HORSEHEADS
CENTRAL SCHOOL DISTRICT

Registrar's Office
1 Raider Lane • Horseheads, NY 14845
(607) 739-2400, x4251 • Fax (607) 795-2435
www.horseheadsdistrict.com

Dear Parents and Guardians:

Welcome to the Horseheads Central School District! We have designed our enrollment forms to make the registration process as convenient as possible for parents to register their children. Please complete one Household Packet per family and one Student Packet for every child you are registering.

When you register at the appropriate building, along with these completed forms, please also bring:

1. Your child's ***original*** birth certificate (we will make a copy and return your original to you)
2. Your child's up-to-date immunization records
3. Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers
4. TWO proofs of residency. Acceptable proofs include:

    - Bank contract or mortgage agreement showing purchase of home with name and address
    - Signed and dated rent or lease agreement with landlord's name, address, and telephone number, or DSS processed landlord statement
    - Most recent utility bill (phone, gas, electric)
    - Deposit receipt for gas, electric, phone service start-up
    - Driver's license or government issued ID card with picture showing current district address.
    - Currently active bank statement with name and address imprinted (bank may be contacted to verify existence of account)
    - Payroll stub with address
    - Change of address verification from Post Office or U.S. postmark dated business mail
    - Receipt from major moving company or local firm showing delivery of newly purchased major appliance or furniture
    - Income tax forms
    - Voter Registration document(s)
    - Documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement)

If you are having difficulty obtaining any of these documents or have any questions about which elementary school your child would attend, please call me at (607) 739-5601 ext. 4251.

Once you have the necessary documents, you're ready to register your child. Please call ahead to let the school know to expect you. If you're registering children at the high school, they will set up an appointment for you to meet with a guidance counselor.

Big Flats Elementary (grades K – 4)	(607) 739-6373
Gardner Road Elementary (grades K – 4)	(607) 739-6347
Ridge Road Elementary (grades K – 4)	(607) 739-6351
Horseheads Intermediate School (grades 5 & 6)	(607) 739-6366
Horseheads Middle School (grades 7 & 8)	(607) 739-6357
Horseheads High School (grades 9 – 12)	(607) 795-2500

Sincerely,

Genie Connel

Central Registrar and Information Specialist
(607) 739-5601 ext. 4251

Horseheads Central School District
New Student Registration Form

Please print clearly in ink.

Student Name _____ **Grade** _____ **Gender** Male or Female
Last First Middle (circle)

Does the student have an affirmed name and/or gender? _____ No _____ Yes (If yes, please complete information on Health Form)

Student resides with (check one) _____ Both Father & Mother _____ Mother Only _____ Father Only

_____ Legal Guardian (specify relationship to child) _____

Name(s) of Adults this Student lives with _____

If both parents do not reside in same household, please answer below and provide documentation of custody agreement.

Custody is: _____ Sole _____ Joint _____ Protection Order

Physical Custody with _____ Legal Custody with _____

****

Student's Date of Birth _____ **Place of Birth** _____
mm/dd/yyyy city, state country

If birthplace was not in the United States, please give the date and location the student was first enrolled in a US School:

_____ **Number of Years in U.S. Schools** _____
date location

Has the student ever previously attended another New York State School? _____ No _____ Yes (if yes, how many years has this student attended in a NYS School? _____)

Is the student Hispanic, Latino or of Spanish origin (a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race)?

_____ No _____ Yes, Hispanic

Please circle one or more races that apply to this student from the following 5 racial groups:

American Indian or Alaskan Native Asian Black White Native Hawaiian or Other Pacific Islander

****

Does this student have a current IEP (Individualized Education Plan)? _____ No _____ Yes

Does this student receive Academic Intervention Services (AIS)? _____ No _____ Yes

Does this student have a current 504 Plan? _____ No _____ Yes

Does this student receive any support services? _____ No _____ Yes

If you answered Yes to any of the above 4 questions, please complete an "Additional Education Services Information" form.

****

Does the student have any health/special needs? _____ No _____ Yes (if yes, please explain below)

_____

****

Is this child's mother, father, or legal guardian Active-Duty Military or a civilian working on a military post? _____ No _____ Yes (if yes, please state who below)

_____

Is this student under your care as a foster child? _____ No _____ Yes (if **yes**, please **complete a & b** below)

a. If yes, in what school district does the student's parent reside? _____

b. Caseworker Name and Telephone Number _____
Name Telephone (w/ area code)

****

Previous School Information

Name of last school attended _____

District Name and Address _____

Years/Grades in Attendance _____

Has this student ever attended a Horseheads Central School District building before? _____ No _____ Yes (if yes, list dates and grade level below)

Horseheads building attended _____
building name dates grade levels

****

Parent/Guardian Statement

I understand that proof of New York State required immunizations for polio, mumps, measles, diphtheria, hepatitis, and rubella from a physician or clinic is required for admission to school. If there is a medical or religious exemption, statements of such must be presented. Failure to present either proof of immunization or exemptions will result in the exclusion of the pupil from school until such time as an appropriate immunization statement is submitted.
I certify that the information provided is accurate to the best of my knowledge and that I have legal custody of the above-named child.

Signature _____ **Date** _____

Please note: Proof of residency in the Horseheads district is required at the time of registration.

****

*** Below for District Use Only ***

Student ID _____

Building Assignment BF CS GR RR IS MS HS Other _____

Date Registration Form Rec'd _____

Grade _____ **HR** _____ **Cohort Year** _____ (High School only)

Date Student is Beginning School _____

Elementary Teacher _____

Date Records Requested _____

Secondary Counselor _____

Date Records Received _____

A.M. Bus _____ **P.M. Bus** _____

Parent presented the following documentation:

_____ Proof of Residency (two) _____
_____ Original Birth Certificate (reviewed by _____) initials
_____ Immunizations (must receive within 14 days)
_____ Lead Assessment Questionnaire (Pre-K and Kdg only)
_____ Dental Certificate (Pre-K and Kdg only)
_____ Custody Papers (if applicable)

_____
Building Staff Initials and Date

Please send copy of NSRF & HIF to Central Registrar (if student has an IEP, please also send copies to Student Services)
File originals in student permanent folder
Copy of BC, Immunizations, Lead Assessment, and Dental Certificate to Health Office

NSRF Rev 12/19/16
ESC/km

Horseheads Central School District
Household Information Form

Please list ALL children under 21 residing in the household, include date of birth and grade (if applicable).

Student Name (last, first, middle)	Date of Birth	Grade	Student Name (last, first, middle)	Date of Birth	Grade
1			4		
2			5		
3			6		

Please list the residential address and mailing address for the above children and please note that proof of residency in the Horseheads district is required at the time of registration.

Residence

house number street name apt or lot #

city state zip code

Mailing (if different from Residence)

house number street name apt or lot #

city state zip code

Is this address a temporary living arrangement? _____ No _____ Yes **If Yes, is this living arrangement due to loss of housing or economic hardship?** _____ No _____ Yes If both are yes, please complete a **Student Residency Questionnaire**.

Information on Adults who are living with children	1st Adult Guardian living at above address Primary Contact	2nd Adult Guardian living at above address Secondary Contact
Relationship to children (circle one)	Father Mother Step-Parent Other (specify)_____	Father Mother Step-Parent Other (specify)_____
Parent/Guardian Name (last, first)		
Landline Telephone	( ) -	( ) -
Cell Phone	( ) -	( ) -
Employer		
Work Telephone	( ) - ext	( ) - ext
E-mail Address		

If the natural mother and/or father do not live with the children at above address, please list their information below:

Parent/Guardian Information	1st Parent NOT living at above address	2nd Parent NOT living at above address
Relationship to children (circle 1)	Father Mother Step-Parent	Father Mother Step-Parent
Parent Name (last, first)		
Address (street address) (city, state, zip)		
Landline Telephone	( ) -	( ) -
Cell Phone	( ) -	( ) -
Employer		
Work Telephone	( ) - ext	( ) - ext
E-mail Address		
Is this parent allowed to have contact with children?	Yes No	Yes No
Should this parent receive mailings such as report cards?	Yes No	Yes No

Please also complete the reverse side

Emergency Contacts Other than Parents/Guardians

It is mandated, in case a parent or legal guardian cannot be reached during the school day, to give the names of two **nearby** relatives or reliable neighbors who will come for and take care of your child should he/she become ill or injured during the school day. All attempts will be made to reach parents first. If they are not reachable, the school will attempt to reach the emergency contacts below:

Adults other than Parents or Legal Guardians	**1st Emergency Contact**	**2nd Emergency Contact**
Emergency Contact Name (last, first)		
Landline Telephone	( ) -	( ) -
Relationship to children (i.e. grandparent, sitter, neighbor)		
Address (street address) (city, state, zip)		
Cell Phone	( ) -	( ) -

If you have any specific custody arrangements or issues that the Horseheads Central School district needs to be aware of, please use the space below to explain. Please note that you must provide proof of custody.

_____

_____

_____

Please list the name, date of birth and special needs (if any) of any child younger than Kindergarten living in your home:

_____

_____

_____

I certify that the information provided is accurate to the best of my knowledge and that I have legal custody of the above named children.

Parent/Guardian Signature _____ **Date** _____

The district is collecting your phone number for communications purposes. By providing phone number(s) on this document, you agree that the district may contact you by phone, text, or email (including auto-calls and auto-emails) regarding school emergencies, events, and other communications, including, but not limited to, attendance calls, lunch balance calls, and school event reminders.

Please note: Proof of residency in the Horseheads district is required at the time of registration.

Copies to: Parent (for other buildings if multiple children)
Central Registrar (from first building only)
Student Permanent Folder

HIF Rev 8/17/16
ESC/kp

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:

Horseheads Central School District

Parent Portal Registration

A Parent Portal account allows parents to electronically view their child's grades, assignments, and attendance from the SchoolTool website. **A valid email address is required.**

Please note: In order to sign up for the Parent Portal, you must visit the office of the school your child attends, complete this form and show proper ID. Thank you.

Date _____

Student Name _____ Grade _____

Student Address _____

house number street name apt or lot #

_____

City State Zip Code

Parent Name _____ Phone _____

E-Mail Address **(required)** _____

Parent Address (if different from student)

_____

house number street name apt or lot #

_____

City State Zip Code

User Authorization Agreement - Required

As a user of the Horseheads Central School District Parent Portal, I agree not to:

- Obtain unauthorized access to and use of an account for purpose other than those for which they were permitted to the user (do not share accounts).
- Read or use private files/data without proper authorization.
- Divulge the contents of any database holding personal and confidential information related to children, parents, or school business operations.
- Attempt, without authorization, to modify system software.
- Use the mail system to send, store or forward unsolicited, non-educational personal messages.
- Use another person's name to fraudulently send or receive messages.

I have read fully and agree to abide by the above:

Parent Signature _____ Date _____

For Office Use Only: Date _____ ID checked _____

Custodial or Non Custodial Staff Initials _____

Rev 11/7/14
ESC/kp

Horseheads Central School District

Bus Request Process for New Registrants

Welcome to the Horseheads Central School District!

In Horseheads, we provide busing to all those K-12 resident students who require transportation. Please submit the information below to inform us of your busing needs.

If at any time your transportation needs change, please notify the Transportation Department. We simply ask for 48 hours' notice in the event we need to adjust bus routes.

Parent/Guardian Name _____

Email Address: _____ Phone Number: _____

Check the appropriate box below:

☐ My child(ren) **will not** need busing in the _____ school year.

Children(s)' Name(s): _____

_____

-- If no busing is needed, your form is complete. Thank you. --

☐ My child(ren) **will** need busing in the _____ school year.

If you have more than one child needing transportation, please complete a form for each child.

Child's First and Last Name: _____

School _____ Grade _____

continued

Will this child need morning bus transportation to school? ☐ **Yes** ☐ **No**

If yes, will morning pickup be from the bus stop nearest to: ☐ Home Address ☐ Alternate Location

Please note: If pick up is at an alternate location, it must be within the district, and for elementary schools, it must be within the elementary school's boundaries.

Address for morning pickup: _____

_____

Will pickup at the bus stop for this location be every day of the week? ☐ Yes ☐ No

If no, which day(s) of the week will pickup be for this address?

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

If morning pickup is not every day of the week, please explain transportation for the days this student will not be picked up at this address (i.e. parent will transport, need transportation from another address, etc.).

_____

_____

_____

Will this child need afternoon bus transportation from school? ☐ **Yes** ☐ **No**

If yes, will afternoon dropoff be from the bus stop nearest to: ☐ Home Address ☐ Alternate Location

Please note: If dropoff is at an alternate location, it must be within the district, and for elementary schools, it must be within the elementary school's boundaries.

Address for afternoon dropoff: _____

_____

Will dropoff at the bus stop for this location be every day of the week? ☐ Yes ☐ No

If no, which day(s) of the week will dropoff be for this address?

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

If afternoon dropoff is not every day of the week, please explain transportation for the days this student will not be dropped off at this address (i.e. parent will transport, need transportation from another address, etc.).

_____

_____

_____

Questions or changes? Contact the Transportation Office by email or phone:
lboncirosplock@horseheadsdistrict.com, nbond@horseheadsdistrict.com, or eemanuel@horseheadsdistrict.com
607-739-6338

Health History for School Admission

Student Name:	DOB:
Affirmed (preferred) Name (if applicable):	
Sex Assigned at Birth: Female ☐ Male ☐	Gender Identity (if applicable): Female ☐ Male ☐ Nonbinary ☐ X ☐
Primary Care Provider:	Dentist:
Grade:	Date Form Completed:

The school nurse will require a copy of an up-to-date physical completed by a NYS provider on the NYS physical form and copies of immunization records.

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.

DOES OR HAS YOUR CHILD

General Health	NO	YES
Have an ongoing medical condition?	☐	☐
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Cystic Fibrosis ☐ Scoliosis ☐ Autism ☐ ADHD ☐ Mental Health Condition (Depression/Anxiety, OCD, ODD, etc.) ☐ Other: (Additional medical history can be listed on page 2)		
Take any medication?	☐	☐
If yes, please list name and reason for taking: (Additional medications can be listed on page 2)		
Ever had surgery?	☐	☐
If yes, please list: (Additional surgeries can be listed on page 2)		
Spent the night in the hospital?	☐	☐
If yes, why?		
Current injuries/restriction from activity?	☐	☐
If yes, why?		

DOES OR HAS YOUR CHILD

General Health	No	Yes
Have allergies?	☐	☐
If yes, check all that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other:		
Had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐
Has a bleeding disorder?	☐	☐
Have a kidney/urinary condition?	☐	☐
Have any problems with hearing or have congenital deafness?	☐	☐
Have any problems with vision or only have vision in one eye?	☐	☐
Brain/Head Injury History	**NO**	**YES**
Ever been told they had a concussion?	☐	☐
If yes, date of concussion:		
Receive treatment for a seizure disorder or epilepsy?	☐	☐
If yes, type of seizure: ☐ Tonic-Clonic ☐ Focal ☐ Absence ☐ Fever Date of last seizure:		
Ever had migraines?	☐	☐
Breathing	**No**	**Yes**
Ever been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐
Use an inhaler or nebulizer?	☐	☐

Please continue on page 2 ⇨

Student Name:		DOB:	

DOES OR HAS YOUR CHILD

Heart Health	No	Yes
Heart or blood vessel problem?	☐	☐

If yes, check all that apply:

☐ Chest Tightness or Pain ☐ Heart infection
☐ High Blood Pressure ☐ Heart Murmur
☐ High Cholesterol ☐ Low Blood Pressure
☐ New fast or slow heart rate ☐ Kawasaki Disease
☐ Followed by a cardiologist ☐ Has a pacemaker
☐ Has implanted cardiac defibrillator (ICD)

Other:

Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Digestive (GI) Health	No	Yes
Have stomach or other GI problems?	☐	☐
Have a special diet or need to avoid certain foods?	☐	☐
Has an eating disorder?	☐	☐

DOES OR HAS YOUR CHILD

Skin Health	No	Yes
Have any chronic skin conditions?	☐	☐

If yes, list:

Head, Ear, Nose, Throat	No	Yes
Frequent ear infections?	☐	☐
Recurring strep throat?	☐	☐
Devices / Accommodations	No	Yes
Use a brace, orthotic, wheelchair, or another device?	☐	☐
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wear a hearing aid or cochlear implant?	☐	☐
Has your child ever had speech therapy?	☐	☐
Does your child require any medical services at school?	☐	☐
Does your child have any other medical and/or emotional issues?	☐	☐

If YES to any questions, give details/additional information. Sign and date below.

I certify that the information provided is accurate to the best of my knowledge and that I have legal custody of the above-named child.

Parent/Guardian Signature:	Date:

Horseheads Central School District

*Child's Name*_____ *Date*_____

Parent/Guardian _____ *District RN Initials* _____

Lead Exposure Risk Assessment Questions

In addition to the required screening at ages one and two, assessments of risk for high-dose lead exposure should be done at least annually for each child six months to six years of age. The following questions serve as a risk assessment tool based on currently accepted public health guidelines. Children found to be at risk for lead exposure should receive a blood lead test whenever such risk is identified.

Risk Assessment Questionnaire	Yes	No
1. Does your child live in or regularly visit a house/building built before 1978 with peeling or chipping paint, or with recent, ongoing or planned renovations or remodeling Note: This could include a day care center, preschool, and the home of a babysitter or a relative.		
2. Has your family/child ever lived outside the United States or recently arrived from a foreign country?		
3. Does your child have a brother, sister, housemate or playmate being or treated for lead poisoning?		
4. Does your child frequently put things in his/her mouth such as toys, jewelry, or keys? Does your child eat non-food items (pica)? Note: Should emphasize the possibility of mouthing behaviors on toys due to the recent recalls.		
5. Does your child frequently come in contact with an adult whose job or hobby involves exposure to lead? Note: Jobs such as house painting, renovations, construction, welding or making. Hobby examples are making stained glass or pottery, fishing, making firearms and collecting lead figurines.		
6. Does your child live near an active lead smelter, battery recycling plant, or another industry likely to release lead or does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead? Note: May need to alert parent/caregiver if such an industry is local. Ask any additional questions that may be specific to situations in a particular community.		

If the answer to any of the above questions is YES, then the child is considered to be at risk of high dose lead exposure and should be screened with a blood lead test

This form was recreated with permission from the Chemung County Health Department 2/8/08 SS Form

CONSENT FOR RELEASE OF INFORMATION

HORSEHEADS CENTRAL SCHOOL DISTRICT
143 HIBBARD RD
HORSEHEADS, NY 14845

Student Name:	Date of Birth:	Gender: M F NB

This form permits the mutual exchange of information between the following parties:

Horseheads Central School District **143 Hibbard Rd.** **Horseheads, NY 14845**	**Medical Provider Name: _____** **Medical Office Name: _____** **Address: _____** **Phone Number: _____**

Extent or Nature of Information to be Released:

__ X___ Medical records and evaluations **__X___ Immunization records** **_____ Other (specify):_____**	

Purpose or Need for Information:

The information will be used in relation to services provided in the educational environment.

Acknowledgement of Terms of Release of Information:

1. **I understand that I may revoke this authorization at any time by notifying, in writing, either of the parties listed above; however, that revocation won't have any effect on any actions taken before the receipt of the revocation.**
2. **I acknowledge, and hereby consent, that the released information may contain alcohol, drug abuse, HIV testing, HIV results, or AIDS information. If I do <u>not</u> consent to the release of such information, I must initial here. _____ (Initials)**
3. **I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal medical privacy regulations.**
4. **I understand that the person or organization providing the information may not condition my treatment, payment for that treatment, enrollment or eligibility for benefits on my signing this authorization.**
5. **I understand that I may refuse to sign this authorization and that it is strictly voluntary.**

I hereby authorize the release of the information indicated above. I understand that the information to be released is confidential and protected from disclosure. If the signer is not the student, I further certify that I am the parent or legally appointed guardian of the student and have the authority to sign this release for the above-referenced student.

This consent to release information will be in effect until the student is no longer enrolled in the Horseheads Central School District or otherwise revoked, whichever is sooner.

Signature of student/person acting for student:	Relationship	Date Signed		

Revised
7/13/23

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors:Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

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

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

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

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.