Fort Ann Elementary School

One Catherine Street
Fort Ann, NY 12827

518-639-5594

May 14, 2020

Dear Parents/Guardians:

We are delighted that you are planning to enroll your child in Fort Ann Central School District's Pre-Kindergarten Program. Beginning pre-kindergarten is an exciting moment for you and your child! Our staff welcomes this opportunity to help your child develop a love of learning.

The purpose of this letter is to provide clear directions for the registration process. Due to the current school closure required by Governor Cuomo, we have adjusted our procedures for pre-kindergarten registration and we intend to complete the process by mail. We also plan to post a video on the school website, with information related to the educational program, in lieu of the evening informational night we typically hold for parents.

Please complete the enclosed registration packet. **Next, please mail the completed packet, along with a copy of your child's birth certificate, immunization records, and proof of residency, to:**

Mrs. Krista Crosbie
Fort Ann Elementary School
One Catherine Street
Fort Ann, NY 12827

We encourage families to return the completed packet and copies of records, as soon as possible, to help us prepare for the 2020-2021 school year. Immunization records may also be faxed directly from the pediatrician's office to Krista Crosbie, at 518-639-4341, if this is more convenient.

Our pre-kindergarten program has a morning (8:30-10:45) and an afternoon (11:45-2:00) session. These classes are created at the beginning of August. If you have extenuating circumstances and need to request a specific session, please contact Michelle Discenza, Elementary Principal, prior to July 15th. You may email mdiscenza@fortannschool.org or call the school.

We hope to invite you to bring your child to school for a screening process in late August, if regulations permit. This will allow us to learn more about your individual child and also give you an opportunity to meet with our guidance secretary and school nurse, to review paperwork. If we are able to offer a screening procedure, you will be contacted by mail.

We look forward to helping your child learn, explore, grow, and create memories that will last a lifetime. We welcome any questions you may have prior to the start of the new school year. Thank you.

Sincerely,

Michelle Discenza

Michelle Discenza
Elementary Principal

Fort Ann Elementary School

One Catherine Street
Fort Ann, NY 12827

518-639-5594

PRE-KINDERGARTEN REGISTRATION

The following information must be completed and submitted:

1. Pre-Kindergarten Questionnaire
2. Student Information Sheet
3. Student Racial and Ethnic Identification Form
4. Housing Questionnaire along with **two** Proofs of Residency (see list)
5. Pre-Kindergarten Pick up Authorization Form
6. Speech and Language Questionnaire
7. Do not Photograph Form (if applicable)
8. Student Health History Form (completed by parent/guardian)
9. Copy of Immunization Record (from doctor)
10. NYS Health Examination Form (to be completed by doctor)*
11. Dental Health Certificate (to be completed by dentist)
12. Physician's Authorization form Admin. of Medication
13. Custody Papers, Orders of Protection, and Guardianship Documents (if applicable)
14. Proof of Identity (birth certificate, baptism certificate, or passport)

*Must be dated within the last 12 months

*Can be faxed directly to 518-639-4341

Fort Ann Central School

Pre-Kindergarten Questionnaire

Family Information

Child's Full Name: _____ Date of Birth: _____

Mother's Name: _____ Email: _____

Mother's Address: _____ Best Number to Reach Mom: _____

Father's Name: _____ Email: _____

Father's Address: _____ Best Number to Reach Dad: _____

Siblings (please include birthdate/grade/teacher as applies)

_____

_____

Social & Health History

Has your child attended school and/or daycare? _____

If yes, where: _____

Does your child have any health or social concerns? Allergies? _____

_____

Does your child use the toilet/get dressed independently?	Yes	Not yet	Sometimes
Does your child use crayons/pencils/scissors?	Yes	Not yet	Sometimes
How often do you read with your child?	Daily	Weekly	Monthly
Does your child play well/share with other children?	Yes	No	Sometimes

Is there anything else you wish to share about your child? _____

_____

_____

Thank you!

I know you feel like you have answered these questions a thousand times but I like to have a copy to keep in the classroom. I am looking forward to a great year! ~Mrs. Hull, Pre-K Teacher

FORT ANN CENTRAL SCHOOL DISTRICT

STUDENT INFORMATION SHEET

STUDENT'S FULL NAME:_____
First Middle Last

Date of Birth: _____ Teacher_____ Grade_____

Home Address:_____

Mailing Address:_____

Primary Phone (This number will receive the District's Emergency Notifications):_____

Student Lives With (Circle One): Both Parents Mother Father Other

Parent/Guardian Name:_____ Relationship:_____

Mailing Address:_____

Contact Email:_____

Place of Business:_____

Phone Numbers: Home_____ Cell:_____ Work:_____

Custodial Parent: Yes_____ No_____ Emergency Contact?: Yes_____ No _____

Is this parent active duty military or a veteran?_____

Parent/Guardian Name:_____ Relationship:_____

Mailing Address:_____

Contact Email:_____

Place of Business:_____

Phone Numbers: Home_____ Cell:_____ Work:_____

Custodial Parent: Yes_____ No _____ Emergency Contact?: Yes_____ No_____

Is this parent active duty military or a veteran?:_____

Do you have or have there been any changes to any custodial agreements? (If yes, please provide an updated custody order)_____

_____

Parents/Guardians listed above will be contacted **FIRST** in the event of emergency. Please list **additional emergency contacts** below in the *order* you would like them contacted:

EMERGENCY CONTACT #1

Name:_____

Daytime Location Address:_____Relationship:_____

Daytime Phone:_____Cell:_____

EMERGENCY CONTACT #2

Name:_____

Daytime Location Address:_____Relationship:_____

Daytime Phone:_____Cell:_____

EMERGENCY CONTACT #3

Name:_____

Daytime Location Address::_____Relationship:_____

Daytime Phone:_____Cell:_____

Does your child have any medical conditions, illnesses or allergies? **Yes**_____**No**_____ If **yes**, our School Nurse will contact you for details_____

Does your child have an IEP or 504 Plan, or has he/she been referred for evaluation (Speech, OT, PT, etc)? If yes, please provide a copy of the IEP/504 Plan or provide name of tests, dates and location of any testing:

_____

_____

Other siblings (Both in household or out of household) Date of Birth:

_____ _____

_____ _____

_____ _____

What school district is your child transferring from if any?:_____

_____ _____

Signature of Parent/Guardian Today's Date

Fort Ann Central School District

Student Racial and Ethnic Identification

The Fort Ann Central School District has adopted a policy that requires the collection and recording of the ethnic identity of students within the district in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and Federal Education Departments.
- Plan educational programs and make sure they are available to all students.
- Study the movement of students in different ethnic groups as they move from school to school.
- Analyze the differences in academic performance, attendance, and completion of school.

We need your help in order to accomplish the above tasks. Please review the Racial/Ethnic definitions on the reverse side of this form. Place a ✓ in the box that best describes your child. *We understand the sensitive nature of this information and wish to assure you it will be kept secure and confidential in accordance with all State and Federal privacy laws and regulations.*

If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

Confidentiality Procedures and Regulations

To School Staff: This form will be filed in the student's permanent record as confidential information.

To the Parent/Guardian: The information you have provided on this form is confidential. It is protected by the confidentiality regulation cited as follows:

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to students records and unauthorized release of any student record information identifiable by either student name or student identification number.

Please complete the questions on the next page.

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.

Fort Ann Central School District

Student Racial and Ethnic Identification

Name of School: Fort Ann Elementary School	**Student Identification Number** (school staff to fill in):

Student Name (Last, First, Middle):

Date of Birth (Month/Day/Year):	**Grade Level:**

1. **Is this student Hispanic, Latino, or or Spanish origin?**
   Please check only ONE box.

   Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture of origin, regardless of race.

   ☐ YES - Hispanic ☐ NO - Not Hispanic

2. **Select one or more races from the following five racial groups.**
   Check ALL groups that apply to your child. Please check <u>at least one</u> box.

   ☐ **American Indian or Alaska Native** - A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation of community recognition. E.g. Cherokee, Mohawk, Inuit.

   ☐ **Asian** - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Phillipine 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** - 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.

3. **Is there a language other than English which is spoken in your home?**

   ☐ YES. The language is _____.

   ☐ NO. The only language spoken at home is English.

Signature of Parent/Guardian:	**Relationship to student:**	**Date:**

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female 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 <u>one</u> 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 <u>**ANY box other than "In Permanent Housing" is checked,**</u>, 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**.

<u>**After**</u> 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.

<u>**NOTE TO SCHOOLS/LEAS:**</u> If the student is <u>**NOT**</u> living in permanent housing, please ensure that a DESIGNATION FORM is completed.

CUESTIONARIO DE VIVIENDA

Nombre del Distrito Escolar: _____

Nombre de la Escuela: _____

Nombre del Estudiante: _____
Apellido Primer Nombre Segundo Nombre

Género: ☐ Hombre ☐ Mujer Fecha de Nacimiento: _____ / _____ / _____ Grado: _____ ID#: _____
Mes Día Año (jardín de infantes – 12) (opcional)

Dirección: _____ Teléfono: _____

Su respuesta abajo permitirá al distrito escolar definir los servicios que puede aprovechar su hijo/hija según el Acto de McKinney-Vento. Los estudiantes elegibles tienen derecho a la inscripción inmediata en la escuela, aun si ellos no tienen los documentos necesarios tales como: prueba de residencia, documentos escolares, documentos de inmunización, o partida de nacimiento. Los estudiantes elegibles según el Acto de McKinney-Vento tienen además derecho al transporte gratuito y otros servicios que ofrece el distrito escolar.

¿Donde está el estudiante viviendo actualmente? (*Por favor marque <u>una</u> caja.*)

- ☐ En un refugio
- ☐ Con otra familia o otra persona debido a la pérdida del hogar o a dificultades económicas
- ☐ En un hotel/motel
- ☐ En un carro, parque, autobús, tren, o camping
- ☐ Otra vivienda temporal (Por favor describa):

  _____

- ☐ En un hogar permanente
- ☐

_____ _____
Nombre de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento) **Firma** de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

_____
Fecha

Si CUALQUIER caja que no sea "En un hogar permanente" está marcada, **no se requieren prueba de domicilio** u otros documentos normalmente requeridos para inscripción **y el estudiante debe ser matriculado inmediatamente**. Después de que el estudiante sea matriculado, el distrito o la escuela debe pedir los documentos escolares, incluyendo los documentos de inmunización, al distrito o la escuela anterior. El enlace del distrito debe ayudar al estudiante conseguir cualquier otro documento necesario o inmunización.

<u>ATENCIÓN ESCUELAS Y DISTRITOS</u>: Si el estudiante **<u>NO</u>** vive en un hogar permanente, favor de asegúrese que una Formulario de Designación sea completado.

Fort Ann Elementary School

One Catherine Street
Fort Ann, NY 12827

Phone 518-639-5594 Fax 518-639-4341

To enroll your child/children in Fort Ann Central School District, you must provide two proofs of residency:

Preferred:

- Lease Agreement or notarized statement from landlord - must include tenants' names and physical address
- Copy of deed
- Driver's license or NYS Identification card issued by DMV
- State or Government issued identification card with name and address
- Voter Registration card
- Homeowner's Insurance Policy (active) with name and full physical address
- Income Tax Form - most recent year
- School Tax bill - most recent year
- Mortgage Statement*
- Pay Stub* - must include name and full physical address of parent/guardian
- Utility Bill* - National Grid, Local water/sewer, cable
- Notices/Award Letters from DSS, OTDA, SSA*

Accepted only if none of the above are available and with approval of the District:

- Notarized statement from a third party which must include all tenants' names and the full physical address as well as the date tenancy began
- Copy of proof of purchase contract with a letter from an attorney listing the expected closing date/time

*Proof of Residency with * must be within 30 days of receipt by district.

*All above documents must include name of parent/guardian or child's name and the full physical address.

*Call Krista Crosbie, Guidance Secretary, with questions. 518-639-5594

Fort Ann Central School District

1 Catherine Street
Fort Ann, NY 12827
Telephone: (518)639-5594 Fax: (518)639-8911
www.fortannschool.org

PRE-K PICK UP AUTHORIZATION

Student name_____

Address_____

Parent/guardian_____

Contact number_____

The following list of people has my authorization to pick my child up from school. I understand that these people must show identification each time they pick my child up at the elementary entrance of the building or cafeteria at dismissal time. All others will ***NOT*** be permitted to pick up my child.

NAME	HOME PHONE	CELL PHONE
1.		
2.		
3.		
4.		
5.		

_____ _____

Signature of parent/guardian Today's date

SPEECH AND LANGUAGE QUESTIONNAIRE

Student_____

Birth date_____Grade entering_____

Parent/Guardian with whom student lives_____

Siblings and their ages_____

Address_____

Home phone_____Cell_____Work_____

_____ My child is currently receiving speech and language therapy
Agency name_____

_____ My child was but is no longer receiving speech and language therapy.
Agency name_____

_____ My child has never received speech and language therapy.

_____ My child says all speech sounds correctly.

_____ My child does not say all speech sounds correctly

To the best of your knowledge, please list all the speech sounds which your child does not say correctly._____

How well do you understand your child's speech?

Not well at all 1 2 3 4 5 Very Well

How well do you think others understand your child's speech?

Not well at all 1 2 3 4 5 Very Well

Please comment on your child's general communication skills. Include any medical information which may be relevant.

DO NOT PHOTOGRAPH FORM

Dear Parents/Guardians,

We like to promote Fort Ann Central School events and activities through publishing photographs of students on our website, district newsletter, or in other locations. At times, we have also have the opportunity to have photographs of students included in the local newspaper. We would appreciate your permission to publish photographs of your child, should the occasion arise.

Please return this form by 09/18/20 ***ONLY*** if you ***DO NOT*** wish to give permission for your child to be photographed. Thank you.

( ) I **DO NOT** give permission for my child/children to be photographed or have their photo released to the media for educational purposes.

Parent/Guardian Signature:_____

Child's Name:_____

Child's Grade:_____

Date:_____

FORT ANN CENTRAL SCHOOL DISTRICT

STUDENT HEALTH HISTORY

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Dental Injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
- ☐ Scoliosis
- ☐ Single Organ (☐kidney, ☐testicle)
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Urinary Condition

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?

☐No ☐Yes:_____

Please list any additional concerns: (use back of sheet if necessary)_____

_____

Parent/Guardian Signature:_____ Date:_____

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 ☐ HgbA1c 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.

Dental Health Certificate - Optional

Parent/Guardian: Please complete Section 1 and take the form to your dentist/dental hygienist for an assessment. Request your dentist/dental hygienist to fill out Section 2. Return the completed form to your child's teacher as soon as possible.

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

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

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

School: Name

Grade

Section 2. To be completed by the Dentist/Dental Hygienist

I. Oral Health Status (check all that apply)

☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated?

[A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity?

[At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

II. Treatment Needs (check all that apply)

☐ **No need for Treatment**

☐ **Urgent Treatment** – abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** – amalgams, composites, crowns, etc.

☐ **Preventive Care** – sealants, fluoride treatment, prophylaxis, mouthguard etc.

☐ **Other** – periodontal, orthodontic treatments

Please note _____

The Dental Health condition of _____ on _____ (date of exam) Check one:

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

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

Dentist's Name and Address (Please Print or Stamp):

Dentist/Dental Hygienist Signature:

Date of Exam: / /

* The dental health condition of the student when the exam is made and the date of exam shall not be more than 12 months prior to the commencement of the school year in which the exam is requested.

FORT ANN CENTRAL SCHOOL DISTRICT
PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

1) To be completed by the parent or guardian:

I request that my child, _____ DOB_____

GRADE _____ receive the medication as prescribed below by our physician.

The medication is to be personally delivered by me (parent or guardian) in the original labeled pharmacy container stating the specific name of the medication and dispensing orders.

Signature (Parent/Guardian): _____

Telephone: Home _____ Work _____ Date _____

2) To be completed by physician

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

Name of Student: _____ DOB: _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

*Order may extend to a summer school session if needed [ ] Yes [ ] No

Possible Side Effects and Adverse Reactions (if any): _____

PLEASE CHECK ONE:

[ ] I deem this child to be **self-directed** and understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips.

[ ] I deem this child to be **non-self-directed** and understand that administration of oral topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Physician's Signature:_____ Date: _____

Address:_____ Phone: _____

Plan reviewed with parent(s)/guardian(s):

Parent Signature:_____ Date: _____

*Parent/Guardian must submit written request to School Nurse prior to summer session.

FORT ANN CENTRAL SCHOOL DISTRICT
SELF-MEDICATION RELEASE FORM

Date: _____

Student's Name: _____

has been instructed in the proper use of the following medication procedures: _____
_____
_____
_____

We (Physician's signature) _____ and

(Parent or Person in Parental Relation's signature) _____

Request that **(Student's name)** _____ be permitted to

carry the medication on his/her person or to keep same in his/her locker or physical education locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use. He/she understands the importance of immediately notifying the teacher or school registered professional nurse of the use of an anaphylactic medication.

Note: This form must be completed *in addition* to the routine District medication form for those students who request permission to carry their own medication on campus or keep this medication in a school or physical education locker.

Fort Ann Central School
2020 - 2021 SCHOOL CALENDAR

JULY 2020

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

AUGUST 2020

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23/30	24/31	25	26	27	28	29

SEPTEMBER 2020

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

OCTOBER 2020

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

NOVEMBER 2020

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

DECEMBER 2020

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

JANUARY 2021

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24/31	25	26	27	28	29	30

FEBRUARY 2021

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

MARCH 2021

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

APRIL 2021

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

MAY 2021

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23/30	24/31	25	26	27	28	29

JUNE 2021

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

July 3	Independence Day Observed
September 1 & 2	Supt. Conference Days
September 7	Labor Day
September 8	Classes Begin
October 12	Columbus Day
October 21	2-hour delay, Prof. Dev.
November 3	WCC Supt Conf. Day
November 5	PT Conference 1/2 day PM
November 6	PT Conference 1/2 day PM
November 11	Veterans' Day
November 13	Emergency Release Day
November 25-27	Thanksgiving Recess
December 24	Holiday Recess Begins
January 4	Classes Resume
January 18	Martin Luther King, Jr. Day
January 26-29	Regents Testing Days
February 15-19	Mid-Winter Recess
March 24	2-hour delay, Prof. Dev.
April 1	PT Conference 1/2 day PM
April 2	Good Friday
April 5-9	Spring Recess
April 16	PT Conference 1/2 day PM
May 31	Memorial Day
June 16-25	Regents Testing Days
June 25	Regents Rating Day
June 25	Last Day of School

Classes Not in Session

Regents Testing Days

Supt. Conference Day

September	17
October	21
November	16
December	17
January	19
February	15
March	23
April	16
May	20
June	19
Total Number of Pupil Days	183
Supt. Conference Day:	3
TOTAL DAYS	186

BOE APPROVED
March 17, 2020