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## WEST SENECA K-12 REGISTRATION

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### Welcome to the West Seneca Central School District!

We are looking forward to working with you as members of the West Seneca School community! The Board of Education, administration, teachers, and support staff are all committed to providing your student(s) with a high quality educational program in safe and secure schools. We encourage you to join us in fulfilling the District's Mission "to provide a diversified educational program that will produce literate, caring, ethical responsible, and productive citizens who are capable of adapting to change."

### NEW STUDENT REGISTRATION

Please carefully complete this entire West Seneca Student Registration packet, and submit it to the Registration Clerk at the building located in your residential attendance zone.

(Please see the Building Information page in this packet for a complete list of buildings).

If you are unsure of your Home Building, a complete Street Guide can be found at:

<https://www.wscschools.org/STREETGUIDE>

**Please see page 3 for information regarding Homeless Registration.**

### REQUIRED DOCUMENTATION

Pursuant to Regulations of the Commissioner of Education, the following documentation **must be** submitted for the District's consideration regarding your child's enrollment and/or residency.

**The following items are required to complete the registration process:**

- **Proof of Parent or Guardian's Identity (NYS Valid Driver's License, Passport, or Non-Driver's Identification Card)**
- **Proof of Residency and Supporting Documentation**
  - **ONE (1) Proof of Residency:**
    - Documentation of Purchase of Home in District: Town Tax Bill, Current Mortgage Statement, Current Signed Lease Agreement, HUD Papers or Closing Statement
    - If you do not have the residency documentation shown above please provide a Notarized Statement from your Landlord accompanied by their Proof of Ownership (Town Tax Bill, Mortgage Statement)
  - **TWO (2) additional proofs of Supporting Documentation which may include the following:**
    - Car registration, utility bill, bank statement, payroll stub, government benefit document
- **Child's Birth Certificate (Original with raised seal)**
- **Immunization Records signed by doctor, along with a current Physical. \*Please refer to the Immunization Guide**
- **Last Report Card (If available)**
- DSS-2999 required at registration for a child in foster care
- Guardianship/Custody papers, Court Document papers signed by a judge (If applicable)
- Agency Counselor or Probation Officer's Name (If applicable)

### For Students with a Disability

- **Provide a copy of the current IEP & psychological reports**
- **Social History form**
- **Consent IEP Amendment Meeting form**

# West Seneca Central School District K-12 Registration

## BUILDING INFORMATION

Please contact the Registration Clerk at the building located in your residential attendance zone to make an appointment to submit the completed registration packet.

**Registration Hours:**  
**Monday - Friday**  
**9 am until 2 pm**

If you are unsure of your Home Building, a complete Street Guide can be found at:  
<https://www.wscschools.org/STREETGUIDE>

**Allendale Elementary School**  
**Dr. Holly Quinn, Principal**  
1399 Orchard Park Rd.  
West Seneca, NY 14224  
Phone: (716) 677-3660  
Fax: (716) 675-3104

**Clinton Elementary School**  
**Kim McCartan, Principal**  
4100 Clinton St.  
West Seneca, NY 14224  
Phone: (716) 677-3622  
Fax: (716) 674-7821

**Northwood Elementary School**  
**Angela Ferri, Principal**  
250 Northwood Ave.  
West Seneca, NY 14224  
Phone: (716) 677-3642  
Fax: (716) 674-3505

**West Elementary School**  
**Dr. Kristen Frawley, Principal**  
1397 Orchard Park Rd.  
West Seneca, NY 14224  
Phone: (716) 677-3260  
Fax: (716) 677-3123

**Winchester Potters Elementary**  
**Robyn Brady, Principal**  
675 Potters Rd.  
West Seneca, NY 14224  
Phone: (716) 677-3582  
Fax: (716) 677-3599

**East Middle School**  
**Jason Marchioli, Principal**  
1445 Center Rd.  
West Seneca, NY 14224  
Phone: (716) 677-3530  
Fax: (716) 674-1046

**West Middle School**  
**David Kean, Principal**  
395 Center Rd.  
West Seneca, NY 14224  
Phone: (716) 677-3501  
Fax: (716) 675-6134

**East Senior High School**  
**Jason Winnicki, Principal**  
4760 Seneca St.  
West Seneca, NY 14224  
Phone: (716) 677-3301  
Fax: (716) 677-2933

**West Senior High School**  
**John Brinker, Principal**  
3330 Seneca St.  
West Seneca, NY 14224  
Phone: (716) 677-3352  
Fax: (716) 674-3551

**Out-of-District and Non-Public**  
1397 Orchard Park Rd.  
West Seneca, NY 14224  
Phone: (716) 677-3137  
Fax: (716) 677-3153

**Identified English Language Learners (ELL) Attend the Following Buildings:**

### Primary School Grades K-5

**Northwood Elementary School**  
**Angela Ferri, Principal**  
250 Northwood Ave.  
West Seneca, NY 14224  
Phone: (716) 677-3642  
Fax: (716) 674-3505

### Middle School Grades 6-8

**East Middle School**  
**Jason Marchioli, Principal**  
1445 Center Rd.  
West Seneca, NY 14224  
Phone: (716) 677-3530  
Fax: (716) 674-1046

### High School Grades 9-12

**East Senior High School**  
**Jason Winnicki, Principal**  
4760 Seneca St.  
West Seneca, NY 14224  
Phone: (716) 677-3301  
Fax: (716) 677-2933

**NOTE TO SCHOOLS/Local Education Agency (LEA): Please assist students and families filling out this form.**

## ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: \_\_\_\_\_

Name of School: \_\_\_\_\_

Name of Student: \_\_\_\_\_  
Last First Middle

Gender:  Male  
 Female  Other  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Grade: \_\_\_\_ ID#: \_\_\_\_\_  
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): \_\_\_\_\_
- Migratory living in circumstances described above
- 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**

If the student is **NOT** living in permanent housing, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled**. **After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

**NOTE TO SCHOOLS/LEAS:** If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

IDENTIFICATION & RECRUITMENT OFFICE PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

*Please take few minutes to complete this questionnaire.*

**Has anyone in your family worked or looked for work at the following occupations during the past 3 years?**

- Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- Work related to logging, harvesting, or initial processing of trees.
- Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



*If you answered YES, please provide your contact information below:*

Parent/Guardian Name: \_\_\_\_\_

Home address: \_\_\_\_\_

Telephone number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Best time to be reached: \_\_\_\_\_ AM/PM

Previous Address: \_\_\_\_\_

Student name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Student name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

**To submit this referral please fax to 607-436-3606, or by mail to NYS Migrant Education Program- Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.**

OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Acta de Educación Elemental y Secundaria (ESEA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, **sin importar su nacionalidad o estado legal**. Este programa **es gratuito** para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito en la escuela, excursiones, programa de verano, actividades de involucramiento para padres, programa de emergencias y referidos a otras organizaciones o agencias.

***Por favor tome unos minutos para completar este cuestionario.***

**¿Usted o algún miembro de su familia ha trabajado o buscado trabajo en algunas de las siguientes ocupaciones en los pasados 3 años?**

- Cualquier trabajo agrícola (como plantando, seleccionando, o cosechando frutas o vegetales, cultivando o cortando flores o árboles, trabajo en lechería u otro rancho de animales, pescando, etc.)
- Trabajando en la cultivación o procesamiento de los árboles.
- Trabajando en una planta de procesamiento, empacando, lavando o cortando vegetales, frutas o carnes.



***Si usted contestó que sí, por favor complete la siguiente información:***

Nombre del Padre/Encargado: \_\_\_\_\_

Dirección Física: \_\_\_\_\_

Teléfono: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Mejor tiempo para ser contactado \_\_\_\_\_ AM/PM

Dirección anterior: \_\_\_\_\_

Nombre del estudiante: \_\_\_\_\_ Edad \_\_\_\_\_ Grado \_\_\_\_\_

Nombre del estudiante: \_\_\_\_\_ Edad \_\_\_\_\_ Grado \_\_\_\_\_

**Para someter este referido, por favor envíelo por fax a 607-436-3606, o por correo a**  
**NYS Migrant Education Program- Identification & Recruitment Office**  
**100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020**



Lissette Colón-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.**

<b>STUDENT NAME:</b>		
_____		
<i>First</i>	<i>Middle</i>	<i>Last</i>
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
_____		<input type="checkbox"/> Male
<i>Month</i>	<i>Day</i>	<i>Year</i>
_____		<input type="checkbox"/> Female
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
_____		
<i>Last Name</i>	<i>First Name</i>	<i>Relation to Student</i>
_____	_____	_____

HOME LANGUAGE CODE

_____
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### Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	_____	<input type="checkbox"/> Father
		<i>specify</i>	<i>specify</i>
	<input type="checkbox"/> Guardian(s)	_____	<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak
		<i>specify</i>	
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
		<i>specify</i>	
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write
		<i>specify</i>	

### 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

<b>Educational History</b>
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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *If yes, please explain: _____
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes*    *Please complete 10b below
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____
Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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: \_\_\_\_\_

<b>OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ</b>	
NAME: _____	POSITION: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS: _____	
<b>NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW</b>	
NAME: _____	POSITION: _____
ORAL INTERVIEW NECESSARY: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <small>MO.    DAY    YR.</small>	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
<b>NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL</b>	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <small>MO.    DAY    YR.</small>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: _____ _____	

**WEST SENECA CENTRAL SCHOOL DISTRICT**

**GENERAL INFORMATION REGISTRATION FORM**

**(Office Use Only)**  
**Student No.** \_\_\_\_\_

**School Year** \_\_\_\_\_ **Grade** \_\_\_\_\_ **Date of Registration** \_\_\_\_\_  
**School** \_\_\_\_\_ **Gender** \_\_\_ Male \_\_\_ Female \_\_\_ Other

**\*Student Name** \_\_\_\_\_  
 (Last) (First) (Middle)

**\*Address (Where you live)** \_\_\_\_\_  
 (Street) (Apt. No. / Upper/Lower)  
 \_\_\_\_\_  
 (City) (Zip Code)

**\*Mailing Address (If different from where you live)** \_\_\_\_\_  
 (Street / Apt. No. / Upper/Lower) (City) (Zip Code)

**\*Child's Ethnic Group:** \_\_\_\_\_  
 (Indicate Letter) [A] Asian [B] Black or African American [H] Hispanic or Latino [I] American Indian or Alaska Native  
 [M] Multiracial [P] Native Hawaiian/Other Pacific Islander [W] White

**\*Entry Date to U.S.** (if not born in U.S.) \_\_\_\_/\_\_\_\_/\_\_\_\_

**Dominant Language** \_\_\_\_\_ **Interpretive Services Needed** \_\_\_\_\_  
 (Yes / No)

**\*Date of Birth** \_\_\_\_\_ **Place of Birth** \_\_\_\_\_  
 (City) (State) (Country)

**\*Proof of Age:** Original Birth Certificate \_\_\_\_\_ Passport \_\_\_\_\_  
 (Indicate Number)

**\*Contact 1: Primary Residential Parent:** \_\_\_\_\_  
 (Last) (First) (Middle)

**Relationship** \_\_\_\_\_ **Address** \_\_\_\_\_  
 (Street) (City) (State) (Zip)

**Home #** \_\_\_\_\_ **Cell #** \_\_\_\_\_ **Work #** \_\_\_\_\_ **Email** \_\_\_\_\_

**Dominant Language** \_\_\_\_\_ **Interpretive Services Needed** \_\_\_\_\_  
 (Yes / No)

**\*Contact 2: Person in Parental Relationship** \_\_\_\_\_  
 (Last) (First) (Middle)

**Relationship** \_\_\_\_\_ **Address** \_\_\_\_\_  
 (Street) (City) (State) (Zip)

**Home #** \_\_\_\_\_ **Cell #** \_\_\_\_\_ **Work #** \_\_\_\_\_ **Email** \_\_\_\_\_

**Dominant Language** \_\_\_\_\_ **Interpretive Services Needed** \_\_\_\_\_  
 (Yes / No)

**If Separated/Divorced (Legal Custody of Child)** **Mother** \_\_\_\_\_ **Father** \_\_\_\_\_ **Both** \_\_\_\_\_ **Other** \_\_\_\_\_  
 (A signed and dated court order must be present in the student file before a parent can be denied access to his/her child.)

**\*Other Children in the Family** \_\_\_\_\_  
 (Last) (First) (Middle) (Birth Date) (Last) (First) (Middle) (Birth Date)

**Brothers/Sisters** \_\_\_\_\_  
 (Last) (First) (Middle) (Birth Date) (Last) (First) (Middle) (Birth Date)

\_\_\_\_\_ (Last) (First) (Middle) (Birth Date) (Last) (First) (Middle) (Birth Date)

**Contact 3: Emergency Contact:** \_\_\_\_\_  
 (Last) (First) (Middle)

**Relationship** \_\_\_\_\_ **Home #** \_\_\_\_\_ **Cell #** \_\_\_\_\_

**Contact 4: Emergency Contact:** \_\_\_\_\_  
 (Last) (First) (Middle)

**Relationship** \_\_\_\_\_ **Home #** \_\_\_\_\_ **Cell #** \_\_\_\_\_



RESIDENCY VERIFICATION

School Year \_\_\_\_\_ Grade \_\_\_\_\_ Date of Registration \_\_\_\_\_

\*Student Name \_\_\_\_\_  
 (Last) (First) (Middle)

\*Address \_\_\_\_\_  
 (Street/Apt. No. / Upper/Lower) (City) (Zip Code)

Gender Male \_\_\_\_\_ Female \_\_\_\_\_ Other \_\_\_\_\_ Special Education? YES \_\_\_\_\_ NO \_\_\_\_\_

Last Grade Completed \_\_\_\_\_ Years in U.S. Schools \_\_\_\_\_ Entry Date to U.S. \_\_\_\_/\_\_\_\_/\_\_\_\_

Please Check if child is a Foster Child \_\_\_\_ Yes \_\_\_\_ No

Name of Agency/Social Worker \_\_\_\_\_

PRIMARY RESIDENTIAL CUSTODY

**Contact 1: Primary Residential Parent/Primary Parental Relationship:** \*Relationship \_\_\_\_\_

\_\_\_\_\_  
 (Last) (First) (Middle)

\*Address \_\_\_\_\_  
 (Street) (City) (State) (Zip)

\*Home Phone \_\_\_\_\_ \*E-mail \_\_\_\_\_

\*Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Contact 1** *Currently* a member of the Armed Forces  Yes  No What Branch \_\_\_\_\_

If Separated or Divorced – Legal Custody of Child \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Both \_\_\_\_\_ Other \_\_\_\_\_

**Contact 2: Person in Parental Relationship:** \*Relationship \_\_\_\_\_

\_\_\_\_\_  
 (Last) (First) (Middle)

\*Address \_\_\_\_\_  
 (Street) (City) (State) (Zip)

\*Home Phone \_\_\_\_\_ E-mail \_\_\_\_\_

\*Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Contact 2** *Currently* a member of the Armed Forces  Yes  No What Branch \_\_\_\_\_

ORIGINAL DOCUMENTATION SUBMITTED - Documents must show the address of residence

- |   |  |
|---|--|
| <input type="checkbox"/> Documents of Purchase of Home/Condo in District (Closing Papers, Mortgage Statement, Signed and Dated Lease, HUD papers) | <input type="checkbox"/> Membership documents based on residency         |
| <input type="checkbox"/> Lease Agreement  | <input type="checkbox"/> Utility Bill or other Bill(s)                   |
| <input type="checkbox"/> Notarized Statement from Landlord  | <input type="checkbox"/> Tax Bill  |
| <input type="checkbox"/> New York State Valid Driver's License or Learner's Permit  | <input type="checkbox"/> Statement from a financial institution          |
| <input type="checkbox"/> Non-driver's Identification Card   | <input type="checkbox"/> Income Tax form                                 |
| <input type="checkbox"/> Car Registration   | <input type="checkbox"/> Voter registration document                     |
| <input type="checkbox"/> State or other Government issued identification (Government Benefits Document)   | <input type="checkbox"/> Court – Custody evidence or Guardianship papers |
|   | <input type="checkbox"/> Other: _____                                    |

I understand that the provisions of false information on this residency form could constitute a crime. I understand that the District reserves its right to recover from parents, persons in parental relations or other responsible parties the entire actual cost of educating a student (as established by the New York State Education Department), plus related costs, for the entire period that any non-resident student is enrolled in the District's schools without authorization and/or under false pretenses.

I hereby certify that the student listed on this residency form actually resides at the address specified above, within the West Seneca Central School District boundaries. I further certify that all information I provided on this residency form is true and correct. I understand that I must immediately notify the District if the residency of the student changes from the address listed on this form.

\_\_\_\_\_  
 (Signature of Parent / Person in Parental Relation)

\_\_\_\_\_  
 (Date)



# WEST SENECA CENTRAL SCHOOL DISTRICT

Administrative Offices • 1397 Orchard Park Road • West Seneca, New York 14224

## CONSENT TO OBTAIN/RELEASE RECORDS TO A THIRD PARTY

I authorize information to be obtained from (Previous school/Agency):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous School Phone Number (\_\_\_\_) \_\_\_\_\_ Fax No. (\_\_\_\_) \_\_\_\_\_

Recommended School: \_\_\_\_\_ Student's DOB: \_\_\_\_\_

I, \_\_\_\_\_, the undersigned, authorize release of and/or access to records for:

(Parent/Guardian's Name)

\_\_\_\_\_  
(Student's Name)

### Please release records to (New school/Agency):

**West Seneca Central School District**  
Special Education/Pupil Services Department  
1397 Orchard Park Rd.  
West Seneca, NY 14224  
Phone: (716) 677-3160  
Fax: (716) 677-3159

**OR**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

### Information to be obtained/released to include (check all that apply):

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Academic   | <input type="checkbox"/> Standardized Test(s)                                  |
| <input type="checkbox"/> Health     | <input type="checkbox"/> Psychological/Social Work                             |
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Professional Reports (i.e. Speech, OT, PT Evaluation) |
| <input type="checkbox"/> I.E.P.     | <input type="checkbox"/> Medical / Hospital                                    |
|                                     | <input type="checkbox"/> Other: _____  |

Print Parent/Guardian Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/ Guardian: \_\_\_\_\_

**The party receiving/reviewing the student record is NOT authorized to transfer this information to a third party without further consent.**

Parents, students age 18 or older, or students attending a post-high school education institution, are advised they have the right to be notified of the student's transfer of records to another school; that they may receive a copy of the student's record if desired, and have an opportunity for a hearing to challenge the content of the record prior to its being sent.

### **VERIFICATION OF ACCESS OR RELEASE**

*Office Use Only*

The records indicated on this form were:

- Released       Obtained

Release to/Obtained By: \_\_\_\_\_ on \_\_\_\_\_

(Date)

Office Representative: \_\_\_\_\_

*Consent with original authorized signatures is required in addition to any facsimile communication*

*Parent approval is not required when authorized school personnel requests records.*

**(FAMILY EDUCATION RIGHTS AND PRIVACY ACTS, FEDERAL REGISTER, VOL. 41, No. 118, AND PAGE 24673)**



WEST SENECA CENTRAL SCHOOL DISTRICT

West Seneca Transportation

3300 Seneca Street

West Seneca, New York 14224

[Empty box for Name of School]

Name of School

TRANSPORTATION REQUEST FORM

PLEASE NOTE:

- Phone requests from parents for routing will not be accepted!
- Parents are responsible for transportation until notified.
- Please be aware that a **three-day notice is advised** prior to transportation being started.

Date of Request: \_\_\_\_\_

Name of Student \_\_\_\_\_

Student Number \_\_\_\_\_ Student D.O.B. \_\_\_\_\_

Home Address \_\_\_\_\_  
(Number and Street) (Town) (Zip Code)

Parent or Guardian \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

School to which transportation is being requested \_\_\_\_\_

For School Year \_\_\_\_\_ to \_\_\_\_\_ Grade Level \_\_\_\_\_

Date Transportation will start \_\_\_\_\_ Authorized \_\_\_\_\_

Student is: New in District \_\_\_\_\_ Transfer from \_\_\_\_\_

TRANSPORTATION OFFICE USE ONLY

Route No. \_\_\_\_\_ Pick Up Location \_\_\_\_\_

AM Pick Up Time \_\_\_\_\_ Existing Stop \_\_\_\_\_ New Stop \_\_\_\_\_

Date Processed \_\_\_\_\_ Authorized \_\_\_\_\_

School Notified \_\_\_\_\_ Parent Notified \_\_\_\_\_

Entered in Students \_\_\_\_\_ Routed \_\_\_\_\_

CHECK HERE IF YOU ARE FAXING THIS FORM FIRST, THE ORIGINAL FORM MUST FOLLOW.

West Seneca Central School District

# Health Information

***To Parents/Guardians:***

*Please keep the following pages for your records:*

- Health Services Information
- Letters from School Physician
- NYS Mandated Physical Examination Information
- NYS Immunization Requirements

***For All Students:***

*The following **must** be completed by your physician and returned to the school Health Office:*

- Health Appraisal Form
- Record of State Mandated Immunizations
- Dental Examination Record

# Student Health History

**Parent/Guardian Please Complete**

Name \_\_\_\_\_  
(Last) (First) (Middle)

Date of Entry \_\_\_\_\_ Entering Grade \_\_\_\_\_ Birth Date \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Other \_\_\_

Address \_\_\_\_\_  
(Street) (Town) (Zip Code)

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Student's Primary Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Last school attended? \_\_\_\_\_

<b>DOES YOUR CHILD:</b>	<b>PLEASE CHECK</b>			<b>COMMENT IF NECESSARY</b>
1. Have allergies (insect/food/environment)? <b>CHECK</b>				1. _____
• What was your child's reaction/ANAPHYLAXIS? _____				_____
• How was this treated?	911	Benadryl	Epi-Pen	2. _____
• Was testing done to confirm the diagnosis?	Yes		No	3. _____
2. Have athsma?	Yes		No	4. _____
History of lung disease?	Yes		No	5. _____
3. Have frequent sore throats/strep throat?	Yes		No	6. _____
4. Have frequent stomach aches?	Yes		No	7. _____
5. Have ear problems/tubes/loss of hearing?	Yes		No	8. _____
6. Wear glasses or contact lenses? (Please circle)	Yes		No	9. _____
7. Have an orthopedic/bone/joint problem?	Yes		No	10. _____
8. Have frequent headaches?	Yes		No	11. _____
9. Have fainting spells?	Yes		No	12. _____
10. Have a seizure disorder/staring spells?	Yes		No	13. _____
History of concussion?	Yes		No	14. _____
11. Have diabetes?	Yes		No	15. _____
12. Have a heart condition, chest pain?	Yes		No	16. _____
Family history of sudden death (cardiac/heart)	Yes		No	17. _____
13. Have kidney or bladder problems?	Yes		No	_____
14. Have anemia or other blood disorder?	Yes		No	_____
15. Have any skin conditions?	Yes		No	_____
16. Have scoliosis?	Yes		No	_____
17. Wear dental braces?	Yes		No	_____

## Student Health History

Has your child ever been hospitalized for tests, illness, surgery? Explain if yes \_\_\_\_\_

---

---

Has your child ever been treated for serious injuries or fractures? Explain if yes \_\_\_\_\_

---

---

Does anyone at home have a medical problem? Explain if yes \_\_\_\_\_

---

Are there any special problems or conditions we should know about to better understand your child?

Explain if yes \_\_\_\_\_

---

Does your child take any medication at home? \_\_\_\_\_

Will it be necessary for your child to take medication in school? Explain \_\_\_\_\_

---

(See nurse for medication regulations).

### **Students Entering UPK through Grade 6**

Growth and Development of your Child

Premature birth? Yes No Birth weight \_\_\_\_\_

Age at which your child: walked \_\_\_\_\_ toilet trained \_\_\_\_\_

### **Students Entering Grades 7 through 12**

Does your child know how to swim? Yes No

Does your child have any medical restrictions that would prevent full participation in a swim program? Yes No

Explain if yes \_\_\_\_\_

---

Additional Comments:

---

---

If you wish to have a conference with the school nurse, please check here



# WEST SENECA CENTRAL SCHOOL DISTRICT

Administrative Offices • 1397 Orchard Park Road • West Seneca, New York 14224

## NEW YORK STATE GUIDELINES FOR ADMINISTRATION OF MEDICATION IN A SCHOOL SETTING

School nurses, principals and other school personnel are often asked to dispense internal medication to school children. Internal medication can only be dispensed under the following policy:

1. **A written request from the parent/guardian.**
2. **A written request from the physician, which indicates the frequency and the dosage of the prescribed medication.**
3. **The medication is to be brought in the prescribed-labeled bottle by an adult to the office.**

**Please do not send aspirin, cold pills, cough drops, inhalers etc.** to school with your child. The dangers of this practice are possible choking and consumption of medication by another student resulting in serious consequences.

As stated above, medication will only be dispensed under the described conditions and this will be strictly adhered to within the school setting.

Please keep a copy of this notice for your records and forward the attached form to the school nurse.

HS82b-4/06

----- PLEASE DETACH AND RETURN TO SCHOOL -----

I, \_\_\_\_\_, have received a copy of the  
(Please Print Parent/Guardian Name)

### NEW YORK STATE GUIDELINES FOR ADMINISTRATION OF MEDICATION IN A SCHOOL SETTING.

Name of Student \_\_\_\_\_  
(Please Print Name)

Teacher \_\_\_\_\_ Grade \_\_\_\_\_ Room \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_





## HEALTH SERVICES INFORMATION FOR PARENTS

HS82a - 6/18

**Physical Exams:** Physical examinations are required for students in Universal Pre-K or Kindergarten, grades 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup>, 7<sup>th</sup>, 9<sup>th</sup>, 11<sup>th</sup> and any student new to the West Seneca Central School District. Students classified with disabilities will need a physical exam every three years. School physicals will be scheduled unless the student returns a physical exam form from their own physician.

**Dental Certificates:** Students requiring physical exams are also required to have dental exam certificates completed by a licensed dentist. See the above Physical Exams for grades required.

**Preventative Screening:** During the school year students are screened for possible difficulties in the following areas:

- A) Vision • New students and grades UPK or K, 1, 3, 5, 7, and 11<sup>th</sup>
- B) Hearing • New students and grades UPK or K, 1, 3, 5, 7, 11<sup>th</sup>
- C) Postural Defects - Scoliosis • Grades 5-9<sup>th</sup>

**Notification of Defects to the Parents:** Parents are notified of health concerns found in all health appraisals and failure on vision, hearing and scoliosis screening by phone and paper referral sent home with your child. This notification should be returned as soon as possible stating the action taken by the medical examiner. The Health Office Staff welcomes information relative to your child's health. We are willing to assist you in referrals for health care, health education and health insurance.

**Continuous Health Records:** Please assist us in keeping your child's health record up-to-date by notifying the health office of any new physical condition, treatments, or immunizations for your child.

**Notification:** Parent's will be notified of serious injury or illness. Parents are responsible for the transportation of ill children to home. Emergency phone numbers and details will be obtained from the student's emergency information sheet. **PLEASE NOTIFY THE SCHOOL OF ANY CHANGES IN YOUR WORK, CELL, OR HOME PHONE NUMBERS.** If the parents are unable to be reached, the emergency contact sheet should reflect who is allowed to pick your child up if we are unable to reach you. Please make sure that these adults as listed **HAVE ACCESS TO A CAR AND ARE AVAILABLE DURING SCHOOL HOURS.**

**Attendance:** Please encourage regular school attendance as each day adds a step in his/her total development. However, please keep your child home if he/she shows any suspicious symptoms such as: sore throat, rash, colds, persistent cough, fever (anything over 100 degrees), "weepy lesions", inflamed eyes or symptoms of a contagious disease. Please call the school if your child is absent.

**Medication Policy:** If it is necessary for your child to take medication during school hours, New York State Law requires a **written NOTE FROM THE PARENT, and a written NOTE FROM THE DOCTOR.** The supply of medications must be **brought to the Health Office BY AN ADULT IN THE PHARMACY CONTAINER.** This law applies to all medications including INHALERS, PAIN MEDICATION, COUGH DROPS, AND ALL OVER THE COUNTER MEDICATION. Students who are self-directed for their medication administration must have medical provider and parental written permission and must see the nurse at the beginning of the year to review technique regarding proper handling of the medication. Also per the law (1999), for self-directed students, parents are encouraged to ask the pharmacist for an additional labeled container to be used for medications that must be given during field trips. For students who are not self directed, parents/guardians may attend the activity and administer the medication. The parent may personally request another adult who is not employed by the district to voluntarily administer the medication and inform the school in writing of such request. The student's health care provider can be consulted who may order the medication time to be adjusted or the dose eliminated. If no other alternatives can be found the medication will be administered by a licensed professional employed by the district. Forms for medication administration (parent, medical provider and self-directed) may be obtained from the Health Office.

**Physical Education Program:** Please inform the school if your child is unable to participate in a full physical education program (gym and swim). New York State Law requires a DOCTOR'S WRITTEN STATEMENT if a child is to be excluded from physical education for a length of time (i.e. over 1 week). A doctor's permission is required for complete re-entry into the physical education program after a serious illness, sutures, surgery, fractures or other injuries. Physical Education is a **REQUIRED** course to graduate. If your child has medical/physical limitations, the physician must complete a Medical Recommendations Form to help design a program to meet your child's individual needs.

**Care for Injuries:** School authorities may provide emergency care for illness and injuries which occur WHILE THE STUDENT IS IN SCHOOL. Treatment is limited to FIRST AID ONLY. HOME injuries are the responsibility of the parents/guardians.

**Sports:** If your child wears glasses and will be participating in interscholastic sports, **it is strongly recommended that he/she wear polycarbonate, impact resistant safety lenses or polycarbonate goggles over their eye wear for added protection.** It is also recommended that polycarbonate goggles be worn in addition to contact lenses to protect eyes that are impaired from injury.

If you have any questions regarding the health or health care of your student, feel free to call your School Nurse.



# WEST SENECA CENTRAL SCHOOL DISTRICT

Administrative Offices • 1397 Orchard Park Rd • West Seneca, New York 14224

Dear Parent(s)/Guardian(s):

This letter is to inform you of our procedure in regards to children who are sick.

If your child is ill, it is often most appropriate to keep him/her home from school. A child who is sick will not be able to perform well in school and is likely to spread the illness to other children and staff. Please make arrangements for childcare ahead of time so you will have a place for your child to stay if he/she is ill.

Our school protocol states that you should not send your child to school if he/she had:

- Fever in the past 24 hours
- Vomiting in the past 24 hours
- Diarrhea in the past 24 hours
- Chills
- Sore throat
- Rash
- Strep Throat - must take an antibiotic for at least 24 hours before returning to school
- Bad cold (upper respiratory infection) with a very runny nose or bad cough especially if it has kept the child awake at night.
- Head lice - must be treated according to the nurse or doctor's instruction and are completely nit (egg) free, before returning to school
- Eye infection - must take an antibiotic for at least 24 hours before returning to school

If your child becomes ill at school and the school nurse feels the child is too sick to benefit from school or is contagious to other children, you will be called to come and take him/her home from school. It is essential that the health office have a phone number where you can be contacted during the day and an emergency number in the event you cannot be reached. Please be sure that arrangements can be made to transport your child home from school and that childcare is available in case of illness. Thank you for your cooperation.

Dr. Kim Prise  
School Physician



# WEST SENECA CENTRAL SCHOOL DISTRICT

Administrative Offices • 1397 Orchard Park Rd • West Seneca, New York 14224

**Matthew J. Bystrak**  
Superintendent of Schools

**Jacquelyn R. Fowler**  
Assistant Superintendent of Exceptional  
Education

**Dr. Sharon M. Loughran**  
Director of Pupil Personnel Services

Dear Parent/Guardian:

This letter is to inform you of our procedure regarding children who present with symptoms of COVID-19.

If your child is ill and presents with symptoms of COVID-19 it is necessary to keep him/her home from school. An ill child will not be able to perform well in school and is likely to spread the illness to other children and staff. Please arrange for childcare ahead of time so you will have a place for your child to stay if he/she is ill.

Our school protocol states that you should not send your child to school if he/she had:


- Fever in the past 24 hours
- Cough
- Shortness of breath and/or difficulty breathing without activity
- Fatigue
- Muscle/body aches
- Headache
- Loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea, vomiting or diarrhea

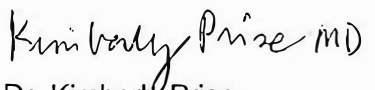
If your child becomes ill at school and presents with COVID-19 symptoms, they may be contagious to other children and staff. You will be called and will be required to take your child home.

***It is essential that the health office have a phone number where you can be reached during the day. Also, please provide an emergency contact person and phone number in the event you cannot be reached.*** Please be sure arrangements can be made to safely transport your child home from school in a timely fashion and that childcare is available.

***We recommend that you contact your child's health care provider for further evaluation and care instructions.***

Thank you for working with us to keep our children and community safe from COVID-19.

  
Matthew J. Bystrak  
Superintendent of Schools

  
Dr. Kimberly Prise  
School Physician



# WEST SENECA CENTRAL SCHOOL DISTRICT

Administrative Offices • 1397 Orchard Park Rd • West Seneca, New York 14224-4098

**Matthew J. Bystrak**  
Superintendent of Schools

**Jacquelyn R. Fowler**  
Assistant Superintendent of Exceptional Education

**Dr. Sharon M. Loughran**  
Director of Pupil Personnel Services

Dear Parents and Person(s) in Parental Relation:

The West Seneca Central School District supports New York State and the recognition of the importance of the importance of medical supervision and the need for annual preventative physical examinations. In addition, the district recognizes the strong connection in academic achievement and physical, emotional, and medical wellness.

**PLEASE NOTE:**

New York State mandates physical examinations for:

- Students attending UPK or Kindergarten and Grades 1st, 3rd, 5th, 7th, 9<sup>th</sup> and 11<sup>th</sup>
- Students transferring into the West Seneca Central District.
- Students with disabilities are required to have an examination every three years.
- The physical exam must be done within the last 12 months of the student entering school.
- Students participating in interscholastic sports require a physical annually.

Area physicians have designed a universal form to assist in streamlining the physical examination reporting system. ***This universal form will be acceptable for both the mandated physical and sport physical.*** (Forms will be available in the school main and health offices, downloading it from the district website and at most physician offices).

***If the physical exam is not completed, the school will work with you to schedule an exam with your own physician or will provide you an opportunity to have your child seen by the District's physician.***

The District encourages you to continue good health practices by having your child receive annual preventive physicals and by collaborating with the school Health Office to meet the state mandates. If you should have any questions or concerns, please contact the school Health Office. If at any time you lose your health insurance, contact the School Nurse or Social Worker.

## HEALTH OFFICES

**Allendale Elementary**  
677-3664

**East Middle School**  
677-3564

**East Senior High School**  
677-3319

**Clinton Elementary**  
677-3624

**West Middle School**  
677-3508

**West Senior High School**  
677-3380

**Northwood Elementary**  
677-3644

**West Elementary**  
677-3256

**Winchester-Potters Elementary**  
677-3584

# 2022-23 School Year

## New York State Immunization Requirements for School Entrance/Attendance<sup>1</sup>

**NOTES:**  
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for **each** vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

**Dose requirements MUST be read with the footnotes of this schedule**

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
<b>Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)<sup>2</sup></b>	<b>4 doses</b>	<b>5 doses or 4 doses</b> if the 4th dose was received at 4 years or older or <b>3 doses</b> if 7 years or older and the series was started at 1 year or older	<b>3 doses</b>	
<b>Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)<sup>3</sup></b>	<b>Not applicable</b>		<b>1 dose</b>	
<b>Polio vaccine (IPV/OPV)<sup>4</sup></b>	<b>3 doses</b>	<b>4 doses or 3 doses</b> if the 3rd dose was received at 4 years or older		
<b>Measles, Mumps and Rubella vaccine (MMR)<sup>5</sup></b>	<b>1 dose</b>	<b>2 doses</b>		
<b>Hepatitis B vaccine<sup>6</sup></b>	<b>3 doses</b>	<b>3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years</b>		
<b>Varicella (Chickenpox) vaccine<sup>7</sup></b>	<b>1 dose</b>	<b>2 doses</b>		
<b>Meningococcal conjugate vaccine (MenACWY)<sup>8</sup></b>	<b>Not applicable</b>		<b>Grades 7, 8, 9, 10 and 11: 1 dose</b>	<b>2 doses or 1 dose</b> if the dose was received at 16 years or older
<b>Haemophilus influenzae type b conjugate vaccine (Hib)<sup>9</sup></b>	<b>1 to 4 doses</b>	<b>Not applicable</b>		
<b>Pneumococcal Conjugate vaccine (PCV)<sup>10</sup></b>	<b>1 to 4 doses</b>	<b>Not applicable</b>		

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.
2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
  - b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
  - c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
  - d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6, 7 and 8: 10 years; minimum age for grades 9 through 12: 7 years)
  - a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
  - b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2022-2023, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6, 7 and 8; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 9 through 12.
  - c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.
4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
  - b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
  - c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
  - d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.
5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
  - a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
  - b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
  - c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
  - d. Rubella: At least one dose is required for all grades (prekindergarten through 12).
6. Hepatitis B vaccine
  - a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).
  - b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.
7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
  - a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
  - b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.
8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7, 8 and 9: 10 years; minimum age for grades 10 through 12: 6 weeks)
  - a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
  - b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
  - c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.
9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
  - b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
  - c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
  - d. If dose 1 was received at 15 months or older, only 1 dose is required.
  - e. Hib vaccine is not required for children 5 years or older.
10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
  - b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
  - c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
  - d. If one dose of vaccine was received at 24 months or older, no further doses are required.
  - e. PCV is not required for children 5 years or older.
  - f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: [www.health.ny.gov/prevention/immunization/schools](http://www.health.ny.gov/prevention/immunization/schools)

For further information, contact:

**New York State Department of Health  
Bureau of Immunization  
Room 649, Corning Tower ESP  
Albany, NY 12237  
(518) 473-4437**

**New York City Department of Health and Mental Hygiene  
Program Support Unit, Bureau of Immunization,  
42-09 28th Street, 5th floor  
Long Island City, NY 11101  
(347) 396-2433**

# REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

**TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

## HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> <b>Allergies</b>	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> <b>Asthma</b>	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> <b>Seizures</b>	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> <b>Diabetes</b>	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

**Risk Factors for Diabetes or Pre-Diabetes:** Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.

BMI \_\_\_\_\_ kg/m<sup>2</sup>

**Percentile (Weight Status Category):**  < 5<sup>th</sup>  5<sup>th</sup>- 49<sup>th</sup>  50<sup>th</sup>- 84<sup>th</sup>  85<sup>th</sup>- 94<sup>th</sup>  95<sup>th</sup>- 98<sup>th</sup>  99<sup>th</sup> and >

**Hyperlipidemia:**  Yes  Not Done      **Hypertension:**  Yes  Not Done

## PHYSICAL EXAMINATION/ASSESSMENT

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Lead Level</b> Required for PreK & K
TB-PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 µg/dL
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

**System Review Within Normal Limits**

**Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid	



Name:		Affirmed Name (if applicable):		DOB:	
<b>SCREENINGS</b>					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
<b>Vision Screening</b>	<b>With Correction</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
Notes					
<b>Hearing Screening:</b> Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz for grades 7 & 11 also test at 6000 & 8000 Hz.					<b>Not Done</b>
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
<b>Scoliosis Screening:</b> Boys grade 9, Girls grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
<b>FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>*Family cardiac history reviewed</b> – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b>					
<b>If Restrictions Apply</b> – Complete the information below					
<input type="checkbox"/> <b>Student is restricted from participation in:</b>					
<input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> <b>Other Restrictions:</b>					
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level.					
<b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> <b>Other Accommodations*:</b> Provide details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
<b>MEDICATIONS</b>					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
<b>COMMUNICABLE DISEASE</b>			<b>IMMUNIZATIONS</b>		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
<b>HEALTHCARE PROVIDER</b>					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form to Your Child's School Health Office When Completed.</b>					



# RECORD OF NEW YORK STATE MANDATED IMMUNIZATIONS

HS 323-2/18

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**This form MUST be completed by a Medical Provider.**

New York State Public Health Law, Section 2164 mandates that no school shall permit any child to attend or be admitted unless the parent provides the school with a certificate of required immunizations. The current NYS immunization schedule can be found at [www.health.ny.gov](http://www.health.ny.gov). Schools must have in their possession a complete list of your child's immunization record signed by a medical provider.

It is duty of the West Seneca Central School District to enforce the New York State Education Law. In accordance to this law, proof of the mandated immunizations or a note from your medical office indicating the date of a scheduled appointment is required within the time frame listed below.

- Students **within** NYS have **14 days** to provide a record of mandated immunizations.
- Students **outside** NYS have **30 days** to provide a record of mandated immunizations.

If you fail to provide this required information, you will receive an exclusion date in writing for your child.

Please contact your school nurse with any questions or concerns.

Diphtheria/Pertussis/Tetanus: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Tdap (Adacel/Boostrix): \_\_\_\_\_

Polio: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,

MMR: \_\_\_\_\_, \_\_\_\_\_

Hepatitis B: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Varicella: \_\_\_\_\_, \_\_\_\_\_

Meningococcal: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,

Hib: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Pneumococcal: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ \_\_\_\_\_

Other (Specify): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Healthcare Provider's Name \_\_\_\_\_  
(print)

Date \_\_\_\_\_

Signature of Healthcare Provider \_\_\_\_\_



# WEST SENECA CENTRAL SCHOOL DISTRICT

Administrative Offices • 1397 Orchard Park Road • West Seneca, New York 14224

As of September 1, 2008, school districts are now required to request dental health certificates from their students in Pre-Kindergarten or Kindergarten, grades 1, 3, 5, 7, 9, 11 and any student new to the West Seneca Central School District. Please call your school nurse if you have any questions.

## DENTAL EXAMINATION RECORD

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

### **NOTE CONDITIONS AS CHECKED**

Cavities

Home brushing care

Good

Needs improvement

Urgently needs improvement

Occlusion or Bite Relation

Normal

Abnormal

Prompt and urgent attention is advised

Mouth in apparently good condition

**SPECIAL NOTE:** Even though your child's mouth condition may be good at this time, routine and regular examinations by your family dentist are advisable. See her/him before your child complains of pain. Be watchful! Keep sugar intake low!

\_\_\_\_\_  
Signature of Examining Dentist

D.D.S.

\_\_\_\_\_  
Date