EDINBURG COMMON SCHOOL
4 Johnson Road Edinburg, NY 12134
Phone: (518) 863-8412 Fax: (518) 863-2564

RELEASE OF INFORMATION/RECORDS REQUEST AUTHORIZATION

TO: _____

_____

_____

RE: _____
Student's Name

_____
Date of Birth

_____
Date/Grade Last Attended

The student named above registered at Edinburg Common School on _____.
We would appreciate a copy of the following records. Your attention to this matter will be greatly appreciated.

General Education Information	CSE Information
Birth Certificate	Student's IEP
Free/Reduced Eligibility	Psychological Report
Student Transcript	Social History
Test/Assessment Results	Discharge Reports
Health Records/Physical/Immunization/Dental	Medical Evaluations
Attendance Records	

Other (describe):_____

Sincerely,

Michelle Ellis
Superintendent

I (We), the undersigned, hereby authorize the release of academic and health records as requested above relating to the student named above to the EDINBURG COMMON SCHOOL DISTRICT. I understand that my consent is voluntary, and that this information may include personally identifiable information including the name and address of my child and myself. I also understand that my child's school identification number and/or social security number may be released.

PARENT/GUARDIAN SIGNATURE: _____DATE:_____

RELATIONSHIP TO STUDENT: _____

Edinburg Common School
PK-6 Enrollment Packet

"A Great Place to Grow and Learn!"

MISSION STATEMENT:

THE MISSION OF EDINBURG COMMON SCHOOL IS TO PROVIDE A QUALITY EDUCATION AND A CARING ENVIRONMENT FOR ALL STUDENTS SO THAT THEY MAY GROW, ACHIEVE, AND MAKE A POSITIVE CONTRIBUTION TO OUR EVER CHANGING WORLD.

***All Forms must be completed and returned to the District Office Prior to your child starting school.**

- **Birth Certificate**
- **Emergency Release Form**
- **Copy of immunization records**
- **A completed physical form**
- **A completed Health update form**
- **An enrollment form**
- **A Residency Form**
- **Medication Form (If applicable)**

For transfer students, we also need the following:

- **A signed release of information and records form**
- **A Transfer Enrollment form**

EDINBURG COMMON SCHOOL DISTRICT
4 Johnson Road Edinburg, NY 12134
Phone: 518-863-8412 Fax: 518-863-2564

ENROLLMENT FORM

Student Name: _____ Grade: _____ ☐ Female ☐ Male

Address: _____ Date of Birth: _____/_____/_____

City/State of Birth: _____

Home Phone: _____ Cell/Alternative Phone: _____

Born in the United States: ☐ Yes ☐ No If no, Country of Origin: _____

Date of U.S.A. Entry: _____

Language Spoken at Home: ☐ English ☐ Other_____

Race(s): Check as many as applies. YOU MUST CHECK AT LEAST ONE BOX.

☐ White ☐ American Indian or Alaska Native

☐ Black or African American ☐ Native Hawaiian or Pacific Islander

☐ Asian

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).

PARENT/GUARDIAN INFORMATION

Who has custody of student? _____

(Parent/Guardian Full Name)

Relationship to student (Please circle all that apply):

Both Parents Mother Father Mother/Stepfather Father/Stepmother

Grandparents Foster Joint Custody Other: _____

Student lives with: _____

(Parent/Guardian Full Name)

Relationship to student (Please circle all that apply):

Both Parents Mother Father Mother/Stepfather Father/Stepmother

Grandparents Foster Joint Custody Other: _____

Are there Custody/Legal Concerns? ☐ Yes ☐ No (If yes, please explain)

_____

Is there a Legal Custody Document? ☐ Yes ☐ No (If yes, please provide copy of document)

Are there other legal documents? ☐ Yes ☐ No (If yes, please provide copy of document)

	PARENT	PARENT	STEPPARENT	LEGAL GUARDIAN
Name				
Person Has Custody	Yes No	Yes No	Yes No	Yes No
Employer				
Work Phone				
Cell Phone				
Same Address As Student	Yes No	Yes No	Yes No	Yes No
Different Address				
Different Home Phone				
Relationship to Student				
Email Address				

Please send school mailings to other custodial parent at a separate address:

Relationship: _____ Name: _____Address:_____

List other children in home 18 years of age or younger:

NAME DATE OF BIRTH SCHOOL, IF ANY

_____

_____

_____

STUDENT HISTORY

1. If entering kindergarten, has your child ever attended Pre-school ☐ Yes ☐ No

   If yes, where? (Pre-school name and address) _____

2. If entering grades 1-6. Name and address of last school attended.

_____

3. Has your child repeated any grade? ☐ Yes ☐ No If yes, which grade? _____

4. Does your child have any difficulties which may restrict his/her activities while in school, or need extra attention?

☐ Vision ☐ Asthma ☐ Hearing

☐ Speech ☐ Diabetes ☐ Frequent ear infections

☐ Allergies Allergy to: _____

Other Health Concerns: _____

5. Is your child on any medications? ☐ Yes ☐ No If yes, please list

_____

Has your child ever received or attended any of the following?

☐ Speech Therapy ☐ Physical Therapy ☐ Occupational Therapy

☐ Remedial Reading ☐ Remedial Math ☐ Counseling

6. Does your child have an IEP? ☐ Yes ☐ No

7. Does your child have a section 504 plan? ☐ Yes ☐ No

8. COMMENTS (Please state anything else that you believe we should know).

_____

_____

_____

_____

Parent/Guardian Signature: _____Date:_____

OFFICE USE ONLY

SCHOOL:_____DATE ENTERED:_____

STUDENT ID#:_____GRADE:_____

EDINBURG COMMON SCHOOL DISTRICT
4 Johnson Road Edinburg, NY 12134
Phone: 518-863-8412 Fax: 518-863-2564
http://www.edinburgcs.org

RESIDENCY QUESTIONNAIRE

The Edinburg Common School District uses this page to identify students in homeless situations as required by the McKinney-Vento Act, U.S.C.A. 42 Section 11302 (a). Answers to these questions will help determine the services the student may be eligible to receive.

Student: _____ Male _____ Female_____

Date of Birth: _____/____ /_____ Age: _____ Grade: _____
Month Day Year

Parent/Legal Guardian: _____

Presently, where is the student living?

- ☐ In a house or apartment that is rented or owned
- ☐ In a shelter
- ☐ In a Motel or Hotel
- ☐ In a car, trailer, or campsite
- ☐ Temporarily in another family's house or apartment due to loss of housing
- ☐ Other temporary living situation (please describe) _____
- ☐ In permanent housing

Current Address: _____

City: _____ Zip: _____ Telephone: _____

Previous Address: _____

City: _____ Zip: _____ Telephone: _____

Signature of Parent/ Legal Guardian/ Caretaker: _____

Date: _____

Administrator: _____ Date: _____

Please answer the following questions about the living arrangements for the child under your supervision. (The following question are for families who have adopted or had a child placed with them)

When did the child begin living at your residence?

Why is the child staying with you?

When the child is in your residence, does he/she have personal space? (i.e. bedroom, sleeping area)

How long will the child be staying at your residence?

When do you expect the child to have permanent living arrangements?

EDINBURG COMMON SCHOOL DISTRICT

EMERGENCY RELEASE FORM

Student Name: _____, _____, _____ *Grade:* _____

Last Name *First Name* *M*

DOB: _____ *Teacher:* _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ *Cell/Alternative:* _____

1st Parent/Guardian:_____ Location During School Hours: _____Phone #:_____

Email Address: _____

2nd Parent/Guardian:_____ Location During School Hours: _____Phone #:_____

Email Address: _____

Student Resides With: _____

Names and Ages of Siblings:_____ _____

_____ _____

MEDICAL INFORMATION

Please note: Medication will not be administered in school without a physician's order and signed parental permission.

List Allergies:_____
List Medication, Dosage, & Frequency:_____
Special Health Problems: _____
Medical Health Insurance Company: _____
_____
Please list for the past year:
Booster Shots: _____ Eye/Ear Exams: _____
Dentist Visits:_____ Accidents/Illness/Surgeries:_____
PLEASE LIST ONLY LOCAL CONTACTS FOR EMERGENCY PURPOSES:
(Please advise these individuals that you are listing them for emergency care)

1) _____ Relationship:_____ Phone #_____
   Cell #_____
2) _____ Relationship:_____ Phone #_____
   Cell #_____
3) _____ Relationship:_____ Phone #_____
   Cell #_____

Physician: _____ in _____ Phone #_____
Dentist: _____ in _____ Phone #_____

I give permission for the school nurse to receive and release medical information on my child to his/her physician, dentist, psychologsit, or counselor. ☐ Yes ☐ No

I understand Edinburg Common School will arrange transportation for my child to the nearest hospital.

PARENTAL SIGNATURE: _____ DATE:_____

Authorization for the Administration of Medications and Treatment

Top Section to be completed by Parent/Guardian

I give permission for the following medication/treatment to given to my child if needed**.**
Child's Name: _____ Grade: _____

I understand that I will need to supply any medications in a properly labeled original container from the pharmacy and my child's physician must sign below.

Parent: Please *initia*l each item giving your permission to administer:

_____ **Hydrocortisone Cream 1%** to affected area 1-2 times per day as needed
_____ **Cough Drops** one every two hours as needed (Parents **must** supply)
_____**"Bactine"** antiseptic/analgesic spray to affected area 3-4 times per day as needed
_____ **Calamine Lotion** to affected area as often as necessary
_____ **Bacitracin Ointment** to affected area 2-3 times per day as needed

Parent/Guardian Signature: _____ Date: _____

The New York State Department of Education requires a doctor's order (including dosage) for any oral OTC medication to be given, including topical applications. Medications will only be administered with both the parent's and Doctor's consent and signature.

****

TO BE COMPLETED BY PHYSICIAN/MEDICAL EXAMINER

[ ] I approve the use if the above medications/treatments PRN for my patient at School _____
Exceptions if any _____ (Provider's initials)

I request that my patient listed below receive the following additional medications at school:

Student Name: _____ DOB: __/__/__
Diagnosis: _____
Name of Medication: _____
Prescribed dosage frequency, route: _____
Name of Medication: _____
Prescribed dosage frequency, route: _____

Pleas list any possible side effects to monitor and any recommendations:
_____
_____

Print Name of Prescribers and Title: _____

Prescriber's Signature: _____Phone: _____

Address: _____ Date: _____

EDINBURG COMMON SCHOOL

HEALTH OFFICE

Lead Testing Requirements

Dear Parents and/or Guardians,

New York State Public Health Law and regulations require medical providers to test ALL children for **lead**, with blood lead tests, at one year and two years of age. The law requires that public schools, day care providers and nursery schools "obtain evidence" of lead screening for all children under six years of age.

Please contact your health care provider for a copy of your child's lead screening results, and send written proof to the Edinburg Common School Health Office at 4 Johnson Road, Edinburg, NY 12134. Proof may be dropped off or faxed to (518) 863-2564.

For children who have not been screened due to lack of health insurance, the Saratoga County Lead Screening Program is available at (518) 584-7460 ext. 8362. Testing is by appointment.

If you have any questions, please contact your primary care provider, the Saratoga County Lead Screening Program or the Edinburg Common School Health Office at (518) 863-8412 ext. 24.

Warm Regards,

School Nurse

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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 oral health assessment? ☐ Yes ☐ No

School: Name

Grade

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

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

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

Parent's Signature_____ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

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

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

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

Dentist's/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist's Signature

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

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

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

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

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

II. Treatment Needs (check all that apply)

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

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

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

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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

STUDENT INFORMATION

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

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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

BMI_____kg/m2

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

Hyperlipidemia: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL				

☐ **System Review and Abnormal Findings Listed Below**

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.

☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.

☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.

☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

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

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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

EDINBURG COMMON SCHOOL

Authorization for Use or Disclosure of Protected Health Information

In order to share protected health information with the school district, your healthcare provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays in care for your child.

I, _____ authorize my child's healthcare provider(s) listed below:
Name_____Phone_____FAX_____Name___
_____Phone_____FAX_____Name_____
_____Phone_____FAX_____

to release the medical records of my child, _____, DOB _____
to the district's: ☼ Medical Director ☼ School Nurse ☼ Athletic Trainer (AT) ☼ Counselor ☼ Occupational Therapist (OT) ☼ Physical Therapist (PT) ☼ Psychologist ☼ Social Worker ☼ Speech Therapist (ST)
☼ other _____

The healthcare provider may disclose the following information: (Parent/School: check all that apply)
☼ Immunizations ☼ Health Appraisals ☼ Past/Current Medical Conditions and impact on attendance, athletics, or school programming or therapy ☼ 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 educational, 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.
☼ This authorization is valid for the entire academic school year_20___- 20_____
☼ This authorization is valid for the duration of attendance within the school district
☼ This authorization shall expire on ____/_____/_____ (MO/DD/YR)

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 health care provider listed.

_____
Signature of Parent/Guardian or student if over 18 Relationship Date

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