Thousand Islands Central School District

8481 Co. Rt. 9 ◆ Clayton, New York 13624
315-654-2144◆ 315-686-5594◆ 315-686-5199
www.1000islandsschools.org

Welcome to the Thousand Islands Central School District!

Please

- Use this packet to enroll your child
- Register at the district office located at the Middle/High School
- Note that, depending on their age and grade, NOT ALL information may be needed for your child (see check list)

Please return packet to:

Mailing Address:

Thousand Islands Central School
Attn: Central Registration
P.O. Box 100
Clayton, NY 13624

Physical Address:

Thousand Islands Middle/High School
8481 County Route 9
Clayton, NY 13624

Contact Information:

Dorene Dickerson	315-686-5594 ext. 2001	Cape Vincent Building
Georgeen Clarke	315-686-5594 ext. 3001	Guardino Building
Melissa Driffill	315-686-5594 ext. 4001	Middle School Building
Kathy Hummel	315-686-5594 ext. 5401	High School Building
Jackie Patterson	315-686-5594 ext. 1007	Central Registration

CHECK LIST

PLEASE HAVE THE FOLLOWING PAPERWORK **COMPLETED AND WITH YOU**
WHEN YOU REGISTER YOUR CHILD:

Required for Enrollment

_____Registration Form *(please complete both front* & *back of form)*

_____Proof of Residency (Family Provides)*

_____Emergency Information Form

_____Transportation Information Form

Required for Student to Attend

_____Birth Certificate ***or*** Proof of Age (Family Provides)*

_____Immunization Record (Family Provides) ***Attendance can be delayed until provided***

_____Request for Previous School Medical/Educational Records

_____Elementary Health History Form ***or*** _____Middle / High School Health Update Form

_____Health Certification / Appraisal Form
(**Required for Grades K, 2, 4, 7, and 10 and new students**)

Additional Information Needed

_____Technology Acceptable Use Agreement

_____Field Trip Permission Form

_____Help Us Get to Know Your Kindergarten Child Form *(please complete both sides of form)*

_____Pre-School Conference Medical History Form
(Kindergarten Enrollment ONLY)

_____Dental Health Certificate Form -Optional

_____Home Language Questionnaire Form

*Please see website for details *or* examples

THOUSAND ISLANDS CENTRAL SCHOOL REGISTRATION FORM

First Name:_____ School Building:_____Year: _____

Middle Name:_____ 911 Address: _____

Last Name: _____

Gender:_____Male _____Female

DOB:_____Grade: _____ Mailing Address: _____

1st Language (spoken in home): _____

2nd Language:_____ Phone:_____Child has IEP:_____Yes_____No

Previous School attended, include Address: _____

Is the student Hispanic, Latino or of Spanish origin:_____Yes _____No

(Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race)

Select one or more races from the following five racial groups:

_____01 White: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

_____02 Black or African American: A person having origins in any of the black racial groups of Africa.

_____03 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.

_____04 American Indian or Alaskan Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.)

_____05 Native Hawaiian/Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Is either parent/guardian connected with: Military only: Unit # / Battalion: _____

_____B2 Military resides in non-801 housing

_____B3 Employed as civilian by the US Government at a federal facility

_____B4 Employed with civilian contractor at a federal facility

_____B5 Customs and Border Protection _____Active Reserve

Student parent / guardian information:

Salutation: **Mr., Mrs., Ms**. and **Miss** are titles that are used before surname or full name

1st Contact: _____ Relation: _____ Salutation: _____

Occupation: _____ DOB: _____ Cell Phone: _____

Education Completed: _____ E-Mail: _____

2nd Contact: _____ Relation: _____ Salutation: _____

Occupation: _____ DOB: _____ Cell Phone: _____

Education Completed: _____ E-Mail: _____

Family Physician: _____ **Family Physician Phone Number:** _____

In case of emergency contact: _____ **Contact's Phone Number:** _____

COMPLETE THIS BOX only **IF IT REFLECTS YOUR CHILD'S** *or* **YOUR CURRENT LIVING SITUATION.**
Check one **box:**

_____S-Shelter _____T-Transitional Housing _____A-Temporarily housed awaiting a foster placement

_____H-Hotel/Motel _____U- Unsheltered (car, parks, campgrounds, temporary trailer or abandoned buildings)

_____D-Doubled-up (with another family due to lack of housing)

CHILDREN RESIDING IN THE HOME: (Including Pre-school)

	Last Name	First Name	Middle Name	Sex	Date of Birth	*Ethnic Code	Child Has IEP	Present GR HMRM TCHR	Previous School, including address
1									
2									
3									
4									
5									

THOUSAND ISLANDS CENTRAL SCHOOL DISTRICT

EMERGENCY INFORMATION AUTHORIZATION

Student's Name_____ Grade Teacher_____

Birth Date_____ 911 Address _____

Student's Primary Mailing Address_____

➢

FATHER'S NAME [STEP / FOSTER / GUARDIAN] ADDRESS PRIMARY PHONE CELL PHONE

➢

FATHER'S PLACE OF EMPLOYMENT ADDRESS PHONE

➢

MOTHER'S NAME (MAIDEN) [STEP / FOSTER / GUARDIAN] ADDRESS PRIMARY PHONE CELL PHONE

➢

MOTHER'S PLACE OF EMPLOYMENT ADDRESS PHONE

IN AN EMERGENCY WHEN YOU CANNOT REACH ONE OF THE ABOVE, I AUTHORIZE THE SCHOOL TO CALL:

➢

NAME OF DOCTOR ADDRESS PHONE

➢

NAME OF PREFERRED HOSPITAL ADDRESS PHONE

➢

NAME OF DENTIST ADDRESS PHONE

If none of the above can be reached, please take my child to the nearest Emergency First Aid Station, by ambulance if necessary. I realize that the school district cannot assume responsibility for the payment of medical fees or expenses incurred.

IF MY CHILD HAS TO BE TAKEN HOME BECAUSE OF MINOR ILLNESS AND I CANNOT BE REACHED, PLEASE CALL:

1ST_____
RELATIONSHIP (RELATIVE / FRIEND / NEIGHBOR) ADDRESS PHONE

2ND_____
RELATIONSHIP (RELATIVE / FRIEND / NEIGHBOR) ADDRESS PHONE

3RD_____
RELATIONSHIP (RELATIVE / FRIEND / NEIGHBOR) ADDRESS PHONE

I request that all pertinent staff be aware that my child has the following condition(s) that requires special handling in an emergency (example: peanut allergy, food allergy, asthma, heart condition, head injury, etc.)

_____

During the past summer, my child had the following illness, immunization, or diagnosis:

_____

SAFE TO SCHOOL PROGRAM: In order to ensure the safety of our students, it is important that you call the attending school when your child is ill or will be absent for any reason. **Please call 315-686-5594 and listen for prompts**. The telephones are open 24 / 7 to allow you to leave a message. This program is designed to account for the whereabouts of all our students with SAFETY being our main concern.

Preferred first contact for student absence: _____
(Name and Telephone Number)

Parent / Guardian Signature:_____ Date: _____

Thousand Islands School

TRANSPORTATION INFORMATION

STUDENT NAME _____ Male ☐ Female ☐
(One student only please)

GRADE _____ TELEPHONE # _____

1. Does this student need transportation? Yes (AM ☐ PM ☐) No (AM ☐ PM ☐)

2. Where & ***who from*** can the bus pick-up / drop-off this student?

Please give exact location and person's name:

Monday: AM:_____ PM:_____

Tuesday: AM:_____ PM:_____

Wednesday: AM:_____ PM:_____

Thursday: AM:_____ PM:_____

Friday: AM:_____ PM:_____

I understand that an adult must be present and visible for an elementary student to be dropped off by school transportation.

Signature:_____ Date:_____

If any of the above information changes, prior to the first day of school, ***it is important that you contact our office.***

Thousand Islands School

EMERGENCY / EARLY DISMISSAL

TRANSPORTATION INFORMATION

STUDENT NAME _____

Please give exact location and person's name:

Monday: AM:_____ PM:_____

Tuesday: AM:_____ PM:_____

Wednesday: AM:_____ PM:_____

Thursday: AM:_____ PM:_____

Friday: AM:_____ PM:_____

3. If this student is a walker, where does he / she go?

_____

I understand that an adult must be present and visible for an elementary student to be dropped off by school transportation.

Signature:_____ Date:_____

If any of the above information changes, prior to the first day of school, ***it is important that you contact our office.***

Thousand Islands Central School

8481 Co. Rt. 9 ◆ Clayton, New York 13624
315-654-2144 or 315-686-5594
www.1000islandsschools.org

REQUEST FOR EDUCATIONAL / MEDICAL RECORDS

Please enter date you have withdrawn student from your records (New York State only): _____

RECORDS REQUESTED FROM:

_____

(Previous School)

_____

(Address)

_____(___)_____(___)_____

(City) (State) (Zip) (Phone #) (Fax #)

STUDENT NAME:_____DOB: _____

The above referenced student has enrolled within our district in grade ____. Please send a copy of his / her records, including the entire confidential file (*i.e.* psychological evaluation, individualized educational plans, *immunization and health* records, *etc.*), so that proper placement can be made and continuity of record keeping maintained.

PARENTAL PERMISSION is no longer required when authorized school personnel request records. *(Family Education Rights and Privacy Act, Final rule on Educational Records, Federal Register, June 17, 1976, Vol. 41, No. 118, Page 24673)*

Upon entry into our school, parent / guardian and student are notified of their right: (1) to inspect and review educational records; (2) to challenge contents of records; and (3) to obtain a copy of records.

Thank you for your assistance and early attention to this request

DATE REQUESTED: _____ _____

(Signature of Parent / Guardian Requesting Records)

_____

(Signature of Official Requesting Records)

Please return the information to:
Thousand Islands Central School
Registration Office
Post Office Box 100
Clayton, New York 13624

2017-18 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades Pre-k through 9, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: intervals between doses of polio vaccine DO NOT need to be reviewed for grades 4, 5, 10, 11 and 12.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 10 through 12. See footnotes for specific information for **each** vaccine. Children who are enrolling in grade-less classes should 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	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2 and 3	Grades 4 and 5	Grades 6, 7, 8 and 9	Grades 10, 11 and 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 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	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**3 doses**
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**	**1 dose**	**2 doses**	**1 dose**
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**			**Grades 7 and 8: 1 dose**	**Grade 12: 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

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday.

   b. If the fourth dose of DTaP was administered at 4 years or older, the fifth (booster) dose of DTaP vaccine is not required.

   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.

   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. If the first dose was received before their first birthday, then 4 doses are required. If the first dose was received on or after the first birthday, then 3 doses are required. A Tdap vaccine (or incorrectly administered DTaP vaccine) received at 7 years or older will meet the 6th grade Tdap requirement.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)

   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap. A dose received at 7 years or older will meet this requirement.

   b. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)

   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.

   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

   d. Intervals between the doses of polio vaccine do not need to be reviewed for grades 4, 5, 10, 11 and 12 in the 2017-18 school year.

   e. If both OPV and IPV were administered as part of a series, the total number of doses and intervals between doses is the same as that recommended for the U.S. IPV schedule. If only OPV was administered, and all doses were given before age 4 years, 1 dose of IPV should be given at 4 years or older and at least 6 months after the last OPV dose.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)

   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

   c. Mumps: One dose is required for prekindergarten and grades 10 through 12. Two doses are required for grades kindergarten through 9.

   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine

   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks.

   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)

   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine. (Minimum age: 6 weeks)

   a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7 and 8.

   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.

   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.

   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.

   d. If dose 1 was received at 15 months or older, only 1 dose is required.

   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)

   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

   b. Unvaccinated children ages 7 through 11 months of age are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.

   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.

   d. If one dose of vaccine was received at 24 months or older, no further doses are required.

   e. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

Elementary HEALTH HISTORY FORM

STUDENT'S NAME (Last, First, Middle) _____

BIRTHDATE (M / D /Y_____AGE_____PLACE OF BIRTH_____

PRIMARY ADDRESS_____

FATHER [STEP / FOSTER / GUARDIAN] _____

FATHER'S OCCUPATION_____PLACE OF EMPLOYMENT_____
PHONE NUMBER_____(FULL TIME / CASUAL / SEASONAL)

MOTHER [STEP / FOSTER / GUARDIAN] _____

MOTHER'S OCCUPATION_____PLACE OF EMPLOYMENT_____
PHONE NUMBER_____(FULL TIME / CASUAL / SEASONAL)

FAMILY PHYSICIAN_____PHONE NUMBER_____

IS THERE A FAMILY HISTORY OF ANY OF THE FOLLOWING? *IF YES, INDICATE RELATIONSHIP TO STUDENT. (Example: maternal grandmother)*

DIABETES_____HYPERTENSION_____MENTAL RETARDATION_____

HEART DISEASE_____LUNG DISEASE_____BIRTH DEFECTS_____

OTHER_____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING? ***INDICATE DATE****. USE BACK OF SHEET FOR ANY ADDED INFORMATION / EXPLAINATION.*

ANEMIA_____CHICKEN POX_____STREP THROAT_____

ASTHMA_____RHEUMATIC FEVER_____SCARLET FEVER_____

PNEUMONIA_____FREQUENT COLDS_____HEART DISEASE/DEFECT_____

CHEST X-RAY_____FREQUENT EAR INFECTIONS_____VISION LOSS/DEFECT_____

ALLERGIES_____ HEARING LOSS/ IMPAIRMENT_____ HEAD INJURY_____

TUBERCULOSIS_____ CONVULSIONS_____ LOSS OF CONSCIOUSNESS_____

CONTACT W/ TUBERCULOSIS_____ EPILEPSY_____ FRACTURES_____

TUBERCULIN TEST (RESULT)_____SEISURE DISORDER_____BONE PROBLEMS_____

DIABETES_____KIDNEY DISEASE_____HERNIA_____

BEE STING ALLERGY_____CONGENITAL DEFECT_____OPERATIONS_____

HAS YOUR CHILD EVER BEEN STUNG BY A BEE?_____ANY REACTION?_____

OTHER PERTINENT INFORMATION AND / OR SERIOUS ILLNESS_____

PLEASE LIST ALL MEDICATIONS THAT YOUR CHILD IS CURRENTLY TAKING WITH NAME OF DRUG, DOSAGE, FREQUENCY GIVEN AND MEDICAL DIAGNOSIS PERTAINING TO THAT SPECIFIC MEDICATION. [EXAMPLE: Albuterol inhaler 2 puffs every 4 hours as needed for cough/wheeze]
If any medications are required to be given during school, you will need a written doctor's order and signed parental permission for it to be legally dispensed by the school nurse.

_____

_____

_____

_____

_____

NEW YORK STATE LAW REQUIRES THAT ALL CHILDREN BE IMMUNIZED BEFORE ENTERING KINDERGARTEN. PLEASE SUBMIT VALID PROOF OF IMMUNIZATIONS. MINIMUM MANDATORY IMMUNIZATIONS FOR GRADES K-5 INCLUDE 3-5 doses DTaP/DTP/Tdap, 3-4 doses Polio, 2 doses MMR, 3 doses Hep B, 1-2 doses Varicella. Subject to review and verification by the School Nurse.

The above health information that I have provided is confidential. For the benefit and well being of my child, I give my permission for the school nurse to inform/educate all pertinent staff members as to the condition and/or interventions to be implemented for my child.

DATE

SIGNATURE OF PARENT or GUARDIAN Reviewed 2017

ANY QUESTIONS PLEASE CALL 315 686-5578 EXT. 3088 (Guardino Elementary) EXT. 2088 (Cape Vincent Elementary)

THE INFORMATION YOU PROVIDE HELPS US IN MAINTAINING ACCURATE RECORDS AND ASSISTS WITH THE HEALTH CARE OF YOUR CHILD.
THANK YOU FOR YOUR COOPERATION.

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). This exam complies with NYSED requirements and is valid for 12 months, with the exception of any illness or injury lasting more than 5 days that will require review by private healthcare provider and/or the school Medical Director. 2/14

HEALTH CERTIFICATE / 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 Date: _____ ☐ Not done
PPD: ☐ Positive ☐ Negative Date: _____ ☐ Not done
Elevated Lead: ☐ Yes ☐ No Date: _____ Not done
Dental Referral ☐ Yes ☐ No Date: _____ Not done

Significant Medical/Surgical History: ☐ See attached _____

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	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	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): _____

MEDICATIONS

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

Name: _____ Dosage/Time: _____

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: _____

OPTIONAL INFORMATION, if known

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

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____

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). This exam complies with NYSED requirements and is valid for 12 months, with the exception of any illness or injury lasting more than 5 days that will require review by private healthcare provider and/or the school Medical Director. 2/14

Please bring or send the completed Health Certificate form to:

Grades 6-12

Thousand Islands High School / Middle School
Attn: Robin Leavery, RN
8481 Co. Rt. 9
Clayton, New York 13624

Grades K-5

Guardino Elementary
Attn: Lorraine Ward, RN
600 High Street
P.O. Box 100
Clayton, New York 13624

or

Cape Vincent Elementary
Attn: Elizabeth Mason, RN, BSN
410 South Esselstyne Street
P.O. Box 282
Cape Vincent, New York

Dental Health Certificates are requested at the same time a Health Certificate is required. This request pertains to students' first entering school (kindergarten and new enrollees) and grades 2, 4, 7, and 10. A Dental Health Certificate form will be provided with the Health Certificate form for those grade levels.

A student's health examination is required to include BMI and determination of weight status. However, if a parent requests that this information not be included as part of the aggregated summary report submitted to the State Health Department, then the student's information will be excluded upon signed request from the parent. Please ask for a *Parental Notice for BMI and Weight Status Reporting* form only if you request your student's information not be included.

ADDITIONAL INFORMATION

Thousand Islands Central School
Technology Acceptable Use Agreement Form

Students

The District's Acceptable Use Policy document serves as official notification of acceptable use procedures for computer systems and district network access. Students wishing to utilize these technologies must agree to do so in a responsible, decent, ethical and polite manner.

USER: I have read the Technology Acceptable Use Policy. I understand that this technology is designed for educational purposes. I understand and will abide by the Conditions, Rules and Acceptable Use Agreement. I also recognize that it is impossible for the Thousand Islands Central School District to restrict access to controversial materials and I will not hold them responsible for materials acquired on the network. Should I commit any violation, my access privileges may be revoked, disciplinary action may be taken.

Name of User:_____ **Grade Level:** _____
Please print

School Building: _____

Students & Parents/Guardian:
My child has my permission to access electronic media including Internet and e-mail via the district network:

_____ _____
Parent Signature Date

_____ _____
Student Signature Date

The AUP is to be read, signed and returned to your home room teacher. Technology privileges will not be allowed without this agreement on file.

Home room teachers are to return this signed form to the office.

The complete policy can be found in the student agendas, handbook, and on TICSD website > Technology Department.

Thousand Islands Central School

Field Trip Permission Form

Dear Parents or Guardians:

In order for your child,_____,
to participate in **field trips** this coming year, it is necessary to have your signed permission on file with his/her teacher, _____, before he/she may go.

Please **sign on the line below, date and return** this form to school immediately.

You will be notified, in advance, of all upcoming trips.

_____ _____

Parent or Guardian Signature Date

Thousand Islands Central School District

Help Us Get To Know Your Kindergarten Child

Dear Parents,

Please help us get to know your child by completing the information on this form and returning it to school, thank you.

Child's Birth Name _____

Name you want your child to be called in school (i.e. Birth Name is Robert, referred to as Bobby) _____

Who does your child live with? Both Parents One parent Other_____

Brothers & Sisters: Name(s) Age

_____ ____

_____ ____

_____ ____

Please mark the box ✓ in each area to indicate what you feel best describes your child:

	Most of the Time	Some of the Time	Seldom
Uses self-control			
Independent			
Pleasant			
Attentive			
Follows directions			
Confident			

What are your child's favorite play activities and interests?_____

_____

What does your child like to watch on TV?_____

_____

About how much time does your child spent watching TV each day? _____

About how often does your child visit friends or relatives in their homes?

Daily Weekly Monthly Other_____

Is, or has your child been, involved in any special groups? (classes, lessons, etc)

_____

Describe ways you feel your child might be different from other children his/her age.

_____

Tell us about any of your child's travel experiences. _____

_____

What are your child's responsibilities at home? _____

_____

What does your child enjoy doing with the family? _____

_____

How does your child get along with other children? _____

How does your child get along with adults? _____

What is your biggest discipline problem? _____

_____

How do you usually discipline your child? _____

_____

How well do you think your child will adjust to school? _____

_____

What fears does your child have? Animals Dark Storms Strangers

Other: _____

Does your child have any nervous habits? _____

How does your child feel about going to school?_____

What do you hope your child will learn this year? _____

_____

Is there any additional information that you would like to share with us? _____

_____

Thank you very much for taking the time to fill out this information.

The Thousand Islands Teachers

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: Month Day Year

Sex: Male Female

Will this be your child's first visit to a dentist? Yes No

School: THOUSAND ISLANDS CENTRAL SCHOOL DISTRICT

Grade

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

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

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

Parent's Signature Date

Section 2. To be completed by the Dentist

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

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

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

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

Dentist's name and address (please print or stamp) Dentist's Signature

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

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

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

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

Yes No **Dental Sealants Present**

Other problems (Specify):_____

III. Treatment Needs (check all that apply)

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

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

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

THOUSAND ISLAND CENTRAL SCHOOL DISTRICT
PRE-SCHOOL CONFERENCE
MEDICAL HISTORY

Mother's Name:_____ Father's Name: _____
Child's Name:_____ Date of Birth: _____

Circle no or yes. **If yes, please explain using back of sheet if necessary.**

I. PREGNANCY AND BIRTH

A. Were you ill during pregnancy? No Yes_____

B. Did you take any medication or drugs? No Yes _____

C. Did you have high blood pressure? No Yes_____

D. Was the baby premature? No Yes_____

E. Was the baby overdue? No Yes_____

F. Was there a problem during delivery? No Yes_____

II. POST NATAL

A. Was the baby excessively over or under weight? No Yes_____

B. Did the baby ever need oxygen? No Yes_____

C. Was the baby jaundiced? No Yes_____

D. Did the baby need medication? No Yes_____

III. BABYHOOD

A. Did the baby have any bowel or feeding trouble? No Yes_____

B. Did the baby seem slow in performing? No Yes_____

IV. CHILDHOOD

A. Has there ever been a head injury? No Yes_____

B. Has there ever been a prolonged high fever or prolonged illness? No Yes_____

C. Does the child have any allergies? (environmental, drug, food, latex, or other) No Yes_____

D. Have there ever been any difficulties with sight or hearing? No Yes_____

E. Does the child seem to be in constant motion? No Yes_____

F. Does the child have difficulty making himself understood verbally? No Yes_____

G. Does the child repeatedly injure himself? No Yes_____

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

Lissette Colon-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

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

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

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

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		☐ Father	
	☐ Guardian(s)		*specify*	
4. What language(s) does your child understand?	☐ English	☐ Other	*specify*	
5. What language(s) does your child speak?	☐ English	☐ Other	*specify*	☐ Does not speak
6. What language(s) does your child read?	☐ English	☐ Other	*specify*	☐ Does not read
7. What language(s) does your child write?	☐ English	☐ Other	*specify*	☐ Does not write

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

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

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

*Yes** ☐ *No* ☐ *Not sure* ☐ *If yes, please explain:

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

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

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

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

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

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

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

Month: Day: Year:

Signature of Parent or of Person in Parental Relation *Date*

Relationship to student: ☐ Mother ☐ Father ☐ Other:

OFFICIAL ENTRY ONLY - NAME/POSITION OF QUALIFIED 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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Oswego County BOCES
Migrant Educallon Outreach Pro11ram
Paul GugeJ, Migrant Education Coordinator

179 County Route 64
Mexico, NY 13114
315-963-4265 or 1-800-474-1632

Eligibility screen for Migrant Education services

***Migrant Education Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed. •**

Has your family moved to a different school district in **the last 3 years? YES NO___ _**

Has the parent or guardian of the child enrolling worked on a dairy farm, planting, picking/harvesting fruits or vegetables, food processing or packaging, logging or tree farming? YES_ _NO _ _

If yes, what farm did you work on and where?

Child's name_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ D.O.B. _ _ _ _ _ _ Grade• _ _ _ _

Child's name _____ D.O.B. _____ Grade_ _ _ _

Child's name_____D.O.B._____Grade_ _ _ _

Child's name _____ D.0.B. _____ Grade_ _ _ _

Parents/ Guardians

Father's Name _____

Mother's name _ _ _ _ _ _ _ _ _ _ _ _

Home Address _ _ _ _ _ _ _ _ _ _ _ _ Home Phone#_ _ _ _ _ _ _ _ _ _ _ _

(Street **Address)**

_____

_____ Work or Message#_____

(city, town or village) (Zip)

School District_ _ _ _ _ _ _ _ _ _ _ _ School Buildin,,,

School Contact Person_ _ _ _ _ _ _ _ _ _ _ _ _ _ Contact Number_ _ _ _ _ _ _ _ _

Other Useful information (directions, farm names, best time to contact, etc.)_____

If **you can answer** YES to BOTH **of the above questions, your family MAY qualify for Migrant Education services. To be contacted by a Migrant Education recruiter, please complete the information below.**

To submit this referral please fax to the Oswego BOCES at (315) 963-4242 or mail to the address above. For more information please call the Migrant Program at 963-4265 or 1-800-474-1632. Thank you for your assistance.

Oswego County BOCB8
Migrant Education Outrach Proaram
Paul Cup!, Migrant Education Coordinator

179 **County Route 64**
Me::xicp, NY 13114
315-963-4265 or 1-800-17+1632

Cuestionario de Eligibilidad para Servicios de Educaci6n Migrante

*** Servicios del Programa de Educaci6n Migrante son gratuitos y pueden incluir tutoria, ayuda con necesidades de salud, viajes educacionales, programas del verano, actividades de involuncrar a los padres, educaci6n para adultos, ayuda de emergencia y referidos a otros servicios como necesario. ***

;,Ha mudado su familia a un distrito escolar diferente en los ultimos 3 **aiios?** Si__ **NO**___ _

;,En los ultimos 3 aiios ha trabajado un padre o guardian en granja como: lecheria, plantando, cosechando fnat11s o leg11mhres, el procesamiento o empacar de comida, corta de arboles o cultivo de arboles? Sf_ NO

Si Ud dijo que si, en que granja y donde? _____

Si Usted contest6 que Si **a AMBOS, pregun tas de arriba, su familia** PUEDA **calificar para servicios de Educaci6n Migrante. Para estar contactado por una reclutadora del Programa de Educacion Migrante, favor de llenar la** inf**ormacion de abajo.**

Nombre de] nifio(a}_____ Fecba de Nacimiento_ _ _ _ _ _Grado_ _ _ _

Nombre del niiio{a) _____ Fecha de Nacimiento Grado___

Nombre de] nifio(a) _____ Fecba de Nacimiento Grado_ - - - 11

Nornbre del niiio{a) _____ Fecha de Nacimiento_____Grado- - - - n

Padres/ Guardianes

Nombre de la Mama _ _ _ _ _ _ _ _ _ _ Nombre de1 Papa_____

Direcci6n de la Casa _ _ _ _ _ _ _ _ _ _ _ Numero de telefono en casa_ _ _ _ _ _ _ _ _ _

(Dircci**6n de la Calle}**

#delefono del trabajo o de Mensaje_____

_____

(Ciudad o Pueblo) (C6digo Postal}

Distrito escolar _ _ _ _ _ _ _ _ _ _ _ _ edificio escolar _ _ _ _ _ _ _ _ _ _ _ _ _

Persona para contactar_____ numero para contactar_____

Otra infonnaci6n Util (direcciones, nombres de granjas, mejor horn de Hamar, etc.)_____

_____

_____

Para someter este referido, favor de mandarlo por fax al BOCES de Oswego a (315) 963-4242 o mandar por correo al direcci6n de arriba. Para mas informaci6n, favor de

Hamar al Program.a Migrante a 963-4265 o a 1-800-474-1632. Gracias.

PARENTAL RIGHTS REGARDING THE REFERRAL AND EVALUATION OF CHILDREN FOR THE PURPOSES OF SPECIAL EDUCATION SERVICES OR PROGRAMS

Upon a child's enrollment or attendance at a public school in New York State, the child's parent, guardian, or person in parental relation to that child has the right to refer the child to the school district's Committee on Special Education to have the child evaluated and a determination made whether the student is a student with a disability and therefore eligible for special education and/or related services.

For additional information regarding this process, please visit the State Education Department's website and review "A Parent's Guide to Special Education," at http://www.p12.nysecl.gov/specialed/publications/policy/parentsguide.pdf.

You may also contact the District's Committee on Special Education ("CSE") Chairperson,

Robin Colello-Poplaski (315) 654-2142 Ext. 2201

Name Phone Number

Thank you.

Ref: Chapter 434, Laws of2014, eff. July 1, 2015