



Dear Resident of the District:

Welcome to Schodack Central School District. Our district consists of two school buildings. Castleton Elementary School (CES) serves students in grades kindergarten-6. Maple Hill Jr./Sr. High School serves students in grades 7-12.

For any student, starting a new school environment can be stressful with new surroundings, new teachers and new friends. Our goal is to make this transition process as smooth as possible. Please take the time to review the registration packet. We ask for you to bring all necessary forms with you when you register. Our registration is a three-step process. The first step will be meeting with me to review all necessary documents. The second step, which often can be at the same time, will be a meeting at the actual building your child(ren) will be attending. The third step will be to establish residency (this needs to be completed three days of initial registration). Having all papers carefully filled out and with you will move the process along quickly.

Enclosed you will find a checklist of items required at the time of registration along with any forms you will need to fill out. Please call me when you are ready to register your child.

Sincerely,

Jill Hanrahan  
District Registrar  
518-732-4982

# SCHODACK CENTRAL SCHOOL DISTRICT

## REGISTRATION CHECKLIST

### Forms to be Provided/Completed for Registration

- **Registration Form**
- **2 Proofs of Residency (see attached note)**
- **Acceptable\*\* proof of Birth Date**
- **Authorization for Release of Records and Information**
  - It would be very helpful to have a copy of current schedule or most recent progress or report card for scheduling purposes.
- **Health Registration Forms**
  - Health History form
  - SCSD Health Office emergency card
  - Student's Immunization record (official record signed by physician) This document may be faxed directly from the physician's office for your convenience
  - Physical/Health Appraisal Form
- **Documentation relating to Special Circumstance**
  - If you are not the natural parent but have legal guardianship of the student, please provide us with any available relevant documents or complete a Custody Affidavit.
  - If there are any other special circumstances such as: custody agreements, orders of protection, etc., please bring those documents with you. They will be copied and filed in the student's records. The schools cannot refuse to release a child to a parent/legal guardian unless there are court documents on file. A parent's written or verbal instructions are not sufficient.

### If Relevant, Additional Documentation Needed for School Information

- **IEP (Individualized Education Plan) from previous school**
- **Home and Language Questionnaire**
- **Student Racial and Ethnic Identification**
- **Free/Reduced Lunch Forms**
- **HS Athletic Forms**
- **Others, please list: \_\_\_\_\_**

\*\*birth certificate, passport, driver's license, state or government issued identification, school photo identification, consulate identification card, hospital or health records, military dependent identification card, documents issued by federal, state or local agencies, court orders or other court issued documents, Native American tribal document or records from non-profit international aid agencies and voluntary agencies.

# Schodack Central School District -Registration Form

Today's date: \_\_\_\_\_ Start date: \_\_\_\_\_

## Student Information

Name: \_\_\_\_\_ Gender: M F

Home Street Address: \_\_\_\_\_

Mailing address (if different): \_\_\_\_\_

Date of birth: \_\_\_\_\_ Place of birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**Your answer below, for the living situation, will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act.**

Where is the student living? (Circle one that applies) 1. Permanent housing (own/rent) 2. Shelter  
3. with another family ("doubled up") 4. Hotel/Motel 5. Car, park, bus, train or campsite  
6. Temporary living situation (please describe): \_\_\_\_\_

Is this child in foster care or under supervision of Social Services? YES NO

If yes, is the DSS-2999 form provided? YES NO

Are there custodial issues (court papers) regarding your child? YES NO

\_\_\_\_ Custodial Papers Attached

Last school attended: \_\_\_\_\_

School Name

City/Town

Is your child under the Committee on Special Education (IEP)? Yes No

Does your child have a 504 Accommodation Plan? Yes No

Is your child receiving Academic Intervention Services? Yes No

Was your child ever retained? Yes No Grade \_\_\_\_\_

## Parent/Guardian Information

Mother/Female Guardian: \_\_\_\_\_ relationship to student: \_\_\_\_\_

Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Email address: \_\_\_\_\_

Father/Male Guardian: \_\_\_\_\_ relationship to student: \_\_\_\_\_

Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Email address: \_\_\_\_\_

Parents marital Status: (please circle) married divorce single widow separated

## Siblings

Name(s): \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Name(s): \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Name(s): \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

## Additional Household/Family Members

Name(s): \_\_\_\_\_

Office Use: CES Jr/Sr HS Grade: \_\_\_\_\_ Student ID #: \_\_\_\_\_ BUS: am: \_\_\_\_\_ pm: \_\_\_\_\_



### Proof of Residency

Any two (2) of the following items must be provided to establish residency. Both are required within 3 days of registration.

- **Utility Bill**-with current address and name of registrant
  - **House Deed**
  - **Mortgage Statement**
- **Sale Contract/Homeowners agreement**
  - **Property Tax Bill**
  - **Lease Agreement**
  - **Landlord Affidavit**
- **Driver's License with insurance card**

## **SCHODACK CENTRAL SCHOOL DISTRICT**

1477 South Schodack Road  
Castleton-on-Hudson, New York 12033

JASON M. CHEVRIER  
Superintendent  
518-732-2297

### **Schodack Central School District Health Services**

We would like to welcome you to the Schodack Central School District. In this packet you will find information and forms to be completed that will help us to ensure that your child will have a healthy experience at our school.

New York State Education Law requires that all newly entering students have up-to-date immunizations and a current physical. Attached are forms for your physician to complete. If needed, we can arrange for the physical to be done at school by the school doctor.

Also attached are a health history form for a parent/guardian to complete, information regarding medication at school, a medication administration form, and a Health Office Emergency Card to be completed by a parent/guardian. Should you need additional copies of any forms, they may be obtained through the school website, [www.schodack.k12.ny.us](http://www.schodack.k12.ny.us).

For students in grades 7-12 that are interested in participating in sports, please check the athletic portion of the website.

Please feel free to contact us at any time if you have any health-related concerns or questions. We look forward to getting to know your child and to provide for their health needs throughout their school career.

Thank You.

Heather Brewer, RN (Castleton Elementary School) – 518-732-7946 or at [hbrewer@schodack.k12.ny.us](mailto:hbrewer@schodack.k12.ny.us)

Betsy Croft, RN (Maple Hill Jr./Sr. High School) – 518-732-7701 or at [bcroft@schodack.k12.ny.us](mailto:bcroft@schodack.k12.ny.us)

## Health History to be Completed by Parent/Guardian

Has your child ever had: (please check)			STUDENT NAME _____		
	Yes	No		Yes	No
Allergies:	_____	_____	Elevated Blood Pressure	_____	_____
Medication Allergy	_____	_____	Head Injury/Concussion	_____	_____
Bee Sting Allergy	_____	_____	Heart Problems/Murmur	_____	_____
Food Allergy	_____	_____	Chest Pains	_____	_____
Environmental	_____	_____	Fainting Spells	_____	_____
Seasonal/Hay fever	_____	_____	Anxiety/Depression	_____	_____
Diabetes	_____	_____	Nose Bleeds/frequent or severe	_____	_____
Missing organs (eye, kidney, testicle)	_____	_____	Nose fracture	_____	_____
Bladder/Kidney problem or injury	_____	_____	Injury to Spleen	_____	_____
Ear Problems/Hearing Loss	_____	_____	Joint Sprain/Ligament tear	_____	_____
Eye Problems/Vision Loss	_____	_____	Muscle Pull	_____	_____
Ankle/Knee Pain/Injury	_____	_____	Fracture-Dislocation Bones/Joints	_____	_____
Neck/back Pain or Injury	_____	_____	Other Concern or Injury	_____	_____

If you answered "yes" to any of the above, please explain: \_\_\_\_\_  
 \_\_\_\_\_

### Does Your Child Have Any of the Following:

Has your child ever had an illness, condition or injury that required him/her to go to the hospital, either as a patient overnight or in the emergency room for x-rays; required an operation; caused your child to miss a game or practice? Please explain: \_\_\_\_\_  
 \_\_\_\_\_

Has your child been ill for five (5) consecutive days? Yes \_\_\_ No \_\_\_ Please explain: \_\_\_\_\_

Is your child under medical care now? Yes \_\_\_ No \_\_\_

Has your child taken any medication in the past year? Yes \_\_\_ No \_\_\_ If so, why? \_\_\_\_\_

Is your child taking medication now? Yes \_\_\_ No \_\_\_ If so, why? \_\_\_\_\_

Has your child ever fainted, felt dizzy or experienced chest pain during exercise? Yes \_\_\_ No \_\_\_  
 If so, explain \_\_\_\_\_

Has there ever been a sudden death in a family member under fifty (50) years of age? Yes \_\_\_ No \_\_\_

Does anyone in the child's family smoke? Yes \_\_\_ No \_\_\_ If so, whom? \_\_\_\_\_

Does your child have Orthodontic Appliances? (bridges, plates, capped teeth)? Yes \_\_\_ No \_\_\_

Does your child wear contact lenses or glasses? Yes \_\_\_ No \_\_\_

Since your child's last physical examination, has your child had any injury or medical illness? Yes \_\_\_ No \_\_\_  
 If so, please describe: \_\_\_\_\_

Date \_\_\_\_\_ Parent/guardian Signature \_\_\_\_\_

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**

**TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**

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

**STUDENT INFORMATION**

Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

**HEALTH HISTORY**

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

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

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

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> 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):  <5<sup>th</sup>  5<sup>th</sup>-49<sup>th</sup>  50<sup>th</sup>-84<sup>th</sup>  85<sup>th</sup>-94<sup>th</sup>  95<sup>th</sup>-98<sup>th</sup>  99<sup>th</sup> and >

Hyperlipidemia:  No  Yes      Hypertension:  No  Yes

**PHYSICAL EXAMINATION/ASSESSMENT**

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

System Review and Exam Entirely Normal

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

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

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

Additional Information Attached

<b>Name:</b>	<b>DOB:</b>
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**SCREENINGS**

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

**Recommendations:**

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

**Full Activity** without restrictions including Physical Education and Athletics.

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

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

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

**Other Restrictions:**

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

**Accommodations:** Use additional space below to explain

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

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

Explain: \_\_\_\_\_

**MEDICATIONS**

**Order Form for Medication(s) Needed at School attached**

**List medications taken at home:**

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**IMMUNIZATIONS**

Record Attached  Reported in NYSIS Received Today:  Yes  No

**HEALTH CARE PROVIDER**

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

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



**Schodack Central School District – Health Office Emergency Card**

Date \_\_\_\_\_

Name \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_  
Last First MI month/date/year

Student's Address \_\_\_\_\_ Student's Home Phone # \_\_\_\_\_

**Parent/Guardian – Relationship (Mother, Stepmother, Guardian, Other):**

Name \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Last First

Address \_\_\_\_\_ Home Phone # \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

**Parent/Guardian – Relationship (Father, Stepfather, Guardian, Other):**

Name \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Last First

Address \_\_\_\_\_ Home Phone # \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

Custodial concerns: \_\_\_\_\_ Yes \_\_\_\_\_ No (If yes, please furnish court papers)

**Emergency contacts if needed:**

	Name	Relationship	Home Phone	Cell Phone	Work Phone
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

Names and ages of school-age siblings: \_\_\_\_\_

Names of other individuals residing at this address: \_\_\_\_\_

Any childhood disease, injuries, operations or emotional concerns: \_\_\_\_\_

Is there any specific information you would like the nurse to have in regards to your child? \_\_\_\_\_

Family doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

If your child must be taken to the hospital, which do you prefer? \_\_\_\_\_

Current medications: \_\_\_\_\_

Known allergies: \_\_\_\_\_

School personnel (teachers, aides and bus drivers, etc.) will be informed of medical information as needed. Confidentiality will be protected. I hereby give the school authorities permission to arrange for emergency medical treatment as needed if the parent/guardian is not available. Please call us if we can help you any time. Thank you!

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_



# SCHODACK

## CENTRAL SCHOOL DISTRICT

### AUTHORIZATION FOR THE RELEASE OF STUDENT RECORDS

\_\_\_\_\_ (grade \_\_\_\_\_) has begun the registration process in the Schodack CSD  
(Student name)

**PLEASE SEND US ANY OF THE FOLLOWING INFORMATION THAT MAY BE AVAILABLE:**

1. Academic Records
2. Attendance Records
3. Health and Immunization Records
4. Individual Education Program (IEP) or 504 Plan (Confidential)
5. Psychological test results
6. Standardized/State Test Results
7. Science Labs

**PLEASE FORWARD INFORMATION TO THE CIRCLED LOCATION BELOW:**

CES	Maple Hill Jr./Sr. HS	PPS
Attn: Regina Maier	Attn: Mary Southard	Attn: Angie Beber
(518)732-7755 rmaier@schodack.k12.ny.us	(518)732-7701 (518)732-0494(fax) msouthard@schodack.k12.ny.us	(518)732-2523 (518)732-2184(fax) abeber@schodack.k12.ny.us

**Thank you.**

I hereby grant permission for \_\_\_\_\_ fax # \_\_\_\_\_ to  
release all medical and school records for my child \_\_\_\_\_ DOB \_\_\_\_\_.

\_\_\_\_\_  
(Signature of Parent/Guardian)

*For Office  
Use Only*

*Request for Records Sent to Former School* \_\_\_\_\_  
*Date Initials*