# CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

**Clinton High School**
**75 Chenango Avenue**
**Clinton, NY 13323**
**315-557-2235**
**FAX: 315-557-2225**

Date: ____________________________

To: Educational Records Access Officer

Prior School Name ___________________________

Address____________________________________

____________________________________

____________________________________

Fax Number ________________________________

Name: ________________________________________ Date of Birth: _____________________

has enrolled in our school, grade level ______________.

Please send the following:

- Transcripts
- Final Grades, if possible
- Standardized Test Scores
- Current Student Schedule
- Health Records
- Psychological Records
- IEP or 504 for current/ previous school year. (Including phase I for current year)
- Results of any other educational testing on individual student

Please send records to: Counseling Department
Clinton High School
75 Chenango Avenue
Clinton, NY 13323

_______________________________________________
Counselor Signature
Jacqueline Snizek (Last names A-K, grades 9-12)
Kelly Zegarelli (Last names L-Z, grades 9-12)

I give permission for my student's educational records and pertinent information to be released to Clinton High School.

_______________________________________________
Parent/ Guardian Signature

# Clinton Central School District
# SchoolTool Parent Portal Access Request Form

The Clinton Central School District is pleased to offer "Parent Portal" through our student management system. SchoolTool provides access to parents and guardians for student information at the high school level. Parents and guardians will be able to access their child(s) academic, attendance, class schedule, and discipline information at their convenience. The attendance and discipline information will automatically be updated in the Parent Portal, but report cards and progress report grades will be uploaded at the appropriate times.

**Please provide the following information which will assist us in granting you access to the Parent Portal:**

Parent/Guardian name (please print): ___________________________________

Parents, guardians, or person in parental relation of the student(s) please fill out the information in the table below:

| First Name | Last Name | Address where Student Resides | Date of Birth | Grade |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

The district will provide the chosen parent/guardian with a login and password that will allow access information about their student(s) school performance. This information is stored in a database called SchoolTool which is maintained by the District with support from the Mohawk Regional Information Center of the Madison-Oneida BOCES.

In return for the District providing me with a login/password, I agree to the following Terms of Network Access:

***Please initial each item to acknowledge it, and sign at the end***

__________ I will maintain a valid email address that the District may use to send me pertinent information concerning my Parent Portal Account.

My email address: ________________________________________

__________ I will only attempt to view information about the student(s) listed on the second page of this form. I will not attempt to "hack", manipulate, or otherwise try to evade the security measures to access information regarding any other person.

__________ I will not intentionally transfer to the schooltool™ system any virus, Trojan horse, or other malicious computer code.

__________ If granted the ability (at a future time) to enter data into my child's record, I will only enter accurate information.

***Continue to the next page***

## CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

***Please initial each item to acknowledge it, and sign at the end***

___________ I understand that the District's use of the schooltool™ software is supported by technical assistance from the Mohawk Regional Information Center (MORIC), Mindex™ Technologies Inc., and possibly other consultants and employees of these entities. They are instructed to keep any confidential personally-identifiable information, including educational records, they may see in the performance of their duties. I consent to the disclosure of information about me or the student(s) listed above under these circumstances.

___________ I understand that all information stored in the schooltool™ database remains property of the District, and may be accessed, examined, or modified by the District or its vendors at any time.

___________ I understand that the schooltool™ database may record and retain information about when and how I use schooltool™ through the Parent Portal and that this information is the property of the District and subject to review by the District.

___________ I agree that I will not disclose my username and password to any other person, not even other people in my family or household. I accept responsibility for all actions that are performed by anyone gaining access to the schooltool™ database using the username and password assigned to me.

___________ I understand that the District retains the discretion to block my access to schooltool™ whenever it has reasonable suspicion to believe that I have violated one of the aforementioned Terms of accessing schooltool™ and other network resources.

______________________________________________ **Date:** ____________________

**Parent/Guardian Name (please print)**

______________________________________________ **Date:** ____________________

**Parent/Guardian Signature**

**Please have your child return this completed form to the main office.**

# CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

## New Student Health History

**STUDENT INFORMATION:**

| Last Name, First Name, Middle | Date of Birth (MM/DD/YEAR) | Place of Birth (City/State/Country) |
|---|---|---|
| | | |

| Gender ◯ Male ◯ Female | Mother's Name | Father's Name |
|---|---|---|

| House #, Street Address | Apt. # |
|---|---|

| City | State | Zip Code | Home Phone # |
|---|---|---|---|

**Number and ages of siblings:**

**STUDENT HEALTH INFORMATION:**

**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.**

- ☐ Ear problems ____________________
- ☐ Eye problems ____________________
- ☐ Diabetes ____________________
- ☐ Headaches ____________________
- ☐ Hearing Loss ____________________
- ☐ Heart Condition ____________________
- ☐ Nosebleeds ____________________
- ☐ Seizure Disorder ____________________
- ☐ Other ____________________

**4. What medications have been prescribed for these episodes? Are the medications taken on a daily or as needed basis?**

- ☐ Medications/Drugs: ____________________
- ☐ Foods/Plants: ____________________
- ☐ Bee/Insect Bites: ____________________
- ☐ Animals/Other: ____________________
- ☐ Treatment recommended by a physician for allergic response: ____________________

Is your child receiving allergy shots? ◯ YES ◯ NO

Has asthma been diagnosed by a physician? ◯ YES ◯ NO

What treatment or medications have been prescribed for these episodes are/or to be taken on a regular basis?

# CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

**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 or a family member (indicate relationship to child) ____________________

____________________

**6. Please list specific illnesses, injuries or surgeries:**

____________ @ age ______ hospitalized for ____________ days

____________ @ age ______ hospitalized for ____________ days

____________ @ age ______ hospitalized for ____________ days

**7. Does your child have any disabilities or chronic illness?** ○ **YES** ○ **NO**

**8. Does your child take any medications on a regular basis?** ○ **YES** ○ **NO**

***IF YOUR CHILD REQUIRES MEDICATION DURING THE SCHOOL DAY, PLEASE CONTACT THE SCHOOL NURSE REGARDING THE SCHOOL MEDICATION POLICY***

**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**

For what situation are glasses worn? ____________________

Are they safety plastic or polycarbonate lenses? ____________________

Date of most recent vision exam: ____________________

**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, <u>New York State Public Health Law</u> requires that your child be excluded from school.)**

____________________________ **Date:** ____________

**Parent/Guardian Signature:**

**PLEASE RETURN THIS FORM TO THE SCHOOL HEALTH OFFICE.**

# CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

## REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

### TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

**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:** | **Gender:** ◯ Male ◯ Female | **DOB:** |
| **School:** | **Grade:** | **Exam Date:** |

**HEALTH HISTORY:**

| | |
|---|---|
| **Allergies:** ◯ NO ◯ YES, Indicate Type | ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached<br>☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental |
| **Asthma :** ◯ NO ◯ YES, Indicate Type | ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached<br>☐ Intermittent ☐ Persistent ☐ Other: |
| **Seizures:** ◯ NO ◯ YES, Indicate Type | ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached<br>☐ Other: ☐ Date of last seizure: |
| **Diabetes:** ◯ NO ◯ YES, Indicate Type | ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached<br>☐ Type 1 ☐ Type 2 ☐ HbA1c results: ☐ Date Drawn: |

**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 ☐ 95th-98th ☐ 99th and>

**Hyperlipidemia:** ◯ NO ◯ YES **Hypertension:** ◯ NO ◯ YES

**PHYSICAL EXAMINATION/ASSESSMENT**

| **Height:** | **Weight:** | **BP:** | **Pulse:** | **Respirations:** |
|---|---|---|---|---|

| **TESTS** | **Positive** | **Negative** | **Date** |
|---|---|---|---|
| PPD/PRN | ☐ | ☐ | |
| Sickle Cell Screen/PRN | ☐ | ☐ | |
| **Lead Level Required Grades Pre-K & K** | | | **Date** |
| ☐ Test Done ☐ Lead Elevated ≥ µg/dL | | | |

**Other Pertinent Medical Concerns**

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle

☐ Concussion - Last Occurrence:

☐ Mental Health:

☐ Other:

☐ **System Review and Exam Entirely Normal**

**Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities**

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

☐ Assessment/Abnormalities/Recommendations:

☐ Additional Information Attached

| Diagnoses/Problems (list) | ICD-10 Code |
|---|---|
| | |
| | |
| | |
| | |

# CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

| Name: | DOB: |
|---|---|

## SCREENINGS

| Vision | Right | Left | Referral | Notes |
|---|---|---|---|---|
| Distance Acuity | 20/ | 20/ | ☐ Yes ☐ No | |
| Distance Acuity With Lenses | 20/ | 20/ | | |
| Vision — Near Vision | 20/ | 20/ | | |
| Vision — Color ☐ Pass ☐ Fail | | | | |
| **Hearing** | **Right** dB | **Left** dB | **Referral** | |
| Pure Tone Screening | | | ☐ Yes ☐ No | |
| **Scoliosis** Required for boys grade 9 and girls grades 5 & 7 | **Negative** | **Positive** | **Referral** | |
| | ☐ | ☐ | ☐ Yes ☐ No | |
| Deviation Degree: | | Trunk Rotation Angle: | | |
| **Recommendations:** | | | | |

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations**

Use Interscholastic Sports Categories (below) for Restrictions or modifications

☐ **No Contact Sports**

**Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling.

☐ **No Non-Contact Sports**

**Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, skiing, swimming and diving, tennis, and track & field

☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level OR grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

| | | |
|---|---|---|
| ☐ Brace*Orthotic | ☐ Colostomy Appliance* | ☐ Hearing Aids |
| ☐ Insulin Pump/Insulin Sensor* | ☐ Medical/Prosthetic Device* | ☐ Pacemaker/Defibrillator* |
| ☐ Protective Equipment | ☐ Sport Safety Goggles | ☐ Other: |

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain:

## MEDICATIONS

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

List medications taken at home:

## IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS ☐ Received Today: ☐ Yes ☐ No

## HEALTH CARE PROVIDER

| Medical Provider Signature: | **Date:** |
|---|---|
| Provider Name: *(please print)* | Stamp: |
| Provider Address: | |
| Phone: | |
| Fax: | |

**Please return this form to your child's school when entirely completed.**

# CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

## AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

**A. TO BE COMPLETED BY A PARENT OR GUARDIAN:**

I request that my child ______________________________ grade __________ receive medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication.

______________________________ Date: ______________

**Parent/Guardian Signature:**

**B. TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER:**

I request that my patient, as listed below, receive the following medication:

| Name of student: | Date of birth: |
|---|---|
| Diagnosis: | |
| Name of medication: | |
| Prescribed dosage, frequency, and route of administration: | |
| Time to be taken during school hours: | |
| Duration of medication order: | |
| Possible side effects and adverse reactions (if any): | |
| Other recommendations: | |

______________________________

**Name of licensed prescriber and title (please print):**

______________________________ **Date:** ______________

**Prescriber's Signature:**

______________________________ **Phone:** ______________

**Address:**

*Under certain conditions it may be necessary for a student to carry and self administer his or her own medication. The decision to allow a student to do this will be made on an individual basis, according to the severity of the health condition, with parental request, by a physician's order, and an assessment by the school nurse of the student's ability to carry and administer his/her medication properly.* **The self medication release form must be completed.**

**STATE EDUCATION DEPARTMENT** / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colon-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

# Home Language Questionnaire (HLQ)

*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 in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated.*
*Thank you.*

**Please write clearly when completing this section.**

| STUDENT NAME: | | |
|---|---|---|
| | | |
| *First* | *Middle* | *Last* |

| DATE OF BIRTH: | | | GENDER: |
|---|---|---|---|
| | | | ❑ Male<br>❑ Female |
| *Month* | *Day* | *Year* | |

| PARENT/PERSON IN PARENTAL RELATION INFO: | | |
|---|---|---|
| | | |
| *Last Name* | *First Name* | *Relation to Student* |

HOME LANGUAGE CODE ______

## *Language Background*

***(Please check all that apply.)***

| | | | |
|---|---|---|---|
| **1. What language(s) is(are) spoken in the student's home or residence?** | ❑ English | ❑ Other ______ *specify* | |
| **2. What was the first language your child learned?** | ❑ English | ❑ Other ______ *specify* | |
| **3. What is the Home Language of each parent/guardian?** | ❑ Mother ______ *specify*<br>❑ Guardian(s) ______ *specify* | ❑ Father ______ *specify* | |
| **4. What language(s) does your child understand?** | ❑ English | ❑ Other ______ *specify* | |
| **5. What language(s) does your child speak?** | ❑ English | ❑ Other ______ *specify* | ❑ Does not speak |
| **6. What language(s) does your child read?** | ❑ English | ❑ Other ______ *specify* | ❑ Does not read |
| **7. What language(s) does your child write?** | ❑ English | ❑ Other ______ *specify* | ❑ Does not write |

**THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:**

| SCHOOL DISTRICT INFORMATION: | | STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM: |
|---|---|---|
| | | |
| *District Name (Number) & School* | *Address* | |

# Home Language Questionnaire (HLQ)—Page Two

### *Educational History*

8. Indicate the total number of years that your child has been enrolled in school ____________

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** ❑ *No* ❑ *Not sure* ❑ *If yes, please explain:______________________________________

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

**10a.** Has your child ever been *referred* for a special education evaluation in the past? ❑ No ❑ Yes* **Please complete 10b below*

**10b.** **If referred for an evaluation,* has your child ever *received* any special education services in the past?
❑ No ❑ Yes – Type of services received:______________________________________

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

**10c.** Does your child have an Individualized Education Program (IEP)? ❑ No ❑ Yes

**11.** Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

______________________________________

______________________________________

**12.** In what language(s) would you like to receive information from the school? ______________________________________

______________________________________ Month: Day: Year:
*Signature of Parent or of Person in Parental Relation* *Date*

Relationship to student: ❑ Mother ❑ Father ❑ Other:______________________

**OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ**

NAME: ______________________ POSITION: ______________________

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

**NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW**

NAME: ______________________ POSITION: ______________________

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

**DATE OF INDIVIDUAL INTERVIEW: ______________ MO DAY YR.

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

**NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL**

NAME: ______________________ POSITION: ______________________

DATE OF NYSITELL ADMINISTRATION: ______________ MO. DAY YR.

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

# CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

## NEW STUDENT ATHLETIC PARTICIPATION FORM

Student: ______________________________ Date: ______________

Entering Grade: ______________ ☐ Male ☐ Female Date of Birth: __________ Age ______

Date of last Health Examination (Physical): ______________________________

☐ **Attached Documentation**

New Address: ______________________________

Parents' Name: ______________________________ Telephone: ______________

With Whom Are You Living In This District? ______________________________

********** PREVIOUS SCHOOL INFORMATION **********

Previous School: ______________________________

| **Sports Played in Previous School** | | | **Level & Number of Years Played** | | |
|---|---|---|---|---|---|
| Fall | Sport | ______________ | ________ Modified | ________ JV | ________ Varsity |
| Winter | Sport | ______________ | ________ Modified | ________ JV | ________ Varsity |
| Spring | Sport | ______________ | ________ Modified | ________ JV | ________ Varsity |

Previous Address: ______________________________

With Whom Did You Live? ______________________________

Reason For Leaving Previous School: ______________________________

Were you subject to the APP Process as a 7th or 8th grader? ☐ Yes ☐ No

********** ACADEMIC INFORMATION **********

Year Entered 9th Grade: __________ Verification: ______________________________

**Counselor's Initials**

Have you repeated a grade in JR High or High School? ☐ Yes ☐ No

If Yes, which grade: __________

Date of the student's registration accepted: ______________________________

**Guidance Department should forward this form to the Director of Athletics when student has been accepted for registration. Please list any other high school attended on back.**