

Central Valley School District PreK-12 Enrollment Form

Central Valley Academy
111 Frederick Street
Ilion, NY 13357
Phone: 315-895-7471
Fax: 315-895-5255

Gregory B. Jarvis Middle School
28 Grove Street
Mohawk, NY 13407
Phone: 315-866-2620
Fax: 315-867-2909

Barringer Road Elementary
326 Barringer Road
Ilion, NY 13357
Phone: 315-894-8420
Fax: 315-894-0153

Harry M. Fisher Elementary
10 Fisher Avenue
Mohawk, NY 13407
Phone: 315-866-4851
Fax: 315-866-0055

District Registrar use only		Student ID: _____	Enter date: _____
Placement:	<input type="checkbox"/> CVA <input type="checkbox"/> JMS <input type="checkbox"/> BR <input type="checkbox"/> F <input type="checkbox"/> Other _____	Grade: _____	Teacher: _____
Documentation:			
<input type="checkbox"/> Proof of age	<input type="checkbox"/> Proof of residency	<input type="checkbox"/> New student	<input type="checkbox"/> Returning student
<input type="checkbox"/> Guardianship/custody paperwork (if applicable)	<input type="checkbox"/> Foster care	<input type="checkbox"/> CSE	<input type="checkbox"/> School records received
<input type="checkbox"/> Immunization records	<input type="checkbox"/> Physician physical		<input type="checkbox"/> CSE records received

STUDENT INFORMATION

Last: (Legal name only)	First:	Middle:	Suffix (Jr., II, III):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Other name(s) used previously (AKA):	Nickname:	Date of birth:	Place of birth:	

PARENT/GUARDIAN INFORMATION

<i>Indicate child's primary residence if not with both parents. Documentation of legal custody must be provided.</i>			
Father/Guardian <input type="checkbox"/> Primary Residence	Mother/Guardian <input type="checkbox"/> Primary Residence	Maiden Name:	
Name:	Name:		
Address:	Address:		
Mailing Address (if different):	Mailing Address (if different):		
Phone 1: <input type="checkbox"/> home <input type="checkbox"/> cell	Phone 2: <input type="checkbox"/> work <input type="checkbox"/> cell	Phone 1: <input type="checkbox"/> home <input type="checkbox"/> cell	Phone 2: <input type="checkbox"/> work <input type="checkbox"/> cell
Email:	Email:		
Place of employment:	Place of employment:		
Education/Highest grade completed:	Education/Highest grade completed:		
Other relationship if applicable:	Other relationship if applicable:		

FOSTER CARE PLACEMENT – complete this section only if child is in foster care

Foster Parent name:	Relationship to child:	Phone 1: <input type="checkbox"/> work <input type="checkbox"/> cell	Phone: <input type="checkbox"/> work <input type="checkbox"/> cell
Address:			
Employer:	Child's School District of Origin:		
Agency placing child:	Date Child was placed:		
Name of agency caseworker assigned to the child:	Phone:		
School Last Attended:	School Address:		

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STUDENT RESIDENCY QUESTIONNAIRE

Note: The questions in this section are used to help identify students in homeless situations as required by the McKinney-Vento Homeless Assistance Improvements Act, 42U.S.C. 11435. Answers to this residency information help determine the services the student may be eligible to receive.	
Is your current address a temporary living arrangement? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is this temporary living arrangement due to loss of housing or economic hardship? <input type="checkbox"/> No <input type="checkbox"/> Yes
If you answered YES to the above questions, please complete the Student Residency Questionnaire available from the district registrar.	

SIBLINGS

Name	Gender: M/F	Date of Birth	Grade	Full/Half/Step	Residence
					<input type="checkbox"/> Home <input type="checkbox"/> Other
					<input type="checkbox"/> Home <input type="checkbox"/> Other
					<input type="checkbox"/> Home <input type="checkbox"/> Other
					<input type="checkbox"/> Home <input type="checkbox"/> Other
					<input type="checkbox"/> Home <input type="checkbox"/> Other
					<input type="checkbox"/> Home <input type="checkbox"/> Other
					<input type="checkbox"/> Home <input type="checkbox"/> Other

OTHERS IN HOUSEHOLD

Name	Date of Birth	Relationship to Child

EMERGENCY CONTACTS

<i>Person or relative who we can contact if you are not reachable by phone.</i>			
Name	Address	Phone	Relationship to Child

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EDUCATION/SCHOOL BACKGROUND

Previous Schools Attended	Address	Entry Date/Grade	Left Date/Grade

Has your child ever been retained? <input type="checkbox"/> No <input type="checkbox"/> Yes		Grade:	Year:
Has your child ever been in a special program? <input type="checkbox"/> No <input type="checkbox"/> Yes		In a special education program? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If YES, for what program?		Date in program?	
Specific Learning Disability <input type="checkbox"/> No <input type="checkbox"/> Yes Dates in program:	Educable Mentally Disabled <input type="checkbox"/> No <input type="checkbox"/> Yes Dates in program:	Emotionally Disabled <input type="checkbox"/> No <input type="checkbox"/> Yes Dates in program:	
Visually Impaired <input type="checkbox"/> No <input type="checkbox"/> Yes Dates in program:	Physically Disabled <input type="checkbox"/> No <input type="checkbox"/> Yes Dates in program:	Occupational/Physical Therapy <input type="checkbox"/> No <input type="checkbox"/> Yes Dates in program:	
Speech, Hearing, and Language Impaired <input type="checkbox"/> No <input type="checkbox"/> Yes Dates in program:	Remedial Reading <input type="checkbox"/> No <input type="checkbox"/> Yes Dates in program:	Remedial Math <input type="checkbox"/> No <input type="checkbox"/> Yes Dates in program:	
Gifted and Talented <input type="checkbox"/> No <input type="checkbox"/> Yes Dates in program:	Other: Dates in program:		
<i>If your child was in a special program, indicate where school records may be obtained:</i>			
School Name:		Phone:	
Address:			
Information and documentation provided:			
<input type="checkbox"/> Current IEP <input type="checkbox"/> Current Psychological <input type="checkbox"/> Current Social History <input type="checkbox"/> Current medical Records			
Current physician's prescription for any of the following therapies being received in school:			
<input type="checkbox"/> Speech Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy			

CHAPTER 53, EDUCATION LAW OF 1980 - SCREENING

According to Chapter 53, Education Law of 1980, all new entrants to public schools in New York State must be screened for possibly handicapping conditions (such as learning disabilities, sensory deficits, physical impairments, etc.) or for giftedness (students who are capable of high academic aptitude, leadership, or special talent in one or more of the arts). Your child will be screened soon in areas of physical development, speech, and language, motor abilities and cognitive development. You will be notified of the results.

Parent/Guardian Signature	Date:
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PARENT GUARDIAN SIGNATURE/AUTHORIZATION

Please forward student records to the school circled below to the attention of "Building Registrar."

Central Valley Academy
111 Frederick Street
Ilion, NY 13357
Phone: 315-895-7471
Fax: 315-895-5255

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Student Name:	Date of Birth:	Grade Level:	Entry Date:
Previous school name:	Phone number:	Fax number:	
Previous school address:			
By signing below: I give permission for Central Valley School District to request all transfer records and pertinent information from my child's former school. I certify that the student has had polio, diphtheria (DPT), MMR, and varicella vaccines. I certify that the information contained in this enrollment form is true and correct to the best of my knowledge.			
Parent/Guardian Signature:		Date:	

ADDITIONAL PARENTAL CONSENT FOR STUDENTS ENTERING A SPECIAL EDUCATION PROGRAM

I, as parent or guardian, agree with the Committee on Special Education's initial educational placement recommendations for:	
Student name:	Classification from current IEP:
Program placement based on current IEP:	
By signing below: I understand that this placement is based on current records that have been obtained from my child's previous school. I understand that this placement may have been adjusted as determined by the Central Valley School District staff. I understand that this placement is temporary and that the Central Valley School District Committee on Special Education will convene in the near future to review the records from my child's previous school, and will make formal recommendations for program and services.	
Parent/Guardian Signature	Date:

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MEDICAL INFORMATION (TO BE COMPLETED BY PARENT/GUARDIAN)

<i>The following information is a necessity to insure that health records pertaining to your child are current and accurate.</i>					
(Legal name only) Last name		First	Middle	Suffix (Jr., II, III)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Other name(s) used previously (AKA)	Nickname	Date of birth	Place of birth	Grade Level	
Student Address:				Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell	
Father's Name:		Mother's Name:		Mother's Maiden Name:	
Guardian/Step-parent's Name:		Student resides with (<i>Father, Mother, Guardian, Other-Indicate relationship</i>)			
Physician Name and Address:				Phone:	
Dentist Name and Address:				Phone:	
Emergency Contact Name (1):		Phone:		Relationship:	
Emergency Contact Name (2):		Phone:		Relationship:	

Immunizations: *Please attach a copy of your child's most recent immunization records from their physician.*

Health History		
<i>Please complete the following as accurately as possible.</i>		
Allergies to food, drugs, bees, animals, or environmental	<input type="checkbox"/> No <input type="checkbox"/> Yes	Type of allergy : Medication taken:
Hay fever, asthma wheezing	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Eczema or frequent skin rashes	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Convulsions or seizures	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Heart trouble or murmurs	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Pneumonia	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Frequent (more than 3 times a year) colds, sore throat, or ear aches	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Rheumatic fever / scarlet fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Mononucleosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Chicken Pox	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Measles/mumps/rubella (3 day measles)	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Meningitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Strep infections	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Speech problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Bowel or urinary problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:

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Nutrition or weight problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Behavior, developmental, or maturity problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Social adjustment problems (family, friends, school)	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Severe accidents or injuries	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Hospitalizations	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Surgery	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Known vision problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Known hearing problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Pain in legs, arms, back or joints	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Limp or unusual walk	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Balance issues or unexplained sudden movements	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Other physical problems not mentioned	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate dates and explain:
Did child attend preschool?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, what school?

Medications: Is your child taking any medication? (If child needs medication administered in school, a medication request form must be completed and signed by a physician before medication will be given at school.)			
<input type="checkbox"/> No <input type="checkbox"/> Yes	Name of medication and dosage:	Reason for medication:	
Prenatal history:	Child's birth weight:	Duration of pregnancy:	Prenatal difficulties:
Did the child have any difficulties at birth? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, explain:	
Physical Activity: Does your child have any physical difficulty that would prevent them from participating in the normal physical education class or other activities? (If your child is unable to participate in physical education class, then a physician's certificate is required.)			
<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, explain:		

NOTE: A student who has been absent more than 5 consecutive days and under the care of a physician should have a doctor's note before re-admittance. A child absent more than 5 consecutive days and not seen by a physician is required to be examined by the school nurse before re-admittance.		
Annual Physical Examinations: The New York State Education Law requires a physical examination before entrance to school and routinely at grades Pre-K, K, 2, 4, 7, and 10. Our school physician examines grades 2, 4, 7, and 10, all athletes, and those with physical disabilities are examined yearly.		
Student to be examined: <input type="checkbox"/> In school <input type="checkbox"/> By family physician	Parent/Guardian Signature:	Date:

Central Valley School District PreK-12 Enrollment Form

PHYSICIAN PHYSICAL EXAMINATION (TO BE COMPLETED BY PHYSICIAN) Page 1 of 2

Please forward student records to the school circled below to the attention of "School Nurse."

Central Valley Academy
111 Frederick Street
Ilion, NY 13357
Phone: 315-895-7471
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New York State Regulations require that before entering school, a child must have a physical examination and be on a regular schedule for completing required immunizations. The physician is requested to complete pertinent information on this form and check vaccinations schedule to make recommendations for completing the required immunizations.

(Legal name only) Last name:	First:	Middle:	Suffix (Jr., II, III):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Date of Birth:	School:	Grade Level:	Date of physical:
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Height (inches) _____ Weight _____ BMI _____ BMI % _____ Blood Pressure _____ Urinalysis: Albumen/Sugar _____ Blood Count/HCT _____ Nervous System (Neurological) _____ Ears (Otosopic) or Auditory _____ Hernia _____ Speech/Language _____ Lymph Nodes (Lymphatic) _____ Psycho-Motor Development _____ Lead Screening/Results _____	Structural: <ol style="list-style-type: none"> 1. Scoliosis Check _____ 2. Posture _____ 3. Feet _____ Teeth _____ Nose _____ Heart _____ Abdomen _____ Lungs _____ Skin _____ Eyes _____ Nutrition _____ Genito-Urinary _____ Tanner Stage _____ Tine Test – Tuberculin _____ Tonsils _____
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Specific recommendations or remarks:

Is there a condition that may require a classroom emergency? No Yes If yes, explain:

Is there a condition that may require a limitation or compensation in the school environment, program, or physical education?
 No Yes If yes, explain:

Is this child on regular medication or under regular medical observation? No Yes If yes, explain:

(If child needs medication administered in school, a medication request form must be completed and signed by a physician before medication will be given at school.)

Should this child be seen by you again? No Yes If yes, when?

Physician's name (printed):	Physician's signature:
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Address:	Phone:
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PHYSICIAN PHYSICAL EXAMINATION (TO BE COMPLETED BY PHYSICIAN) Page 2 of 2

IMMUNIZATIONS/HEALTH HISTORY

Immunization record attached No immunizations given today
 Immunizations given since last health appraisal: _____

Sickle Cell Screen: Positive Negative Not Done Date: _____
 PPD: Positive Negative Not Done Date: _____
 Elevated Lead: Positive Negative Not Done Date: _____
 Dental Referral: Positive Negative Not Done Date: _____

Significant Medical/Surgical History: See attached

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

Allergies: Life Threatening Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

Vision: Without glasses/contact lenses R: _____ L: _____ Referral: _____
 With glasses/contact lenses: R: _____ L: _____ Referral: _____
 Near point: R: _____ L: _____ Referral: _____

Hearing: Pass 20 dB sc both ears or: R: _____ L: _____ Referral: _____

Immunizations Give dates by month/day/year

	#1	#2	#3	#4	#5
Oral Polio vaccine					
D.P.T. (Diphtheria/Pertussis/Tetaus) D.T. or DPAT/DT	#1	#2	#3	#4	#5
Hep. B	#1	#2	#3		
Measles	#1	#2			
Mumps	#1	#2			
Rubella (three-day measles)	#1	#2			
Tuberculin Test					
Chicken Pox vaccine					
Menactra					
Hib/B-Capsa	#1	#2	#3	#4	
Prevnar/Pneumonia	#1	#2	#3	#4	
Influenza	#1	#2	#3	#4	#5

If child is exempt from any vaccination, please specify vaccine and reason:

Additional comments:

Physician's name (printed):

Physician's signature:

Address:

Phone: _____ Fax: _____ Date completed: _____

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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:

Birth Date: / / Month Day Year	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No
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School:	Grade
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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

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.