East Rochester Schools, District Office

222 Woodbine Ave. East Rochester, NY 14445 (585) 248-6302 Fax: (585) 586-3254
Website: http://www.erschools.org

Welcome to The East Rochester School District

Please be sure to use the attached checklist to ensure you have all the necessary documents to enroll your student.

Completed packets may be:

- Dropped off Monday-Friday between 8:00AM - 2:00PM at the main entrance outside the High School
- Left in the black mailbox outside the District Office

Please be sure all documents are in an envelope and labeled Attn: Michele Griffith

- Mailed to the address below;

East Rochester School District
Attn: Michele Griffith
222 Woodbine Avenue
East Rochester, NY 14445

If you have any questions, please call at 585-248-6306 or email er.registrar@erschools.org

Please Note: East Rochester Union Free School District is a walking district. We do not provide transportation.

New Student Registration Checklist

The following information is required to register your child:

_____ Completed Student Registration Packet

_____ Proof of residency
Copy of mortgage statement, lease agreement, recent utility bill or DDS paperwork

_____ Copy of Birth Certificate

_____ Complete Immunization Records

_____ Recent Physical signed by a Physician or Nurse Practitioner

_____ If possible, last report card from previous school

If Applicable:

_____ Copy of Custody Documents

_____ Copy of IEP

Incomplete packets will delay the registration process

Student Registration Form

East Rochester School District

ID# _____ (for office use only)

Student Information

Student Name: _____ **Preferred Name:** _____
Last First Middle

Gender: M F **Birth date:** ____/____/____ **Grade Entering:** _____ **Start Date:** _____

Circle documents that were provided

Proof of Age: Birth Certificate or Baptism Certificate; if not available, then Passport; if not available then

Other: _____ (see Enrollment Procedures)

Residency Information

Proof of Residency: ☐ Tax Bill ☐ Mortgage ☐ Deed ☐ Lease; if not available, then

☐ Statement from Landlord, Owner or Tenant with whom property is Shared (Shared Housing Agreement); if not available, then ☐ Other _____ (see Enrollment Procedures)

Permanent Address:	**Temporary Address Until:** (date)
Street	Street
City	City
State Zip	State Zip
Phone	Temporary Telephone

Has the student ever attended public school in New York State? (Circle One) Y N

If yes, please specify:

School(s): _____ Grade(s): _____ Year(s): _____

Previous school phone number: _____

School(s): _____ Grade(s): _____ Year(s): _____

Previous School Phone Number: _____

STUDENT REGISTRATION FORM (PAGE 2 OF 3)

Parent/Guardian Information

Parent/Guardian: Own Step Other	Parent/Guardian: Own Step Other
Name:	Name:
Address:	Address:
Gender: Male Female	Gender: Male Female
Bus. Phone: Cell Phone	Bus. Phone Cell Phone
Email:	Email:

Additional Parents/Guardians if applicable: ☐ **Custodial** ☐ **Non-Custodial**

Parent/Guardian: Own Step Other	Parent/Guardian: Own Step Other
Name:	Name:
Address:	Address:
Gender: Male Female	Gender: Male Female
Bus. Phone Cell Phone	Bus. Phone Cell Phone
Email:	Email:

Siblings: (only list brothers and sisters birth through grade 12)

Name	M/F	Birth date	School Attending	Grade

STUDENT REGISTRATION (page 3 of 3)

Information Regarding Educational Program

Based on your experiences and feedback from educational providers, how would you rate your child's academic progress?

Below Average for age and grade **Average for age and grade** **Above average for age and grade**

Does your child currently receive Enrichment Services? (please specify):

Is your child currently enrolled in any type of Special Education or Support Programs? Y N

Does your child have an individualized education plan (IEP) Y N

(Please Circle all Supports that Apply to your child's CURRENT Educational Program):

Reading Math Small Group Learning Speech/Language

English for Speakers of Other Languages Other: _____

Does your child have a 504 plan? Y N

Other: _____

Are there significant health problems: Y N

Please specify: Asthma Allergies Diabetes Seizures Other _____

There may be times when you are unavailable, or cannot be reached, and we must contact an adult regarding your child. Please provide at least two EMERGENCY CONTACTS who can be contacted and who can transport your child.

Name	Address	Contact Number	Relationship

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.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:
☐ 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

TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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:

NOTE TO SCHOOLS / LEAS: Please assist students and families filling out this form. 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.

EAST ROCHESTER SCHOOL DISTRICT
ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____ Grade: _____ ID#: _____
Month Day Year (preschool-12) (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): _____
- ☐ Migratory living in circumstances described above
- ☐ 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 the student is NOT living in permanent housing, 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.

STUDENT RACIAL AND ETHNIC INFORMATION

The U.S. Department of Education requires the collection and recording of the ethnic identity of students. The information will be used to:

- Report information to the State and federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Study the movement of students in different ethnic groups as they move from school to school.
- Analyze differences in academic performance, attendance and completion of school.

This information will be kept secure and confidential in accordance with all State and federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

Student Name:

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

DIRECTIONS TO PARENT/GUARDIAN: PLEASE ANSWER QUESTIONS (1) and (2).

Question (1) place an "X" in the box that best describes your child.

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

   ☐ **Yes, Hispanic** ☐ **No, not Hispanic**

2. **Select one or more races from the following five racial groups.** Question (2) Place an "X" in the group (s) that apply to your child; **You must select at least ONE box.**

	AMERICAN INDIAN OR ALASKA NATIVE: A person having origins in any of the original people of North American and South America (including Central America), and who maintains tribal affiliation or community recognition.
	ASIAN: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
	BLACK: A person having origins in any of the black racial groups of Africa.
	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
	WHITE: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Signature of Parent/Guardian _____ Date_____

Relationship to Student (please check one box below): **Mother** **Father** **Guardian**

Other _____

Authorization for Release of Student Information

Student Name:		Current Grade
Current Address:		
Current School:		Phone:
School Address		Fax:

Permission is given to release the following records:

- Permanent record/transcript of grades, current report card, health records, attendance, discipline records, and additional data as determined by the school principal, or principal designee, as necessary and relevant to the appropriate educational programming of the student.
- State and standardize assessment results

Parent Signature: _____ Date: _____

****

IF APPLICABLE:

Authorization for Release of Student Special Education Information

Permission is given to the East Rochester School District to receive the following student records:

- Psychological Testing
- Individual Education Plan (IEP)
- 504 Plan
- Other Testing/Assessment Information (e.g. Physical Therapy, Occupational Therapy, Speech and Language)

Parent Signature: _____ Date: _____

Please Forward Information to:
Registrar
East Rochester Union Free School District
222 Woodbine Avenue
East Rochester, NY 14445

email: er.registrar@erschools.org
Phone: 585-248-6328
Fax: 585-248-6333

Dear Parents/Guardians,

The information below is about required health documentation for your child. New York State Education Law requires each new student to provide proof of required immunizations within 14 days of their entrance into school or 30 days if from out-of-state and proof of a physical examination **within 30 days of their entrance into school.** The law also requires school districts to request dental health certificates.

Health Information Documents: 1). Health Appraisal Form, 2). Student Health Information Form, and 3). Dental Health Certificate.

What Form	Who Completes	What's Included	When Due
Health Appraisal Form	Family Physician	Immunizations: diphtheria, pertussis, polio, measles, mumps and rubella (MMR), tetanus, Hepatitis B, and Varicella **MUST BE COMPLETED WITHIN ONE YEAR OF FIRST DAY OF SCHOOL.**	**In State:** Within 14 days **Out-of-State:** Within 30 days
Student Health Information Form	Parent/Guardian	Specific health needs, health history, current medical needs	At time of registration
Dental Health Certificate (OPTIONAL)	Section 1: Parent Section 2: Dentist	Dental history, treatment status • A list of dentists available from your school nurse for those families who qualify for an examination on a free or reduced cost basis.	At time of registration

Please return the completed forms to your child's health office within thirty days of the date your child(ren) started school. For further information, please feel free to call the nurse at your child's school.

East Rochester District Registrar: (585)-248-6328
East Rochester Elementary School Nurse: Phone: (585)-248-6317 Fax: 585-248-6326
East Rochester Middle School/High School Nurse: Phone: (585)-248- 6372 Fax: 585-248-6336

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).

Health Appraisal Form

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

School:_____ **Gender:** ☐ M ☐ F **Grade:**_____

IMMUNIZATIONS / HEALTH HISTORY

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

Sickle Cell Screen:	Positive	Negative	Not done	Date: _____
PPD:	Positive	Negative	Not done	Date: _____
Elevated Lead:	Yes	No	Not done	Date: _____
Dental Referral	Yes	No	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: _____

Weight Status Category (BMI Percentile):

___ less than 5th ___ 5th through 49th

___ 50th through 84th ___ 85th through 94th

___ 95th through 98th ___ 99th and higher

Vision – without glasses/contact lenses	R	L	Referral
Vision – with glasses/contact lenses	R	L	
Vision – Near Pont	R	L	
Hearing ☐ Pass 20 db sc Both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____

Specify any abnormality (use reverse of form if needed): _____

_____

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.

Health Appraisal Form (page 2 of 2)

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).

MEDICATIONS

Medications (list all): None Additional medications listed on reverse of form

Name:_____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed Yes No
Student may self-carry and self-administer medication 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, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school:**_____ None

☐ **Known or suspected disability:**_____ Please monitor

☐ **Restrictions:**_____ Please monitor

☐ **Protective equipment required:** Athletic Cup Sport goggles/impact resistant eyewear Other: _____

(Stamp below)

Provider's Signature:_____ Phone: _____

Provider's Name/Address:_____ Fax: _____

Parent Signature (Parent Signature):_____ Date (Date): _____

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

Student Health Information Form and Athletic Recertification Form

To be completed by parent or guardian and returned to the Registrar & School Health Office

Child's Name_____Birthdate_____Grade_____Sex M / F

Physician's Name_____Phone _____

Date of last physical exam_____Preferred Hospital _____

Health History (circle all that apply and explain below)

ADD/ADHD	Chicken Pox	Heart Condition	Scoliosis
Anemia	Dental Injuries	Hernia Repair	Seizure Disorder
Arthritis	Diabetes	Hypertension	Single Organ
Asthma /trouble breathing	Ear Infections	Mental Health/Psych Issue (depression, eating disorder anxiety, OCD, ODD, etc.)	Skin Condition
Autism Spectrum Disorder	Gastrointestinal Condition (ulcer, reflux, IBS, etc.)		Speech Condition
Bleeding Disorder			Urinary/Kidney Problem
Cancer	Headaches/Migraines	Orthopedic Condition	
Vision Deficit Wears Glasses Uses Contact Lenses	**Hearing Deficit** Uses Hearing Aid Cochlear Implant	Allergies (specify type of allergy: environmental, food, insects, latex, medication and previous reactions):	
Congenital Condition (explain):			
Concussion with or without loss of consciousness (list dates injury occurred)			

Please list any injuries requiring medical care:	
Please list any hospitalizations or surgeries:	

Does your child receive treatments or use assistive equipment during or outside the school day?
(Circle All that Apply)
Insulin/blood glucose monitoring Inhaler/nebulizer/peak flow monitoring
Special diet Crutches Walker Wheelchair Other_____

Does your child take medication either at home or at school? (list name, dose, and time(s) of administration)

Name of Medication	Dose	Time of Administration

Is there any condition that would prevent your child from participating in physical education or sports? YES NO
Explain: _____

Completed by: _____ Date: _____

Dental Health Certificate- Optional Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools **to request** a dental examination 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 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: M F Will this be your child's first visit to dentist? Y or N
MM/DD/YY

School Name: _____ Grade _____

Have you noticed any problems that interferes with your child's ability to chew, speak or focus on school activities?

Y or N

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 II on Reverse Side

Dental Health Certificate- Optional Dental Health Certificate- Optional (page 2 of 2)

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 Name Address (print or Stamp):	Dentist Signature:

Optional Sections: Parent/Guardian, If you agree to release this information to your child's school, please initial here	

I. **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

Since April 2003, HIPPA (Health Information Proliferation Privacy Act) requires you to complete the form below for your healthcare provider to share protected health information with the school district. Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____, authorize my child's healthcare provider(s) listed
(Name)

below to release the medical records of my child,_____DOB_____, to
(Child name) (Date of birth)

the district's: Medical Officer, School Nurse, Occupation Therapist (OT), Physical Therapist (PT), Speech Therapist (ST), Athletic Trainer (AT), Psychologist, Social Worker, Counselor, other (specify)_____.

I authorize my child's healthcare provider(s) listed below to release the medical records of my child, to the district's: Medical Officer, School Nurse, Occupation Therapist (OT), Physical Therapist (PT), Speech Therapist (ST), Athletic Trainer (AT), Psychologist, Social Worker, Counselor, other (specify).

Parent, list all your child's healthcare providers below:

Name_____Phone_____Fax_____

Name_____Phone_____Fax_____

Name_____Phone_____Fax_____

The healthcare provider may disclose the following protect health information to: **PARENT/SCHOOL:** check all that apply.

____Immunizations
____Health Appraisals
____Past/Current Medical Condition and its impact on Attendance, Athletics, or School Programing or Therapy(ies).
____Other _____

The Protected Health Information may be used, disclosed or received for the following purpose(s):
PARENT/SCHOOL: check all that apply

____To develop care or therapy plans for routine and emergent school management
____To design appropriate education, school, or athletic programs
____To assess the impact of the medical condition(s) on school programming and/or attendance
____To share school observations/concerns surrounding behavior
____To assess a medical basis for modification of transportation and/or home tutoring
____Medication delivery or therapy prescriptions
____At patient's request with no specified purpose
____Other _____

PARENT: Please select one.
(Note: if you do not sign for the complete academic year, you may need to complete another form)

This authorization is valid for the entire academic school year 20____- 20___.

This authorization shall expire on____/____/____(MM/DD/YY).

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building. I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the healthcare providers listed.

Date Signature of Patient (over 18), Parent, or Guardian Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE ADULT PATIENT OR PARENT OF THE MINOR CHILD IF YOU CHILD REQUIRES MEDICATION IN SCHOOL, PLEASE SIGN THE PERMISSION BELOW.

I give permission for my child to receive medication or therapy in school as prescribed by my healthcare provider.

Name_____Date _____

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.

Permission to Administer Medication in School and During School-Sponsored After-School and Weekend Activities/Sports

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

Student's Name_____ Date of Birth _____

Medication_____Dose_____Route_____Time(s) _____

Purpose _____

Side Effects _____

All medications should be given as close to the prescribed time as possible, however may be given up to one hour before and no later than one hour after the prescribed time. Please advise the school if there is a time- specific concern regarding administration of the medication.

Physician please check if applicable:

- ☐ If morning dose is not given at home, nurse may administer **morning dose of** _____ **after** verbal or written notification from parent.
- ☐ Medication **should** be taken on field trips.
- ☐ Medication **should** be given during school sponsored after school and/or weekend activities/sports

Physician's Signature_____Date _____

Physician's Name (Please Print)_____Phone _____

I give permission for the above medication to be administered to my child as ordered by my health care provider and for the school nurse to share information with physician regarding this medication.

Parent's Signature_____Date _____

Permission to Administer Medication School and During School Sponsored After School and Weekend Activities/Sports (page 2 of 2)

Permission for Students to Carry Medication

A student may self-carry if:

- The student is in grades 6-12. An exception to this rule is when the medication is a metered dose inhaler for asthma, an Epi-Pen, diabetic medication or Lactaid in which case younger students may be permitted to carry and self-administer.
- The medication is not a controlled substance.
- An assessment by the school nurse confirms that the student is self-directed to carry and self-administer her/his medication properly.
- Parent assumes responsibility for insuring that his/her child is carrying and taking the medication as ordered.

I give permission for this student to self-carry and self-administer the above medication as I consider her/him responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of administration of this medication.

_____ _____

Physician's Signature* Date

I assume responsibility for ensuring that my child is carrying and taking his/her medication as ordered.

_____ _____

Parent's Signature Date

* A non-parent licensed prescriber is required for all prescription medication