Central Valley School District PreK-12 Enrollment Form

Central Valley Academy	Gregory B. Jarvis Middle School	Barringer Road Elementary	Harry M. Fisher Elementary
111 Frederick Street	28 Grove Street	326 Barringer Road	10 Fisher Avenue
Ilion, NY 13357	Mohawk, NY 13407	Ilion, NY 13357	Mohawk, NY 13407
Phone: 315-895-7471	Phone: 315-866-2620	Phone: 315-894-8420	Phone: 315-866-4851
Fax: 315-895-5255	Fax: 315-867-2909	Fax: 315-894-0153	Fax: 315-866-0055

District Registrar use only Student ID: _____ Enter date: _____

Placement: ☐ CVA ☐ JMS ☐ BR ☐ F ☐ Other _____ Grade: _____ Teacher: _____

Documentation:

☐ Proof of age ☐ Proof of residency ☐ New student ☐ Returning student ☐ School records received

☐ Guardianship/custody paperwork (if applicable) ☐ Foster care ☐ CSE ☐ CSE records received

☐ Immunization records ☐ Physician physical

STUDENT INFORMATION

Last: (Legal name only)	First:	Middle:	Suffix (Jr., II, III):	Gender: ☐ Male ☐ Female
Other name(s) used previously (AKA):	Nickname:	Date of birth:	Place of birth:	

PARENT/GUARDIAN INFORMATION

Indicate child's primary residence if not with both parents. Documentation of legal custody must be provided.

Father/Guardian ☐ Primary Residence		Mother/Guardian ☐ Primary Residence	Maiden Name:
Name:		Name:	
Address:		Address:	
Mailing Address (if different):		Mailing Address (if different):	
Phone 1: ☐ home ☐ cell	Phone 2: ☐ work ☐ cell	Phone 1: ☐ home ☐ cell	Phone 2: ☐ work ☐ 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: ☐ work ☐ cell	Phone: ☐ work ☐ 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:		

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? ☐ No ☐ Yes	Is this temporary living arrangement due to loss of housing or economic hardship? ☐ No ☐ 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
					☐ Home ☐ Other
					☐ Home ☐ Other
					☐ Home ☐ Other
					☐ Home ☐ Other
					☐ Home ☐ Other
					☐ Home ☐ Other
					☐ Home ☐ Other

OTHERS IN HOUSEHOLD

Name	Date of Birth	Relationship to Child

EMERGENCY CONTACTS

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

EDUCATION/SCHOOL BACKGROUND

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

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

Forward school records to:	District Registrar Central Valley School District 111 Frederick Street Ilion, NY 13357	Phone: 315-894-3210 Fax: 315-894-3274

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:**

MEDICAL INFORMATION (TO BE COMPLETED BY PARENT/GUARDIAN)

The following information is a necessity to insure that health records pertaining to your child are current and accurate.				
(Legal name only) Last name	First	Middle	Suffix (Jr., II, III)	Gender ☐ Male ☐ Female
Other name(s) used previously (AKA)	Nickname	Date of birth	Place of birth	Grade Level
Student Address:				Phone: ☐ Home ☐ Cell
Father's Name:	Mother's Name:			Mother's Maiden Name:
Guardian/Step-parent's Name:	Student resides with *(Father, Mother, Guardian, Other-Indicate relationship)*			
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			
Please complete the following as accurately as possible.			
Allergies to food, drugs, bees, animals, or environmental	☐ No ☐ Yes	Type of allergy :	Medication taken:
Hay fever, asthma wheezing	☐ No ☐ Yes	If yes, indicate dates and explain:	
Eczema or frequent skin rashes	☐ No ☐ Yes	If yes, indicate dates and explain:	
Convulsions or seizures	☐ No ☐ Yes	If yes, indicate dates and explain:	
Heart trouble or murmurs	☐ No ☐ Yes	If yes, indicate dates and explain:	
Diabetes	☐ No ☐ Yes	If yes, indicate dates and explain:	
Tuberculosis	☐ No ☐ Yes	If yes, indicate dates and explain:	
Kidney Disease	☐ No ☐ Yes	If yes, indicate dates and explain:	
Pneumonia	☐ No ☐ Yes	If yes, indicate dates and explain:	
Frequent (more than 3 times a year) colds, sore throat, or ear aches	☐ No ☐ Yes	If yes, indicate dates and explain:	
Rheumatic fever / scarlet fever	☐ No ☐ Yes	If yes, indicate dates and explain:	
Mononucleosis	☐ No ☐ Yes	If yes, indicate dates and explain:	
Chicken Pox	☐ No ☐ Yes	If yes, indicate dates and explain:	
Measles/mumps/rubella (3 day measles)	☐ No ☐ Yes	If yes, indicate dates and explain:	
Meningitis	☐ No ☐ Yes	If yes, indicate dates and explain:	
Strep infections	☐ No ☐ Yes	If yes, indicate dates and explain:	
Speech problems	☐ No ☐ Yes	If yes, indicate dates and explain:	
Bowel or urinary problems	☐ No ☐ Yes	If yes, indicate dates and explain:	

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

☐ No ☐ 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? ☐ No ☐ 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.)

☐ No ☐ 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: ☐ In school ☐ By family physician	Parent/Guardian Signature:	Date:

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

Complete form and forward to: District Registrar
Central Valley School District
111 Frederick Street
Ilion, NY 13357

Phone: 315-894-3210
Fax: 315-894-3274

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: ☐ Male ☐ Female
Date of Birth:	School:	Grade Level:	Date of physical:	

Height (inches)		Structural: 1. Scoliosis Check	
Weight		2. Posture	
BMI		3. Feet	
BMI %		Teeth	
Blood Pressure		Nose	
Urinalysis: Albumen/Sugar		Heart	
Blood Count/HCT		Abdomen	
Nervous System (Neurological)		Lungs	
Ears (Otoscopic) or Auditory		Skin	
Hernia		Eyes	
Speech/Language		Nutrition	
Lymph Nodes (Lymphatic)		Genito-Urinary	
Psycho-Motor Development		Tanner Stage	
Lead Screening/Results		Tine Test – Tuberculin	
		Tonsils	

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:

Address: Phone:

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

IIMMUNIZATIONS/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				
Oral Polio vaccine	#1	#2	#3	#4	#5
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: ☐ Male ☐ Female	Will this be your child's first visit to a dentist? ☐ Yes ☐ No
School:		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

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.