Documentation Regarding Enrollment

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

To prepare for your appointment please make sure to bring the following items that are needed for registration:

- Proof of Parent or Guardian Identity (**NYS Valid Driver's License** or Non-driver's Identification Card)
- **Proof of Residency and supporting documentation** (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 with TWO additional proofs** which may include the following: car registration, utility bill, bank statement, payroll stub, government benefit document
- **Child's Birth Certificate** (Original with seal)
- Immunization Records signed by doctor, along with a current Physical. *Please refer to the **Immunization Guide**
- Last Report Card (If available)
- IEP for Special Education Needs (If Applicable)
- Court Documents such as: Custody Papers (If Applicable)
- Agency Counselor or Probation Officer's Name (If Applicable)

361-2/2018reg

REGISTRATION FORM
RESIDENCY VERIFICATION

*Student Name _____ _____ _____ Student's DOB _____
(Last Name) (First) (Middle)

*Address _____ _____ _____
(Street) (City) (Zip Code)

CONTACT 1 Primary Residential Custody

Relationship _____

*Person in Parental Relationship _____ _____ _____
(Last Name) (First) (Middle)

*Address _____ _____ _____
(Street) (City) (Zip Code)

*Home Phone _____ E-mail _____

Cell Phone _____ Work Phone _____

CONTACT 1 ***Currently*** a member of the Armed Forces and on ***Active Duty*** ☐

****If Separated or Divorced - Legal Custody of Child*** ☐ Mother ☐ Father ☐ Both ☐ Other _____

CONTACT 2

Relationship _____

*Person in Parental Relationship _____ _____ _____
(Last Name) (First) (Middle)

*Address _____ _____ _____
(Street) (City) (Zip Code)

*Home Phone _____ E-mail _____

Cell Phone _____ Work Phone _____

CONTACT 2 ***Currently*** a member of the Armed Forces and on ***Active Duty*** ☐

ORIGINAL DOCUMENTATION SUBMITTED
Documents must show the address of residence

- ☐ Documentation of Purchase of Home/Condo in District *(closing papers, Mortgage statement, HUD papers)*
- ☐ Lease Agreement
- ☐ Notarized Statement from a Landlord
- ☐ New York State Valid Driver's License or learner's permit
- ☐ Non-driver's Identification Card
- ☐ Car Registration
- ☐ State or other Government issued identification *(Government benefits document)*
- ☐ Membership documents based on residency *(such as a library card)*
- ☐ Utility Bill or other Bill(s)
- ☐ Tax Bill
- ☐ Statement from a financial institution
- ☐ Income Tax form
- ☐ Voter registration document
- ☐ Court - Custody evidence or Guardianship papers
- ☐ Other _____

I understand that the provision of false information on this residency form could constitute a crime. In addition, I understand that the District reserves its right to recover from parents, persons in parental relation 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 the 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*

Please complete both sides

West Seneca Central School District

GENERAL INFORMATION

Date _____

Previous School Attended _____

Last Grade Completed _____ Years in U.S. School(s) _____

Please check if child is a Foster Child ❒ Yes ❒ No

Name of Agency/Social Worker

_____

Entry Date to U.S. *(If not born in U.S.A.)* _____

Did child ever attend pre-school? ❒ Yes ❒ No

Special Education? ❒ Yes ❒ No

Child will walk to school? ❒ Yes ❒ No

Sex: ❒ Male ❒ Female

Legal Custody Alert:

A court order must be present in the file before a parent can be denied access to his/her child.

Doctor:

Phone Number:

Date of First Polio Vaccine _____

Medical Information/Medical Alert:

Other Children in the Family - Brother(s)/Sister(s)

(Last Name)	(First)	(Birth Date)	(Last Name)	(First)	(Birth Date)

_____ _____

Signature of Person in Parental Relationship *Date*

NON-CUSTODIAL EMERGENCY CONTACTS

CONTACT 1

Name _____ Relationship _____

Home Phone _____ Alternate Phone _____

CONTACT 2

Name _____ Relationship _____

Home Phone _____ Alternate Phone _____

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at the top page of registration materials that the district shares with families. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the **student is not required to submit proof of residency** and other required documents that may be part of the registration packet.

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____ *Month Day Year* Grade: ____ *(preschool-12)* ID#: _____ *(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

If **ANY box other than "In Permanent Housing" is checked,** , then the student/family should be immediately referred to the MV Liaison. In such cases, **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.

West Seneca Central School District

Student Racial and Ethnic Identification

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Student Name _____ _____ _____
Last *First* *Middle*

Date of Birth _____ / _____ / _____
Month *Day* *Year*

Name of School _____ Grade _____

Parents/Person in Parental Relation _____
Please Print

Relationship:

☐ Mother ☐ Father ☐ Guardian ☐ Other _____
Specify

Check (✓) the box that best describes your child, select one.

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 ***or*** ☐ NO, not Hispanic

Check, (✓) all groups that apply to your child;

2. Select **at least one** race from the following five racial groups.

☐ ***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

_____ _____
Signature of Parent/Person in Parental Relation *Date*

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

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.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH: *Month* *Day* *Year*

GENDER: ❑ Male ❑ Female

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*	❑ Father *specify*	❑ Guardian(s) *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:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Home Language Questionnaire (HLQ)

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 ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

West Seneca Central School District

Student Health History

Parent/Guardian Please Complete

Name _____ _____ _____
(Last) (First) (Middle)

Date of Entry _____ Entering Grade _____ Birth Date _____ Male/ Female

Address _____
(Street) (Town) (Zip Code)

Fathers Name _____ Mothers Name _____

Student's Primary Doctor _____ Phone _____

Last school attended _____

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

West Seneca Central School District

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 _____ toliet 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 ☐

PLEASE COMPLETE THE REVERSE SIDE p2.

West Seneca Transportation
3300 Seneca Street
West Seneca, New York 14224

Name of School

Transportation Request

Please Note:

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

Date of Request _____

Student Number _____

Name of Student _____

Home Address _____ _____
(Number & Street) (Town & Zip Code)

Parent or Guardian _____

Home Phone # _____ Student DOB _____ /_____ /_____

School to which transportation is 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.**

2018-19 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

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). For grades pre-k through 10, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: intervals between doses of polio vaccine DO NOT need to be reviewed for grades 5, 11 and 12.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 11 and 12. 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 and 4	Grade 5	Grades 6, 7, 8, 9 and 10	Grades 11 and 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older		**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)[3]		**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**3 doses**
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**		**2 doses**		
Hepatitis B vaccine[6]	**3 doses**		**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		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**	**1 dose**	**2 doses**	**1 dose**
Meningococcal conjugate vaccine (MenACWY)[8]		**Not applicable**		**Grades 7, 8 and 9: 1 dose**	**Grade 12: 2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**		**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**		**Not applicable**		

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. 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.
   b. If the fourth dose of DTaP was administered at 4 years or older, 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 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. A Tdap vaccine (or incorrectly administered DTaP vaccine) received at 7 years or older will meet the 6th grade Tdap requirement.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap. A dose received at 7 years or older will meet this requirement.
   b. 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. Intervals between the doses of polio vaccine do not need to be reviewed for grades 5, 11 and 12 in the 2018-19 school year.
   e. If both OPV and IPV were administered as part of a series, the total number of doses and intervals between doses is the same as that recommended for the U.S. IPV schedule. If only OPV was administered, and all doses were given before age 4 years, 1 dose of IPV should be given at 4 years or older and at least 6 months after the last OPV dose.

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 and grades 11 and 12. Two doses are required for grades kindergarten through 10.
   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.
   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. (Minimum age: 6 weeks)
   a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7, 8 and 9.
   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 of age 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. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: 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

West Seneca Central School District

Health Information

To Parents/Guardians:

Please keep the following pages for your records:

1. Health Services Information *(HS82a)*
2. Letter from School Physician *(HS82sc)*
3. NYS Mandated Physical Examination Information *(HS82d)*

For All Students:

The following are to be completed by your physician and returned in the enclosed envelope:

4. Health Appraisal Form *(HS324)*
5. Record of State Mandated Immunizations *(HS323)*
6. Dental Examination Record *(HS334)*

West Seneca Central School District

HEALTH SERVICES INFORMATION FOR PARENTS

HS82a - 6/18

Physical Exams: Physical examinations are required for students in Universal Pre-K or Kindergarten, grades 1st, 3rd, 5th, 7th, 9th, 11th 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 11th

B) Hearing • New students and grades UPK or K, 1, 3, 5, 7, 11th

C) Postural Defects - Scoliosis • Grades 5-9th

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 • 675 Potters Road • West Seneca, New York
14224-2683 *Telephone: 716/677-3156* • *Facsimile: 716/677-3159*

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. Kimberly Prise

Dr. Kim Prise
School Physician

West Seneca Central School District

Administrative Offices • 675 Potters Road • West Seneca, New York 14224-2683
Telephone: 716/677-3156 • Facsimile: 716/677-3159

Dear Parents and Person(s) in Parental Relation:

The West Seneca Central School District supports New York State in their recognition of the importance of medical supervision and the need for annual preventive 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, 9th and 11th**
- **Students transferring into the West Seneca Central School 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.

82d - 4/18

Health Offices

Allendale Ellementary
677-3664

Clinton Elementary
677-3624

East Middle
677-3569

East Senior
677-3319

Northwood Eelementary
677-3644

West Elementary
677-3256

West Middle
677-3508

West Senior
677-3380

Winchester Elementary
677-3584

HEALTH APPRAISAL 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:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached ☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached ☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached ☐ 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 ☐ 85th-94th ☐ 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 >10 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 Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

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	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ 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 the 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.

RECORD OF NEW YORK STATE MANDATED IMMUNIZATIONS

HS 323-2/18

Student Name: _____ Date of Birth: _____

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*. 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: _____, _____

Hlb: _____, _____, _____, _____

Pneumococcal: _____, _____, _____, _____

Other (Specify): _____ _____, _____, _____, _____

Healthcare Provider's Name _____ Date _____

(print)

Signature of Healthcare Provider _____

WEST SENECA CENTRAL SCHOOL DISTRICT

Administrative Offices • 675 Potters Road • West Seneca, New York 14224-2683

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!

_____ D.D.S. _____

Signature of Examining Dentist Date

HS334-2/18