



2020-21 REGISTRATION FORMS

Gananda Central School District, 1500 Dayspring Ridge, Walworth, NY 14568, 315-986-3521

Welcome to Gananda Schools!

When the registration packet is complete and the documents described in the attached letter are collected, please bring them to the Gananda District Office, 1500 Dayspring Ridge, Walworth, NY 14568.

Registration Checklist:

- ___ **Completed registration packet**
 - ___ **Proof of student's age** – original (Birth Certificate, Passport, Baptismal Record)
Children MUST be 5-years old on or before December 1, 2019 to enroll in kindergarten.
 - ___ **Proof of residence within the Gananda Central School District** – one copy
If you cannot provide proof of residency in your name, please call the district office, 315-986-0610 prior to registering your child.
 - ___ **A copy of your child's current immunization record and last physical provided by your physician's office.** "My Chart" reports are not admissible. A physical dated within one year from the start of school and signed by a physician may be faxed before your registration appointment. *For more information regarding new student physical and immunization requirements, please refer to the Health Services webpage on our website, gananda.org.*
 - ___ **IEP or 504 Plan** – Only applicable for students receiving special education services. If your child receives special education services *by a district other than Gananda*, please provide one copy of your child's IEP or 504 Plan.

PROOF OF AGE:

Please provide documentation establishing your child's age.

Evidence may include:

- 1) a certified transcript of a birth certificate or record of baptism (including a certified transcript of a foreign birth certificate or record of baptism) giving the date of birth.
- 2) Where such documentation is not available, a passport (including a foreign passport) may be used.

If the birth certificate or passport is not available, the District may consider certain other evidence, which has been in existence two years or more. An affidavit of age cannot be accepted as verification. Other evidence may include, but will not be limited to the following:

- official driver's license
- state or other government issued identification
- school photo identification with date of birth
- consulate identification card
- hospital or health records
- military dependent identification card
- documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement)
- court orders or other court-issued documents
- Native American tribal document
- records from non-profit international aid agencies and voluntary agencies

EVIDENCE OF IMMUNIZATIONS & PHYSICAL:

In accordance with New York State Department of Health Immunization Bureau's Immunization Requirements for School Entrance/Attendance (NYS Public Health Law), the District must receive evidence that your child has been immunized. These records are necessary to ensure your child's continued attendance.

Additionally, please provide record of the most recent physical examination your student has received. New York State mandates that each new student entering a public school is required to have a physical examination upon entering the District. A physical completed no more than twelve months before the first day of the school year in question will meet this requirement.

PROOF OF RESIDENCY:

You must be a resident of our school district and submit proof of your residency in the form of house closing papers, lease agreement or recent gas & electric bill in your name and address. If you are residing with someone who lives in the district, they need to submit a notarized letter stating that you and your children (listed by name) are living at their address and provide proof that their residence is in the Gananda CSD. If it is determined that registered students are not legal residents, the parent/guardian can be held financially responsible for educational services provided prior to the discovery of non-residence.

NOTICE OF RIGHTS REGARDING REFERRAL FOR EVALUATION FOR SPECIAL EDUCATION:

If you suspect that your child is in need of special education services or programs, you may refer your child to the District's Director of Special Education for evaluation. The referral should be made to Melissa Phelps, Director of Special Education, Gananda CSD, 1500 Dayspring Ridge, Walworth, NY 14568. The New York State Education Department website has information regarding this process and your rights. A copy of the Parent Guide to Special Education may be obtained from the following websites.

<http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm>

<http://www.p12.nysed.gov/specialed/publications/policy/spanishparentguide.htm>

If you have any questions with respect to the foregoing, please contact Leslie Ferrante, Registrar, at 315-986-0610

STUDENT & HOUSEHOLD INFORMATION

Gananda Central School District, 1500 Dayspring Ridge, Walworth, NY 14568, 315-986-3521

For Office Use:

Registration Date: _____ Assigned School: _____ Grade: _____

Start Date: _____ Student ID #: _____

STUDENT INFORMATION

Student's Full Name: <i>Last</i> _____ <i>First</i> _____ <i>Middle Initial</i> _____ <i>Nick Name</i> _____			
Student Address: Street _____ Apt. _____		Proof of Age: <input type="checkbox"/> Provided:	
Town/City _____ Zip _____		Proof of Residency: <input type="checkbox"/> Provided:	
Birth Date: <i>mm / dd / yyyy</i> _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Grade Entering: _____	

Ethnicity NYSED & the Federal Government Department of education require each school report some enrollment data on basis of national origin or race. The Gananda CSD does not discriminate and is in compliance with the Title IX of the Education Amendments of 1972 and section 504 of the Rehabilitation Act of 1973.

Is the child Hispanic/Latino? Yes No

Is the student from one or more of these races? (Check all that apply.)

American Indian-Alaskan Asian Black/African American (Not Hispanic) White

Primary Household Information		Household Phone #: _____	
Complete Address: _____ <i>(area code)</i>			
Parent/Guardian Name: <i>Last</i> _____ <i>First</i> _____ <i>Gender</i> _____		Relationship to student: <input type="checkbox"/> Bio-Parent <input type="checkbox"/> Legal Guardian	
<small>(First Contact)</small>		Foster Parent Step-Parent Other _____	
Phone #s: (Include Area Code) _____		Cell: _____	
Email Address: _____		Work: _____	
Parent/Guardian Name: <i>Last</i> _____ <i>First</i> _____ <i>Gender</i> _____		Relationship to student: <input type="checkbox"/> Bio-Parent <input type="checkbox"/> Legal Guardian	
<small>(Second Contact)</small>		Foster Parent Step-Parent Other _____	
Phone #s: (Include Area Code) _____		Cell: _____	
Email Address: _____		Work: _____	

SCHOOLS PREVIOUSLY ATTENDED

Name of School	City/Town/State/Country	Grade	Start Date	End Date

Is this student currently suspended from his/her most recent school? Yes No

Did the student receive free or reduced priced lunch at previous school district? Yes No

CUSTODY INFORMATION

Information of Rights of Parent from the Family Education Rights and Privacy Act (FERPA): An education agency or institution shall give full rights under the Act to either parent, unless the agency or institution has been provided with evidence that there is a court order, State statute, or legally binding document relating to such matters as divorce, separation or custody that specifically revokes the rights. (Authority: 20U.S.C 1232g) Please inform your school of changes in custodial arrangements -

<input type="checkbox"/> Two parents in Home	<input type="checkbox"/> Divorced/Separated	<input type="checkbox"/> Joint Custody	<input type="checkbox"/> Single Parent	<input type="checkbox"/> Sole Custody
<input type="checkbox"/> Custody Transfer	<input type="checkbox"/> Foster Placement (DDS-2999/3424 must be provided)	<input type="checkbox"/> Unaccompanied Youth		
Custody paperwork provided during registration? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Restrictions of contact and/or information: Custody papers/court order MUST be provided.				
<input type="checkbox"/> No Restrictions for Parents/Guardians		<input type="checkbox"/> Custody Papers Specify Restriction		<input type="checkbox"/> Order of Protection
<input type="checkbox"/> Other Documentation, specify: _____		Expiration Date: _____		
Person(s) Restricted: _____		Relationship to Student: _____		

SECONDARY HOUSEHOLD INFORMATION

Parent/Guardian Name: <i>Last</i> _____ <i>First</i> _____	Relationship to student: Has permission to pick student up from school.
Complete Address: _____	Cell: _____
	Home: _____
	Work: _____
Email Address: _____	Receives mail <i>(Include area codes.)</i> Yes <input type="checkbox"/> No <input type="checkbox"/>

SIBLING INFORMATION

Siblings Residing in Primary Residence:					
Last Name	First Name	Gender	Date of Birth	Grade	School
		<input type="checkbox"/> M <input type="checkbox"/> F			
		<input type="checkbox"/> M <input type="checkbox"/> F			
		<input type="checkbox"/> M <input type="checkbox"/> F			
		<input type="checkbox"/> M <input type="checkbox"/> F			

STUDENT'S PHYSICIAN INFORMATION

Name: _____	Phone: _____
Name of Practice: _____	
Address: _____	

EMERGENCY CONTACT INFORMATION: *(Please list in order of who should be contacted after parents/guardian, include area codes.)*

Name: _____	Home #: _____
Relationship to student: Has permission to pick student up from school.	Cell #: _____
	Work #: _____
Name: _____	Home #: _____
Relationship to student: Has permission to pick student up from school.	Cell #: _____
	Work #: _____
Name: _____	Home #: _____
Relationship to student: Has permission to pick student up from school.	Cell #: _____
	Work #: _____
Name: _____	Home #: _____
Relationship to student: Has permission to pick student up from school.	Cell #: _____
	Work #: _____

Signature: _____ **Relationship to Student:** _____

RESIDENCY QUESTIONNAIRE

Gananda Central School District, 1500 Dayspring Ridge, Walworth, NY 14568, 315-986-3521, x8-4313

Under the State Education Department's Title 1 Plan, all school districts that receive Title I funds must use a residency questionnaire that asks about a student's housing status. This form must be completed for all students seeking enrollment as well as those changing address.

Name of Local Education Agency: GANANDA CENTRAL SCHOOL DISTRICT

Name of Student _____
Last First MI

Address _____
Street Town/City State Zip Code

Gender Male Female Date of Birth ____ / ____ / ____ Grade _____ ID# _____
mm dd yyyy (Preschool-12) (Optional)

Name of School _____

Is parent guardian enlisted in a branch of the United States Armed Forces Yes No

If yes, name of parent and enlistment:

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (Please check one box.)

In a shelter

With another family or other person because of loss of housing or as a result of economic hardship (sometimes 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

Presenting a false record or falsifying records is an offense under section 37.10 Penal code and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec.25.002(3)(d)

Print Name of Parent, Guardian, or Unaccompanied Youth

Signature of Parent, Guardian, or Unaccompanied Youth

Date

FOR OFFICE USE ONLY:

I certify that the above named student qualifies for services and the Child and Nutrition Program under the provisions of the McKinney-Vento Act.

Signature of McKinney-Vento Liaison

Date

REQUEST FOR RECORDS

Gananda Central School District, District Office, 1500 Dayspring Ridge, Walworth, NY 14568

Authorization for Release of Information

Student Name _____
Last _____ *First* _____ *MI* _____

Date of Birth _____
mm / *dd* / *yyyy*

Name of Previous School

School Address

City _____ *State* _____ *Zip Code* _____

Telephone _____ *Fax* _____

Permission is hereby given to the Gananda Central School District to release information to you and/or receive information from you regarding the above-named student.

Reason for request: _____

Please forward the following information as soon as possible:

- Official administrative records: name, address, birth date, grade level
- Birth Certificate
- Immunizations and most recent physical
- Attendance Records/Disciplinary Reports
- Grade K-6 students – Current Report Card
- Grade 7-12 students – Cumulative Academic Record
- Unofficial transcript
- NYS Assessment and/or standardized test scores
- Current IEP or 504 Plan (if applicable)
- All reports associated with Special Education Services (if applicable)
- ESL reports and NYSESLAT scores (if applicable)

Date

Signature of Parent

Printed Name of Parent

Please fax records to:

Grades K-5 (315) 986-3506
Grades 6-8 (315) 986-1927
Grades 9-12 (315) 986-1761

Parents, guardians or students 18 and over may receive a copy of these records and have them interpreted or have an opportunity for a hearing to challenge the contents of these records.

SPECIAL EDUCATION REGISTRATION & HOME LANGUAGE QUESTIONNAIRE

Gananda Central School District, Office of Special Services 315-986-3521 x8-4334

To be completed by parent or guardian. This form, and the Release of Information, must be completed and signed before a student may enroll.

Student Name: _____ Medicaid CIN # _____

1. Is Home Language a Language Other Than English? YES (Complete Home Language Form) NO
2. Is this student classified by the Committee on Special Education? YES NO

What is students current Classification?

- | | |
|---|--|
| <input type="checkbox"/> Learning Disability (LD) | <input type="checkbox"/> Hearing Impairment (HH) |
| <input type="checkbox"/> Speech or Language Impairment (SI) | <input type="checkbox"/> Mental Retardation (MR) |
| <input type="checkbox"/> Emotional Disturbance (ED) | <input type="checkbox"/> Traumatic Brain Injury (TBI) |
| <input type="checkbox"/> Autism (AU) | <input type="checkbox"/> Deaf – Blindness (DB) |
| <input type="checkbox"/> Multiple Disabilities (MD) | <input type="checkbox"/> Deafness (DF) |
| <input type="checkbox"/> Orthopedic Impairment (OI) | <input type="checkbox"/> Preschool student w/disability (PD) |

3. What special education services did student receive? (Check all that apply)

- Special Education Classroom Resource Room Consultant Teacher
- Speech Therapy Physical Therapy Occupational Therapy Counseling

4. Did student attend a BOCES program? YES NO

Where? _____ Type of program? _____

5. Did Student attend a PRIVATE or RESIDENTIAL program outside of public school district?

Where? _____ Type of program? _____

6. Does student have a Section 504 Accommodation Plan? YES NO

If yes, please describe/list the accommodations _____

I consent to the sharing of information regarding my child, _____, between Gananda Central School District and those listed below. This information will be used to help determine educational needs.

Name *Address* *Phone*

Name *Address* *Phone*

Name *Address* *Phone*

Parent/Guardian signature Date

PARENTAL CONSENT FOR RELEASE OF EDUCATIONAL INFORMATION FOR MEDICAID FUNDING

Gananda Central School District, Office of Special Services 315-986-3521 x8-4334

TERMS, RIGHTS AND RESPONSIBILITIES

By signing this application, I understand and confirm that:

- I have been fully informed in my native language or other mode of communication that the granting of my consent to share information for the purpose of obtaining the Medicaid reimbursement for the services provided per my child's individualized education program (IEP) is voluntary and may be revoked at any time and that if I revoke my consent, it does not negate (undo) an action that occurred after my consent was given and before my consent was revoked.
- If I refuse consent to allow use of Medicaid insurance to pay for special education services, the school district must still provide all required special education services at no cost to me.
- The use of Medicaid insurance for special education services will not decrease the available lifetime coverage, increase premiums or lead to the discontinuation of benefits, result in my family paying for services required for my child outside of school that would otherwise be covered by the Medicaid program or otherwise diminish my family's insured benefits under the Medicaid program.
- I will not incur an out-of-pocket expense such as payment of a deductible or co-pay amount.

I, _____ as parent/guardian of
(Print name of parent or person in parental relationship)

(Print child's name)

Medicaid CIN # (REQUIRED)

I give permission to the Gananda Central School District to use Medicaid to pay for IEP services and to such public agency and to each approved private special education school or provider who provides IEP services to my child to disclose information regarding diagnosis and procedure codes for billing Medicaid for services described in my child's IEP and for evaluations in relation to the services; and in the event of an audit, documentation required to support services reimbursed by Medicaid from my child's educational records to local, State and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for covered health-related support services for each service and for each school year in which service is provided as recommended in my child's IEP if my child is or becomes Medicaid-eligible.

I give my consent voluntarily and understand that I may withdraw that consent at any time. I also understand that my child's entitlement to free and appropriate public education (FAPE) is in no way dependent on my granting consent.

Signature: _____

Date: _____



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

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

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

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section.

STUDENT NAME:		

<i>First</i>	<i>Middle</i>	<i>Last</i>
DATE OF BIRTH:		GENDER:
_____		<input type="checkbox"/> Male
<i>Month</i>	<i>Day</i>	<i>Year</i>
_____		<input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		

<i>Last Name</i>	<i>First Name</i>	<i>Relation to Student</i>
_____	_____	_____

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"/> Mother	_____	<input type="checkbox"/> Father
		<i>specify</i>	<i>specify</i>
	<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:

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

District Name (Number) & School

Address

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

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

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

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

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

Age at which services received (Please check all that apply):

Birth to 3 years (Early Intervention) 3 to 5 years (Special Education) 6 years or older (Special Education)

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

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

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

Month: _____ Day: _____ Year: _____

Signature of Parent or of Person in Parental Relation

Date

Relationship to student: Mother Father Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

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

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

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: No Yes

**DATE OF INDIVIDUAL INTERVIEW: _____
 MO. DAY YR.

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

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING
 MO. DAY YR.

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

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Gananda Central School District, 1500 Dayspring Ridge, Walworth, NY 14568, 315-986-3521

Student Name _____ Birth Date _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

I hereby authorize my child's physician(s) listed above to exchange the following information with Gananda Central School staff, including:

- | | |
|---|---|
| <input type="checkbox"/> School Nurse | <input type="checkbox"/> Immunizations/physical exams to comply with NYS regulations |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Psychological evaluations/reports |
| <input type="checkbox"/> Speech Therapist | <input type="checkbox"/> Medical clearances as needed following an injury or change in condition |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Medical orders required for therapy needs; evaluations |
| <input type="checkbox"/> Vision Department | <input type="checkbox"/> Authorization for medications during the school day or on school |
| <input type="checkbox"/> Admissions officer | <input type="checkbox"/> Medical condition/ treatment plans that may have an impact in the school environment |
| <input type="checkbox"/> School Psychologist | <input type="checkbox"/> Physician referral for services (OT, PT) |
| <input type="checkbox"/> School Social Worker | <input type="checkbox"/> Other _____ |

This information will be used to provide a safe and healthful environment and develop an appropriate program for this student at school. Enrollment is not contingent upon obtaining this release, however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment. This release expires on the last day of the enrollment of the above student in school and may be revoked at any time by sending the request to cancel this permission in writing to the address above. Such revocation will not affect any disclosure made prior to its receipt. Protected health information will not be disclosed without consent per FERPA regulations. **A copy of this release has been provided to me and will be sent to the appropriate provider when requests are made.**

I waive my right to receive a copy of this notice.

(Printed Name of Parent/Guardian or Student Over 18)

(Signature of Parent/Guardian or Student Over 18)**

****If a student is under 18 years of age, parent or legal guardian must sign consent form.**

If other representative is signing, authority to act on student's behalf: _____

MEDICAL FORM – TO BE FILLED OUT BY A PARENT/GUARDIAN

Gananda Central School District, 1500 Dayspring Ridge, Walworth, NY 14568

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).

Name of School _____ Grade _____ ID# _____

Name of Student _____ Date of Birth / / Male Female
Last First MI mm dd yyyy

Address _____
Street apt# Town/City Zip Code

Mother's Name _____ / _____
(Home address if different than above) (Home phone) (Work Phone)

Father's Name _____ / _____
(Home address if different than above) (Home phone) (Work Phone)

Physician's Name _____ Physician's Phone _____

Dentist's Name _____ Dentist's Phone _____

1. Any known allergies to foods, bee/insect stings, latex, medicines, etc.? <ul style="list-style-type: none"> • Describe reaction: (local swelling, hives, face swelling) • Are emergency meds required? Yes No 	Yes	No
1. Sustained any injury or illness which required medical attention and/or hospitalization or surgery? If YES your child may need to be cleared with an MD note to participate in sports/gym.	Yes	No
2. Is your child under a physician's care now for any existing problem?	Yes	No
3. Absence or loss of function for eye, kidney, testicle, or other organ?	Yes	No
4. Requires any ongoing medication at home or school? List below	Yes	No
5. Has asthma? If yes, are emergency meds required? Yes No	Yes	No
6. Had a convulsion, seizures, concussion, or loss of consciousness?	Yes	No
7. Has diabetes?	Yes	No
8. Has recurrent headaches? Explain below (frequency, intensity, any medication)	Yes	No
9. Complained of chest pain or fainting during physical exertion?	Yes	No
10. Has heart disease, murmur, or irregular heart beat?	Yes	No
11. Wears Orthodontic braces? <ul style="list-style-type: none"> • Is a specialized mouthpiece from an orthodontist required for sports/PE? Yes No 	Yes	No
12. Had any teeth capped or replaced artificially?	Yes	No
13. Wears glasses? <ul style="list-style-type: none"> • For Sports? Yes No • If YES, are glasses impact resistant? Yes No • Contact lenses? Yes No If YES, How long? 	Yes	No
14. Wears Hearing Aid Devices? If YES, Type?	Yes	No
15. Is there any medical condition or restriction which may be made worse by playing sports/PE?	Yes	No
16. Required by MD to wear brace/support device to play sports/PE?	Yes	No
IF ANSWER IS YES TO ANY OF THE QUESTIONS ABOVE, EXPLAIN BY NUMBER AND GIVE DATE OF OCCURRENCE: _____ _____ _____		

I certify that the above information is true and accurate and understand that it will be relied upon by the Gananda Central School District. If medication is prescribed (only valid for current school year) on the health appraisal form completed by the health care provider, I authorize the school nurse to administer the prescribed medication as directed by the health care provider. I authorize the school nurse to contact the health care provider regarding information on this form and the health appraisal form for one calendar year from the date I signed below.

Parent/Legal Guardian Signature _____ Date _____ / _____ / _____
mm dd yyyy

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE 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:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Anaphylaxis Care Plan Attached <input type="checkbox"/> Environmental
---	---	---

Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	<input type="checkbox"/> Asthma Care Plan Attached
--	--	--

Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type: _____	<input type="checkbox"/> Seizure Care Plan Attached Date of last seizure: _____
--	--	--

Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____ Date Drawn: _____	<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/m2 **Percentile (Weight Status Category):** <5th 5th-49th 50th-84th 85th-94th 95th-98th 99th and >

Hyperlipidemia: No Yes **Hypertension:** No Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

<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	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name:	DOB:
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SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis	Negative	Positive	Referral	
Required for boys grade 9 And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:	Trunk Rotation Angle:			

Recommendations:

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

Full Activity without restrictions including Physical Education and Athletics.

Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications

No Contact Sports **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

No Non-Contact Sports **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

Other Restrictions:

Developmental Stage for Athletic Placement Process ONLY
 Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports
 Student is at **Tanner Stage:** I II III IV V

Accommodations: Use additional space below to explain

<input type="checkbox"/> Brace*/Orthotic	<input type="checkbox"/> Colostomy Appliance*	<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Insulin Pump/Insulin Sensor*	<input type="checkbox"/> Medical/Prosthetic Device*	<input type="checkbox"/> Pacemaker/Defibrillator*
<input type="checkbox"/> Protective Equipment	<input type="checkbox"/> Sport Safety Goggles	<input type="checkbox"/> Other:

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

Explain: _____

MEDICATIONS

Order Form for Medication(s) Needed at School attached

List medications taken at home:		

IMMUNIZATIONS

Record Attached Reported in NYSIIS Received Today: Yes No

HEALTH CARE PROVIDER

Medical Provider Signature:	Date:
Provider Name: <i>(please print)</i>	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child’s School When Entirely Completed.

TRANSPORTATION FORM

Gananda Central School District, Transportation Department, 2067 O'Neil Road, Macedon, NY 14502, 315-986-4278

School: _____ Grade: _____ Start Date: _____

Student's Name: _____ Last Name First Name M F

Date of Birth: ____ / ____ / ____

Parent/Guardian:

Name

Street Address

Town *Zip code*

1st Contact Phone # _____
(area code)

2nd Contact Phone # _____
(area code)

Child Care Provider:

Name

Street Address

Town *Zip code*

Phone # _____
(area code)

Place a check (✓) in the appropriate boxes. You must make a selection for each day of the week for both pick up and drop off.

THIS SCHEDULE WILL PERTAIN TO THE INSTRUCTIONAL SCHOOL DAY ONLY

BEFORE SCHOOL PICK UP

	Home	Child Care	No Transport
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

AFTER SCHOOL DROP OFF

	Home	Child Care	No Transport
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

Faxed copies will be accepted. Fax to: 315-986-7391

My signature certifies that I am the parent/legal guardian of the above student and authorized to request transportation to/from the location(s) listed above.

Date

Signature of Parent/Guardian

- The transportation requested must be on a "regular basis" meaning that the student's weekly schedule is the same for the entire school year.
- The student must board and disembark the bus from established stops
- Transportation to and from child care will end when your student completes 8th grade.

FOOD SERVICE INFORMATION

Gananda Central School District, Department of Dining Services, 315-986-3521, x8-3156

Dear Parents:

Gananda School District's Food Service Department is excited to provide parents a convenient, easy and secure online prepayment service for your child's school meal account at any time. With money in your child's account prior to entering the cafeteria, the lunch lines move faster giving your child more time to eat and be with friends. This is all done through a web site called **MySchoolBucks.com**.

Important things to note about your free MySchoolBucks account:

- Registering for MySchoolBucks and monitoring your child's lunch account is free
- There is a convenience fee for any payments made on line that covers all deposits made within a single transaction
- The Gananda School District does not receive any of the convenience fee
- Automatic payment from your bank account is available when your child's account balance runs low
- Extended purchase history for the past 90 days - Free
- Low balance alerts can be emailed to you - Free
- There is a phone app available - Free
- You may fund up to \$120 per child, but you may pay for all of your children on a single transaction.
- The charge on your credit card statement may appear as HEARTLAND PAYMENT SYSTEMS
- MySchoolBucks has the following payment methods available for use:
 - Visa®, Mastercard®, Discover®, or Electronic Check

Please allow 24-48 hours for funds to be available in your child's account.

If you choose not to take advantage of the online prepayment service you still can use the services free of charge and you may continue to make payments/deposits to the cashier in your child's school kitchen. Either cash or check is accepted at the school. Please make checks payable to the Gananda Central School District. Write **your child's full name** in the memo area on the check. The entire amount of your check or cash is directly deposited into your child's lunch account; for your convenience, and to avoid lost money, change is not given for prepayments. If you have any questions about these services, please contact the Food Service Office at 315-986-3521,x8-3156

To access these services & register for a MySchoolBucks.com account:

You will need your child's student ID number. If you do not have this number, please call the Food Service Office @ 315-986-3521, x8-3156 or your child's school.

1500 Dayspring Ridge
Walworth NY 14568
Phone: 315-986-3521
Fax 315-986-2003
www.gananda.org



Shawn Van Scoy, Ed.D.
Superintendent of Schools
Robin Vogt
Board of Education President

Kindergarten Parent Interview

Any information you give us about your child will help your child's teacher become familiar with him/her before starting school and will also help us in placing your child in the best possible classroom environment.

Child's Name: _____ Date of Birth: _____

Nickname: _____

My child feels that coming to Kindergarten is going to be _____

I hope that my child's teacher will _____

Some of my child's favorite activities/books are _____

What do you feel, as a parent, are your child's greatest strengths? _____

What do you feel, as a parent, are your child's greatest areas of need? _____

Has your child had any pre-school experiences? _____

Is there any other information you would like to share with us to help your child's Kindergarten experience be the best possible? _____

