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

We offer a full-day Kindergarten program that is available for residents of the East Rochester School District. Our registration process begins on March 1, 2024, and ends on March 29, 2024.

Children must be five years old on or before December 1, 2024.

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 8:00 AM - 2:00 PM at the Single Point of Entry
- Left in the black mailbox outside the District Office or
- Mailed to the address below;

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

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

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

Information required at the time of registration:

- ☐ Completed Student Registration Packet

Proof of residency

Copies of at least one:

- ☐ mortgage statement/Tax bill
- ☐ Lease Agreement
- ☐ Utility bill or
- ☐ DSS paperwork

- ☐ Birth certificate
- ☐ Recent Physical exam
- ☐ Complete Immunization Record
- ☐ If possible, the last report card from the previous school.
- ☐ Custody documents **(if applicable)**
- ☐ Copy of IEP **(if applicable)**

STUDENT REGISTRATION FORM (PAGE 1 OF 3)

Student Information

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

Gender: M F Non-Binary *Birth date:*____/____/____ *Grade Entering:* _____

Circle documents that were provided:

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

*Other:*_____

Residency Information

Proof of Residency:

- ☐ *Tax Bill*
- ☐ *Mortgage*
- ☐ *Utility Bill*
- ☐ *Lease*

*if not available, then a Statement from the Landlord, Owner, or Tenant with whom property is Shared (Shared Housing Agreement); if not available, then Other*_____

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 Non-Binary	Gender: Male Female Non-Binary
Bus. Phone: Cell Phone	Bus. Phone Cell Phone
Email:	Email:

1. Additional Parents/Guardians If applicable: Custodial or Non-Custodial

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

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

Name	M/F/Non-Binary	Birth date	School Attending	Grade

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 [ ] Average for age [ ] Above Average for age and grade

Is your child currently enrolled in any type of Special Education or Support Program? ***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):

Speech/Language Occupational Therapy Physical Therapy

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

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:

STUDENT RACIAL AND ETHNIC IDENTIFICATION

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.

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). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) Check (√) the box that best describes your child.]

Student Name:

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** [For question (2) **Check (√) all groups that apply to your child**; check (√) **at least** ONE box.]:

☐ **AMERICAN INDIAN OR ALASKA NATIVE**: A person having origins in any of the original people of North America 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/Other Date

Relationship to Student (please check one box below):

☐ Mother ☐ Father ☐ Guardian ☐ Other: _____ (Please specify relationship)

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 Non-Binary 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 <u>one</u> 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 <u>NOT</u> 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. <u>After</u> 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 <u>NOT</u> living in permanent housing, please ensure that a Designation Form is completed.

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: ______________	Vision without glasses/contact lenses	R	L	Referral
Weight Status Category (BMI Percentile):	Vision with glasses/contact lenses	R	L	
___ less than 5th ___ 5th through 49th	Vision - Near Pont	R	L	
___ 50th through 84th ___ 85th through 94th ___ 95th through 98th ___ 99th and higher	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.

WE ARE...ER
Students First
Soaring to Excellence

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

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.