SYRACUSE CITY SCHOOL DISTRICT
Jaime Alicea, Superintendent of Schools

Department of Student Registration **Akua A. Goodrich, Director**

Dear Parent or Person in Parental Relation:

Thank you for your interest in the Syracuse City School District. Please provide the following information along with the attached registration paperwork so that we may enroll your child in the District's schools.

PROOF OF RESIDENCY:

Please submit evidence of you and your child's physical presence in the school District. This evidence may include:

1) A copy of a residential lease or proof of ownership of a house or condominium, such as a deed or mortgage statement;
2) A statement by a third-party landlord, owner or tenant from whom the parent(s) or person(s) in parental relation leases or with whom they share property within the District, which may be either sworn or unsworn; or
3) Such other statement by a third party establishing the parent(s)' or person(s) in parental relation's physical presence in the District.

If the documentation listed above is not available, the District will consider other forms of documentation, which may include, but will not be limited to:

- pay stub;
- income tax form;
- utility or other bills;
- membership documents (e.g., library cards) based upon residency;
- voter registration document(s);
- official driver's license, learner's permit or non-driver identification;
- State or other government issued identification;
- documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement); or

evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers.

The District may also require the parent(s) to provide an affidavit either:

1) indicating that they are the parent(s) with whom the child lawfully resides; or

2) indicating that they are the person(s) in parental relation to the child, over whom they have total and permanent custody and control, and describing how they obtained total and permanent custody and control, whether through guardianship or otherwise.

The District will also accept other proof, such as documentation indicating that the child resides with a sponsor with whom the child has been placed by a federal agency.

PROOF OF AGE:

The District will require documentation and/or information establishing your child's age. Please supply a certified transcript of a birth certificate or record of baptism (including a certified transcript of a foreign birth certificate or record of baptism) giving the date of birth. Where this documentation is not available, a passport (including a foreign passport) may be used.

Where birth certificate or passport is not available, the District may consider certain other evidence, which has been in existence two years or more. Other evidence may include, but will not be limited to, the following:

- official driver's license;
- state or other government issued identification;
- school photo identification with date of birth;
- consulate identification card;
- hospital or health records;
- military dependent identification card;
- documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement);
- court orders or other court-issued documents;
- Native American tribal document; or

records from non-profit international aid agencies and voluntary agencies.

EVIDENCE OF IMMUNIZATIONS & PHYSICAL:

In accordance with New York State's Public Health Law, the District must also receive evidence that your child has been immunized in accordance with the New York State Department of Heath Immunization Bureau's Immunization Requirements for School Entrance/Attendance. These records will be necessary to ensure your child's continued attendance. Additionally, please provide us with records of any recent physical examination your student has received. New York State mandates that each new student entering a public school is required to have a physical examination upon entering the District. A physical completed no more than twelve months before the first day of the school year in question will meet this requirement.

NOTICE OF RIGHTS REGARDING REFERRAL FOR EVALUATION FOR SPECIAL EDUCATION:

If you suspect that your child is in need of special education services or programs, you may refer your child to the District's Committee on Special Education for evaluation. The referral should be made to the **Director of Special Education**, at the following address: **Syracuse City School District, Department of Special Education, 725 Harrison Street, Syracuse, New York, 13210**. The New York State Education Department website has information regarding this process and your rights. A copy of the Parent Guide to Special Education may be obtained from the following website or upon your written request to the Department of Special Education.

http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm
http://www.p12.nysed.gov/specialed/publications/policy/spanishparentguide.htm

If you have any questions with respect to this information, please contact the Department of Student Registration at (315) 435-4545. Thank you.

Sincerely,

Jaime Alicea
Superintendent of Schools

SYRACUSE CITY SCHOOL DISTRICT
Department of Student Registration
Jaime Alicea, Superintendent of Schools

REGISTRATION REQUIREMENTS

The Syracuse City School District requires parents or persons in parental relation to provide the following documentation when registering a child for school:

A. Proof of Address (1 document required)

The Syracuse City School District requests submission of one proof of address. The item must include the name of a parent or guardian and must be dated within 30 days prior to registration.

1. A copy of a residential lease or proof of ownership of a house or condominium, such as a deed or mortgage statement; or
2. A statement signed by a third-party landlord, owner, or tenant from whom the parents or person(s) in parental relation leases or with whom they share property within the District, which may be either sworn or unsworn; or
3. Some other signed statement from a third party establishing the parent(s)' or person(s) in parental relation's physical presence within the District

PLEASE NOTE: If the documentation listed above is not available, the District will consider other documentation of residency, which may include, but will not be limited to the following:

- Pay stub
- Income tax form
- Utility or other bills
- Membership documents based on residency
- Voter registration documents
- Official driver license, learner permit, or non-driver identification;
- State or other government issued identification or documents relating to government services or benefits
- Documents issued by federal, state or local agencies (e.g. local social service agency, federal Office of Refugee Resettlement)
- Evidence of custody of the child, including, but not limited to judicial custody orders or guardianship papers

IMPORTANT NOTE: EVIDENCE OF CUSTODY OR GUARDIANSHIP

The District may also require parent(s) or persons in parental relation to provide an affidavit either:

1. indicating that they are the parent(s) with whom the child lawfully resides; or
2. indicating that they are the person(s) in parental relation to the child, over whom they have total and permanent custody and control, and describing how they obtained total and permanent custody and control, whether through guardianship or otherwise.

The District will also accept other proof, such as documentation indicating that the child resides with a sponsor with whom the child has been placed by a federal agency, if applicable.

B. Proof of Age (1 document required)

1. A **certified transcript of a birth certificate** or **record of baptism**, including a certified transcript of a foreign birth certificate or certificate of baptism.
2. *If* a certified transcript of a birth certificate or record of baptism is not available, *then* the District will accept a **certified passport**, including a foreign passport, to establish the child's age.
3. *If* neither a certified transcript of a birth certificate or record of baptism, or a passport, is available, *then* the District will consider **other documentation**, including but not limited to the types in this list, provided that those documents have been in existence for two (2) years or more:
    - Official driver's license for the child;
    - State or other government issued identification;
    - School photo identification with date of birth;
    - Consulate identification card;
    - Hospital or health records;
    - Military dependent identification card;
    - Documents issued by federal, state or local agencies (e.g. local social service agency, federal Office of Refugee Resettlement);
    - Court orders or court-issued documents;
    - Native American tribal documents; or
    - Records from non-profit international aid agencies and voluntary organizations.

C. Physical and Immunization Records

The District must obtain proof of immunization, as required by Section 2164(7) of the New York State Public Health Law, or lawful exemption from that requirement, before a student may attend school.

Those requirements can also be reviewed in Board Policy 7022. Therefore, the District requires the following:

- Physical Exam Records (signed by a physician or clinical staff)
- Up-to-Date Immunizations

IMPORTANT NOTE: The District may exclude any student who has not received the required immunizations. The District requests that families provide a copy of an appointment card or letter with the appointment date(s) if the student is not up-to-date on their immunizations. The District may also exclude an enrolled student from attending school when the student has a communicable or infectious disease that imposes a significant risk of infection of others, as required by Section 906 of the New York State Education Law.

Students are allowed 14 days from the date they start school to receive the necessary immunizations before being excluded from school. Refugee students and students from out-of-state are allowed 30 days, when the district receives documentation of a Good Faith Effort (GFE) such as an appointment card or other statement from the provider's office that includes the appointment date.

D. Additional Documentation

The Syracuse City School District requests submission of the latest report card or transcripts for children entering grades 1 through 12. A current Individualized Education Program (IEP) should be submitted for all children who receive special education services. This enables the district to ensure appropriate grade level placement, and the provision of services and supports to meet the individualized needs of each child. If this information is not available at the time of registration, the district will request records from the previous school of enrollment to obtain the required documentation.

SYRACUSE CITY SCHOOL DISTRICT

Department of Student Registration

Jaime Alicea, Superintendent of Schools

McKinney–Vento Act
Notice Housing Questionnaire PreK-12

STUDENT INFORMATION Last Name	First Name	Middle Name

Current School	District of Origin	Grade

Student ID#	DOB	Gender
		☐ Male ☐ Female ☐ Other

New PHYSICAL Address	Mailing Address

Yes	No		Parent, Guardian, Unaccompanied Student Name	Phone
☐	☐	Is the entire family at the new PHYSICAL address?		
☐	☐	Have you notified the school of siblings?	**Date Transportation Notified**	
☐	☐	Is the current address a temporary living arrangement?		
☐	☐	If YES, is this due to loss of housing or economic hardship?	***Student automatically qualifies for Free School Meals**	

HOUSING: Where is the student currently living? (Please check one box).

- ☐ **Shelter (S)**
- ☐ **Doubled-up (D)**
  With another family or other person because of a loss of housing, economic hardship or similar reason (also called temporarily living)
- ☐ **Hotel or motel (H)**
- ☐ **Other Temporary Living Situation (O)**
  In a car, park, bus, train station, campsite, or public or private place not designed for, or ordinarily used as a regular sleeping accommodation for human beings
- ☐ **Permanent Housing (P)**
- ☐ **CPS Direct Placement**
- ☐ **Respite (Please select which below)**
  - ☐ *Family Support Center (960 Salt Springs Road)*
  - ☐ *Child and Adolescent Crisis Respite (650 Madison Street)*

If the student is NOT living in Permanent Housing (P), please also indicate if the below applies:

- ☐ **Unaccompanied youth (U)**
  Any age, not accompanied by a guardian

SIBLINGS: Are all siblings at same address? ☐ Yes ☐ No

1	Sibling Name		
	School	School Notified? ☐ Yes ☐ No	
	Current Physical Address		
	Same Address? ☐ Yes ☐ No	☐ Permanent	☐ Temporary
2	Sibling Name		
	School	School Notified? ☐ Yes ☐ No	
	Current Physical Address		
	Same Address? ☐ Yes ☐ No	☐ Permanent	☐ Temporary
3	Sibling Name		
	School	School Notified? ☐ Yes ☐ No	
	Current Physical Address		
	Same Address? ☐ Yes ☐ No	☐ Permanent	☐ Temporary
4	Sibling Name		
	School	School Notified? ☐ Yes ☐ No	
	Current Physical Address		
	Same Address? ☐ Yes ☐ No	☐ Permanent	☐ Temporary

SCHOOL AND AGENCY STAFF: Email this form and STAC 202 to Registration@scsd.us and cc: dmontroy@scsd.us

Name (Person Completing this Form): _____ **Date:** _____

Agency: _____ **Phone:** _____

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:

SYRACUSE CITY SCHOOL DISTRICT

Jaime Alicea, Superintendent of Schools

Department of Student Registration **Akua A. Goodrich, Director**

Request for Records

Date: _____

The student named below has entered our school district.

Name: _____ Date of Birth: _____Grade: _____

Releasing School:	**Requesting School:**
School: _____	Syracuse City School District – Registration Center
Address: _____	Name of Registrar:_____
Phone: _____	Phone: (315) 435-4545
Fax: _____	Fax: (315) 435-6210

Please fax or mail the following records for enrollment:

1. **Current transcript**
2. **Grades at time of withdrawal**
3. **Summer school grades**
4. **Report cards from prior schools**
5. **Standardized/State test scores**
6. **Birth certificate**
7. **Immunizations and latest physical**
8. **Discipline Records**
9. **Special Education Records, if applicable:**
   - A. Current IEP
   - B. Latest psychological report
   - C. 504 (active or inactive**)**
   - D. Speech evaluation
   - E. Social history
   - F. Related services report
   - G. If declassified, what test mods continue

Parent/Guardian Consent:

My consent is given for academic records and/or all other pertinent information to be released to the Syracuse City School District. All information obtained will be kept strictly confidential. I give permission for Syracuse City School District to obtain verbal clarification on any information received**. According to the Final Regulations-Family Education Rights and Privacy Act (Buckley Amendment) dated June 17, 1976, it is no longer necessary to obtain written consent to release records between schools.**

This student qualifies under McKinney Vento ☐ Yes or ☐ No (please check box). Per M-V Section 722 (g)(3)(c); N.Y. Education Law Subsection 3209 (2)(3)-(f) within five (5) days of receiving a records request from the new school, the District in which the student was last enrolled must forward all records to the new school.

Print Name – Parent/Guardian

Signature – Parent/Guardian

Parent/Guardian Phone Number:

SYRACUSE CITY SCHOOL DISTRICT
Jaime Alicea, Superintendent of Schools

Health Services

Dr. Ted Triana, Director of Health Services

Dear Parents/Guardians:

We look forward to welcoming your child to a new school year. We are writing to inform you of a change in New York State Department of Health law. As of **September 2018, New York State requires each student have a current physical examination upon entering school at Pre-K or K, if they are new to the school district, and at grades 1, 3, 5, 7, 9 and 11.** If they play sports or need working papers, they must also have a current physical exam. Your own family doctor should do the exam. They know your child well and can measure any changes in your child's health. If needed, they can do referrals for glasses, dentist, etc., at the same time.

Effective **July 1, 2018, New York State has a new form** that should be used to record the physical exam. A copy of this form is enclosed. The medical provider may complete the form electronically or by hand. Please bring it to the nurse's office when you bring your child to school.

A **current physical exam** is defined as an exam dated not more than twelve months prior to the commencement of the school year in which the examination is required. For example, if the school year begins on September 3, 2018, any physical exam conducted on or after September 3, 2017 is valid. An exam completed prior to this date is considered invalid and your child will need a new exam. We understand that some children may not receive their yearly medical exam until after school starts. You can send a copy to the nurse when it is completed. Please call your doctor now to make an appointment.

If you or your child needs health insurance including Medicaid, Medicaid Managed Care, or Child and Family Health Plus, please call the Salvation Army (315-476-1382) or ACR Health (315-475-2430). You will get the assistance of a "navigator" to help you sign up. Benefits include doctor visits; hospital and emergency care; vision, speech and hearing services; prescriptions; mental health; and, in some cases, dental care.

The Health Services Department appreciates your cooperation as we implement this new requirement. For further information or assistance, please contact your school nurse, or the Health Services Office at 435-4145.

SYRACUSE CITY SCHOOL DISTRICT
Health Services
Jaime Alicea, Superintendent of Schools

PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE)

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** ☐ **M** ☐ **F** **Grade:** _____ **Date of Physical Examination:** _____

IMMUNIZATIONS/HEALTH HISTORY

☐ Immunization record attached
☐ No immunization given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen:	☐ Positive	☐ Negative	☐ Not done Date: _____
PPD:	☐ Positive	☐ Negative	☐ Not done Date: _____
Elevated Lead:	☐ Positive	☐ Negative	☐ Not done Date: _____
Dental Referral:	☐ Positive	☐ Negative	☐ Not done Date: _____

Significant Medical/Surgical History: ☐ See attached _____

Specify Current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other _____

Allergies: ☐ LIFE THREATENING ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____
☐ Seasonal ☐ Medication: _____ _____

PHYSICAL EXAM

Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Date of Exam:** _____

Body Mass Index: _____ _____. _____				Referral
Weight Status Category (BMI Percentile):	**Vision** – without glasses/contact lenses	R	L	
☐ less than 5th ☐ 5th – 49th ☐ 50th – 84th	**Vision** – with glasses/contact lenses	R	L	
☐ 85th – 94th ☐ 95th – 98th ☐ 99th + higher	Vision – Near Point	R	L	
	Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ EXAM ENTIRELY NORMAL **Tanner:** I. 11. 111. 1V. V. **Scoliosis:** ☐ Negative ☐ Positive: _____
Specify any abnormality _____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications _____
Name: _____ Dosage/Time: _____
Name: _____ Dosage/Time: _____
Duration of Med order*: ☐ school year ☐ other, please specify: _____
Reason for Med order/Diagnosis* _____
I assess this student to be self-directed ☐ Yes ☐ No
Student may self carry and self administer medication ☐ Yes ☐ No
Student may self carry and self administer medication on a field trip ☐ Yes ☐ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK QUALIFICATION/CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:** _____ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball
_____ Non-contact: badminton, bowl, golf, swim, table tennis, archery, weight train, crew, dance, track, run, walk, rope jump
☐ **Specify medical accommodations needed for school:** _____ ☐ **None**
☐ **Known or suspected disability:** _____
☐ **Restriction:** _____
☐ **Protective equipment required:** ☐ **Athletic Cup** ☐ **Sport goggles/impact resistant eyewear** ☐ **Other:** _____

Provider's Signature: _____ NYS License #*_____

Provider's Name/Address: _____ Phone: _____ Fax: _____

Provider's Stamped Information:
*Required *This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director*

SYRACUSE CITY SCHOOL DISTRICT
Health Services
Jaime Alicea, Superintendent of Schools

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO SCHOOLS

Please sign this so that we may get health information from your child's doctor.

Student Name: _____DOB: _____ Date: _____

As the parent/guardian of the child named, the completion of this form authorizes your doctor, _____ to disclose your child's confidential health-related information to his or her school.

(Name of Doctor)

The purpose for disclosing this information is to promote the accurate exchange of health information and for the coordination of care and treatment with the child's school. This is important information for many reasons. For example the school may need to know this information in order to give medications, monitor the child's illness, and keep track of immunizations.

This authorization limits the disclosure of information to the following:

- ☐ Immunization information
- ☐ Physical exam reports
- ☐ Laboratory tests
- ☐ Medications and treatments

This authorization form does not allow the disclosure of confidential health information that is given special protection under the law. This includes HIV-related information, substance abuse information, psychiatric information and genetic information; the disclosure of this information requires a different specific form.

The information will be disclosed to the school in the school district indicated below until you tell us that the child is no longer an enrolled student at the school. You may revoke this authorization at any time by notifying the child's healthcare provider in writing. Revoking this authorization means that we will no longer disclose the child's information to their school. The child's healthcare will not be affected if you do not authorize us to disclose their information to the school. In other words, we will not refuse your child treatment if you do not sign this authorization. The information we disclose to the school may be redisclosed to others by the school if the school is not required under law to protect the confidentiality of this information. You will be given a copy of this completed authorization to keep for your records.

Child's Name (print)	Date of Birth
Parent/Guardian's Name (print)	Relationship
Parent/Guardian's Signature	School

Please return to School Nurse

Syracuse City School District Health Services **Phone (315) 435-4145** **Fax (315) 435-4859**

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

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

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

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

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

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

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

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HgbA1c results: _____ Date Drawn: _____

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

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and<

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

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

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

☐ **System Review and Exam Entirely Normal**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

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

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

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

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

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

- ☐ **No Contact Sports** — **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** — **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

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

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

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

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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

SYRACUSE CITY SCHOOL DISTRICT
Health Services
Jaime Alicea, Superintendent of Schools

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination upon entering school at Pre-K or K, if they are new to the school district, and at grades 1,3,5,7,9, & 11. Please complete Section 1 and **take this form to your dentist for an assessment**. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date:	Sex: ☐ Male ☐ Female	Will this be your child's first visit to a dentist? ☐ Yes ☐ No
School:		Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date _____

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address **(please stamp)** Dentist's Signature

_____ _____

Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems

FACILITIES OFFERING DENTAL SERVICES

Provider	**Address**	**Telephone**
Loretto Geriatric Center	700 E. Brighton Ave.	(315) 469-5561
St. Joseph's Hospital Health Center	301 Prospect Ave.	(315) 448-5477
Syracuse Community Health Center	819 S. Salina St.	(315) 476-7921
Syracuse Community Health Center	1938 E. Fayette St.	(315) 474-4077
Syracuse Community Health Center	603 Oswego St.	(315) 424-0800
University Hospital SUNY Health Science Center	750 E. Adams St.	(315) 464-4320