Fort Ann Central School District
One Catherine Street
Fort Ann, NY 12827
Telephone: (518)639-5594 Fax: (518)639-4341

# NEW STUDENT REGISTRATION

**Please complete the forms in this packet & submit with the required documentation listed below**

- ☐ Residency Questionnaire & **2 Proofs** of Residency *(see enclosed list)*
- ☐ Registration Form
- ☐ Student Racial and Ethnic Identification Form
- ☐ Migrant Services Screening Form
- ☐ Student Health History Form
- ☐ Health Records/Immunizations/Dental *(Dental Form optional)*
- ☐ Proof of Student's Identity *(birth certificate, passport, baptism certificate)*
- ☐ Transportation Form
- ☐ Custody Papers *(if applicable)* **legal guardians MUST provide court order**
- ☐ Free and Reduced School Meals Application *(if included)*

Please return registration packet to:

Mrs. Krista Crosbie
Registrar/Guidance Secretary
1 Catherine Street, Fort Ann
(518)639-55394 ext. 52101
Fax: (518)639-4341
kcrosbie@fortannschool.org

**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.

**ATENCIÓN ESCUELAS Y DISTRITOS: Ofrezca asistencia a los estudiantes y familias para completar este formulario**. Este formulario debería de ser incluido como la primera página de los materiales de inscripción que el

distrito comparte con familias. No incluya este formulario en el paquete de inscripción sin advertencias apropiadas. Por ejemplo, tendrá que cambiar partes del paquete de inscripción que requieren que se entreguen prueba de inscripción antes de matricular. Estudiantes elegibles según el Acto de McKinney-Vento, no necesitan entregar prueba de residencia y otros documentos normalmente requeridos antes de matricular.

## 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* *Dia* *Año* *(jardin de infantes – 12)* *(opciónal)*

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 **una** 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.

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

# FORT ANN CENTRAL SCHOOL DISTRICT

STUDENT REGISTRATION FORM

**Student's Full Name**: _____
First Middle Last

Grade: _____ Date of Birth: _____

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: _____

Physical & 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: _____

Physical & 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 event of emergency. Please list **additional emergency contacts below** in the order you would like them contacted:

**Emergency Contact #1**

Name: _____

Daytime Location: _____

Relationship: _____ Daytime Phone: _____

Cell: _____

**Emergency Contact #2**

Name: _____

Daytime Location: _____

Relationship: _____ Daytime Phone: _____

Cell: _____

**Emergency Contact #3**

Name: _____

Daytime Location: _____

Relationship: _____ Daytime Phone: _____

Cell: _____

Does your child have any medical conditions, illnesses or allergies? (answer **Yes** or **No**; if you answer **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 & dates of birth (please indicate whether child primarily lives in the household or not):

_____

_____

What school district is your child transferring from? _____

Signature of Parent/Guardian: _____ Date: _____

# Fort Ann 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.**

English Only

**Name of School:**

**School District Student Identification Number:**

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

**Student Name;**
**Last, First, Middle:**

**Grade Level:**

**DIRECTIONS TO PARENT/GUARDIAN**

PLEASE ANSWER QUESTIONS (1) AND (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1), check (✓) the box that best describes your child.] Check (✓) only ONE box.

1. **Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race?**

   **YES, Hispanic**

   **NO, not Hispanic**

2. Select one or more races from the following five racial groups [For question (2), check (✓) all groups that apply to your child; check (✓) at least ONE 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 or 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 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:** 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** **NO**
   **Is yes, what language?**

Signature of Parent/Guardian _____ Relationship to Student _____ Date _____

See reverse for important messages to Parents/Guardians
and Confidentiality Procedures and Regulations.

## FORT ANN CENTRAL SCHOOL DISTRICT
## STUDENT RACIAL AND ETHNIC IDENTIFICATION

**To the Parent/Guardian: 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:**

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

**We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the back of this page. Put a check (✓) in the box for the category or categories which best describe your child. We understand the sensitive nature of this information and wish to assure you that it will be kept secure and confidential in accordance with all State and Federal student 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 that 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 student records and unauthorized release of any student record information identifiable by either student name or student identification number.**

**Please complete the form on the other side of this page.**

Herkimer-Fulton-Hamilton-Otsego BOCES
Migrant Education Tutorial & Support Services
Mary Kline, Migrant Education Director

352 Gros Boulevard
Herkimer NY 13350
315-867-2079

# Eligibility Screen for Migrant Education Services

*** Migrant Education Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed. ***

**Has your family moved to a different school district in the last 3 years? YES _____ NO _____**

**In the last three years, has the parent or guardian of the child enrolling done farm work as a paid job? (Did they work on a dairy farm, planting, picking/harvesting fruits or vegetables, food processing or packaging, logging or tree farming?) YES_____ NO_____**

**If yes, what farm did you work on?_____ Where? _____ When?_____**




**If you can answer YES to BOTH of the above questions, your family MAY qualify for Migrant Education services. To be contacted by a Migrant Education recruiter, please complete the information below.**

Child's name _____ D.O.B. _____ Grade_____

Child's name _____ D.O.B. _____ Grade_____

Child's name _____ D.O.B. _____ Grade_____

Child's name _____ D.O.B. _____ Grade_____

**Parents/ Guardians**

Mother's name _____ Father's Name _____

Home Address _____ Home Phone #_____
(Street Address)

_____ Work or Message # _____
(city, town or village) (Zip)

School District _____ School Building _____

School Contact Person_____ Contact Number _____

Other Useful information (directions, farm names, best time to contact, etc.) _____

_____

_____

**To submit this referral please fax to the Herkimer BOCES at (315) 867-2087 or mail to the address above. For more information please call the Migrant Program at (315) 867-2079. Thank you for your assistance.**

Herkimer-Fulton-Hamilton-Otsego BOCES
Migrant Education Tutorial & Support Services
Mary Kline, Migrant Education Director

352 Gros Boulevard
Herkimer NY 13350
315-867-2079

# Cuestionario de Elegibilidad para Servicios de Educación Migrante

*** Servicios del Programa de Educación Migrante son gratuitos y pueden incluir tutoría, ayuda con necesidades de salud, viajes educacionales, programas del verano, actividades de involucrar a los padres, educación para adultos, ayuda de emergencia y referidos a otros servicios como necesario. ***

**¿Ha mudado su familia a un distrito escolar diferente en los últimos 3 años? Sí_____ NO _____**

**¿En los últimos 3 años ha trabajado un padre o guardián en granja como: lechería, plantando, cosechando frutas o legumbres, el procesamiento o empacar de comida, corta de árboles o cultivo de árboles? Sí_____NO_____**

**Si UD dijo que si, ¿en que granja?_____ ¿Donde?_____ ¿Cuándo?_____**




**Si Usted contestó que Sí a AMBOS preguntas de arriba, su familia PUEDA calificar para servicios de Educación Migrante. Para estar contactado por una reclutadora del Programa de Educación Migrante, favor de llenar la información de abajo.**

Nombre del niño(a) _____ Fecha de Nacimiento_____Grado_____

Nombre del niño(a) _____ Fecha de Nacimiento _____Grado_____

Nombre del niño(a) _____ Fecha de Nacimiento _____Grado_____

Nombre del niño(a) _____ Fecha de Nacimiento _____Grado_____

## Padres/ Guardianes

Nombre de la Mamá _____ Nombre del Papá _____

Dirección de la Casa _____ Numero de teléfono en casa_____
(Dirección de la Calle)

_____ # de teléfono del trabajo o de Mensaje_____
(Ciudad o Pueblo) (Código Postal)

Distrito escolar _____ edificio escolar _____

Persona para contactar_____ numero para contactar _____

Otra información Útil (direcciones, nombres de granjas, mejor hora de llamar, etc.) _____

_____

_____

**Para someter este referido, favor de mandarlo por fax al Herkimer BOCES a (315) 867-2087 o mandar por correo al dirección de arriba.**
**Para más información, favor de llamar al Programa Migrante a (315) 867-2079. Gracias.**

rev 4/23/18

FORT ANN CENTRAL SCHOOL DISTRICT
1 Catherine Street
Fort Ann, NY 12827
(518)639-5594
Fax (518)639-4341 or (518)639-8911

# Acceptable Proof of Residency for Enrollment Purposes
(2 are required)

Preferred:

- Lease agreement or notarized statement from landlord – must include tenants' names and physical address
- Copy of deed
- Copy of purchase contract with a letter from an attorney listing the expected closing date/time
- Driver's License or NYS Identification card issued by DMV
- State or Government issued Identification card with name and address
- Voter Registration Card
- Auto Insurance Card/Policy –policy must be currently active
- Homeowner's Insurance Policy with name and full physical address – policy must be active
- Income Tax Form – most recent year
- School Tax Bill – most recent
- Mortgage Statement *
- 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 District:

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

***Proof of Residency with an * must be within 30 days of receipt by the District
***All Proof of Residency must include parent/guardian or child's name AND the full physical address

**21/22 FORT ANN CENTRAL SCHOOL**
**TRANSPORTATION INFORMATION FORM**

**FORT ANN SCHOOL DISTRICT TRANSPORTATION POLICY**

1. Students who are in Kindergarten **MUST** be met by their parent/guardian, if a parent/guardian is not there to meet their child, they will be taken back to school.
2. Transportation information forms must be completed every school year, even if the information is the same as the previous year.
3. Transportation information forms should be completed anytime there is a change in your child's bus route.
   **NOTE: ANY CHANGES TO BUS ROUTE <u>MUST</u> BE FILLED OUT PRIOR TO THE CHANGE. PLEASE ALLOW FOR 3 TO 5 DAYS FOR PROCESSING.**

Today's Date _____ Effective Date _____

Student's Name _____ Grade _____

Parent/Guardian Name _____

Primary Home Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

**PLEASE CHECK IF YOUR CHILD IS A WALKER OR PARENT DROP OFF/PICK UP _____AM _____PM**

**STUDENT DRIVES SELF _____**

**<u>AM Alternate Bus Route:</u>**

Name Child Care Provider: _____ Phone: _____

Address: _____

Please **circle** which days your child(ren) will be PICKED UP at child care:
MON TUES WED THURS FRI

**<u>PM Alternate Bus Route:</u>**

Name Child Care Provider: _____ Phone: _____

Address: _____

Please **circle** which days your child(ren) will be DROPPED OFF at child care:
MON TUES WED THURS FRI

Parent/Guardian Signature _____

# FORT ANN CENTRAL SCHOOL DISTRICT

## STUDENT HEALTH HISTORY
## 2021-2022

| | |
|---|---|
| **Student Name:** | **Gender:** M ☐ F ☐ |
| **Date of Birth:** | **Age:** |
| **Parent/Guardian:** (person completing form) | **Grade:** |

| Has your child ever: | YES | NO | If yes, please explain and include date |
|---|---|---|---|
| Had an ongoing medical condition | ☐ | ☐ | |
| Seen a medical specialist | ☐ | ☐ | |
| Had surgery/been hospitalized | ☐ | ☐ | |
| Had a bone or muscle injury | ☐ | ☐ | |
| Passed out or fainted | ☐ | ☐ | |
| Had a concussion or head injury | ☐ | ☐ | |
| Had a seizure | ☐ | ☐ | |
| Worn glasses or contact lenses | ☐ | ☐ | |
| Used hearing aids | ☐ | ☐ | |
| Had braces, spacers or other orthodontics | ☐ | ☐ | |

### PLEASE CHECK ALL THAT APPLY TO YOUR CHILD

☐ ADHD/ADD
☐ Asthma
☐ Ear Tubes
☐ Heart Conditions
☐ Seizures
☐ Single Organ ( ☐ kidney, ☐ testicle)
☐ Anaphylaxis
☐ Autism
☐ Eating disorder
☐ OCD/ODD
☐ Skin Conditions
☐ Other: _____
☐ Anxiety/Depression
☐ Diabetes
☐ Headaches/Migraines
☐ Scoliosis

| Please indicate: | YES | NO | Please specify: |
|---|---|---|---|
| Allergies | ☐ | ☐ | Specify: Severity: ☐ mild ☐ severe |
| Medication at Home | ☐ | ☐ | Name: Dose: |
| Medication at School | ☐ | ☐ | Name: Dose: |
| Dietary Concerns | ☐ | ☐ | ☐ Gluten Free ☐ Lactose Free Other: _____ |

Any additional health concerns: _____

_____

Parent/Guardian Signature: _____ Date: _____

# 2021-22 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). 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 |
|---|---|---|---|---|
| **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 adolescent 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 | | |
| **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** | | |
| **Meningococcal conjugate vaccine (MenACWY)[8]** | | **Not applicable** | **Grades 7, 8, 9, 10 and 11: 1 dose** | **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** | | |

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 and 7: 10 years; minimum age for grades 8 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 2021-2022, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 and 7; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 8 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 and 8: 10 years; minimum age for grades 9 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

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 HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**
**IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

**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 — Type:
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached

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

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

**Diabetes** ☐ No
☐ Yes, indicate type — Type: ☐ 1 ☐ 2
☐ Medication/Treatment Order Attached ☐ 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/m2

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

**Hyperlipidemia:** ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

**Height:** **Weight:** **BP:** **Pulse:** **Respirations:**

| Laboratory Testing | Positive | Negative | Date |
|---|---|---|---|
| TB- PRN | ☐ | ☐ | |
| Sickle Cell Screen-PRN | ☐ | ☐ | |

**Lead Level Required Grades Pre- K & K** — **Date**
☐ Test Done ☐ Lead Elevated ≥5 µg/dL

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

☐ **System Review and Abnormal Findings Listed Below**

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

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list) ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

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

**SCREENINGS**

| **Vision** (w/correction if prescribed) | **Right** | **Left** | **Referral** | **Not Done** |
|---|---|---|---|---|
| Distance Acuity | 20/ | 20/ | ☐ Yes ☐ No | ☐ |
| Near Vision Acuity | 20/ | 20/ | | ☐ |
| Color Perception Screening ☐ Pass ☐ Fail | | | | ☐ |
| Notes | | | | |

| **Hearing** 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. | | | **Not Done** |
|---|---|---|---|
| Pure Tone Screening | **Right** ☐ Pass ☐ Fail | **Left** ☐ Pass ☐ Fail | **Referral** ☐ Yes ☐ No | ☐ |
| Notes | | | | |

| **Scoliosis** Screen Boys in grade 9, and Girls in grades 5 & 7 | **Negative** | **Positive** | **Referral** | **Not Done** |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ Yes ☐ No | ☐ |

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

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

**Developmental Stage for Athletic Placement Process <u>ONLY</u> required** for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

**Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

**MEDICATIONS**

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

**IMMUNIZATIONS**

☐ Record Attached ☐ Reported in NYSIIS

**HEALTH CARE PROVIDER**

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

**Please Return This Form To Your Child's School When Completed.**

# Dental Health Certificate- Optional

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

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

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

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

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

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

Parent's Signature _____ Date

## Section 2. To be completed by the Dentist

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

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

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

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

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

Dentist's Signature

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

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

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

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

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

### III. Treatment Needs (check all that apply)

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

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

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

# FORT ANN CENTRAL SCHOOL
# 2021 - 2022 SCHOOL CALENDAR

**JULY 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 |

**AUGUST 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 | | | | |

**SEPTEMBER 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 | | |

**OCTOBER 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 |

**NOVEMBER 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 | | | | |

**DECEMBER 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 | |

**JANUARY 2022**

| 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 | | | | | |

**FEBRUARY 2022**

| 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 2022**

| 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 2022**

| 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 2022**

| 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 | | | | |

**JUNE 2022**

| 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 4 | Independence Day |
| July 5 | Independence Day Observed |
| September 1 | Supt. Conference Day |
| September 6 | Labor Day |
| September 7 | Supt. Conference Day |
| September 7 | 6th Grade Orientation |
| September 7 | K-5 Meet & Greet |
| September 8 | Classes Begin |
| October 11 | Columbus Day |
| November 4&5 | Elem Parent/Teacher Conf. |
| November 10 | Emergency Release Day |
| November 11 | Veterans' Day |
| November 24-26 | Thanksgiving Recess |
| December 24 | Holiday Recess Begins |
| January 3 | Classes Resume |
| January 17 | Martin Luther King, Jr. Day |
| January 25-28 | Regents Testing Days |
| February 21-25 | Mid-Winter Recess |
| April 7&8 | Elem Parent/Teacher Conf. |
| April 15 | Good Friday |
| April 18-22 | Spring Recess |
| May 30 | Memorial Day |
| June 15-17 | Regents Testing Days |
| June 20 | Juneteenth (6/19) Observed |
| June 21-24 | Regents Testing Days |
| June 24 | Regents Rating Day |
| June 24 | Graduation |
| June 24 | Last Day for 10 Month Staff |

Classes Not in Session

Regents Testing Days

Supt. Conference Day

| | |
|---|---|
| September | 17 |
| October | 20 |
| November | 18 |
| December | 17 |
| January | 20 |
| February | 15 |
| March | 23 |
| April | 15 |
| May | 21 |
| June | 17 |
| Total Number of Pupil Days: | 183 |
| Supt. Conference Day: | 2 |
| TOTAL DAYS: | 185 |

**BOE APPROVED**
**3/16/2021**