2023-24 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, please bring it to the Gananda District Office located in the Gananda Middle School, 1500 Dayspring Ridge, Walworth, along with the documents described on page 2.

Children MUST be 3 -years old on or before December 1 of the incoming school year to enroll in UPK. If your child will be 5 years old on or before December 1 of the incoming school year they are not eligible for the Gananda UPK program, they will need to enroll in kindergarten or a private UPK program.

☐ I am enrolling my child in the 2023-24 half-day 3-year old UPK program. I

☐ am enrolling my child in the 2023-24 full-day 4-year old UPK program.

Registration Checklist:

☐ **Completed registration packet**

☐ **Proof of student's age** – original (Birth Certificate, Passport, Baptismal Record) Children MUST be 3 -years old on or before December 1 of the incoming school year to enroll in UPK. If your child will be 5 years old on or before December 1 of the incoming school year they are not eligible for the Gananda UPK program, they will need to enroll in kindergarten or a private UPK program.

☐ **Proof of residence within the Gananda Central School District** – one copy. You and your child MUST be a Gananda CSD resident to enroll. *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.** (Not required upon enrollment but **MUST** be received prior to the start of the school year in September.) "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** – Only applicable for students receiving special education preschool services. If your child receives special education services *by a district other than Gananda*, please provide one copy of your child's IEP.

☐ **Custody Papers** - If applicable.

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 Heath 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: *Last*	*First*	*Middle Initial*	*Nick Name*

Student Address: Street Apt. Town/City Zip	**Proof of Age:** ☐ Provided:
	Proof of Residency: ☐ Provided:

Birth Date: *mm / dd / yyyy*	**Gender:** ☐ Male ☐ 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 (List parent(s)/guardian(s) that reside at the address below.)	**Primary Phone #:** *(area code)*
Complete Address:	
Parent/Guardian Name: (First Contact) *Last* *First* *Gender*	
Relationship to student: ☐ *Bio-Parent* ☐ *Legal Guardian* ☐ *Foster Parent* ☐ *Step-Parent* ☐ *Other*_____	**Phone #s:** *(Include Area Code)*
	Cell:
Email Address:	**Work:**
Parent/Guardian Name: (Second Contact) *Last* *First* *Gender*	
Relationship to student: ☐ *Bio-Parent* ☐ *Legal Guardian* ☐ *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
		☐		

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 -**

☐ Two parents in Home	☐ Divorced/Separated	☐ Joint Custody	☐ Single Parent	☐ Sole Custody
☐ Custody Transfer	☐ Foster Placement (DDS-2999/3424 must be provided)			☐ Unaccompanied Youth

Custody paperwork provided during registration? ☐ Yes ☐ No

Restrictions of contact and/or information: ***Custody papers/court order MUST be provided.***

☐ No Restrictions for Parents/Guardians ☐ Custody Papers Specify Restriction ☐ Order of Protection
☐ Other Documentation, specify:_____ Expiration Date:_____
Person(s) Restricted:_____ Relationship to Student:_____

SECONDARY HOUSEHOLD INFORMATION

Parent/Guardian Name: *Last* *First*	**Relationship to student:** ☐ Has permission to pick student up from school.
Complete Address:	**Cell:**
	Home:
	Work:
Email Address:	*(Include area codes.)* **Receives mail** ☐ **Yes** ☐ **No**

SIBLING INFORMATION

Siblings Residing in Primary Residence:

Last Name	First Name	Gender	Date of Birth	Grade	School
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			

STUDENT'S PHYSICIAN INFORMATION

Name:	Phone:
Name of Practice:	
Address:	

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

Name:	Home #:
Relationship to student:	Cell #:
☐ Has permission to pick student up from school.	Work #:
Name:	Home #:
Relationship to student:	Cell #:
☐ Has permission to pick student up from school.	Work #:
Name:	Home #:
Relationship to student:	Cell #:
☐ Has permission to pick student up from school.	Work #:
Name:	Home #:
Relationship to student:	Cell #:
☐ Has permission to pick student up from school.	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 (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:
UPK-5: 315-986-3506
6-8: 315-986-1927
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?

- ☐ Learning Disability (LD)
- ☐ Speech or Language Impairment (SI)
- ☐ Emotional Disturbance (ED)
- ☐ Autism (AU)
- ☐ Multiple Disabilities (MD)
- ☐ Orthopedic Impairment (OI)
- ☐ Hearing Impairment (HH)
- ☐ Mental Retardation (MR)
- ☐ Traumatic Brain Injury (TBI)
- ☐ Deaf – Blindness (DB)
- ☐ Deafness (DF)
- ☐ 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: _____

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

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

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

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

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section.

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

HOME LANGUAGE CODE _____

Language Background
(Please check all that apply.)

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

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

SCHOOL DISTRICT INFORMATION:		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: _____ (MO. DAY YR.)

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

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

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:

☐ School Nurse
☐ Physical Therapist
☐ Occupational Therapist
☐ Speech Therapist
☐ Audiologist
☐ Vision Department
☐ Admissions officer
☐ School Psychologist
☐ School Social Worker

☐ Immunizations/physical exams to comply with NYS regulations
☐ Social History
☐ Psychological evaluations/reports
☐ Medical clearances as needed following an injury or change in condition
☐ Medical orders required for therapy needs; evaluations
☐ Authorization for medications during the school day or on school
☐ Medical condition/ treatment plans that may have an impact in the school environment
☐ Physician referral for services (OT, PT)
☐ 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: _____

This form complies with all HIPAA regulations. Revised 1.07 KM

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.? • 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? • 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? • 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: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

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

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code
_____	_____
_____	_____
_____	_____
_____	_____

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ 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

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ 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: *(please print)*	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: _____ _____ ☐ M ☐ F
Last Name *First Name*

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 both pick up and drop off. The transportation requested must be on a "regular basis" meaning that the student's schedule is the same for the entire school year.

THIS SCHEDULE WILL PERTAIN TO THE INSTRUCTIONAL SCHOOL DAY ONLY

BEFORE SCHOOL PICK UP

Home	Child Care	No Transport
☐	☐	☐

AFTER SCHOOL DROP OFF

Home	Child Care	No Transport
☐	☐	☐

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.