# Student Registration Requirements

Welcome to the New Hartford Central School District! We are excited that you are considering enrolling your child(ren) in our school district. The first step in this process is to provide the following information:

1. Original birth certificate
2. Proof of residency:
    - a copy of a residential lease or proof of ownership of a house or condominium such as a deed or mortgage statement;
    - a statement signed by a landlord, property owner, or tenant from whom the adult leases or rents property, or with whom the adult shares property within the District (the District prefers a sworn statement, but this is not required);
    - some other signed statement from a third party establishing that the adult maintains a physical presence within the District.

    **-AND-**

    - One other form of documentation of residency, including, but not limited to:
        - Paystub
        - Income tax form
        - Utility or other bills
        - Membership documents based on residency
        - Voter registration documents
        - Official driver's license, learner permit, or non-driver identification.
        - State or other government-issued identification or documents relating to government services or benefits
3. Custody papers (if applicable)
4. Academic records from your previous school (if applicable)
5. Health records including immunizations
6. Committee on Special Education (CSE) records (if applicable)
7. Discipline records from your previous school (if applicable)
8. Completed New Hartford Student Registration Packet.

Using one of the following options, please return the above information to the Office of Student Services, along with a phone number so you may be contacted if further information or clarification is needed:

- Via fax: 315-624-1236
- Via e-mail: schoolregistration@nhart.org
- Via U.S. mail: New Hartford Central School District, Office of Student Services, 33 Oxford Road, New Hartford, NY 13413
- Via in person: Please deliver the completed registration packet, along with the required documentation, to the respective school building(s) which your child(ren) will attend
- Any questions, please contact the Office of Student Services at 315-624-1231.

# NEW HARTFORD CENTRAL SCHOOL DISTRICT STUDENT INFORMATION FORM

Student Information:

| Last Name, First Name, Middle | Nickname | Date of Birth (MM/DD/Year) | Gender |
|---|---|---|---|
| Entering Grade | Ethnicity (Choose one)<br>☐ Hispanic/Latino<br>☐ Not Hispanic/Latino | Place of Birth | Primary Language Spoken at Home |

Select one or more races from the following five racial groups. Mark at least **ONE** box.

- ☐ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North America and who maintains a cultural identification through tribal affiliation or community recognition. E.g. Cherokee, Mohawk, Inuit.
- ☐ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **BLACK:** A person having origins in any of the black racial groups of Africa.
- ☐ **WHITE:** A person having origins in any of the original peoples of Europe, North America, or the Middle East.

**STUDENT RESIDENTIAL INFORMATION:**

| **House #, Street Address** | | **Apt.#** | **Student's Home Phone:** |
|---|---|---|---|
| **City** | **State** | **Zip Code** | |
| **Mailing Address if different:** | | | |
| **Is this address a temporary living arrangement:** ☐ **Yes** ☐ **No** | | | |
| **Resident of New Hartford School District:** ☐ **Yes** ☐ **No, please list District:** | | | |

**ACADEMIC INFORMATION:**

| **Has the student attended New Hartford Central School District in the past?** ☐ **Yes** ☐ **No** | | |
|---|---|---|
| **List Grade Levels Repeated:** | | |
| **Last Two Schools Attended** | **School 1** | **School 2** |
| **Name of School** | | |
| **Address of School** | | |
| **Phone Number** | | |
| **Grade Levels Completed** | | |
| **Last Date of Attendance** | | |
| **Name of Counselor or Contact Person** | | |

Please describe any special education needs of the student: _____

_____

_____

**Parent/Guardian Information (Primary Household)**

| Relationship to student | Gender | Custody? ☐ N/A ☐ Yes ☐ No ☐ Joint | Relationship to student | Gender | Custody? ☐ N/A ☐ Yes ☐ No ☐ Joint |
|---|---|---|---|---|---|
| Last Name, First Name | | | Last Name, First Name | | |
| Home Phone | | | Home Phone | | |
| Cell Phone | | | Cell Phone | | |
| Work Phone | | | Work Phone | | |
| Employer | | | Employer | | |
| Email Address | | | Email Address | | |
| Can you pick up student? | | | Can you pick up student? | | |
| Residential Address SAME as Student<br>If no, please complete the area below: | | | Residential Address SAME as Student<br>If no, please complete the area below: | | |
| House #/Street Name | | | House #/Street Name | | |
| City/State/Zip Code | | | City/State/Zip Code | | |

**Parent/Guardian Information (Secondary Household)**

| Relationship to student | Gender | Custody? ☐ N/A ☐ Yes ☐ No ☐ Joint | Relationship to student | Gender | Custody? ☐ N/A ☐ Yes ☐ No ☐ Joint |
|---|---|---|---|---|---|
| **Last Name, First Name** | | | **Last Name, First Name** | | |
| **Home Phone** | | | **Home Phone** | | |
| **Cell Phone** | | | **Cell Phone** | | |
| **Work Phone** | | | **Work Phone** | | |
| **Employer** | | | **Employer** | | |
| **Email Address** | | | **Email Address** | | |
| **Can you pick up student?** | | | **Can you pick up student?** | | |
| **Residential Address SAME as Student<br>If no, please complete the area below:** | | | **Residential Address SAME as Student<br>If no, please complete the area below:** | | |
| **House #/Street Name** | | | **House #/Street Name** | | |
| **City/State/Zip Code** | | | **City/State/Zip Code** | | |

**Emergency Contacts:**

| Name | Gender | Relationship | Home Phone | Work Phone | Cell Phone | Pick up from school |
|---|---|---|---|---|---|---|
| | | | | | | ☐ YES ☐ NO |
| | | | | | | ☐ YES ☐ NO |

**Siblings who will enroll (or are currently enrolled) in the New Hartford Central School District:**

| Name | DOB | Grade | School |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Parent/Guardian Signature:**_____ **Date**_____

# NEW HARTFORD CENTRAL SCHOOL DISTRICT
## NEW STUDENT INFORMATION

**This information is required to meet New York State guidelines that require local school districts to screen all new entrants. This information will be treated as confidential.

Name of Child:_____ DOB_____ Phone Number_____

Address:_____

I. Family Information

| Parent Information | Name | DOB | Occupation/Employer | Marital Status |
|---|---|---|---|---|
| Parent/Guardian | | | | |
| Parent/Guardian | | | | |
| | | | | |
| | | | | |
| Sibling Information | | | School/Grade Level | In the home? |
| Sibling | | | | |
| Sibling | | | | |
| Sibling | | | | |
| Sibling | | | | |

Is your child adopted: ☐ Yes ☐ No Is there any further information you would like to share regarding the adoption?_____

II. Developmental Information:

The child was born: ☐ Full-Term ☐ Cesarean ☐ Premature Birth Weight_____

Were there any complications at birth?_____

| Milestones | Early | Typical | Late | Comments/Current Concerns |
|---|---|---|---|---|
| Teething | | (6 months) | | |
| Crawling | | (9 months) | | |
| Walking | | (1 year) | | |
| Toilet Trained | | (2-3 yrs.) | | |

Was your child's development unusual in any way?_____

_____

Please list any serious illness, operations, or injuries that your child has had and at what age:

_____

_____

Do you have any concerns about your child's eating habits or sleeping patterns:_____

_____

Do you have concerns about your child's vision or hearing: ☐ YES ☐ NO

If yes, please explain:_____

***If your child is **not** entering Kindergarten, please skip to Section IV***
If your child **is** entering Kindergarten, please complete all sections

III. School Readiness:

Has your child attended nursery school? ☐ YES ☐ NO If yes, where?_____

Do you have any concerns about your child's readiness for school? (such as academic, social, or behavior management)_____

_____

Does your child have independent self-care skills (e.g. toileting, dressing, etc.) ☐ YES ☐ NO

If no, please explain:_____

Have there been any major changes in the home (divorce, marriage, separation, death, etc.) that may affect your child?_____

IV. Speech/Language:

Has your child ever been enrolled in a speech or language therapy program? ☐ YES ☐ NO

If yes, where?_____ What was addressed:_____

Do you or others have difficulty understanding your child's speech? ☐ YES ☐ NO

Does your child pronounce any sounds incorrectly? ☐ YES ☐ NO Which sounds?_____

V. Evaluations/Services:

Has your child been evaluated for any other concerns? ☐ YES ☐ NO

If yes, what was the area of concern?_____

What was the outcome of the evaluation?_____

Does your child receive any services as a result of the evaluation? ☐ YES ☐ NO

If yes, where?_____

Do you have any concerns or comments that were not addressed?_____

_____

_____

Please do not hesitate to contact the Social Worker in your child's building if you wish to further elaborate on the information you have provided, or express any specific concerns.

All the information provided on this form will be treated as confidential.

Form completed by:_____ Date:_____

Dear Parents/Guardians,

Chapter 53 of the Education Law-1980 requires local school districts to screen all new entrants, including Kindergarten.

Screening is a preliminary method of distinguishing from the general population, those students, who may possibly have a handicapping condition or those who may be gifted. Screening should not be viewed as an in-depth method of assessing development. It is a quick method of determining overall performance and should indicate whether or not a comprehensive evaluation is necessary. Based upon the results of screening, students who are in need of further evaluation will be referred to appropriate school and medical personnel.

New Hartford's screening process will include:

1. A health examination by a licensed physician, or evidence of such, in the form of a health certificate.
2. Certificates of immunization or referral for immunizations
3. Request for a Dental Health Certificate for school entry (Grades K, 2, 4, 7 and 10)
4. Articulation skills and receptive and expressive language development
5. Cognitive development (learning strengths and weaknesses)
6. Motor development

Screening will be conducted under the following schedule:

1. Kindergarten-May/June
2. New Entrants-August/September
3. New Entrants after Sept. 1st-Individually as needed

When screening has been completed, you will receive a copy of the Screening Profile, which will contain the results of the testing. All data pertaining to your child(ren) will be treated in a confidential manner.

Your assistance and cooperation in supplying information and completing necessary forms will be appreciated. If you have any questions, please contact your building principal.

Thank you!

(*FORM E4)*

Dear Parents/Guardians,

Please help us help your child(ren) with these very important safety tips.

1. Be sure your child(ren) is ready when the bus arrives and is at the bus stop, not waiting in the house. If for some reason your child(ren) isn't going to school, motion the bus on.

2. Have your child(ren) use a backpack, or tote bag to carry paper, books, etc. to and from school.

3. DO NOT ALLOW your child to take large, bulky items on the school bus. This can be dangerous for them due to the inability to handle such items and the limited space on the bus. (This includes musical instruments to large to hold.) Glass containers are not permitted on the bus.

4. Please keep all pets restrained at bus arrival times, morning and afternoon.

5. Please instruct your child(ren) when getting off the bus in the afternoon to go directly to the house. DO NOT allow your child(ren) go to the mailbox or wait out by the bus when it is leaving as this is a dangerous area.

6. IN THE MORNING, if your child(ren) must cross the road to get to their bus, instruct them to wait at the end of your driveway (back ten feet or so from the end), until the bus stops, flashing red lights are on, and the bus driver signals your child(ren) to cross.

7. It is very important to teach your child(ren) on the proper way to cross the highway. Teach them to walk in front of the bus until they can see their bus driver's face (ten feet or more), STOP and wait for the bus driver's signal before starting to cross the road. Also, show them how to look for themselves as they cross and not to run. If you want to meet your child(ren) in the afternoon when getting off the bus, please meet them where they depart from the bus as the excitement of the child(ren) seeing a parent or guardian is apt to make unsafe crossing.

8. We ask that your child(ren) keep noise to a reasonable level so the bus driver can hear the hazards of the road, other vehicle horns, sirens of emergency vehicles, and trains at railroad crossings.

9. Emergency bus evacuation drills will be conducted three times during the year. These will include safe crossing of the highway.

10. With your cooperation, I am sure we can have another safe transportation year.

Thank you!

Transportation Office

*(Form E3)*

**New Hartford Central School District**
**Student Photo and Media Release Form**

The New Hartford Central School District promotes school programs, activities, awards, recognitions, and accomplishments of its students through publications and digital media. This includes, but is not limited to the use of photos and videos of students in newsletters, social media, promotional materials, the district website and any other form of publication, or broadcast media.

☐ I **give** the District permission to use a photo or video of my child in any and all publications and digital media.

☐ I **do not give** the District permission to use a photo or video of my child in any and all publications and digital media.

| **Student Name** | **School** |
|---|---|
| **Teacher** | **Grade** |

_____ _____
Parent/Guardian Name (please print) Date

_____
Parent/Guardian Signature

******If this form is not submitted to your child's respective building, the District assumes that it is permissible to use a photo and/or video of your child***.

Revised 09/25/2024

# 2024-25 School Year
# New York State Immunization Requirements for School Entrance/Attendance[1]

**NOTES:**
All children must be age-appropriately immunized to attend school in New York State. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the "ACIP-Recommended Child and Adolescent Immunization Schedule." Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes must meet the immunization requirements of the grades for which they are age equivalent.

**Dose requirements MUST be read with the footnotes of this schedule**

| Vaccines | Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K) | Kindergarten and Grades 1, 2, 3, 4 and 5 | Grades 6, 7, 8, 9, 10 and 11 | Grade 12 |
|---|---|---|---|---|
| **Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]** | **4 doses** | **5 doses**<br>**or 4 doses**<br>if the 4th dose was received at 4 years or older or<br>**3 doses**<br>if 7 years or older and the series was started at 1 year or older | **3 doses** | |
| **Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]** | **Not applicable** | | **1 dose** | |
| **Polio vaccine (IPV/OPV)[4]** | **3 doses** | **4 doses**<br>**or 3 doses**<br>if the 3rd dose was received at 4 years or older | | |
| **Measles, Mumps and Rubella vaccine (MMR)[5]** | **1 dose** | **2 doses** | | |
| **Hepatitis B vaccine[6]** | **3 doses** | **3 doses**<br>**or 2 doses** of **adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years | | |
| **Varicella (Chickenpox) vaccine[7]** | **1 dose** | **2 doses** | | |
| **Meningococcal conjugate vaccine (MenACWY)[8]** | **Not applicable** | | **Grades 7, 8, 9, 10 and 11: 1 dose** | **2 doses**<br>**or 1 dose**<br>if the dose was received at 16 years or older |
| **Haemophilus influenzae type b conjugate vaccine (Hib)[9]** | **1 to 4 doses** | **Not applicable** | | |
| **Pneumococcal Conjugate vaccine (PCV)[10]** | **1 to 4 doses** | **Not applicable** | | |

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019, and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.

   c. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 10: 10 years; minimum age for grades 11 and 12: 7 years).

   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.

   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2024-25, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 10; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 11 and 12.

   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)

   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.

   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward New York State school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)

   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

   b. Measles: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.

   c. Mumps: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.

   d. Rubella: At least one dose is required for all grades (pre-kindergarten through 12).

6. Hepatitis B vaccine

   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).

   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)

   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 11: 10 years; minimum age for grade 12: 6 weeks).

   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.

   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.

   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.

   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.

   d. If dose 1 was received at 15 months or older, only 1 dose is required.

   e. Hib vaccine is not required for children 5 years or older.

   f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)

    a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

    b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.

    c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.

    d. If one dose of vaccine was received at 24 months or older, no further doses are required.

    e. PCV is not required for children 5 years or older.

    f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

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For further information, contact:

**New York State Department of Health**
**Division of Vaccine Excellence**
**Room 649, Corning Tower ESP**
**Albany, NY 12237**
**(518) 473-4437**

**New York City Department of Health and Mental Hygiene**
**School Compliance Unit, Bureau of Immunization**
**42-09 28th Street, 5th floor**
**Long Island City, NY 11101**
**(347) 396-2433**

New York State Department of Health/Division of Vaccine Excellence
health.ny.gov/immunization

2370 04/24

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization/Division of Epidemiology

# Immunization Requirements for School Attendance
## Medical Exemption Statement for Children 0-18 Years of Age

**NOTE: THIS EXEMPTION FORM APPLIES ONLY TO IMMUNIZATIONS REQUIRED FOR SCHOOL ATTENDANCE**

**Instructions:**

1. Complete information (name, DOB etc.).
2. Indicate which vaccine(s) the medical exemption is referring to.
3. Complete contraindication/precaution information.
4. Complete date exemption ends, if applicable.
5. Complete medical provider information. Retain copy for file. Return original to facility or person requesting form.

1. Patient's Name _____
2. Patient's Date of Birth _____
3. Patient's Address _____
4. Name of Educational Institution _____

Guidance for medical exemptions for vaccination can be obtained from the contraindications, indications, and precautions described in the vaccine manufacturers' package insert and by the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) available in the Centers for Disease Control and Prevention publication, Guide to Vaccine Contraindications and Precautions. This guide can be found at the following website: **http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm**.

*Please indicate which vaccine(s) the medical exemption is referring to:*

- ☐ Haemophilus Influenzae type b (Hib)
- ☐ Polio (IPV or OPV)
- ☐ Hepatitis B (Hep B)
- ☐ Tetanus, Diphtheria, Pertussis (DTaP, DTP, Tdap)
- ☐ Measles, Mumps, and Rubella (MMR)
- ☐ Varicella (Chickenpox)
- ☐ Pneumococcal Conjugate Vaccine (PCV)
- ☐ Meningococcal Vaccine (MenACWY)

Please describe the patient's contraindication(s)/precaution(s) here: _____

Date exemption ends (if applicable)

*A New York State licensed physician must complete this medical exemption statement and provide their information below:*

Name (print) _____ NYS Medical License # _____

Address _____

_____ Telephone _____

Signature _____ Date _____

**For Institution Use ONLY:** Medical Exemption Status ☐ Accepted ☐ Not Accepted Date: _____

**New Hartford Central School District**
Dr. Christopher Alinea
Julie Shankman, FNP

Hollice Paciello, BSN, RN
School Nurse Coordinator
New Hartford High School Nurse
315-624-1235

Jessica Wellington, RN
Myles Elementary School Nurse
315-624-1106

Marie Perrotta, RN
Perry Junior High School Nurse
315-738-9317

Nicole Getz, RN
Bradley Elementary School Nurse
315-624-1232

Cathy Clark, RN
Hughes Elementary School Nurse
315-738-9357

# Health History Form

| Child's Name | | Birth Date | | | Gender |
|---|---|---|---|---|---|
| Mother's Name | | Father's Name | | | |
| Mailing Address: | | | | | |
| Parent Home Phone | | Cell | | Work | |
| Parent Home Phone | | Cell | | Work | |

Please list siblings:

| Name of Sibling | Age | School Sibling Attends | Grade |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

With whom does the child live?_____

Who is the legal guardian?_____

## Perinatal and Development

Did the mother have any unusual problems/illness during pregnancy or birth? If yes, please explain

Please check if these factors were present:

| | | | | | |
|---|---|---|---|---|---|
| **Toxemia** | | **Cesarean Section** | | **Bleeding** | |
| **Fetal Problems** | | **Infection** | | **Labor Difficulties** | |

Please check accordingly

| | | | | | |
|---|---|---|---|---|---|
| The infant was full term: | | The infant was early: | | The infant was late: | |

| | |
|---|---|
| What was the infant's birth weight? | |

## Perinatal and Development (Continued)

| **Did the infant have any illness or problems while in the hospital?** | If yes, please explain: |
|---|---|

Please check:

1. How does this child's development compare with other children such as brother's, sister's or playmate's

   ☐ Same ☐ Slower ☐ Faster

2. This child is usually:

   ☐ Active ☐ Very Active ☐ Quiet

Please check all that apply:

| | | | |
|---|---|---|---|
| Sore Throats ☐ | Headaches ☐ | Chicken Pox ☐ | Date |
| Eye Problems ☐ | High Fevers ☐ | | |
| Ear Infections ☐ | Diabetes ☐ | | |
| Nosebleeds ☐ | Heart Conditions ☐ | | |
| Poor Hearing ☐ | Seizures ☐ | | |

## Allergies and Asthma

| | |
|---|---|
| Medicine/Drugs | |
| Foods/Plants | |
| Bee/Wasp Stings | |
| Animals/Other | |

Treatment recommended by MD for severe allergic response:_____

_____

## Allergies and Asthma (continued)

**Please be aware we do not stock medications for severe allergic responses, parents are responsible for providing these medications to the school nurse with the doctor's orders.**

Is the child having allergy shots? ☐ Yes ☐ No

Has asthma been diagnosed by a physician? ☐ Yes ☐ No

What treatment/medication have been prescribed?_____

_____

Are there specific triggers causing an asthma episode? ☐ Yes ☐ No

Please describe the triggers:_____

_____

## Injuries, Illness and Surgery

Please list severe injuries, illness, or surgeries?

| Injury/Illness/Surgery | Age | Hospital Yes/No | Length of Hospital Stay |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Medications

| List medications given daily: | List medications given frequently | List medications your child is allergic to? |
|---|---|---|
| | | |
| | | |
| | | |

If your child needs to take medication in school, please contact the school nurse for the district's protocol to have medication given in school.

| Does this child have any disability or chronic illness? Yes/No | If yes, please explain |
|---|---|
| | |

| | |
|---|---|
| Are there any health concerns that you would like to discuss with the school nurse? | If yes, please explain: |
| Please provide a phone number(s) where you can be contacted. | Phone number(s) |
| Does any family member have any long-term illness such as diabetes, high blood pressure or heart disease? | If yes, please explain: |

# New Hartford Central District School Health Services

Dr. Chris Alinea
Julie Shankman, FNP

Hollice Paciello, BSN, RN
School Nurse Coordinator
New Hartford Senior High School
(315) 624-1235

Jessica Wellington, RN
School Nurse
Myles ElementarySchool
(315) 624-1106

Marie Perrotta, RN
School Nurse
Perry Jr. High School
(315) 738-9317

Nicole Getz, RN
School Nurse
Bradley Elementary School
(315) 624-1232

Cathy Clark, RN
School Nurse
Hughes Elementary School
(315) 738-9357

## DENTAL HEALTH CERTIFICATE

Dear Parent/Guardian:

New York State Law (chapter 281) asks schools to request proof of a dental examination in the following grades: school entry, K, 1, 3, 5, 7, 9, and 11. Please fill out this form and return to the School Nurse. This is a request and as such is optional.

**Student Name:**_____ **Grade**_____ **Teacher**_____

This student has had a complete dental exam on: Date:_____

Dentist Name_____
(please print or stamp)

Dentist Signature_____

Dentist Phone_____

Comments:_____

_____

Thank you for your cooperation in this new health endeavor.

New Hartford Central School District

**Provider and Parent Permission to Administer Medication at School/School Sponsored Events**

**To Be Completed by Parent**

Student Name_____ DOB_____
Grade_____ Teacher_____ School _____

I request that the school nurse administer the medication listed on this plan. I will provide the medication in the original pharmacy or over the counter container. This plan may be shared with the school staff caring for my child.

**Parent/Guardian Signature**_____ **Date**_____
**Phone Number**_____ **Email**_____

**To Be Completed by Health Care Provider-Valid for 1 Year**

Diagnosis_____

Medication_____

Dose_____ Route_____ Time(s)_____

Recommendations_____ ICD Code_____

**Note**: Medication will be administered as close to the prescribed time as possible, but may be administered up to one hour before or after the prescribed time, unless it is documented that it is a time sensitive medication. Please advise if there is a time-specific concern regarding administration.

**Independent Carry and Use Attestation Attached (Required for independent carry and use)**

NYS law required both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medications, epinephrine auto-injector, insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

**Name/Title of Prescriber** (Please Print)_____

Prescribers Signature_____

Date_____ Phone_____

# New Hartford Central School District

## PROVIDER AND PARENT PERMISSIONS
## REQUIRED FOR INDEPENDENT MEDICATION USE AND CARRY

**Directions for the Health Care Provider:** This form may be used as an addendum to a medication order which foes not contain the required diagnosis and attestation for a student to independently use and carry their medication as required by NYS law. A provider order and parent/guardian permission is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

**Student Name**_____ **DOB**_____

**Health Care Provider Permission for Independent Use and Carry**

I attest that this student has demonstrated to me that they can self-administrator the medication (s) listed below safely and effectively, and may carry and use this medication (which delivery device is needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications checked below:

This student is diagnosed with:

- ☐ Allergy and required Epinephrine Auto-Injector
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and required insulin/Glucagon/Diabetes Supplies
- ☐ _____which requires rapid administration of
  (state diagnosis)
  _____(medication name)

**Provider Signature**:_____ **Date**_____

**Parent/Guardian Permission for Independent Use and Carry**

I agree that my child can use their medication effectively and may use and carry this medication independently at any school/school sponsored activity with no supervision by school staff.

**Signature:**_____ **Date**_____

**Please return to the School Nurse with the Provider and Parent Permission to Administer Medication form.**

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

Elisa Alvarez, Associate Commissioner Office of
Bilingual Education and World Languages

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

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

# Home Language Questionnaire (HLQ)

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

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

**HOME LANGUAGE CODE** _____

## *Language Background*
***(Please check all that apply.)***

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

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

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

# Home Language Questionnaire (HLQ)—Page Two

## *Educational History*

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

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

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

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

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

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

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

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

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

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

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

**Relationship to student: ❑ Parent ❑ Other:**_____

### OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

**NAME:** _____ **POSITION:** _____

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

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

**NAME:** _____ **POSITION:** _____

**ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES**

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

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

### NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

**NAME:** _____ **POSITION:** _____

**DATE OF NYSITELL ADMINISTRATION:** _____ (MO. DAY YR.)

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

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