February 17, 2015

Dear Families,

Welcome! The Clinton Elementary School faculty and staff are looking forward to the beginning of your child’s formal public school education in September. We have several things planned over the next few months to make your child’s initial experiences at our school as positive as possible.

Kindergarten registration is scheduled for the week of March 9-13. Please complete the enclosed forms and return them to school during that week. The office will be open from 8:00 a.m. - 4:00 p.m. Please bring your child’s original birth certificate and immunization records with you.

Parent-Student Kindergarten Orientation Days will be held on May 6 and May 13. The orientation program will include time for your child to “play” in a kindergarten classroom (without parents) while the parents meet with the kindergarten teachers and principal in a different area. The children will also learn about school bus safety. The parents and children will have an opportunity to ride on a school bus together. Parents who are unable to attend may send an adult relative or friend with their child. The Kindergarten Orientation Days are scheduled from 12:30 - 2:00 p.m. as follows:

   May 6 - Last names A - K  
   May 13 - Last names L - Z

(Please check in at the Main Office)

Your child will return for kindergarten screening in June. We will be doing the vision, hearing, and basic skills screening at that time. You will have an opportunity to schedule an appointment for kindergarten screening at the Orientation Day in May.

Please contact our office should you have questions concerning information in this letter or about our kindergarten program in general. This will be an exciting new experience for everyone and we look forward to welcoming your family into our school family.

Sincerely,

Steven Marcus, Principal

cc: S. Grimm  
K Teachers  
Transportation
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Scroll down for form
CLINTON CENTRAL SCHOOL REGISTRATION

Date Registered ___________ Entry Date ___________ ID # ____________________ Busing ___ Yes ___ No

Student’s Last Name ___________ First __________________ M.I. ___________

Date of Birth ___________ Birthplace ___________
• Born a U.S. Citizen yes no Date Entered U.S. ___________

Gender: Male ___ Female ___ Grade _____ HR _____
Date Entered 9th Grade ___________ (HS students only)

Mailing Address

Residential Address (if different)

Telephone ___________ Listed Number: yes no

Parent/Guardian Information

Parent/Guardian Name ___________________________ Relationship

Address ___________________________ Home Phone Number ___________

Employer ___________________________ Work Phone ___________ Cell

E-Mail Address

Parent/Guardian Name ___________________________ Relationship

Address ___________________________ Home Phone Number ___________

Employer ___________________________ Work Phone ___________ Cell

Other Children in Household (under age 21):

Name ___________________________ Date of Birth ___________ School
Grade ___________ M/F ___________

Other Adults in Household:

Name ___________________________ Relationship to Student

School/District Last Attended:

Address: ___________________________
Telephone: ___________________________
Contact Person/Position: ___________________________

Residency: Where is the student currently living? Please check appropriate box:

□ In permanent housing  □ With another family for economic reasons
□ Other (specify) ___________________________
Emergency Contact Information
The individuals below have authorization to pick up my child and can be reached during school hours at the number listed.

Name 1 __________________________ Relationship to Child __________ Phone ______________________
Name 2 __________________________ Relationship to Child __________ Phone ______________________
Name 3 __________________________ Relationship to Child __________ Phone ______________________

Emergency & Health Information
Physician’s Name: __________________________ Phone: ______________________
Dentist’s Name: __________________________ Phone: ______________________
Preferred Hospital: ______________________
Emergency Comments/Special Circumstances: __________________________________________

Physical Update:
Has your child had any corrective treatment (glasses, dental care, immunizations, scoliosis checkup, etc.) surgery or illness requiring a physician’s care this summer? Please specify: __________________________________________

Is there anything concerning the health of your child which the school should know to adjust or modify the school program? __________________________________________

Health Information Release: I give permission for the school nurse to share health information with his/her teachers and coaches. _____ Yes _____ No

1. Is the student Hispanic, Latino, or of Spanish origin? 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.

☐ YES, Hispanic  ☐ NO, not Hispanic

2. Select one or more races from the following five racial groups [For question (2) Check (ü) all groups that apply to your child; check (ü) at least ONE box.]:

☐ AMERICAN INDIAN OR ALASKA NATIVE: A person having origins in any of the original peoples of North and South America (Including Central America), and who maintains tribal affiliation or community attachment.

☐ ASIAN: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ BLACK OR AFRICAN AMERICAN: A person having origins in any of the Black racial groups of Africa.

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

Photographs: Throughout the school year there are times when the media may be publicizing our students and the school. A photo of your child may be taken at school or while on a field trip. Please note if we have permission to include your child in a photo or news clip if that opportunity arises.

_____ Yes, you may include my child.

_____ No, do not include my child in a photo opportunity.

I hereby declare under penalty of perjury that the information provided on this enrollment form is accurate and truthful to the best of my knowledge. I understand that the provision of false information may result in the exclusion of my child(ren) from attendance at the Clinton Central School District, the demand by the District for the payment of tuition, and/or the institution of any other appropriate legal action available to the District.

Parent/Guardian Signature ____________________________ Date ____________________________
CLINTON ELEMENTARY CONFIDENTIAL

Questionnaire completed by: ___________________________ Relation __________

Child’s Name: ___________________________ Date of Birth: __________

Child’s Nickname: ___________________________

Father/Guardian’s Name: ___________________________ Year of Birth: ______

Mother/Guardian’s Name: ___________________________ Year of Birth: ______

Occupation: ___________________________ Father ___________________________ Mother

Step Parent: ___________________________ Occupation: ___________________________

I. Developmental History:

1. Were there any problems during the pregnancy with this child? (e.g. German measles, toxemia, bleeding, RH incompatibility) ___________________________________________

2. What was the child’s condition at birth? (normal weight, breathing difficulties, etc.) ___________________________________________

3. In your opinion, was this child low, average, or fast in: Walking ______ Talking ______ Toilet Training ______

4. Does this child have any difficulty with speech, hearing, or sight? ___________________________________________

5. Is this child or has this child been in speech therapy? ___________________________________________

II. Description of Child:

1. Please use a few words to describe this child’s personality. ___________________________________________

2. ___________________________________________
2. What are his/her strengths? What does he/she do best? What does he/she like to do?

3. What are the most difficult subjects or areas for this child?

4. Do you feel this child has any special needs in school?

5. Did this child attend a preschool program? Yes _____ No _____

   Where? ________________________________ How many years: _____

6. Has this child ever been in any special education program such as a resource room, individual tutoring, work with a teacher of the hearing or vision impaired, psychiatric day care, infant stimulation program, etc.? Please explain: __________________________

7. How does this child get along with others? ______________________________________

   Family:

   Other Children: ____________________________

III. Family History

1. Have there been any events in the life of your family which have affected this child? Examples: Family move, death, divorce, birth of a sibling. Explain: __________________________

2. Have you taken this child for any professional consultations, therapy, clinic visits, etc., which relate to his/her performance in school? __________________________
NEW STUDENT HEALTH HISTORY
Clinton Central Schools
75 Chenango Avenue
Clinton, NY 13323
Phone: (315)557-2255 ♦ Fax: (315)557-2331

NAME OF STUDENT: __________________________ DOB: ________ PLACE OF BIRTH: __________________________

SEX _____ Mother’s Name: ________________________ Father’s Name: __________________________

HOME ADDRESS: __________________________ TELEPHONE #: __________________________

NUMBER & AGES OF SIBLINGS: __________________________

1. Was your child born prematurely? □ Yes □ No

2. Did he/she have any growth or development problems as an infant or young child? □ Yes □ No

3. Does your child have any of these health problems? If so, please check and explain. (Please be specific):
   □ Ear problems
   □ Eye problems
   □ Diabetes
   □ Headaches
   □ Hearing Loss
   □ Heart condition
   □ Nosebleeds
   □ Seizure disorder
   □ Other __________________________

4. Does your child have asthma or allergies? Please provide specific information regarding reactions and treatments:
   □ Medications/Drugs
   □ Foods/Plants
   □ Bee/Insect Bites
   □ Animals/Other
   □ Treatment recommended by physician for allergic response __________________________

Is your child receiving allergy shots? □ Yes □ No
Has asthma been diagnosed by a physician? □ Yes □ No
What triggers your child’s asthmatic episodes (exercise, respiratory infections, cold air, chemical fumes)? __________________________

5. Has your child had any of the following illnesses? If yes, please give dates and explanation.
   □ Chicken Pox
   □ German Measles
   □ Measles
   □ Mononucleosis
   □ Mumps
   □ Pneumonia
   □ Scarlet Fever
   □ Strep throat/multiple infections
   □ Tuberculosis
   □ Tuberculosis of a family member (indicate relationship to child) __________________________
6. Please list specific severe illnesses, injuries or surgeries:

________________________________________ @ age ____________ Hospitalized for ____________ days

________________________________________ @ age ____________ Hospitalized for ____________ days

________________________________________ @ age ____________ Hospitalized for ____________ days

* If your child requires medication during the school day, please contact the school nurse regarding the school medication policy.

7. Does your child have any disabilities or chronic illness? ____________________________________________

8. Does your child take any medications on a regular basis? ____________________________________________

9. Has your child ever been diagnosed or treated for an emotional disorder?  □ Yes  □ No

10. Does your child wear glasses or contact lenses?  □ Yes  □ No

11. Does your child have dental problems, or is he/she receiving orthodontic treatment?  □ Yes  □ No

12. What is the date of his/her most recent exam? ________________________________________________

13. What school did your child last attend? ______________________________________________________

14. Was the most recently completed school year a healthy one for your child?  □ Yes  □ No

15. Approximately how many school days did he/she miss because of illness during the last school year?

16. Have you already provided the school with a record of your child’s immunizations?  □ Yes  □ No

(A signed record from a physician or clinic, or a copy of a school immunization record, must be presented before school attendance begins. If this information is not received, New York State Public Health Law requires that your child be excluded from school.)

Signature of Parent __________________________ Date __________________________

PLEASE RETURN THIS FORM TO THE SCHOOL HEALTH OFFICE.
Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes English. Your assistance in answering these questions is greatly appreciated.

Thank You

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<tr>
<th>TO BE COMPLETED BY SCHOOL PERSONNEL</th>
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<tr>
<td>DISTRICT</td>
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<td>SCHOOL</td>
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<td>GRADE</td>
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<td>STUDENT NAME</td>
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<td>DATE OF BIRTH Month: Day: Year:</td>
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<td>STUDENT IDENTIFICATION NUMBER</td>
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<tr>
<td>COUNTRY OF BIRTH / ANCESTRY</td>
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<tr>
<td>NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.</td>
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<tr>
<td>NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION</td>
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<td>DETERMINATION: □ Possible LEP □ English Proficient</td>
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(✓ boxes that apply)

1. What language(s) is spoken in the student's home or residence? □ English □ Other ___ specify ___

2. What language(s) are spoken most of the time to the student, in the home or residence? □ English □ Other ___ specify ___

3. What language(s) does the student understand? □ English □ Other ___ specify ___

4. What language(s) does the student speak? □ English □ Other ___ specify ___

5. What language(s) does the student read? □ English □ Other ___ specify ___ □ Does Not Read

6. What language(s) does the student write? □ English □ Other ___ specify ___ □ Does Not Write

7. In your opinion, how well does the student understand, speak, read and write English?

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<thead>
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<th></th>
<th>Very well</th>
<th>Only a little</th>
<th>Not at all</th>
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<tr>
<td>Understands English</td>
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<td>Speaks English</td>
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<td>Reads English</td>
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<td>Writes English</td>
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Signature of Parent/Guardian/Other _____________________________ Date _________

Month: Day: Year: HH:MM MM/DD/YYYY

HLQ 12/00 99-337 PM
ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: Mary Hosey-Pardi

Name of School: ________________________________________________________________

Name of Student: ______________________________________________________________

Last                                    First                                    Middle

Gender: □ Male                        Date of Birth: ____ / ____ / ____   Grade: ____   ID#: _______________

□ Female                        Month  Day  Year   (preschool-12)   (optional)

Address: _____________________________________________________________    Phone: ___________________________

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

Where is the student currently living? (Please check one box.)

□ In a shelter
□ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as “doubled-up”)
□ In a hotel/motel
□ In a car, park, bus, train, or campsite
□ Other temporary living situation (Please describe): ____________________________

□ In permanent housing

Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)  Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

Date

Rev. 5/21/09
Dear Parent(s),

Education Law and Regulations of the Commissioner of Education require physical examinations of children when they:
- Enter the school district for the first time
- Are in grades K, 2, 4, 7, and 10
- Participate in interscholastic sports

We are required by New York State Law to give school physicals to all kindergarten, second graders, fourth graders, and new school entrants if a private physical is not provided.

If your child has had or is scheduled to have a private physical for the 2015-2016 school year, please have your physician complete our health form (see attached). You may also submit a physical exam form from your own private physician. Please complete the attached form so that no duplicate or unwanted school physicals are performed on your child. An acceptable physical can date as far back as 12 months from the date of entry. If no records are received your child will be scheduled to receive a school physical.

Please discuss with your child the fact that an exam will be given and that the doctor will listen to his/her heart, lungs, etc. The boys will be given an exam to detect undescended testicles. A few minutes of discussion with your child will make him/her much more at ease.

In addition to the physical exam requirement for school, we are requesting that a dental health certificate be provided. Each dental health certificate must be signed by a duly licensed dentist and shall describe the dental health condition of the student when the exam was conducted. A dental health certificate form is attached and a list of dental providers that offer free or reduced fee screening will be provided upon request.

If you should need any help with these requirements or have any questions, please contact Elizabeth Hobaica, R.N., Clinton Elementary School Nurse at 557-2258.

Sincerely,

Elizabeth Hobaica R.N.
Elementary School Nurse
Clinton Elementary School  
75 Chenango Ave.  
Clinton, NY 13323

STUDENT MEDICATION POLICY

The following procedures will be followed when medication is to be administered/or taken by a student during the school day. This applies to prescription, non-prescription ("over the counter"), short-term, long-term, and as needed (prn’s) medication.

The New York State Education Department mandates the following guidelines:

1. The parent or legal guardian must submit a written request to the school for the administration of any medications. (Forms are available in the Health Office.)

2. A written prescription from the student’s physician indicating name of medication, dosage, frequency, method of administration and reason for medication must be sent to the school. This may be FAXED to 557-2331, attention Elizabeth Hobaica, R. N.

3. All medication must be in a properly labeled container. (Prescription medications must be in the original pharmacy container.) An adult must bring K-5 medication directly to the school nurse.

4. At the conclusion of the school year, an adult must pick up all medications. Unclaimed medication will be disposed of on the last day of school.

Thank you for your help with this. Please call me at 557-2258 if you should have any questions or concerns.

Elizabeth Hobaica, R.N.
Please complete and return to the elementary health office.

Child’s Name: ____________________________

Teacher’s Name: __________________________

_____ I will provide records of my child’s physical exam for the 2013-2014 school year. (Please send in documentation of a completed physical exam form from your physician or the date of the scheduled appointment.)

_________ Date of upcoming physical exam.

_____ My child may have a school physical.

_____ I have already supplied the school nurse with the Physical Exam Record.

_________________________  ________________________
Parent/Guardian Signature   Date
NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

CLINTON CENTRAL SCHOOL HEALTH CERTIFICATE / APPRAISAL FORM

Name: ___________________________ Date of Birth: ___________________________

Date of Exam: ___________________________ Gender: □ M □ F Grade: __________

IMMUNIZATIONS / HEALTH HISTORY:

☐ Immunization record attached
☐ No Immunizations given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen: □ Positive □ Negative □ Not done Date: ___________________________
PPD: □ Positive □ Negative □ Not done Date: ___________________________
Elevated Lead: □ Yes □ No □ Not done Date: ___________________________
Dental Referral: □ Yes □ No □ Not done Date: ___________________________

SPECIFY CURRENT DISEASES: □ Asthma □ Diabetes: □ Type 1 □ Type 2 □ Hypertension □ Hyperlipidemia
Other: ___________________________

Significant Medical/Surgical History: ____________________________________________

Allergies: □ LIFE THREATENING □ Food: ___________________________ □ Insect: ___________________________ □ Other: ___________________________ □ NONE □ Seasonal □ Medication: ___________________________

PHYSICAL EXAM:

Height: ___________ Weight: ___________ Blood Pressure: ___________ Pulse: ___________ Exercise Pulse: ___________

Body Mass Index: ___________________________

Weight Status Category (BMI, centile):
☐ last than 5 ☐ 5th through 85th ☐ 85th through 94th ☐ 95th through 99th ☐ 100th

Vision - without glasses/contact lenses R L
☐ vision - with glasses/contact lenses R L
☐ vision - Near Point R L
☐ Hearing □ Pass 20 db sc both ears or: ___________________________

☐ EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: □ Negative □ Positive:

Specify any abnormality (use reverse of form if needed):

________________________________________________________________________

________________________________________________________________________

Recommendations/Referrals:

________________________________________________________________________

MEDICATIONS:

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

Name: ___________________________ Dosage/Time: ___________________________
Name: ___________________________ Dosage/Time: ___________________________

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:

☐ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.

☐ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ Specify medical accommodations needed for school: ___________________________________________

☐ Known or suspected disability: ___________________________________________

☐ Restrictions: ___________________________________________

☐ Protective equipment required: □ Athletic Cup □ Sport goggles/impact resistant eyewear □ Other: ___________________________________________

Provider's Signature: ___________________________ Phone: ___________________________
Provider's Name/Address: ___________________________ Fax: ___________________________

This form complies with NYSED requirements above and is valid for twelve months.
Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: ___________________________ Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

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

School: ___________________________ 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. Assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

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

Parent's Signature ___________________________ Date ________________

Section 2. To be completed by the Dentist

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

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

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

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

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

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

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

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

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

☐ Yes ☐ No Dental Sealants Present

Other problems (Specify): ___________________________

III. Treatment Needs (check all that apply)

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

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

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