FORT PLAIN CENTRAL SCHOOL

Student Registration Form

(Please Print Clearly)
This form must be completed for each child in the household hat is enrolling.

OFFICE USE ONLY

School _____
Date Enrolled _____Grade _____
Student ID _____
Homeroom _____
Bus #_____

SECTION 1: Student Information

Student's Legal Name _____ Gender: ___ M ___ F
(First Middle Last)
Date of Birth _____ Place of Birth _____ Grade _____

Physical Address _____ Apt. # _____

City _____ Zip _____
Primary Phone Number _____ Text message number _____
This can be landline or cell, but a number where automated messages/attendance calls can be left.)

Previous School Attended _____ City _____ State ____ Zip _____

Has student ever attended Fort Plain CSD before? □ Yes □ No

What kind of pre-school did the student attend (Pre-K): __Home ___Private Day Care ___Pre-K Program

Name of Facility: _____ City _____ State _____

Country of Birth _____ Date first entered U.S. School, if born outside U.S. _____

Primary Language Spoken in Household: _____

If registering for grades 9-12, date student completed 8th grade _____

SECTION 2: Special Programs (Please initial in one of the spaces below)

_____ Initial here if student is CURRENTLY participating in any special program listed below
_____ Initial here if student PREVIOUSLY participated in any special program listed below
_____ Initial here if student HAS NEVER participated in any special program listed below

Please indicate which Special Programs student is/has been in:

____ IEP ____ Speech ____ RTI ____ 504 Plan ____ AIS Math ____ AIS Reading ____Counseling ____ Other

Is there anything you wish to tell us regarding your child, please explain:

_____

_____

Has your student ever been retained? □ Yes □ No If so, what grade? _____.
If your child currently receives services, would you like them to continue to receive these services? ____Yes ____No

SECTION 3: Ethnicity/Race

Is student of Hispanic/Latino Ethnicity?

____ Yes ____ No

*Race (Check all that apply): **You MUST check AT LEAST one option**

____ American ___ Indian or Alaska Native ____ Black or African-American
____ Asian ____ Native Hawaiian or Other Pacific Islander ____ White

SECTION 4: Medical Information

List any medical conditions of the student_____

Does this student have any life-threatening food, nut, or insect allergies? _____

Does this student have any medically documented restrictions that would prevent participating in PE?

_____ Yes (must provide a doctor's statement) ____ No

Emergency Medical Authorization:

____ I, the parent/guardian give permission for emergency medical treatment of my child for illness or accident if a parent/guardian cannot first be contacted or if an ambulance needs to be called.

Doctor's Name: _____ Doctor's Phone: _____

Preferred Hospital: _____

SECTION 5: Custody and Parent/Guardian Information

Student lives with . . .

___ Both Parents ___ Father ___ Mother ___ Grandparent(s) ___ Guardian(s) ___ Foster Parent(s)

___ Alone ___ Other Relative(s) ___ Other, please explain _____

Enrolling Parent/Guardian is: ____ Married ____ Divorced ____ Separated ____ Widowed ____ Single

Is there a custody issue ____ Yes ____ No

Does an order of protection exist? ____ Yes ____ No

(Copy of court order or other legal documents may be required.)

Primary Household Parent/Guardian 1:

Name _____ Cell Phone _____

(First Middle Last)

Employer _____ Work Phone_____

Preferred Email Address _____ Landline Phone _____

Active member of military: ___ Yes ___ No **OR** Member of military reserves: ___ Yes ___ No

Primary Household Parent/Guardian 2:

Name _____ Cell Phone _____

(First Middle Last)

Employer _____ Work Phone _____

Preferred Email Address _____ Landline Phone _____

Active member of military: _____ Yes _____ No **OR** Member of military reserves: _____ Yes _____ No

Is mailing address different than physical address? ____ Yes ____ No

Street or P.O. Box _____

City _____

Zip _____

Secondary Household Information, if applicable (**Applies to parent(s) not living at the same residence as students**)

Secondary Household Parent/Guardian 1

Name _____ Landline Phone _____
(First Middle Last)

Employer _____ Cell Phone _____

Preferred Email Address _____ Work Phone _____

This person is allowed to pick up student from school and can be contacted in the event of an emergency: ____ Yes ____ No

Active member of military: ____ Yes ____ No **OR** Member of military reserves: ____ Yes ____ No

Secondary Household Parent/Guardian 2:

Name _____ Landline Phone _____
(First Middle Last)

Employer _____ Cell Phone _____

Preferred Email Address _____ Work Phone _____

This person is allowed to pick up student from school and can be contacted in the event of an emergency: ____ Yes ____ No

Active member of military: ____ Yes ____ No **OR** Member of military reserves: ____ Yes ____ No

Is a double mailing required? If so, please complete the following.

Street Address _____ Apartment # _____

City _____ Zip _____

Mailing Address (if different) _____ City _____ Zip _____

Primary Telephone Number _____ (If only cell phones are used, please provide primary number at which to be contacted)

SECTION 6: Student Information (Include new students enrolling and currently enrolled students)

Please provide the names of all students residing in the primary household, along with the date of birth and relationship to each Parent/Guardian (that is, son, daughter, stepson, stepdaughter, grandchild, sister, brother, etc.).

First Name	Middle Name	Last Name	Date of Birth	Relationship to Primary Household Parent/ Guardian 1	Relationship to Primary Household Parent/ Guardian 2	Relationship to Secondary Household Parent/ Guardian 1	Relationship to Secondary Household Parent/ Guardian 2

If there are custody issues that prevent any of the previously indicated heads of household from having access to the students listed above, please provide details. If such restrictions apply to a natural parent or legal parent/guardian, court documentation must be provided.

_____

_____

SECTION 7: Additional Household Members (Please list any other adults living in the Primary Household)

_____

SECTION 8: Emergency Contacts

The following people have permission to pick up my child from school without further contact from me and in the event of an emergency when the Parent/Guardian cannot be reached.

	CONTACT ONE	CONTACT TWO	CONTACT THREE
Name			
Relationship			
Cell Phone			
Work/Landline			
Town of Residence			

SECTION 9: Housing Questionnaire

Where is the student currently living?

____ In permanent housing
____ In a hotel/motel
____ In a car, park, bus, train, or campsite
____ In a shelter
____ With another family or person due to loss of housing or as a result of economic hardship
____ Other temporary living situation:_____

The answer you gave above will help the district determine what service 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, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

SECTION 10: Parent/Guardian Signature

My relationship to the student is:

____ Parent
____ Grandparent
____ Legal Guardian (documentation needed)
____ Person having lawful Court Order (copy required)
____ Other (Non-Parental Affidavit required)
____ Self/ Student (must be 18 years or older

I hereby certify that I am either a full-time resident of the Fort Plain school district or am an employee of FPCSD and affirm that all the information contained in this form is true and accurate to the best of my knowledge.

Printed Name _____Date _____

Signature _____

SECTION 11: Transportation

My student will: ____ Walk ____ Will be picked up ____ Will ride the bus

If your child will be riding the bus:

AM Pick-Up: _____

PM Drop-Off: _____

FOR SCHOOL USE ONLY

Enrollment Documents Received:

___ Birth Certificate
___ Records Release
___ Custody Documentation
___ Health Records
___ Report Card
___ SPED Records

Residency Proof:

___ Lease or Mortgage Statement
___ Utility Bill
___ Other: _____
___ Parent is FPCSD Employee
___ Homeless Statement
___ From Parent

___ IT student account
___ Status Codes
___ Parent Notification
___ Email teachers

Approved: _____ (Principal) Date: _____

Approved: _____ (Superintendent) Date: _____

Fort Plain Central School District

25 High Street

Fort Plain, NY 13339

Harry Hoag Elementary School

Mrs. Jodi Coppolo, Principal

Fort Plain Jr. /Sr. High School

Mrs. Deborah Larrabee, Principal

Student Name _____ DOB _____ Grade _____

Prior School District: _____

Fax _____ Phone_____

Parent Signature _____ Date _____

Does your child currently receive Special Education Services Y N (Please circle)

The above student has registered at Fort Plain Central School. This is to request and authorize the release of the following records and information.

----Current transcript with exiting grades

---- Standardized Test Scores

----Health and Immunization Records

----Attendance Records

----Custody/Guardianship/Court Orders

----IEP / 504 / Remediation / Support Services

----Academic Records

----Birth Certificate

----Psychological Evaluation

----Social History

Date of entry at Fort Plain CSD: _____

Please Email or Fax records to:

PK-6

Jennifer Weaver

jennifer.weaver@fortplain.org

Phone: (518) 993-4000 x 3059

Fax: (518) 993-4501

7-12

Karen Shibley

karen.shibley@fortplain.org

Phone: (518) 993- 4000 x 2128

Fax: (518) 993-2897

Fort Plain Central School

Student Name:	DOB:
School Name:	Age:
Grade (check): PK K 1 2 3 4 5 6 7 8 9 10 11 12	Limitations: ☐ NO ☐ YES
Sport	Date of last Health Exam:
Sport Level: ☐ Modified ☐ Fresh ☐ JV ☐ Varsity	Date form completed:

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on last page

Does or Has Your Child

General Health	No	Yes
Ever been restricted by a health care provider from sports participation for any reason?	☐	☐
Ever had surgery?	☐	☐
Ever spent the night in a hospital?	☐	☐
Been diagnosed with mononucleosis within the last month?	☐	☐
Have only one functioning kidney?	☐	☐
Have a bleeding disorder?	☐	☐
Have any problems with hearing or have congenital deafness?	☐	☐
Have any problems with vision or only have vision in one eye?	☐	☐
Have an ongoing medical condition?	☐	☐
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Other:		
Have Allergies?	☐	☐
If yes, check all that apply ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other:		
Ever had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐

Brain/Head Injury History	No	Yes
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?	☐	☐
Receive treatment for a seizure disorder or epilepsy?	☐	☐
Ever had headaches with exercise?	☐	☐
Ever had migraines?	☐	☐

Does or Has Your Child

Breathing	No	Yes
Ever complained of getting extremely tired or short of breath during exercise?	☐	☐
Use or carry an inhaler or nebulizer?	☐	☐
Wheeze or cough frequently during or after exercise?	☐	☐
Ever been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐

Devices / Accommodations	No	Yes
Use a brace, orthotic, or another device?	☐	☐
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wear protective eyewear, such as goggles or a face shield?	☐	☐
Wear a hearing aid or cochlear implant?	☐	☐

Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.

Digestive (GI) Health	No	Yes
Have stomach or other GI problems?	☐	☐
Ever had an eating disorder?	☐	☐
Have a special diet or need to avoid certain foods?	☐	☐
Are there any concerns about your child's weight?	☐	☐

Injury History	No	Yes
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	☐	☐
Have a bone, muscle, or joint that bothers them?	☐	☐
Have joints that become painful, swollen, warm, or red with use?	☐	☐
Ever been diagnosed with a stress fracture?	☐	☐

Does or Has Your Child

Heart Health		
Ever complained of:	No	Yes
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Lightheadedness, dizziness, during or after exercise?	☐	☐
Chest pain, tightness, or pressure during or after exercise?	☐	☐
Fluttering in the chest, skipped heartbeats, heart racing?	☐	☐
Ever been told by a health care provider they have or had a heart or blood vessel problem?	☐	☐

If yes, check all that apply:

☐ Chest Tightness or Pain ☐ Heart infection
☐ High Blood Pressure ☐ Heart Murmur
☐ High Cholesterol ☐ Low Blood Pressure
☐ New fast or slow heart rate ☐ Kawasaki Disease
☐ Has implanted cardiac defibrillator (ICD)
☐ Has a pacemaker
☐ Other:

Does or Has Your Child

Females Only	No	Yes
Have regular periods?	☐	☐
Males Only	**No**	**Yes**
Have only one testicle?	☐	☐
Have groin pain or a bulge, or a hernia?	☐	☐
Skin Health	**No**	**Yes**
Currently have any rashes, pressure sores, or other skin problems?	☐	☐
Ever had a herpes or MRSA skin infection?	☐	☐
COVID-19 Information		
Has your child ever tested positive for COVID-19?	☐	☐
If **NO, STOP.** Go to Family Heart Health History. If **YES,** answer questions below:		
Date of positive COVID test:	No	Yes
Was your child symptomatic?	☐	☐
Did your child see a health care provider for their COVID-19 symptoms?	☐	☐
Was your child hospitalized for COVID?	☐	☐
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	☐	☐

Family Heart Health History

A relative has/had any of the following:

Check all that apply:

☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
☐ Heart rhythm problems, long or short QT interval?
☐ Brugada Syndrome?
☐ Catecholaminergic Ventricular Tachycardia?
☐ Marfan Syndrome (aortic rupture)?
☐ Heart attack at age 50 or younger?
☐ Pacemaker or implanted cardiac defibrillator (ICD)?

A family history of:

☐ Known heart abnormalities or sudden death before age 50?
☐ Structural heart abnormality, repaired or unrepaired?
☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

If you answered **Yes** to any Questions, please give details:

_____
_____
_____
_____
_____
_____

Parent/Guardian Signature:	*Date:*

If you answered **YES** to any questions give details. Sign and date below**.**

Parent/Guardian Signature:	*Date:*

Fort Plain Central School

Student Name:	DOB:
School Name:	Age:
Grade: PK K 1 2 3 4 5 6 7 8 9 10 11 12	Level (check): ☐ Modified ☐ Fresh ☐ JV ☐ Varsity
Sport:	Limitations: ☐ Yes ☐ No
Date of last health exam:	Date form completed:

Health History To Be Completed By Parent/Guardian, Provide Details To Any Yes Answers On Back.
Any medications to be taken at practice and/or athletic event will require the proper paperwork, contact school with questions.

Has/Does your child:		
General Health Concerns	**Yes**	**No**
1. Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason?		
2. Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait or disease ☐ Other		
3. Ever had surgery?		
4. Ever spent the night in a hospital?		
5. Been diagnosed with Mononucleosis within the last month?		
6. Have only one functioning kidney?		
7. Have a bleeding disorder?		
8. Have any problems with his/her hearing or wears hearing aid(s)?		
9. Have any problems with his/her vision or has vision in only one eye?		
10. Wear glasses or contacts?		
Allergies	**Yes**	**No**
11. Have a life threatening allergy? Check any that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other		
12. Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health	**Yes**	**No**
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?		
14. Wheeze or cough frequently during or after exercise?		
15. Ever been told by their health care provider they have asthma?		
16. Use or carry an inhaler or nebulizer?		

Has/Does your child:		
Concussion/ Head Injury History	**Yes**	**No**
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?		
18. Have you ever had a head injury or concussion?		
19. Ever had headaches with exercise?		
20. Ever had any unexplained seizures?		
21. Currently receive treatment for a seizure disorder or epilepsy?		
Devices/Accommodations	**Yes**	**No**
22. Use a brace, orthotic, or other device?		
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes there may be need for another required form to be filled out.		
24. Wear protective eyewear, such as goggles or a face shield?		
Family History	**Yes**	**No**
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Females Only	**Yes**	**No**
26. Begun having her period?		
27. Age periods began:		
28. Have regular periods?		
29. Date of last menstrual period:		
Males Only	**Yes**	**No**
30. Have only one testicle?		
31. Have groin pain or a bulge or hernia in the groin?		

Student Name:	
School Name:	DOB:

Has/Does your child:		
Heart Health	**Yes**	**No**
32. Ever passed out during or after exercise?		
33. Ever complained of light headedness or dizziness during or after exercise?		
34. Ever complained of chest pain, tightness or pressure during or after exercise?		
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?		
36. Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)?		
37. Ever been told they have a heart condition or problem by a physician? If so, check all that apply: ☐Heart infection ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐Other:		
Injury History	**Yes**	**No**
38. Ever been diagnosed with a stress fracture?		

Has/Does your child:		
Injury History *continued*	**Yes**	**No**
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
41. Have a bone, muscle, or joint injury that bothers him/her?		
42. Have joints become painful, swollen, warm, or red with use?		
Skin Health	**Yes**	**No**
43. Currently have any rashes, pressure sores, or other skin problems?		
44. Have had a herpes or MRSA skin infections?		
Stomach Health	**Yes**	**No**
45. Ever become ill while exercising in hot weather?		
46. Have a special diet or have to avoid certain foods?		
47. Have to worry about his/her weight?		
48. Have stomach problems?		
49. Have you ever had an eating disorder?		

Please explain fully any question you answered yes to in the space below. (Please print clearly and provide dates if known.

_____

_____

_____

_____

_____

_____

_____

Parent/Guardian Signature: _____Date: _____

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, prostectic, 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.

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.

(3/2018)

FORT PLAIN CENTRAL SCHOOL DISTRICT
25 HIGH STREET * FORT PLAIN, NEW YORK 13339-1365
"OUR AIM IS EXCELLENCE" TELEPHONE 518-993-4000

Parent and Prescriber's Authorization for Administration of Medication in School

A. To be completed by parent/guardian:
I request that my child _____, grade _____ receive the medication as prescribed below by our licensed health care Prescriber. The medication is to furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, trained staff (per supervised student), or whom I have designated, will administer the medication.
Signature (Parent/Guardian) _____
Address _____
Telephone (Home) _____ (Work) _____ Date _____

B. To be completed by the licensed health care prescriber:
I request that my patient, as listed below, receive the following medication.:
Name of Student: _____ Date of Birth: _____
Diagnosis: _____
Name of Medications:
_____
_____
Prescribed Dosage, Frequency and Route of Administration: _____
Time to be taken during the school hours: _____
Duration of Treatment: _____
Possible side effects and adverse reaction (if any): _____
_____
Other recommendations: _____

Please check all that apply:

_____ Supervised Student – can be assisted by trained staff (Student able to identify medication, knows when, how much, and why they take the medication. They know what happens if they don't take it and knows when to refuse the medication).

_____ Nurse Dependent Student

_____ Independent Student – can take (self-administer) their own medication without assistance.

_____ Student takes medication independently in health office (after being handed the medication container by school staff).

_____ Student is permitted to carry and use medication with the required documentation at school and sporting events.

Name of Licensed Prescriber and Title (Please Print) _____

Signature: _____ Date: _____

2023-2024 Student Technology Sign-Out Agreement

CORE PRACTICE:

- **Technology is to be used for research and school related activities.**
- **Devices will be carried with care and used responsibly.**
- **Food and liquids will be kept away from devices.**
- **Students will ensure their device is charged when not in use.**
- **Websites and apps used will be relevant to the given assignment topic, and appropriate for school.**
- **Students will take care of the device as if it were their own.**

OUT OF BOUNDS BEHAVIOR:

- **Deliberate damage or physical changes to the device.**
- **Carelessness that may result in accidental damage to the device.**
- **Cyberbullying.**
- **Food and drinks near or on the devices.**
- **Inappropriate videos, sites or content that violate the Fort Plain Central School District Code of Conduct.**
- **Using the device for activities not related to school work.**

LOSS OR DAMAGE:

- **If the device or charger is damaged, lost, or stolen, the student and parent are responsible for the cost of the repair or replacement deductible, up to $100.00.**
- **Any damage, loss or theft of the property must be reported to the District as soon as possible, and no later than the next school day following the occurrence.**
- **The District may pursue legal action against any student who willfully, maliciously or unlawfully damages, destroys or steals a District-own device.**

2023-2024 Student Technology Sign-Out Agreement

By signing below, I acknowledge the following:

- I have read the expectations listed above, and the official Fort Plain School District Acceptable Use Policy: Student Use of Computerized Information Resources, Policy #7314.
- I understand that technology access is designed for educational purposes. The Fort Plain School District has taken reasonable steps to control access to the Internet, but cannot guarantee that all controversial information will be inaccessible to students.
- I agree that I will not hold the Fort Plain School District responsible for materials acquired on the device or network. I accept full responsibility for supervision when my child's use is not in a school setting.
- I understand that any violation of the regulations defined in these aforementioned guidelines and policies is unethical, and that violations may constitute the following actions: My child and I may be responsible for the cost of repair or replacement up to $100.00. My child's privileges may be revoked. School disciplinary action against my child may be taken. Appropriate legal action may be initiated against my child or me.

Name of Child(ren) _____

Grade Level of Child(ren) _____

Parent/Guardian Name (print) _____

Parent/Guardian Signature _____

Date of Signature _____

FORT PLAIN CENTRAL SCHOOL DISTRICT

25 HIGH STREET * FORT PLAIN, NEW YORK 13339–1365

"OUR AIM IS EXCELLENCE" TELEPHONE 518–993–4000

New York State requires school districts to collect information regarding student access to technology. Please complete and return to the main office.

Student's Name _____ Today's Date _____
Student's Grade _____

1. Did the school district issue your child a dedicated school or district-owned device for their use during the school year? _____ Yes _____ No

2. What is the device your child uses most often to complete learning activities away from school? (This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.)
   - A. Desktop
   - B. Laptop
   - C. Tablet
   - D. Chromebook
   - E. Smartphone
   - F. Other

3. Who is the provider of the primary learning device identified in question 2? (This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.)
   - A. Personal
   - B. School
   - C. No Device

4. Is the primary learning device (identified in question 2) shared with anyone else in the household?
   - A. No Device
   - B. Shared
   - C. Not Shared

5. Is the primary learning device (identified in question 2) sufficient for your child to fully participate in all learning activities away from school? _____ Yes _____ No

6. Is your child able to access the internet in their primary place of residence? _____Yes _____No

7. What is the primary type of internet service used in your child's primary place of residence?
   - A. Residential Broadband
   - B. Cellular
   - C. Mobile Hotspot
   - D. Community WIFI
   - E. Satellite
   - F. Dialup
   - G. DSL
   - H. Other
   - I. None

8. In their primary residence, can your child complete the full range of learning activities, including video streaming and assignment upload, without interruptions caused by slow or poor internet performance? ____Yes ____No

9. What, if any, is the primary barrier to having sufficient and reliable internet access in your child's primary place of residence?

   A. Availability
   B. Cost
   C. Other
   D. None

ParentSquare

ParentSquare Tips for Parents

1 Activate Account

Click the link in your invitation email/ text or sign up on ParentSquare.com or via the ParentSquare app.

2 Download App

It's easy to stay in the loop with the ParentSquare app. Download it now from the App store or Google Play.

3 Set Preferences

Click your name in the top right to visit your account page and set your notification and language preferences.

4 Get Photos & Files

Click 'Photos & Files' in sidebar to easily access pictures, forms and documents that have been shared with you.

5 Appreciate Posts

Click 'Appreciate' in your email/ app or website to thank a teacher or staff for a post. Teachers love the appreciation.

6 Comment or Reply

Click 'Comment' in app or website to privately ask a question about the post that your teacher or school sent.

7 Participate

Click 'Sign Ups & RSVPs' in the sidebar to see available opportunities. Click bell on top to check your commitments.

8 Join a Group

Click 'Groups' in the sidebar to join a group or committee at your school to participate or to stay up-to-date.

9 Find People

Click 'Directory' in the sidebar to find contact information for teachers and parents (not available at all schools).

10 Get in Touch

Click 'Messages' in the sidebar to privately get in touch with staff, teachers and parent leaders.

FORT PLAIN
HILLTOPPERS

School Bus Behavior Contract

RIDE WITH PRIDE

Please read carefully, then sign and return this agreement to your school office within 3 days after receiving the contract.

General Information

- Bus drivers, students, parents, teachers, and school administrators share the responsibility for bus safety, following all bus rules, and behaving in a responsible manner.

☐ **I agree to ride the bus safely.**

Stay seated
Keep aisles free of backpacks
At stops, remain at designated area until bus comes to complete stop

DO NOT put any part of my body outside the window
DO NOT push or shove others
DO NOT leave seat while bus is in motion

☐ **I agree to follow all bus rules and be responsible.**

Keep hands and feet to myself
No eating on the bus
Respect bus property
Sit in assigned seats

DO NOT possess weapons including laser pens
DO NOT possess alcohol, tobacco, or illegal drugs
DO NOT tamper with emergency door or equipment

☐ **I agree to treat the bus, the driver, and all passengers with respect.**

Obey directions from my bus driver
Talk and act kindly to others

DO NOT leave trash, food, etc. on the bus
DO NOT throw, spit, kick or hit
DO NOT use foul language, tease, threaten others, or use Inappropriate gestures.

If I choose not to follow this contract, I understand the following consequences may occur, or in the event of a serious offense I may be suspended from the bus immediately:

#1 My parent(s)/guardian will be notified by an administrator at my school district and I will be warned about the consequences of not following the school bus rules. I understand that other disciplinary measures may include a change in seat assignment, loss of privileges, parent/student conference with district administration, or other actions that are relevant to the offense.

#2 My parent(s)/guardian will be notified by an administrator and I may lose all bus privileges. If a student loses bus privileges, it is your responsibility to arrange transportation to school to ensure continuity in the student's education.

#3 Severe Clause: Students may be suspended immediately from the bus for severe infractions for a period of time to be determined by the school administrator. A serious infraction, such as a weapon, drug or physical violence, may result in bus privileges being suspended immediately and further disciplinary actions may occur.

NOTE: If bus privileges are suspended, I must arrange my own transportation to and from school.

Please print legibly. Signatures indicate that you have discussed, understand, and agree to the above statements. Thank you.

Parent/Guardian Name _____ Student Name _____

Parent/Guardian Signature _____ Student's Signature _____

Date: _____

FORT PLAIN CENTRAL SCHOOL DISTRICT

25 HIGH STREET * FORT PLAIN, NEW YORK 13339-1365

"OUR AIM IS EXCELLENCE" TELEPHONE 518-993-4000

Dear Parents and Guardians of Fort Plain Students,

On July 1, 2015 an amendment was made to New York State Education Law, pursuant to Chapter 434 of the Laws of 2014, regarding special education parental notification requirements upon a student's entry into school. Section 4402 of the Education Law is an amendment that requires school districts to notify every parent or person in parental relation of their rights regarding the referral and evaluation of their child for the purposes of special education services or programs. This notification is provided to parents of all students in the Fort Plain Central School District, with or without disabilities.

This information may be obtained in either of two ways:

1) Follow the link below to *A Parent's Guide to Special Education* on the New York State Education Department's web site, http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm .
2) Obtain a copy of A Parent's Guide to Special Education from the main office at Harry Hoag Elementary School or the Junior/Senior High School.

If there are any questions regarding special education and/or the referral process, please contact Fort Plain Central School District's Special Education office. Contact information is as follows:

Katrina Cannallatos
Director of Special Education
(518)993-4000 Ext. #3074
Katrina.canallatos@fortplain.org

Sincerely,

Katrina Canallatos

Katrina Canallatos
Director of Special Education

STAC ID
| | | | |

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
STAC/Medicaid Unit
Room EB 25, Education Building
Albany, NY 12234

STAC-202
HOMELESS DESIGNATION
Rev. 11/2022

Designation of School District of Attendance for a Homeless Child

Submitted by: ☐ Local Dept of Social Services (DSS) ☐ Designated School District of Attendance (PSD)

PLEASE READ THE INSTRUCTIONS ON THE REVERSE BEFORE COMPLETING THIS FORM

1. NAME OF CHILD

LAST NAME

FIRST NAME **M.I.**

2. DATE OF BIRTH \| \| **MO / DAY / YR**

3. GENDER
☐ **FEMALE**
☐ **MALE**
☐ **NON-BINARY**

5. Racial/Ethnic Category of Child (See definitions on reverse side of last page.)

American Ind or Alaskan Native ☐ **Asian or Pacific Isl.** ☐ **Black** ☐ **Hispanic** ☐ **White** ☐

6. GRADE LEVEL FOR WHICH PLACEMENT IS SOUGHT \|

7. COMPLETE ADDRESS BEFORE CHILD/FAMILY BECAME HOMELESS

8. COMPLETE ADDRESS OF CURRENT LOCATION

DATE CHILD/FAMILY PLACED IN TEMPORARY HOUSING \| \|
MONTH DAY YEAR

9. DATE DISTRICT OF ATTENDANCE CHOSEN \| \|
MONTH DAY YEAR

10. DATE PLACED IN PERMANENT HOUSING \| \|
MONTH DAY YEAR

7A. NYS SCHOOL DISTRICT OF ATTENDANCE BEFORE BECOMING HOMELESS

7B. NYS SCHOOL DISTRICT WHERE LAST ENROLLED

8A. NYS SCHOOL DISTRICT OF CURRENT LOCATION

9A. NYS DESIGNATED DISTRICT OF ATTENDANCE

One of four school districts may be chosen to provide the education component: the school district of attendance before becoming homeless, the school district where last enrolled, the school district of current location or a school district participating in a Regional Placement Plan. This designation may be changed either prior to the end of the first semester of attendance or within 60 days of making this designation, whichever occurs later.

11. Check the appropriate box if the designated school district of attendance (9A) is different from the district of attendance before becoming homeless (7A) and from the district of current location (8A).

☐ District participating in a Regional Placement Plan OR ☐ District where last enrolled (7B) if it is different from the district where last permanently housed (7A) and the district of current location (8A).

12. ....
NAME OF PARENT OR PERSON IN PARENTAL RELATIONSHIP AREA CODE TELEPHONE NUMBER

13. ....
SIGNATURE OF PERSON IN PARENTAL RELATIONSHIP TO CHILD DATE

IT HAS BEEN REPORTED TO ME THAT THIS CHILD IS UNDER THE AGE OF 21 YEARS AND IS THEREFORE ELIGIBLE FOR EDUCATIONAL SERVICES. THE CHILD HAS BEEN ADVISED OF HIS/HER RIGHT TO DESIGNATE THE SCHOOL DISTRICT OF ATTENDANCE.

14. .....
PRINT NAME OF LOCAL DSS OR SCHOOL DISTRICT REPRESENTATIVE TITLE

15. ....
SIGNATURE OF LOCAL DSS OR SCHOOL DISTRICT REPRESENTATIVE DATE

16. PLACEMENT COUNTY ..... \| \| ....
Local DSS use only AREA CODE TELEPHONE NUMBER

INSTRUCTIONS FOR COMPLETING THE STAC-202 FORM
Designation of School District of Attendance for a Homeless Child

Education of homeless children means 1) a child or youth who lacks a fixed, regular, and adequate night-time residence, including a child or youth who is (i) sharing the housing of other persons due to a loss of housing, economic hardship or a similar reason; (ii) living in motels, hotels, trailer parks or camping grounds due to the lack of alternative adequate accommodations; (iii) abandoned in hospitals, (iv) awaiting foster care placement; or (v) a migratory child, as defined in § 1309(2) of the Elementary and Secondary Education Act of 1965, as amended, who qualifies as homeless under any of the provisions of clauses (i) through (iv) of this subparagraph or subparagraph two of this paragraph; or 2) a child or youth who has a primary nighttime location that is (i) a supervised publicly or privately operated shelter designed to provide temporary living accommodations including, but not limited to, shelters operated or approved by the state or local department of social services, and residential programs for runaway and homeless youth established pursuant to article nineteen-H of the executive law; or (ii) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, including a child or youth who is living in a car, park, public space, abandoned building, substandard housing, bus or train stations or similar setting.

1. Enter the youth's complete last name and first name.
2. Enter the youth's date of birth.
3. Place a check in the box which identifies the gender of the youth.
4. Item reserved for future use.
5. Place a check in the box which identifies, to the best of your knowledge, the racial/ethnic category with which the youth most closely identifies.

Racial/Ethnic Categories:

American Indian or Alaskan Native - A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

Asian or Pacific Islander – A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.

Black – A person having origins in any of the black racial groups of Africa.

Hispanic – A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

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

6. Enter the grade level for which placement is being sought.
7. Enter the complete last permanent address prior to becoming homeless.

7A. Enter the name of the school district that served the area where the child resided prior to becoming homeless.

7B. Enter the name of the school district where the student was last enrolled. This will be different from 7A if the student was previously temporarily housed in a different district and enrolled in that district as a non-resident homeless student.

8. Enter the complete address of current temporary housing including the name of the shelter if applicable and the date the student moved to the current location. If the location is confidential (for example, if the student is living in a domestic violence shelter), the name and address of the location do not need to be provided.

8A. Enter the name of the school district of current location.

9. Enter the date of designation.

9A. Enter the name of the designated school district of attendance. One of four districts may be designated to provide the educational component:
District of attendance before becoming homeless,
District where last enrolled,
District of current location of temporary housing, or
District participating in a Regional Placement Plan (RPP).

10. Enter, if applicable, the date the child moved to permanent housing and is no longer eligible as a homeless student.
11. If the student attends school in a district participating in a Regional Placement Plan or the district where last enrolled (7B), and that district is different from both the district of attendance before becoming homeless (7A) and the district of current location (8A), check the corresponding box where the student attends school (either the District participating in a Regional Placement Plan or the District where last enrolled).
12. Print the name and telephone number of the designator. The designator can be the parent, person in parental relation, the unaccompanied youth (a youth who meets the definition of homeless and is not in the physical custody of a parent or guardian), or the director of a residential program for runaway and homeless youth if the student is living in such a program.
13. The signature of the designator and current date.
14. Print the name of the local Department of Social Services or School District representative and title.
15. The signature of the local Department of Social Services or School District representative is required attesting that this child has moved to temporary housing. A telephone number is required in case the STAC & Special Aids Unit has questions relating to the information provided.
16. The name of the local Department of Social Services that has placed the child in temporary housing, if applicable.

NOTE: Copies should be distributed to the following:

1. State Education Department, only if designated district of attendance is entitled to reimbursement for educational services pursuant to N.Y. Educ. Law § 3209(3);
2. Designated School District of Attendance;
3. District of Attendance before becoming homeless;
4. District where last enrolled;
5. Parent/Guardian/Unaccompanied youth/director of a residential program for runaway and homeless youth; and
6. Local Department of Social Services, only if placed in temporary housing by DSS.