Mechanicville City School District

New Student Registration Packet

Karen Higgins, Registrar
(518)664-9888 ext. 2008
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

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

To Be Completed by Health Care Professional

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

_____ County of Residence: _____
City, State, Zip

Mailing Address: _____ Home Phone # _____
If other than above (ex. PO 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:** ☐ Yes ☐ No

Has your child(ren) ever attended Mechanicville City School District in the past? ☐ Yes ☐ No

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

Parent/Guardian (1): _____ Address: _____ (if different than Student) Email: _____ 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 (1): _____ Address: _____ (if different than Student) Email: _____ 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 one) ☐ 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: _____
☐ **Is Primary Contact** ☐ **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 released 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: _____ DOB: _____ Age: _____ Gender: _____	Name: _____ DOB: _____ Age: _____ Gender: _____	Name: _____ DOB: _____ Age: _____ Gender: _____
Name: _____ DOB: _____ Age: _____ Gender: _____	Name: _____ DOB: _____ Age: _____ Gender: _____	Name: _____ DOB: _____ Age: _____ Gender: _____

In accordance with Chapter 549 of the Education Law of 1986, I am providing the following list of people to whom my child(ren), 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 Phone: _____

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

Name: _____ Address: _____ City, State, Zip: _____

Relationship: _____ Daytime Phone: _____ Alternate Phone: _____

☐ **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** ☐ **Smart Phone** ☐ **Other**

(please check all that apply) Access to the Internet: ☐ **None** ☐ **Wifi** ☐ **Mobile HotSpot** ☐ **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. It also allows the 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/Guardian 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 School Health Exam (Physical)
- ☐ Special Education Records (IEP, 504 Plan, psychological, etc.)
  Please send to Kim Dunn - Fax # 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: 518-514-2108
khiggins@mechanicville.org

Mechanicville Elementary School
Attn: Jen Topetro
Fax: 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 & Addresses of Previous Schools Attended (list most recent first):

Name of School:	Phone #:
Address:	Previous Teacher's Name:
	Month /Year Attended: From_____ To_____
Name of School:	Phone #:
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 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:

_____

_____

_____

General Academic Levels

	Advanced	Average	Developing	Comments
Reading	☐	☐	☐	
Math	☐	☐	☐	
Writing	☐	☐	☐	

Sibling information

Name (first & last)	Sex	DOB	Living in the home?	Grade	School Attending
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

_____ _____

Parent/Guardian Signature **Date**

_____

Parent/Guardian
(Please Print Name)

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

Elisa Alvarez, Associate 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 Person in Parental Relation:
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.

STUDENT NAME:		
First	*Middle*	*Last*
DATE OF BIRTH:		**GENDER:**
		❑ Male ❑ Female
Month	*Day*	*Year*
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to*

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?	❑ Parent 1 _____ *specify*		❑ Parent 2 _____ *specify*	
	❑ Guardian(s) _____ *specify*			
4. What language(s) does your child understand?	❑ English	❑ Other	_____ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other	_____ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other	_____ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other	_____ *specify*	❑ Does not write

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

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School: *Address:*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

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

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

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

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

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

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

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

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

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

Relationship to student: ❑ Parent ❑ 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, NY 12118
Registrar: 518-664-9888 Ext. 2008

RESIDENCY QUESTIONNAIRE FORM

Name of Student: _____

Address: _____

Phone: _____ DOB: _____ Grade: _____

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 certificates. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

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

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

Where is the student currently living? (*Please check <u>one</u> box only)*

- ☐ In a shelter
- ☐ With another family member or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "Doubled-Up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
  Other temporary living situation (Please describe): _____
- ☐ In permanent housing

_____ _____

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

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

Mechanicville City School District

25 Kniskern Avenue - Mechanicville, NY 12118
Registrar: 518-664-9888 Ext. 2008 Fax: 518-514-2108

Eligibility Screen for Migrant Education Services

Migrant Education 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.

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

In the last 3 years, has the parent/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

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 _____ DOB _____ Grade _____

Child's Name _____ DOB _____ Grade _____

Child's Name _____ DOB _____ Grade _____

Child's Name _____ DOB _____ Grade _____

Child's Name _____ DOB _____ Grade _____

Parents/Guardians

Mother's Name _____ Father's Name _____

Home 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 Meghan Warren, mwarren@mechanicville.org or 518-664-5727

Mechanicville City School District

MEDICAL HISTORY FORM

Student's Name:_____ DOB _____ Sex: _____
Last First Middle

Address: _____ City: _____ Zip: _____

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

Father's Name: _____ Phone: _____

Physician to: _____ 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 _____

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)

Other (PLEASE SPECIFY) _____

PLEASE COMPLETE IN DETAIL THE FOLLOWING QUESTIONS RELATING TO YOUR CHILD

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

   Any food allergies? _____ What food(s)? _____

   Describe the allergic reaction: _____

   Is it life threatening? _____

IF YOUR CHILD IS ALLERGIC TO ANY FOODS, YOU 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 or Physical Education?

   _____

   _____

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, PRESCRIPTION AND OVER-THE-COUNTER, REQUIRE A PHYSICIAN'S WRITTEN ORDER (EXAMPLE: LOTIONS, CREAMS, OINTMENTS, COUGH MEDICINE OR DROPS, ANALGESICS, ETC) AN ADULT MUST BRING THE MEDICINE IN THE ORIGINAL LABELED PHARMACY 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 (HIPPA). 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 school district's: Medical Director School Nurse Athletic Trainer (AT) Counselor
Occupational Therapist (OT) Physical Therapist (PT) Psychologist Social Worker Speech Therapist (ST)

The healthcare provider may disclose the following information:
Immunizations, Health Appraisals, Past/Current Medical Conditions and impact on attendance, athletics, and 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 Health Office. 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	**Relationship**	**Date**

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 City 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. 3005 if you have any questions regarding this form. Submit one form for each child.**

Student's Name _____

Current Grade _____ **Current 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

Mechanicville City School District

Medical documents

to be Completed by physician

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	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: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ 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:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: 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	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

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

If Restrictions Apply – Complete the information below

☐ **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

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

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. I understand that the medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature (Parent or Guardian): _____

Telephone: Home _____ Work _____ Cell _____ 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 Benadryl / inhaler / epi-pen with them in school and any sporting event they participate in.
- ❏ Student may not carry Benadryl / 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 the original pharmacy labeled container with specific orders and name of medication.

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

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 medication 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 nurse's 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

Mandy Guerrero-Garmley, RN ~ Elementary School
Barbara Sikamiotis, RN ~ Jr/Sr High School

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: **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**

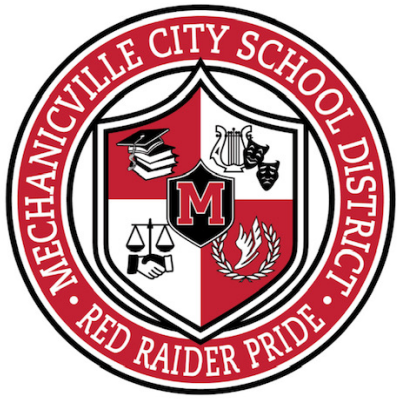
Other problems (Specify):_____

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
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:
Joseph Manzer, LEA Designee
Phone #: (518)664-9888 Ext. 2016

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 eight (8) fire drills, 4 lockdown procedures, 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 #: (518)664-5727 Ext. 1100

Mechanicville City School District

Initial Notification to Persons in Parental Relation and Staff Pursuant to Section 409-h of the State Education Law and Commissioner's Regulation I55.24*

New York State Education Law Section 409-h and State Education Department Commissioner's Regulation I55.24, 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 area
- 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 40CFRI52.25;
- The use of aerosol products with a directed spray in containers of I8 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 Jodi Birch, District Business Manager, 25 Kniskern Avenue, Mechanicville, NY 12118. Ms. Birch is the school pesticide representative. She can be reached by phone at (518)664-5727 Ext. 1100 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:	Email Address:

*Written notification must be provided to **all** person is in parental relation and staff at the following intervals throughout the school year; at the beginning of each school year or the beginning of summer school; within 2 school days of the end of: February 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

The following is an excerpt from the USDA manual on **"Accommodating Children with Special Dietary Needs in the School Nutrition Program".**

In cases of Food Allergy:

Generally, children with food allergies or intolerances do not have a disability as defined under either Section 504 of the Rehabilitation Act or Part B of IDEA, and the SFA (school food authority) may, but is not required to, make food substitutions for them

Other Special Dietary Needs:

The SFA may make food substitutions, at their discretion, for individual children who do not have a disability, but who are medically certified as having a special medical or dietary need.
Such determinations are made on a case-by-case basis. This provision covers those children who have food intolerances or allergies but do not have life-threatening reactions (anaphylactic reactions) when exposed to food(s) to which they have problems.

Medical Statement for Children with Special Dietary Needs:
Each special dietary request must be supported by a statement, which explains the food substitution that is requested. It must be signed by a recognized medical authority.

The Medical Statement MUST include:

An identification of the medical or other special dietary condition which restricts the child's diet.
The food (s) that need to be omitted from the child's diet
The food (s) or choice of food to be substituted.

- In the case of liquid milk allergy or intolerance, we are able to provide Lactaid when proper Medical Statement is provided. Please note that Juice and Water are not allowable substitutes for liquid milk in the National School Lunch Program for a reimbursable meal.
- If an allergy or diet accommodation is lifted, it must be signed by a recognized medical authority.

Sincerely,

Deb Mackey

Deb Mackey, Food Service Director
dmackey@mechanicville.org
1-518-450-4085

Mechanicville City School District
Food Allergy Action Plan

Date: _____ Student's Name _____

Grade _____ DOB _____

Allergy To: _____

Severity Status: _____

Medical Authority Signature _____

Provider Name: _____

Provider Address: _____

Provider Phone: _____

* This form is **invalid** without a signature from a recognized medical authority

* **PLEASE return this form** to your child's school nutrition office when completed

TO: Food Service Director
Mechanicville City School District
25 Kniskern Avenue
Mechanicville, NY 12118
dmackey@mechanicville.org