

**Mechanicville City School District**

# **New Student Registration Packet**

**Karen Higgins, Registrar  
(518)664-9888 ext. 2008  
[khiggins@mechanicville.org](mailto:khiggins@mechanicville.org)**

# Mechanicville City School District

## CENTRAL REGISTRAR CHECKLIST

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

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

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

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

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

*Documents must be from the past 30 days*

### Determination of Student Age:

- Original Birth Certificate
- Baptismal Record
- Passport
- Driver's License (student)
- State or other government issued ID
- Consulate identification Card
- Hospital or Health Records
- Military Dependent Identification Card
- Court orders or other court issued documents with DOB
- Native American Tribal Documents
- Records from non-profit international aid agencies and voluntary agencies

### Health Records:

#### To Be Completed by Parent/Guardian

- o Medical History Form
- o Health Information Release Form

#### To Be Completed by Health Care Professional

- o Health Certificate/Appraisal Form
- o Authorization to Administer Medication (if applicable)\*
- o Dental Health Certificate
- o Immunization Records\*\*  
*\*\* (Proof of up to date immunizations per NYSED requirements. Temporary enrollment will be considered as needed; parents will be given 14 days upon date of registration to supply school with documents, pending administrative approval.)*

### School Records:

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

### Other Required Paperwork:

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

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

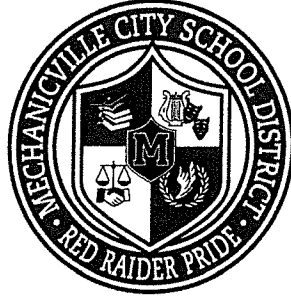
*Individual's attempting to enroll a student must be listed on the child's birth certificate as the natural parent or must provide court documentation proving legal custody. When parents reside in different school districts the child must attend the school in the district of the parent with whom the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

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

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

### Special Education Services:

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



**Mechanicville City School District**

# **Forms to Return to School**

**Completed by  
parent/guardian**

## MECHANICVILLE CITY SCHOOL DISTRICT STUDENT REGISTRATION FORM

Student Name: \_\_\_\_\_ Student #: \_\_\_\_\_ Grade: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
Street

\_\_\_\_\_ 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) <input type="checkbox"/> Student does not have any Special Accommodations <input type="checkbox"/> Special Education Classification <input type="checkbox"/> Section 504 Classification	Ethnicity: (please check all that apply) <input type="checkbox"/> American/Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander  Hispanic/Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No
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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: _____ <small style="margin-left: 100px;">(if different than Student)</small> Email: _____ Place of Employment: _____ Work Phone: _____ Cell Phone: _____ <input type="checkbox"/> Is Primary Contact <input type="checkbox"/> Receives Mail <input type="checkbox"/> Receives Email <input type="checkbox"/> Parent Portal Access <input type="checkbox"/> Automated Emergency Notifications <input type="checkbox"/> Pick up only	Parent/Guardian (1): _____ Address: _____ <small style="margin-left: 100px;">(if different than Student)</small> Email: _____ Place of Employment: _____ Work Phone: _____ Cell Phone: _____ <input type="checkbox"/> Is Primary Contact <input type="checkbox"/> Receives Mail <input type="checkbox"/> Receives Email <input type="checkbox"/> Parent Portal Access <input type="checkbox"/> Automated Emergency Notifications <input type="checkbox"/> Pick up only
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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: _____ <input type="checkbox"/> Is Primary Contact <input type="checkbox"/> Receives Mail <input type="checkbox"/> Receives Email <input type="checkbox"/> Parent Portal Access <input type="checkbox"/> Automated Emergency Notifications <input type="checkbox"/> 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: _____ <input type="checkbox"/> Receives Mail <input type="checkbox"/> Receives Email <input type="checkbox"/> Parent Portal Access <input type="checkbox"/> Emergency Notification <input type="checkbox"/> Pick Up Only
Name: _____ Address: _____ City, State, Zip: _____ Relationship: _____ Daytime Phone: _____ Alternate Phone: _____ <input type="checkbox"/> Receives Mail <input type="checkbox"/> Receives Email <input type="checkbox"/> Parent Portal Access <input type="checkbox"/> Emergency Notification <input type="checkbox"/> 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: <input type="checkbox"/> Desktop Computer <input type="checkbox"/> Laptop <input type="checkbox"/> Smart Phone <input type="checkbox"/> Other (please check all that apply) Access to the Internet: <input type="checkbox"/> None <input type="checkbox"/> Wifi <input type="checkbox"/> Mobile HotSpot <input type="checkbox"/> Cell Phone Only
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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

\_\_\_\_\_  
Date

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

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

Please send to:

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

Mechanicville Elementary School  
Attn: Amy DeMarco  
Fax Number: 518-514-2119  
[ademarco@mechanicville.org](mailto:ademarco@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:**

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**Has there been a recent change in your family (parent separation, death, birth, hospitalization)? If so, please explain:**

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**Does your child receive counseling services?**     Yes     No

**Comments:**

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## General Academic Levels

	Advanced	Average	Developing	Comments
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

## Sibling information

Name (first & last)	Sex	DOB	Living in the home?	Grade	School Attending
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Guardian**  
**(Please Print Name)**





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.*

<b>STUDENT NAME:</b>		
First	Middle	Last
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
Month	Day	Year
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	<input type="checkbox"/> Parent 2	_____
	<input type="checkbox"/> Guardian(s)		_____
			<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write
			<i>specify</i>

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

<b>SCHOOL DISTRICT INFORMATION:</b>	<b>STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:</b>
_____	_____
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: \_\_\_\_\_

<b>OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ</b>	
NAME: _____	POSITION: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:	
<b>NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW</b>	
NAME: _____ POSITION: _____	
ORAL INTERVIEW NECESSARY: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ MO.    DAY    YR.	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
<b>NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL</b>	
NAME: _____ POSITION: _____	
DATE OF NYSITELL ADMINISTRATION: _____ MO.    DAY    YR.	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> 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](mailto: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/  
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.**



**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

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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:** \_\_\_\_\_

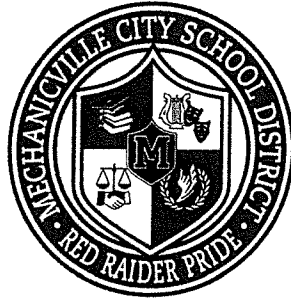
\_\_\_\_\_

**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: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

### HEALTH HISTORY

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

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: <span style="float: right;">Date of last seizure:</span> <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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/m<sup>2</sup>

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

**Hyperlipidemia:**  Yes  Not Done

**Hypertension:**  Yes  Not Done

### PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:	
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Lead Level</b> Required for PreK & K	<b>Date</b>
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g}/\text{dL}$	
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>			

System Review Within Normal Limits

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

Assessment/Abnormalities Noted/Recommendations:

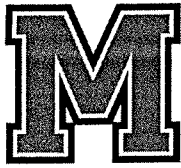
Diagnoses/Problems (list)

ICD-10 Code\*

Additional Information Attached

\*Required only for students with an IEP receiving Medicaid

Name:		Affirmed Name (if applicable):		DOB:	
<b>SCREENINGS</b>					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
<b>Vision Screening</b>	<b>With Correction</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
Notes					
<b>Hearing Screening:</b> 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.					<b>Not Done</b>
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
<b>Scoliosis Screening:</b> Boys grade 9, Girls grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
<b>FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>*Family cardiac history reviewed</b> – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b>					
<b>If Restrictions Apply</b> – Complete the information below					
<input type="checkbox"/> <b>Student is restricted from participation in:</b>					
<input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> <b>Other Restrictions:</b>					
<b>Developmental Stage for Athletic Placement Process</b> <b>ONLY</b> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level.					
<b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> <b>Other Accommodations*:</b> 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.					
<b>MEDICATIONS</b>					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
<b>COMMUNICABLE DISEASE</b>			<b>IMMUNIZATIONS</b>		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
<b>HEALTHCARE PROVIDER</b>					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form to Your Child's School Health Office When Completed.</b>					



## 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**

**Natalie Watson, RN ~ Elementary School  
Barbara Sikamiotis, RN ~ Jr/Sr High School**

# 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.

## 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: / /	Sex: <input type="checkbox"/> Male	Will this be your child's first oral health assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Month Day Year	<input type="checkbox"/> Female				
School Name: <b>Mechanicville City School District</b>					Grade
Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? <input type="checkbox"/> Yes <input type="checkbox"/> 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**

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

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

- Yes  No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
- Yes  No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].
- Yes  No **Dental Sealants Present**

Other problems (Specify): \_\_\_\_\_

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

- No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
- May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
- Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.



Office of P-20 Education Policy  
Child Nutrition Program Administration  
89 Washington Avenue, Room 375 EBA, Albany, NY 12234  
(518) 473-8781 Fax (518) 473-0018  
[www.nysed.gov/cn/cnms.htm](http://www.nysed.gov/cn/cnms.htm)

### Letter to Parents for School Meal Programs Community Eligibility Provision

Dear Parent or Guardian:

We are pleased to inform you that Mechanicville City School District will be implementing a meal certification option available to schools participating in the National School Lunch and School Breakfast Programs for school year 2023-2024.

#### What does this mean for your child(ren) attending the school(s) identified above?

All students enrolled at Mechanicville City Schools are eligible to receive a healthy breakfast and lunch at school at **no charge** to your household each day of the 2023-2024 school year. No further action is required of you. Your child(ren) will be able to participate in these meal programs without having to pay a fee or submit an application.

If you have any further questions, please contact me at 1-518-652-2287 or [dmackey@mechanicville.com](mailto:dmackey@mechanicville.com)

Sincerely,

Deb Mackey

Deborah Mackey  
Food Service Director  
Mechanicville City School District  
25 Kniskern Avenue  
Mechanicville, NY 12118  
1-518-652-2287  
[dackey@mechanicville.org](mailto:dackey@mechanicville.org)

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

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

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

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

This institution is an equal opportunity provider.



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](mailto: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

Mechanicville City School District  
25 Kniskern Avenue  
Mechanicville, NY 12118

Return to: Deb Mackey  
MCSD Food Service Department  
518-652-2287

### Diet Prescription For Meals At School

Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

#### Disability or Medical Condition:

##### Metabolic Diseases

\_\_\_\_\_ Celiac Disease (gluten allergy)      \_\_\_\_\_ Diabetes (circle one: Type I or Type II )

\_\_\_\_\_ Other: \_\_\_\_\_

#### Food Allergies:

\_\_\_\_\_ Egg      \_\_\_\_\_ Fish      \_\_\_\_\_ Peanut      \_\_\_\_\_ Tree Nuts      \_\_\_\_\_ Shellfish      \_\_\_\_\_ Soy

\_\_\_\_\_ Wheat      \_\_\_\_\_ Milk      \_\_\_\_\_ Lactose Intolerance      Other: \_\_\_\_\_

Is this condition temporary or permanent?      \_\_\_\_\_ temporary      \_\_\_\_\_ permanent

If temporary, please give length of time instructions are to be followed with an explanation:

\_\_\_\_\_  
\_\_\_\_\_

#### Diet Prescription:

Foods to be omitted: \_\_\_\_\_

Substitutions: \_\_\_\_\_

Other information regarding diet: \_\_\_\_\_

I certify that the above named student needs special school meals prepared as described above because of student's disability or chronic medical condition.

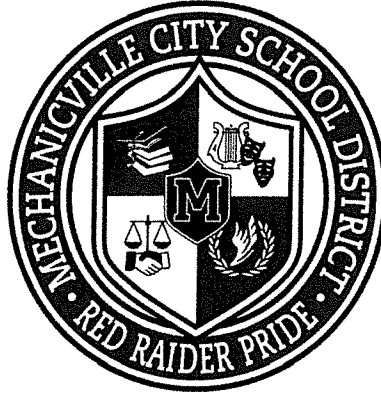
\_\_\_\_\_  
**Physician's Signature**

\_\_\_\_\_  
**Office Phone Number**

\_\_\_\_\_  
**Date**

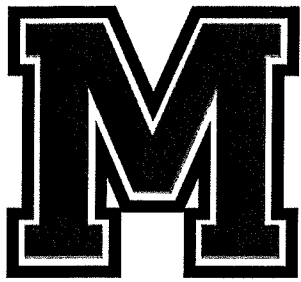
\_\_\_\_\_  
**Print Physician's Name**

\_\_\_\_\_  
**Address**



**Mechanicville City School District**

**Items  
To  
Keep**



# Mechanicville City School District

One School • One Community • One Mechanicville

25 Kniskern Avenue, Mechanicville, NY 12118 Phone: (518) 664-5727

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PLEASE BE ON THE LOOK OUT FOR PARENTSQUARE!!  
THIS IS OUR MAIN COMMUNICATION LINE TO PARENTS!!

**Mechanicville City School District will send an invitation email to join ParentSquare, and you will click a link to activate your account.**

## What to do:

1. Find the email from your school and click to get started, or:
2. Go to [parentsquare.com/signin](https://parentsquare.com/signin) (or install the ParentSquare app) and follow the prompts to sign up.
3. Use Google single sign-on, your email, or your phone number to set up your account. *Your email/phone number must match contact details in the school's database for this to work!*

4. **If your contact details aren't recognized, contact your school administrator to get them added. After they update your information in their database, the new contact details will appear in ParentSquare after the next daily sync, and you will be able to create an account.**

Note: After you are added to ParentSquare by your school, you will receive school communications even if you have not registered your account. However, you will need to register your account in order to participate in two-way communications and to access any confidential student-specific documents or forms.

Hello, Welcome to ParentSquare.



**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

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**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 155.24\*

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

- A school remains unoccupied for a continuous 72-hours following an application;
- Anti-microbial products
- Nonvolatile rodenticides in tamper resistant bait stations in areas inaccessible to children;
- Nonvolatile insecticidal baits in tamper resistant bait stations in 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 40CFR152.25;
- The use of aerosol products with a directed spray in containers of 18 fluid ounces or less when used to protect individuals from an imminent threat from stinging and biting insects including venomous spiders, bees, wasps, and hornets.

In the event of an emergency application necessary to protect against an imminent threat to human health, a good faith effort will be made to supply written notification to those on the 48-hour prior notification list. If you would like to receive 48-hour prior notification of pesticide applications that are scheduled to occur in your school, please complete the form below and return it to 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

## 2023-2024 SCHOOL CALENDAR

July 2023						
Su	M	Tu	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23/30	24/31	25	26	27	28	29

August 2023						
Su	M	Tu	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November 2023						
Su	M	Tu	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

Nov. 1- Superintendent Conference Day  
 Nov. 9- Emergency Release Day  
 Nov. 10 Veterans' Day Holiday  
 Nov. 22 - 24 Thanksgiving Holiday  
**Total student days:17**  
**Total staff days:18**

February 2024						
Su	M	Tu	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29		

Feb. 19-23-February Recess  
 Feb. 19- Presidents Day  
**Total student days:16**  
**Total staff days:16**

May 2024						
Su	M	Tu	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

May 24-27- Memorial Day  
**Total student days:21**  
**Total staff days:21**

September 2023						
Su	M	Tu	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

Sept. 4- Labor Day  
 Sept. 5 & 6 Superintendent's Conference Day  
 Sept. 7- Classes Begin  
**Total student school days:17**  
**Total staff days:19**

December 2023						
Su	M	Tu	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24/31	25	26	27	28	29	30

December 22-January 2- Winter Recess  
**Total student days:16**  
**Total staff days:16**

March 2024						
Su	M	Tu	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24/31	25	26	27	28	29	30

March 29- Good Friday  
**Total student days:20**  
**Total staff days:20**

June 2024						
Su	M	Tu	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23/30	24	25	26	27	28	29

June 4- Regents Testing Day  
 June 14 - 26 Regents Examination Period  
 June 19- Juneteenth – No School  
 June 25- Last Day of School for students  
 June 26- Regents Rating Day  
 June 26- Last day of school for 10-month staff  
**Total student days=16**  
**Total staff days=17**

October 2023						
Su	M	Tu	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Oct. 9- Columbus Day  
**Total student days:21**  
**Total staff days:21**

January 2024						
Su	M	Tu	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Jan. 1- 2 Winter Recess  
 Jan. 15 Martin Luther King Day  
 Jan. 23-26-Regents Testing  
**Total student days:20**  
**Total staff days:20**

April 2024						
Su	M	Tu	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

April 1-5 Spring Recess  
 April 26- Superintendent Conference Day  
**Total student days:16**  
**Total staff days:17**

**First Day of School**  
**Superintendent Conference Days**  
**Emergency Release Day**  
**Observed Holidays/Recess-No School**  
**Regents Testing Day**  
**Regents Examination Period**  
**Last Day of School for Students**  
**Regents Rating Day**  
**Last Day of School for 10-month staff**



Mechanicville  
 City School District

**Total Student Calendar Days: 180**  
**Total Staff Calendar Days: 185**