordered by M.D.

* Medication must be in original pharmacy labeled container with specific orders and name of medication.

* Medication and refills must be brought to school by parent, guardian or responsible adult.

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	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.

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your 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: **MECHANICVILLE CITY SCHOOL DISTRICT**

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.

Mechanicville City School District

Items

To

Keep

MECHANICVILLE CITY SCHOOL DISTRICT
2022 - 2023 SCHOOL CALENDAR

JULY 2022

S	M	T	W	T	F	S
					1	2
3	[4]	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24/31	25	26	27	28	29	30

AUGUST 2022

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

SEPTEMBER 2022

S	M	T	W	T	F	S
				1	2	3
4	5	(6)	(7)	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

OCTOBER 2022

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	[10]	11	12	13	14	15
16	17	18	19	20	21	22
23/30	24/31	25	26	27	28	29

NOVEMBER 2022

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	[11]	12
13	14	15	16	17	18	19
20	21	22	[23	24	25]	26
27	28	29	30			

DECEMBER 2022

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	[23]	24
25	26	27	28	29	30	31

JANUARY 2023

S	M	T	W	T	F	S
1	[2]	3	4	5	6	7
8	9	10	11	12	13	14
15	[16]	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

FEBRUARY 2023

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	[20	21	22	23	24]	25
26	27	28				

MARCH 2023

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	(17)	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

APRIL 2023

S	M	T	W	T	F	S
						1
2	3	4	5	6	[7]	8
9	[10	11	12	13	14]	15
16	17	18	19	20	21	22
23/30	24	25	26	27	28	29

MAY 2023

S	M	T	W	T	F	S
	1	2	3	4	(5)	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	[26]	27
28	[29]	30	31			

JUNE 2023

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	[19]	20	21	22	23	24
25	26	27	28	29	30	

July 4	Independence Day
September 5	Labor Day
September 6	Superintendent Conference Day
September 7	Superintendent ConferenceDay
September 8	First Day of School
October 10	Columbus Day
November 10	Emergency Release Day
November 11	Veterans' Day
November 23-25	Thanksgiving Recess
December 23	Holiday Recess Begins
January 2	New Year's Day Observed
January 3	Classes Resume
January 16	Martin Luther King, Jr. Day
January 24-27	Regents Testing Days
February 20-24	Mid-Winter Recess
March 17	Superintendent Conference Day
April 7	Good Friday
April 10-14	Spring Recess
May 5	Superintendent Conference Day
May 26 & 29	Memorial Day Recess
June 14-16	Regents Testing Days
June 19	Juneteenth
June 20-22	Regents Testing Days
June 23	Regents Rating Day
June 23	Last Day for 10 Month Staff

[ ] Classes Not in Session

_ _ _ _ _ _ _ _ _ Regents Testing Days

( ) Supt. Conference Day

September	18
October	20
November	18
December	16
January	20
February	15
March	23
April	14
May	21
June	16
Total Number of Pupil Days:	178
Supt. Conference Day:	4
TOTAL DAYS:	182

Revised June 8, 2022

Initial Notification to Persons in Parental Relation and Staff Pursuant to Section 409-h of the State Education Law and Commissioner's Regulation 155.24.*

Dear Parent, Guardian, and School Staff:

New York State Education Law Section 409-H and State Education Department Commissioner's Regulation 155.24, effective July 1, 2001, require all public and nonpublic elementary and secondary schools to provide written notification to all persons in parental relation, faculty, and staff regarding the potential use of pesticides periodically throughout the school year. The Mechanicville City School District is required to maintain a list of persons in parental relation, faculty, and staff who wish to receive 48-hour prior written notification of certain pesticide applications. The following pesticide applications are **not** subject to prior notification requirements:

- a school remains unoccupied for a continuous 72-hours following an application;
- anti-microbial products;
- nonvolatile rodenticides in tamper resistant bait stations in areas inaccessible to children;
- nonvolatile insecticidal baits in tamper resistant bait stations in areas inaccessible to children;
- silica gels and other nonvolatile ready-to-use pastes, foams, or gels in areas inaccessible to children;
- boric acid and disodium octaborate tetrahydrate;
- the application of EPA designated biopesticides;
- the application of EPA designated exempt materials under 40CFR152.25;
- the use of aerosol products with a directed spray in containers of 18 fluid ounces or less when used to protect individuals from an imminent threat from stinging and biting insects including venomous spiders, bees, wasps, and hornets.

In the event of an emergency application necessary to protect against an imminent threat to human health, a good faith effort will be made to supply written notification to those on the 48-hour prior notification list. If you would like to receive 48-hour prior notification of pesticide applications that are scheduled to occur in your school, please complete the form below and return it to Todd Woods, District Business Manager, 25 Kniskern Avenue, Mechanicville, NY 12118. Mr. Woods is the school pesticide representative. He can be reached by phone at 664-5727 Ext. 2200 for further information on these requirements.

Mechanicville City School District **Request for Pesticide Application Notification**		
School where your child or children attend?		
Name:		Address:
Day Phone:	Evening Phone:	E-Mail Address:

Sincerely,

Bruce Potter, Superintendent

*Written notification must be provided to **all** persons in parental relation and staff at the following intervals throughout the school year: at the beginning of the school year or the beginning of summer school; within 2 school days of the end of: the January break, spring recess and the end of summer school; and within 10 days of the end of the school year.

The Mechanicville City School District uses an integrated pest management (IPM) approach to pests.
IPM is recommended by the NYS Education Department and the US EPA.

Mechanicville City School District
25 Kniskern Avenue
Mechanicville, NY 12118

Annual Notification of the Availability of the District Asbestos Management Plan

The Mechanicville City School District has submitted information to the New York State Education Department regarding asbestos containing building materials in the school district. This information is documented in the school district's Asbestos Management Plan, which is in accordance with the United States Environmental Protection Agency (EPA) Asbestos Hazard Emergency Response Act (AHERA) of 1987 (40 CFR Part 763). This memorandum is intended to fulfill annual notification requirements.

In compliance with the AHERA Regulation, the school district conducted its Triennial Re-inspection in June. The school continues to perform the Six Month Periodic Surveillances as required under the AHERA Regulation as well. Documentation related to all inspections is available in the Asbestos Management Plan.

The Asbestos Management Plan for the Mechanicville City School District is located in the District Office and is available to the public for review during the following times:

Monday through Friday – 8:00 AM – 3:00 PM

For more information, please contact the following person:
Joespeh Manzer, LEA Designee
Phone Number: (518) 664-5727

Annual Notification of the Availability of the District-wide School Safety Plan

The Mechanicville City School District has developed the SAVE (Safe Schools Against Violence in Education) Plan as required by New York State Education Law Section 155.17. The regulation requires that each public school district have emergency management plans in place and that information on emergency procedures be provided to all students and staff. The district will provide training throughout the year and conduct at least twelve (12) fire drills, as well as a "GO HOME" drill to test transportation and communication systems. Emergency evacuation information is posted in each classroom. For more information concerning the SAVE District-level Plan, please contact the following person:

Jodi Birch, District Business Manager
Phone Number: (518) 664-5727 Ext. 2103