Fort Ann Central School District

STUDENT ENROLLMENT PACKET

Required Forms and Documentation for Enrollment

- ☐ Registration Form
- ☐ **2 Proofs** of Residency *(see enclosed list)*
- ☐ Migrant Services Screening Form
- ☐ Digital Equity Survey
- ☐ Student Health History Form
- ☐ Health Records/Immunizations *(MUST be submitted by the first day of school)*
- ☐ Proof of Student's Identity *(birth certificate, passport, baptism certificate)*
- ☐ Copy of Parent/Guardian's Photo ID
- ☐ Copy of IEP or 504 Plan *(if applicable)*
- ☐ Transportation Form *(PreKindergarten enrollments do not need to complete)*
- ☐ 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, NY 12827
518.639.5594 ext. 52101
Fax: 518.639.4341
kcrosbie@fortannschool.org

Teacher's Name/Grade/Out of District Placement:

FORT ANN CENTRAL SCHOOL DISTRICT

1 Catherine Street, Fort Ann, NY 12827

STUDENT REGISTRATION FORM

Student Information

Legal Name: _____ Date of Birth: _____ Gender: M F NB _____ _____

First Middle Last *Grade* *Preferred Start Date*

_____ _____

Physical Address (Street number, street, city, state, zip code) *Mailing Address (if different)*

Racial Group (Please circle any groups that apply to your child; circle at least one group):

American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander Black/African American White

Is the student Hispanic, Latino, or of Spanish Origin? Yes No Language spoken at home: _____

Does the student have a parent or guardian who is active-duty military or a veteran? Yes No

Has the student ever attended Fort Ann Central School District? If yes, please list date(s) attended: _____

Please list all previous schools attended, including preschool

School Name	Year	Grade	Street Address	City, State, Zip Code	Telephone Number

Are both parents living at home? Yes No Who has legal custody? _____ (* Please supply any custody/guardianship papers or restraining orders)

Parent/Guardian Information:

Name	Relationship	Telephone Number (Home and Cell)	Email Address	Mailing Address (if different from above)	Employer	Work Number

Is this student in a foster care placement? Yes No If yes, name of county placing student (please supply a copy of the DSS-2999 form): _____

Emergency Contacts: Name a responsible party other than a parent or guardian who will be able to pick up your child from school if needed (i.e. illness, injury, discipline reasons, unexpected school closure, etc.), and we are unable to reach a parent or guardian. Emergency contacts will need to bring their photo identification with them when picking up a student.

Name	Relationship	Daytime Address	Home, Cell, or Work Phone Number(s)

Other Siblings or Children in the Household

Name	Date of Birth	Lives in Household?	School Attending	Grade	Relationship to Student being enrolled

Has your child received any of the following services? AIS Math AIS ELA Bilingual Education Special Education Services

Does your child have a 504 Plan? Yes No If yes, please supply a copy of the most recent 504 Plan.

My child has been identified for Special Education Services and is receiving or has received: (Please supply a copy of your child's IEP)

Special Class (i.e. 15:1:1; 4:1:2) Consultant Teacher Services Resource Room Occupational Therapy

Counseling Services Physical Therapy Speech Therapy/Services Other: _____

Has your child ever been evaluated or referred for evaluation to determine eligibility for Special Education programs/services? Yes No

If yes, please list the type of evaluation, date, and who provided the evaluation. Please provide copies of the reports, if available.

_____ _____

_____ _____

_____ _____

_____ _____

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, school meals, and other services. If you check any box other than In Permanent Housing, please contact Mrs. Crosbie (518.639.5594, ext. 52101 or kcrosbie@fortannschool.org), or the District's McKinney-Vento Liaisons: Mr. Hoskins (518.639.5594, ext. 52050 or jhoskins@fortannschool.org), or Mrs. Discenza (518.639.5594, ext. 52100 or mdiscenza@fortannschool.org) as soon as convenient; your child may be eligible to be enrolled without further documentation.

Where is the student currently living?

- ☐ 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

Is there any other information you would like us to know or we need to know about your child?

_____

_____

_____

Please return all the required enrollment forms in this packet, and return to Mrs. Crosbie, Registrar, at the Fort Ann Central School District, 1 Catherine Str, Fort Ann, NY 12827. The District is unable to request school records from your child's previous school until you have submitted the completed forms, 2 proofs of residency (see enclosed list), and your child's birth certificate or passport. If you are unable to supply the proof of residency or your child's birth certificate, please contact Mrs. Crosbie at 518.639.5594. Ext. 52101 or kcrosbie@fortannschool.org to discuss possible alternatives.

Information on Rights of Parents from the Family Education Rights and Privacy Act (FERPA)

An educational agency or institution shall give full rights under the Act of either parent, unless the agency or institution has been provided with evidence that there is a court order, State statute, or legally binding document relating to such matters as divorce, separation or custody that specifically revokes these rights. (Authority: 20 U.S.C.1232g)

Signature of Parent or Guardian: _____ Date: _____

Fort Ann Elementary School

One Catherine Street
Fort Ann, NY 12827

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

Acceptable Proof of Residency

Please submit **2** documents from the list below

Category A:

- **Lease agreement or notarized statement from landlord** - must include tenants' names and physical address **AND BE SIGNED AND NOTARIZED**
- **Copy of deed**
- **Voter registration card**
- **Auto insurance card/policy** - policy must be active
- **Homeowner's insurance policy** - must include name and full physical address of parent/guardian- must be active
- **School Tax bill** - most recent year
- **Mortgage Statement or other documents from your closing**
- **Utility Bill*** - National Grid, Local water/sewer, cable
- **Notices/Award Letters from DSS, OTDA, SSA***

** Items not on this list will NOT be accepted. Mail/Envelopes will not be accepted **

Category B:

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

- Notarized statement from a third party - 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. Must close prior to the first day of school.

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

Please contact me if you are unable to provide
any of the above items or have any questions.

Mrs. Crosbie
Registrar/Guidance Secretary
(518)639-5594 ext. 52101
Fax (518)639-4341
kcrosbie@fortannschool.org

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.

jm 3 23 18

FORT ANN CENTRAL SCHOOL DISTRICT

DIGITAL EQUITY SURVEY

The New York State Education Department is asking parents and guardians to complete the Digital Equity Survey for each student in their family in grades Kindergarten - Grade 12. This survey will provide information on student access to devices and internet access at their residences. This data will be used to help educators better serve students and families. **Please answer each question below,** and follow any additional instructions provided for submitting or returning the survey.

Child's Name: _____ **Grade:** _____

1. What device will your child use to complete learning activities away from school? (This can be a school-provided device or another device; whichever the student will most often use to complete their schoolwork.)

   Desktop Computer **Laptop** **Tablet**

   Chromebook **Smartphone** **No Device**

2. Who is the provider for the device in question #1?

   School **Personal Device**

3. Is the primary learning device identified in questions #1 shared with anyone else in the household?

   Shared **Not Shared**

4. Is the primary learning device sufficient for your child to fully participate in all learning activities away from school?

   Yes **No**

5. Is your child able to access the internet in their primary place of residence?

   Yes **No**

6. What is the primary type of internet service used in your child's primary place of residence?

Residential Broadband	Cellular	Mobile Hotspot
Dial Up	DSL	Community WiFi
No Service	Satellite	Other: _____

7. In your primary residence, can your child complete the full range of learning activities, including video streaming and assignment upload, without interruptions caused by slow or poor internet performance?

Yes No

8. What, if any, is the primary barrier to having sufficient and reliable internet access in your child's primary place of residence?

Cost Availability None Other: _____

Please complete one form for each student in your household

22/23 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 MUST 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 _____

AM Alternate Bus Route:

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

PM Alternate Bus Route:

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

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 <u>Home</u>	○	○	Name:	Dose:
Medication at <u>School</u>	○	○	Name:	Dose:
Dietary Concerns	○	○	○ Gluten Free ○ Lactose Free	Other: _____

Any additional health concerns: _____

_____

Parent/Guardian Signature: _____ Date: _____

2022-23 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**		

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6, 7 and 8: 10 years; minimum age for grades 9 through 12: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2022-2023, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6, 7 and 8; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 9 through 12.
   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7, 8 and 9: 10 years; minimum age for grades 10 through 12: 6 weeks).
   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. PCV is not required for children 5 years or older.
   f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

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

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.