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)	Ethnicity: (please check all that apply)
☐ Student does not have any Special Accommodations ☐ Special Education Classification ☐ Section 504 Classification	☐ 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):	Parent/Guardian (1):
Address: ____________________ (if different than Student)	Address: ____________________ (if different than Student)
Email: ____________________	Email: ____________________
Place of Employment: ____________________	Place of Employment: ____________________
Work Phone: ____________ Cell Phone: ____________	Work Phone: ____________ Cell Phone: ____________
☐ **Is Primary Contact** ☐ **Receives Mail** ☐ **Receives Email** ☐ **Parent Portal Access** ☐ **Automated Emergency Notifications** ☐ **Pick up only**	☐ **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* ❑ Guardian(s) ______ *specify*	❑ Parent 2 ______ *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:*	

ENGLISH

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 one 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

Parent Questionnaire

Carol Mardell, PhD
Dorothea S. Goldenberg, EdD

Child's name ____________________

Address ____________________

City ____________________ State ______ Zip ____________

Child's age in years and months (do not round)			
	Year	Month	Day
Date Form Filled Out			
Birth Date			
Age			

Sex: ☐ Male ☐ Female

This form was filled out by:

☐ Mother ☐ Father ☐ Other (please specify relationship) ____________________

Name of person filling out form ____________________ Home phone # ____________

E-mail address of person filling out form ____________________

To the Parent:

This form has three parts that ask for information about your child.

Part 1. Self-Help Development asks about everyday skills that children are expected to learn (for example, dressing and feeding themselves).

Part 2. Social–Emotional Development asks about how your child gets along with other children and how he or she feels about himself or herself.

Part 3. Overall Development asks about any concerns or worries you might have about your child.

Please note that some items may ask about skills that your child is just not ready for yet. Please do not be concerned. We use the same form for children ages 2 years 6 months through 5 years 11 months, and we ask about some skills that are difficult even for the oldest children.

Thank you for your help.

Copyright © 2011 NCS Pearson, Inc. All rights reserved.

PsychCorp

11 12 A B C D E

Product Number 14705

Part 1. Self-Help Development

Directions: Place an **X** in the appropriate box to indicate how often your child does each task. A young child's behavior is not the same from day to day. Think of your child's typical or usual behavior at home, not his or her very best or worst day. For tasks that you do not allow or don't ask your child to do, place an **X** in the last box. Please provide ONLY one rating for each task.

Task	Most of the time	Sometimes	Rarely or never	Not allowed or not asked
1. Buttons clothing without help	☐	☐	☐	☐
2. Puts toys or books away when asked	☐	☐	☐	☐
3. Spills food or drink when eating	☐	☐	☐	
4. Unscrews bottle caps without help	☐	☐	☐	☐
5. Wets or soils pants	☐	☐	☐	
6. Washes and dries hands when needed	☐	☐	☐	☐
7. Puts clothes or shoes where they belong when asked	☐	☐	☐	☐
8. Brushes teeth without help	☐	☐	☐	☐
9. Blows and wipes nose without being asked	☐	☐	☐	
10. Puts clothes on *backward*	☐	☐	☐	
11. Puts each shoe on correct foot	☐	☐	☐	☐
12. Gets dressed without help	☐	☐	☐	☐
13. Wets bed	☐	☐	☐	
14. Picks up after self without being asked	☐	☐	☐	
15. Brushes or combs hair without being asked	☐	☐	☐	
16. Washes self during bath or shower	☐	☐	☐	☐
17. Pours from a small can or carton without spilling	☐	☐	☐	☐
18. Uses a fork, a spoon, or chopsticks correctly	☐	☐	☐	☐
19. Pours dry cereal and milk into bowl without spilling	☐	☐	☐	☐
20. Uses the toilet without help	☐	☐	☐	☐
21. Wakes up and needs help going back to sleep	☐	☐	☐	
22. Follows safety rules (stays away from hot oven, etc.)	☐	☐	☐	☐

Self-Help Development Raw Score (max = 44) ☐

Part 2. Social–Emotional Development

Directions: Place an **X** in the appropriate box to indicate how often your child shows each feeling or behavior. Think of your child's usual behavior at home or with friends. If you have not observed your child performing the behavior, place an **X** in the "Rarely or never" box. Please provide ONLY one rating for each item.

Feeling or Behavior	Always or almost always	Sometimes	Rarely or never
1. Smiles or laughs when something is funny	☐	☐	☐
2. Argues when denied own way	☐	☐	☐
3. Breaks toys or other objects on purpose	☐	☐	☐
4. Plays well with other children	☐	☐	☐
5. Has tantrums (stamps feet, screams, etc.)	☐	☐	☐
6. Solves problems by talking rather than by hitting, pushing, or biting	☐	☐	☐
7. Acts without thinking (runs into street without looking both ways, etc.)	☐	☐	☐
8. Admits when he or she makes a mistake	☐	☐	☐
9. Stays calm when things do not go as planned	☐	☐	☐
10. Blames others when bad things happen	☐	☐	☐
11. Knows when people are happy or sad	☐	☐	☐
12. Interrupts (talks when others are speaking)	☐	☐	☐
13. Goes to bed easily	☐	☐	☐
14. Asks before using other people's things	☐	☐	☐
15. Works well with others	☐	☐	☐
16. Shows pride in doing something well	☐	☐	☐
17. Bangs head on the floor, wall, or bed	☐	☐	☐
18. Clings or hangs on to you	☐	☐	☐
19. Whines or pouts	☐	☐	☐
20. Seems afraid of many things	☐	☐	☐
21. Shows concern for someone who is crying	☐	☐	☐
22. Hurts others (hits, bites, kicks, punches, etc.)	☐	☐	☐
23. Gives up easily	☐	☐	☐
24. Makes transitions easily (moves easily from one activity to the next, etc.)	☐	☐	☐
25. Falls and hurts self	☐	☐	☐
26. Is restless and can't sit still	☐	☐	☐
27. Wanders away from you in public places	☐	☐	☐
28. Acts very sad or withdrawn	☐	☐	☐

Social–Emotional Development Raw Score (max = 56) ☐

Part 3. Overall Development

Directions: Place an **X** in the box that best describes your level of worry about each of the areas below. We understand that you are naturally concerned about all of these areas. We would like to know about any areas that you think may be problem areas for your child. This information will be used to help us understand your child's growth and needs.

Area	I'm not worried	I'm a little worried	I'm worried	I'm very worried
Health	☐	☐	☐	☐
Motor skills (walking, throwing, balancing, etc.)	☐	☐	☐	☐
Cognitive skills (learning, thinking, problem solving, etc.)	☐	☐	☐	☐
Language skills (talking and understanding)	☐	☐	☐	☐
Self-care skills (dressing and feeding self, etc.)	☐	☐	☐	☐
Social–emotional skills	☐	☐	☐	☐
Vision (seeing)	☐	☐	☐	☐
Hearing	☐	☐	☐	☐

PsychCorp is an imprint of Pearson Clinical Assessment.

Pearson Executive Office 5601 Green Valley Drive Bloomington, MN 55437
800.627.7271 www.PearsonClinical.com

Copyright © 2011 NCS Pearson, Inc. All rights reserved.

Warning: No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without permission in writing from the copyright owner.

Pearson, the **PSI logo, PsychCorp** and **DIAL** are trademarks in the U.S. and/or other countries of Pearson Education, Inc., or its affiliate(s).

Printed in the United States of America.

REMINDER FROM ELEMENTARY HEALTH OFFICE …

REQUESTED MEDICAL PAPERWORK FOR KINDERGARTEN REGISTRATION

Please take a moment to read the following in regards to the medical paperwork requested for Kindergarten to help you understand how this helps us to care for your child while they are at school. Thank you and please contact the nurse with any questions you may have.

Elementary K – 5 Nurse : 664-7336 extension 3014

FORMS FROM YOUR PHYSICIAN: (Please submit both forms at screening appt)

Immunizations - Please present your child's immunizations for review so that we may determine if your child is up to date on all immunizations.

Health Examination/Physical – Please present your child's most recent health examination/physical.

New York State law requires that all KINDERGARTNERS have a health examination/physical by a New York State licensed provider.

The physical helps us to determine and clarify any special needs your child may have. A physical that is dated within the last **school year** of the time of registration will be valid.

FORMS TO BE FILLED OUT AT HOME: (And returned at screening appt)

Medical History – Please make sure you complete both sheets or the front and back of this sheet as this will aid us in caring for your child's individual needs while they are at school.

Health Insurance Portability and Accountability Act (HIPAA) form

Please fill in your name, your child's name, the name of physician and sign and date at the bottom. This form allows us to speak with your physician directly in regards to any questions that we may have regarding immunizations and physical findings.

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/ Scarlet Fever/Rheumatic Fever NO ▢ YES ▢ DATE(s) ____

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