Moriah Central School District
Home of the Vikings

39 Viking Lane, Port Henry, New York 12974 518-546-3301 Fax 518-546-7895

Parents must provide the following to complete registration.

The parent/legal guardian must be present at the time of registration.

- **Proof of Residency-** NYS Commissioner's Regulation § 100.2(y) requires that individuals requesting enrollment prove that they are residents of the district. You will need to provide three current documents showing residency within the Moriah Central School District boundaries.

  Acceptable forms of documentation regarding residency status are of the following:
  - Your lease/rent receipt, deed, or mortgage statement for where you reside.
  - A utility bill, in your name, dated in the last 60 days.
  - A current property tax bill for your residence.
  - A non-expired official New York State driver's license, non-driver identification card, or a learner's permit.
  - A non-expired State, city, or other government issued identification which includes your address of residence.
  - An income tax form for the last calendar year.
  - Official payroll documentation from your employer, dated within the past 60 days. This can be a pay stub or a payroll receipt with your home address on it.
  - Voter registration documents, which includes your name and the address of residence.
  - Evidence of custody of your child, including custody orders or guardianship papers. These documents must have been issued within the past 60 days and must include the name of your student as well as your home address.
- **Proof of your student's age**
  - birth certificate, passport, or record of baptism.
- **Proof of Immunization-** New York State law requires proof of state mandated immunizations at the time of registration for all new or re-entering students to the district. No student may be allowed to start school without an Immunization Record on file.
- **Report Card/Transcript from last school attended.** If applicable,
  - Most current report cards, standardized testing results. Most current Individualized Education Program (IEP) or 504. Name of school(s), contact information including phone/fax numbers and address.
- **Evidence of custody of the child**,
  - **If Applicable-** including but not limited to judicial custody orders or guardianship papers; documents must include name of student and address of residence.

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Registration Form

District Use Only: **Student ID**_____ **Enter date**_____

Placement: Grade_____ Teacher_____

Documentation:

◯ New student ◯ Returning student ◯ School records received ◯ CSE ◯ CSE records received.

◯ Proof of Age ◯ Proof of residency ◯ Physician Physical ◯ Immunization records

◯ Foster care ◯ Guardianship/custody paperwork (if applicable)

STUDENT INFORMATION

Last: (Legal name only):	First:	Middle:	Suffix:	Gender: ◯ Male ◯ Female
Other name(s) used previously (AKA):	Nickname:	DOB:	Place of birth	

Ethnicity: ◯ American Indian/Alaskan Native ◯ Asian ◯ Black/African American ◯ Hispanic/Latino ◯ White/Caucasian ◯ Native Hawaiian/Pacific Islander

PARENT/GUARDIAN INFORMATION

Indicate child's primary residency if not with both parents. Documentation of legal custody must be provided.

Father/Guardian ◯ Primary Residence	Mother/Guardian ◯ Primary Residence
Name:	Name:
Address:	Address:
Mailing Address (if different)	Mailing Address (if different)
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email:	Email:
Place of Employment:	Place of Employment:

FOSTER CARE PLACEMENT-complete this section only if child is in foster care

Foster Parent name:	Relationship to child:	Phone: ◯ work ◯ cell	Phone: ◯ work ◯ cell
Address:			
Child' School District of Origin:			
Agency placing child:		Date Child was placed:	
Name of agency caseworker assigned to the child:		Phone:	
School last Attended:	School Address:		

STUDENT RESIDENCY QUESTIONNAIRE

Note: The questions in this section are used to help identify students in homeless situations as required by the McKinney-Vento Homeless Assistance Improvements Act, 42U.S.C. 11435. Answers to this residency information help determine the services the student may be eligible to receive.

Is your current address a temporary living arrangement? ◯ Yes ◯ No	Is this temporary living arrangement due to loss of housing or economic hardship? ◯ Yes ◯ No

If you answered YES to the above questions, please complete the Student Residency Questionnaire available from the school office.

SIBLINGS

Name	Gender: M/F	Date of Birth	Grade	Full/Half/Step	Residence
					◯ Home ◯ Other
					◯ Home ◯ Other
					◯ Home ◯ Other
					◯ Home ◯ Other
					◯ Home ◯ Other
					◯ Home ◯ Other
					◯ Home ◯ Other

OTHERS IN HOUSEHOLD

Name	Date of Birth	Relationship to Child

EMERGENCY CONTACTS

Person or relative who we can contact if you are not reachable by phone.

Name	Adress	Phone	Relationship to Child
		Home: Cell:	
		Home: Cell:	
		Home: Cell:	
		Home: Cell:	
		Home: Cell:	

HAS YOUR CHILD EVER ATTENDED MORIAH CENTRAL SCHOOL? ◯ Yes ◯ No Last date attended:

Please list all previous schools attended including preschool

School Name	Year	Adress	Phone

Moriah Central School

Protocol for admitting a transfer Student

When a parent requests placement of a new student as a transfer, the following steps will be followed:

Student Name: _____ Grade: _____ Placement: _____

- **First day sheets will be completed, and the parent will be given a copy of the school handbook, a current calendar, a records release sheet to be signed by the parent/guardian, a proof of district residency form and brief tour of the school <u>if possible.</u>**

  Responsibility: Secretary/Principal_____ Date: _____

- **Student records will be received and reviewed for the purpose of establishing a placement.**

  <u>General Education Placement</u>
  Responsibility: Principal_____ Date _____

  <u>Special Needs Placement</u>
  Responsibility: CSE Chair_____ Date_____

- **Upon placement, the arrival of the new Student and placement will be announced to all pertinent**
- **staff by way of e-mail.**
- **Once we have contact information and Emergency contacts on file it will be added to Schooltool.**

  Responsibility: Secretary_____ Date _____

- **On the first day of entry, the student will be directed to the Nurses office. Health Records will be entered and checked for their completeness and compliance with state and district mandates.**

  Responsibility: Nurse_____ Date _____

- **Within five days of entry, the transfer student will be screened for possible speech impairments, and/or motor development difficulties.**

  Responsibility: Speech Therapist_____ Date _____
  Occupational and/or Physical Therapist _____Date_____

- **Within five days of entry, a transfer student entering the general education program will be given a screening in the area of reading and math to determine a grade equivalent. Classroom teachers will assess a new entrant's writing skills and make recommendations to the AIS Committee if the entrant's writing skills indicate a need for remediation.**

  Responsibility: Reading Specialist_____ Date _____

  Classroom Teacher_____ Date_____

  Math Specialist_____ Date_____

  Classroom Teacher_____ Date_____

Dear Parents,

Please complete the information below and return to the elementary office.
** Pre-K parents - the afternoon information will be used for your child's dismissal tag, so please ensure that the information given is accurate!

Thank you for your cooperation!

In the morning, my child will be: ☐ **Dropped off by a parent**

☐ **Will be picked up by the bus at the following location:**

Name: _____

Address: _____

Phone: _____

At dismissal time, my child will be: ☐ **Picked up by a parent**

☐ **Will ride the bus to the following location:**

Name: _____

Address: _____

Phone: _____

☐ **Will attend the afterschool program**

** Please note – your child must have already signed up and have been accepted to attend the afterschool program. This program takes children in grades Kindergarten - 6th grade.

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

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

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

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

Home Language Questionnaire (HLQ)

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

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

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

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

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

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

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

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

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

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

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

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

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

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

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

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

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

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

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

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

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

**DATE OF INDIVIDUAL INTERVIEW: _____ MO DAY YR.	OUTCOME OF INDIVIDUAL INTERVIEW: ❑ ADMINISTER NYSITELL ❑ ENGLISH PROFICIENT ❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ MO. DAY YR.

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

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

Moriah Elementary School

Registration Form Questions

For students entering Pre-Kindergarten or Kindergarten Screening

Please complete the questionnaire in this packet. Our district will use this information to ensure continuation of resources and support for our school. Your participation will help to bring necessary services to our school.

- Your child's Pediatrician:

  Name:

  Address:

  Phone: Fax:

- How many people reside in your household? _____

- What is your annual Household Income?

Please check the appropriate box:

- ☐ 0-11,770
- ☐ 11,771-15,930
- ☐ 15,931-20,089
- ☐ 20,090-24,249
- ☐ 24,250-24,809
- ☐ 24,810-32,569
- ☐ 32,570-36,729
- ☐ 36,730-40,889
- ☐ 40,890-45,049
- ☐ 45,050-49,203
- ☐ 49,204-or more

- Did your child participate in:

Preschool	☐ Yes	☐ No	
Pre-Kindergarten	☐ Yes	☐ No	
Head-start	☐ Yes	☐ No	
Daycare	☐ Yes	☐ No	
Was the daycare registered?	☐ Yes	☐ No	☐ unsure

- Does your child have an IEP through CPSE or early education services: ☐ Yes ☐ No

Thank you for your participation!

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at the top page of registration materials that the district shares with families. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the **student is not required to submit proof of residency** and other required documents that may be part of the registration packet.

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: Moriah Central School

Name of Student: _____
Last First Middle

Gender: Male Female Non-binary

Date of Birth: ____/____/____ (Month / Day / Year)

Grade: ____ (preschool-12)

ID#: _____ (optional)

Address: _____

Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

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

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____
- ☐ In permanent housing

_____ _____

Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____

Date

If **ANY box other than "In Permanent Housing" is checked**, then the student/family should be immediately referred to the MV Liaison. In such cases, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled**. **After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

Rev. 9-28-21

Moriah Elementary School

39 Viking Lane, Port Henry, New York 12974 Fax 518-546-7895

Carrie Langey, Principal
518-546-3301 ext.1120
Michael Dinsmore, CSE Chairperson
518-546-3301 ext. 3515

Chynna Allen, Elementary Secretary
518-546-3301 ext. 1118
Lori Cowin, Elementary Nurse
518-546-3301 ext.1114

Medical Information (to be completed by parent/guardian)

Student Information Student ID # *(District Use only)* _____

Legal Name: _____
Last First Middle

Date of Birth: _____ Age: _____ Place of Birth: _____

Birth Certificate **must be provided for verification*

Gender: ☐ Male ☐ Female Anticipated Year of Graduation: June of

Parent/Guardian:
(person completing this form)

Physician Name_____
Address Phone #

Last physical date: Upcoming physical date:

Immunizations: *Please attach a copy of your child's most recent immunization records from the physician.*

Has your child ever had:

Allergies: ☐Yes ☐No
Type of allergy: ☐ Food ☐environmental ☐ insect ☐ medication ☐ other_____
Reaction: ☐ Anaphylaxis ☐ Difficulty Breathing ☐ Hives ☐ Rashes ☐ Vomiting ☐ Other_____
Does your child require medication for this allergy? ☐Yes ☐ No Medication: _____
Has your child ever needed to use this medication? ☐Yes ☐ No When? _____
Required hospitalizations due to an allergic reaction: ☐Yes ☐No Dates: _____
Specialist Name/Address Phone #

Asthma: ☐Yes ☐No Type: _____
Name of medication: _____
Hospitalization due to Asthma: ☐Yes ☐No Dates: _____
Specialist Name/Address Phone #

Vision Impairment: ☐Yes ☐No ☐Nearsighted ☐Farsighted Glasses/Contacts ☐Yes ☐No
Ophthalmologist Name/Address: _____Phone_____
Last eye appointment date: Scheduled appointment:

Bacterial or Viral illnesses: ☐Frequent (more than 3 times a year) colds or sore throat ☐Strep infections
☐ Lyme ☐ Rheumatic fever/scarlet fever ☐Mononucleosis ☐Pneumonia ☐ Chicken Pox
☐ Measles/Mumps/ Rubella ☐Meningitis ☐Tuberculosis ☐Other_____
Please explain:

Dental Problems: ☐Yes ☐No Please explain: _____
Last Dental Appointment date: _____ Scheduled Appointment: _____
Dentist Name and Address: Phone #

Skin Conditions: ☐Yes ☐No Please explain: _____
Specialist Name/Address Phone #

Diabetes: ☐Yes ☐ No Diagnosed Date: _____
Specialist Name/Address Phone #

Heart Disease or Disorder: ☐Yes ☐No
Please Explain: _____
Heart Surgery: ☐Yes ☐No Date: _____ Please explain: _____
Dates Last seen_____ Scheduled appointment: _____
Specialist Name/Address Phone #

☐**Kidney Disease** ☐**Bladder Problems** **Single organ:** ☐kidney ☐testicle ☐Other_____
Please explain: _____

Gastrointestinal conditions: ☐Eating Problems ☐eating disorder ☐Nutrition or weight concerns
☐ Other _____
Please explain: _____

Toilet independently ☐Yes ☐No Please explain:

Mental health/neurodevelopmental conditions: ☐Yes ☐No
☐Depression ☐anxiety ☐OCD ☐ODD ☐ Behavior, developmental, or maturity problems ☐ADHD ☐ADD
☐Social adjustment problems ☐PTSD ☐Autism or Asperger ☐Other_____
Please explain: _____

Is your child unusually shy, quiet, or sensitive ☐Yes ☐No Please Explain:_____
Does your child cry easily, become overactive, or have temper tantrums: ☐Yes ☐No
Please explain: _____

Psychiatrist/Social worker Name: _____
Address: _____Phone#_____
Specialist Name: _____
Address: _____Phone#_____

Specific Learning Disability: _____
Specialist Name: _____
Address: _____Phone#_____
Date(s) in program:

Language impairment: ☐Yes ☐No Please Explain: _____

Ear Impairment: ☐Yes ☐No Hearing Aids: ☐Left ☐Right ☐Cochlear implant Date placed: _____
Tubes: ☐ Left ☐ Right Are they still in? ☐Yes ☐No Date of procedure(s)_____
Date of future appointment: _____
Frequent Ear Infections: ☐Yes ☐No Please Explain: _____
Has your child been in a special program for speech? ☐Yes ☐No Dates? _____
Specialist Name/Address _____ Phone #_____
Other concerns:

Orthopedic Conditions ☐Yes ☐No ☐ Broken bones ☐Scoliosis ☐Muscle injury ☐Muscle Pain
☐Assistive Equipment _____ ☐Other_____
Please explain: _____
Physically Disabled ☐Yes ☐No Please Explain: _____
Occupational/Physical Therapy: ☐Yes ☐No Please Explain_____
Date(s) in program: _____ Brace(s): _____
Specialist Name: _____
Address: _____Phone#_____
Other physical condition(s) not mentioned_____
Please explain:

Special dietary restrictions Yes ☐ No Please explain: _____

Specialist Name/Address Phone #

☐ Severe injuries: Please explain: _____ Date(s)_____

☐ Hospitalizations: Please explain: _____ Date(s)_____

☐ Surgeries: Please explain: _____ Date(s)_____

☐ Other not listed:

Any other health concerns not listed:

Medication/Treatments *to be given at School.*

Ex: insulin/blood glucose monitoring or inhaler

Medication: Name/dose	**time(s) to be taken**
Treatment: Name/dose	**time(s) to be taken**

If your child needs medication or treatments administered in school, a physician's note and/or action plan is required.

Medication/Treatment *given at Home*

Ex: insulin/blood glucose monitoring or inhaler

Medication: Name/dose	**time(s) to be taken**
Treatment: Name/dose	**time(s) to be taken**

Students in grades Pre-K, K, 1, 3, 5, 7, 9, 11 and newly enrolled are required to receive a health appraisal. We also request those students send in a Dental Health Certificate completed by his/her dentist. NYS requires health appraisal forms to be completed by his/her Medical Provider they MUST use and FULLY complete the attached form and return it to school within 30 days from the start of school. Sports Physicals must be completed by the school's Medical Provider.

Accident Agreement

In case of accident or serious illness, I request the school to contact me. If the school is unable to contact me, I hereby authorize the school to call the physician/dentist indicated above; and follow his/her instructions. If it is impossible to contact the physician/dentist in a timely manner, the school may take whatever actions seem necessary given the nature of the incident.

Signature:

Parent/Guardian_____ Date_____

Parent/Guardian Notification Regarding the Completion of the Required NYS School Health Examination Form

Dear Parent/Guardian, Date:

Education Law requires all New York State (NYS) public school students to have a health exam when they are a new student in a school district and when they enter Pre-K or Kindergarten, and grades 1, 3, 5, 7, 9, and 11.

Schools can ONLY accept a health exam documented on the NYS Required School Health Examination Form or an Electronic Health Record (EHR) equivalent health exam form with the required components and in relatively the same presentation order of those components.

We have attached a copy of the required form for your healthcare provider (HCP). The form is also on our website at www.schoolhealthny.com. Please share the attached papers at your child's health exam visit with their healthcare provider (HCP). This is typically a doctor but may also be a nurse practitioner or physician assistant.

Sincerely,

School District Medical Director/Administrator

If you have questions, please contact:

Nurse: _____ **School:** Moriah Central School

Phone: 518-546-3301 **Fax:** 518-546-7895

Email: _____

*For those Students that do not have a Provider or are Uninsured, a FREE of charge physical can be provide by the Westport Health Center. Westport, NY 12993 518-962-2313.

*Please call the Health Center to make an appointment.

New York State Immunization Requirements for School Entrance/Attendance[1]

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

Dose requirements MUST be read with the footnotes of this schedule

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

NEW YORK STATE | Department of Health

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 ☐ 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):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

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

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐Type 1 ☐ Type 2 ☐ 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):** ☐ <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

☐ **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.

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health exam in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an exam. If your child had a dental check-up before he/she started 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 oral health assessment? ☐ Yes ☐ No

School: **Moriah Central School, 39 Viking Lane, Port Henry, NY 12974** 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/ Dental Hygienist

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/ Dental Hygienist's name and address	**Dentist's/Dental Hygienist'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):_____

II. 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.

Moriah Central School District

Home of the Vikings

39 Viking Lane, Port Henry, New York 12974 518-546-3301 Fax 518-546-7895

Media Consent

Student Name: _____ Date: _____

I consent to the use and disclosure of the image, quotes, name, the participation in interviews, and the taking of photographs, recordings, and videos of the student named above by the Moriah Central School District and invited members of the press for Moriah Central School sponsored events. I grant Moriah and invited members of the press the right to disclose, edit, use, and reuse the student's image, quotes, name, and interviews, and photographs, recordings, and videos of the Student for Moriah Central School's nonprofit and public press purposes. This includes use in print, on broadcasts, in online spaces (such as the Moriah Central School website and social media accounts and those of the press), and all other forms of media. I understand that when the school hosts a public event, individuals at the event may take their own photographs, videos and audio of the event, that such recordings may capture me or my child, and that they may also be made public.

I also release Moriah Central School, its agents, and employees from all claims, demands, and liabilities. in connection with the rights granted above.

☐ I give my consent.

☐ I DO NOT give my consent.

If Student is Under Age 18:

Name of Parent/Guardian: _____

Signature of Parent/Guardian_____

If Student is Age 18 or over:

Name of Student: _____

Signature of Student: _____

For students aged 18 and over, the form must be signed by the student, and not the parent or guardian.

Moriah Central School

Computer, Network, and Internet Access Acceptable Use Policy

It is the policy of the Moriah Central School District that student e-mail be used in a responsible, legal, and ethical manner. Failure to do so will result in the termination of e-mail privileges for the user.

Users of the student e-mail system are responsible for their use of the e-mail. The use of the e-mail must be in support of education and research and must be consistent with the academic actions of the Moriah Central School District. It will be under the supervision of school faculty and administration at the school. Use of the e-mail for any illegal or commercial activities is Prohibited.

A responsible e-mail user will:

- Students will refrain from the use of impolite, abusive, inappropriate, or otherwise objectionable language, pictures, or images in either public or private e-mail messages, text messages, or website postings.
- Never give one's personal home address or phone number or the personal home address or phone number of any other student while using the Internet. Do not share credit card or bank information.
- Users are cautioned not to open e-mail attachments or download any files from unknown sources. Report any unusual activities such as "spam" communications, obscene e-mail, attempts by adults to lure students into dangerous behavior to the office immediately.
- Not forward chain letters or jokes

A responsible e-mail user must be aware that:

- Use of the e-mail is a PRIVILEGE, not a RIGHT.
- The primary purpose of the student electronic mail system is for students to communicate with school staff, outside resources related to school assignments, and fellow students to collaborate on school activities. Account usernames and passwords may be provided to parents if needed so those parents can monitor the account and communicate with teachers. Use of the district's e-mail system is a privilege.
- The use of the e-mail system will align with the school's code of conduct and the code will be used for discipline purposes. Communication through the district's e-mail system will exhibit common sense and civility. It will abide by the community's mode of acceptable behavior. Students are responsible for messages sent from their accounts.
- <u>Students should not share passwords.</u> Persons issued an account are responsible for its use at all times.
- E-mail is not guaranteed to be private. E-mail sent or received by this system is not confidential. Although the Board of Education does not make a practice of monitoring electronic mail, the administration reserves the right to retrieve the contents of user mailboxes for legitimate reasons, such as to find lost messages, to conduct internal investigations, to comply with investigations or wrongful acts or to recover from system failure.
- If necessary, the Board of Education, at its discretion, may close the accounts at any time. Any updates or changes to this e-mail agreement by the Board of Education or administration will be in effect.
- Students will be removed from the system after graduation or leaving the school district.
- Violation of this policy will result in the possible loss of e-mail privileges.

Moriah Central School

Computer, Network, and Internet Access

Student Account Agreement

Student Name: DOB: Grade:

I have read the district's Computer, Network, and Internet Access Acceptable Use Policy. I agree to follow the rules contained in this policy. I understand that if I violate the rules, additional restrictions may also be placed on my account including termination of the account.

Student Signature: Date:

Parent Section

- I have read the district's Computer, Network, and Internet Access Acceptable Use Policy. I hereby release the district, its personnel, and any institutions with which it is affiliated from any and all claims and damages of any nature arising from the unauthorized use of the system to purchase products or service.
- I will provide instructions regarding any restrictions against accessing material that are in addition to the restrictions set forth in the district's Computer, Network, and Internet Access Acceptable Use Policy.
- I will emphasize the importance of following the rules for personal safety.

I give permission to issue an account and certify that the information contained in this form is correct.

Parent Name: Date:

Parent Signature: Phone:

Home Address: