



Dear Parents/Guardians,

We would like to take this opportunity to welcome your family to the Schodack Central School District. Kindergarten is an exciting time for children. The Schodack Central School District has a comprehensive process for registration. Children must be five years of age on or before December 1, in order to register for kindergarten in the upcoming school year.

Castleton Elementary School offers a full-day kindergarten program. During the screening process you will have the chance to meet teachers and ask questions about the upcoming school year.

If you have any questions regarding the registration process, please feel free to contact the District's Registrar, Jill Hanrahan at (518)732-2523 or the elementary building principal, Mr. Derby at (518)732-7755.

The Schodack Central School District welcomes you and encourages you to become actively involved in our school community. If you have questions, please do not hesitate to contact us.

Sincerely,

James Derby
CES Principal

Jill Hanrahan
District Registrar

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.

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

Betsy Croft, RN (Maple Hill Jr./Sr. High School) – 518-732-7701 or at 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 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: <input type="checkbox"/> Female <input type="checkbox"/> Male | Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X | |
| School: | Grade: | Exam Date: |

HEALTH HISTORY

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

| | |
|------------------------------------|--|
| <input type="checkbox"/> Allergies | Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached |
| <input type="checkbox"/> Seizures | Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached |
| <input type="checkbox"/> Diabetes | Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached |

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

BMI _____ kg/m²

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

Hyperlipidemia: 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 |
| TB-PRN | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g}/\text{dL}$ |
| Sickle Cell Screen-PRN | <input type="checkbox"/> | <input type="checkbox"/> | | |

System Review Within Normal Limits

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

| | | | | |
|--|---|--|---------------------------------------|---|
| <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/Neck | <input type="checkbox"/> Skin | <input type="checkbox"/> Social Emotional |
| <input type="checkbox"/> Mental Health | <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* |
| <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No | Right | Left | Referral | Not Done | |
| Distance Acuity | | 20/ | 20/ | <input type="checkbox"/> Yes | <input type="checkbox"/> | |
| Near Vision Acuity | | 20/ | 20/ | <input type="checkbox"/> Yes | <input type="checkbox"/> | |
| Color Perception Screening | | <input type="checkbox"/> Pass <input type="checkbox"/> Fail | | | <input type="checkbox"/> | |
| 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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail | Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail | Referral <input type="checkbox"/> Yes | | <input type="checkbox"/> | |
| Notes | | | | | | |
| Scoliosis Screening: Boys grade 9, Girls grades 5 & 7 | | Negative | Positive | Referral | Not Done | |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> | |
| FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK | | | | | | |
| <input type="checkbox"/> *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act | | | | | | |
| <input type="checkbox"/> Student may participate in all activities without restrictions. | | | | | | |
| If Restrictions Apply – Complete the information below | | | | | | |
| <input type="checkbox"/> Student is restricted from participation in: | | | | | | |
| <input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. | | | | | | |
| <input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball. | | | | | | |
| <input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. | | | | | | |
| <input type="checkbox"/> Other Restrictions: | | | | | | |
| Developmental Stage for Athletic Placement Process <u>ONLY</u> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V | | | | | | |
| <input type="checkbox"/> 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 | | | | | | |
| <input type="checkbox"/> Order Form for medication(s) needed at school attached | | | | | | |
| COMMUNICABLE DISEASE | | | | IMMUNIZATIONS | | |
| <input type="checkbox"/> Confirmed free of communicable disease during exam | | | | <input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS | | |
| HEALTHCARE PROVIDER | | | | | | |
| Healthcare Provider Signature: | | | | | | |
| Provider Name: <i>(please print)</i> | | | | | | |
| Provider Address: | | | | | | |
| Phone: | | | | Fax: | | |
| Please Return This Form to Your Child's School Health Office When 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: Jill Hanrahan |
| (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) jhanrahan@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