Since 1966, The Oysterponds Elementary School has been serving the communities of Orient and East Marion on the North Fork of Long Island New York in providing a pre-kindergarten through sixth grade educational program for an average of 85 to 95 students each year. As a District, we are responsible for the education of students in grades 7 through 12 at the nearby Greenport Union Free School District.

We are a unique community of learners, intent upon both academic excellence and the development of social skills necessary for successful living in a global society. Our goal is to focus on the individual student through the collaboration of teachers, students and parents to construct a Personal Learning Plan, recognizing each student as a whole person, and to help him or her achieve their personal best by understanding how
STEP 1: Central Registration

☐ Photo Identification of Parent/Guardian – Need One (1)
  o NYS Driver’s License or Identification Card
  o Military Identification
  o Passport
  o Resident Alien Card

☐ Proof of Residence – Three (3) Proofs Are Required
  ➢ If you are a Home Owner a Required Proofs may be:
    o Deed, current mortgage statement or tax bill
    o Current utility bill (Cable, LIPA, fuel, water)
    o Photo identification showing address (driver’s license, military ID, passport)
  ➢ If you are a Renter Required Proofs may be:
    o Notarized Lease or Affidavit (enclosed)
    o Current utility bill (Cable, LIPA, fuel, water)
    o Photo identification showing address (driver’s license, military ID, passport)

☐ Student Documentation
  o Copy of original Birth Certificate
  o Home Language Questionnaire
  o Milk Form

☐ Additional Forms may be required
  o Emergency Contact Form
  o One-Call Now
  o Signed Consent for Release of School Records
  o Individualized Education Plan (IEP) or Section 504 Plan
  o Custody and/or Guardianship Documents
  o Latest Transcript and Report Card

STEP 2: Health Office

☐ Health Certificate/Appraisal Form – Up-to date Immunizations (signed/stamped by Physician). Physical Exam must be current (within one (1) year of entrance or re-entry into Oysterponds UFSD)

☐ Non-Prescription Medication Permission Form *REQUIRED*

☐ Student Health History Form

☐ Dental Health Certificate (Optional)

☐ Authorization For Administration of Medication in School (Complete if needed)
WELCOME TO THE OYSTERPONDS

PRE-K PROGRAM

The Oysterponds Union Free School District is pleased to announce it is now accepting applications for its EARLY CHILDHOOD EDUCATION PROGRAM for the 2020-2021 School Year. The program, which is open to residents and non-residents of the District includes:

- A full day program for 3 and 4 year olds
- A full Music, Art, and Physical Education program
- Certified Early Childhood Teachers
- Low Teacher/Student Ratio
- Reasonable non-resident tuition ($5,500 per year)

For further information, please contact the school at (631) 323-2410 ext. 100

OYSTERPONDS

POLICY 5140

Entrance Age

Pre-Kindergarten (3 and 4 yr.): A child who resides in the school district with his parent/legal guardian must be three (3) years of age before December 1 of the school year for which they are enrolling. For program inclusion, both 3 and 4 year old children must be toilet trained and demonstrate age-appropriate behavior as determined by staff observation and review.

Kindergarten: A child who legally resides in the school district with his parent/guardian at the time of the opening day of school must be five (5) years of age on or before December 1 of that year in order to be admitted to the District’s kindergarten in September of that same year.

A child who has regularly attended and satisfactorily completed a year’s work in a kindergarten in a public school in the state of New York will be enrolled in the first grade. Any other child will be evaluated for appropriate educational placement.

Proof of Age: A student’s birth certificate or other satisfactory evidence of age (baptismal certificate or passport) shall be presented at the time of initial registration. The child shall be entered under his/her legal name.

Ref: Education Law §§1709; 1712; 2503; 2514; 2555; 3202; 3205; 3210

Adopted: November 14, 2017
PRE K PROGRAM ENTRANCE CRITERIA

In order for students to successfully participate in our full day Pre K program, it is required that all students meet the following behavioral developmental benchmarks.

Please indicate below by placing a check next to each benchmark to indicate that your child can demonstrate the criteria.

1. Child is able to use bathroom independently  
   (Including dressing, undressing, cleaning themselves)  
   [ ]

2. Child does not require reminders to use the bathroom  
   [ ]

3. Child does not require the use of Pull-Ups  
   [ ]

4. Child does not require a nap in the afternoon  
   [ ]

5. Child can feed him/herself independently  
   (Can use a fork and spoon appropriately)  
   [ ]

I verify that my child can demonstrate the above listed behavioral developmental benchmarks. I understand that my child must demonstrate the above criteria during normal school hours in order to remain in the full day Pre K program.

____________________________________  ________________________  ________________________
Child’s Name                              Parent’s Signature              Date

*Please note: A child’s inability to demonstrate the above behavioral developmental benchmarks does NOT indicate developmental delay. Demonstration of the above criteria indicates the developmental maturity which is necessary for a child to remain in the school setting during normal school hours.
OYSTERPONDS UNION FREE SCHOOL DISTRICT
REGISTRATION INFORMATION

FAMILY

PLEASE PRINT INFORMATION CLEARLY

<table>
<thead>
<tr>
<th>PARENT/GUARDIAN:</th>
<th>Gender</th>
<th>2</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: ___________________</td>
<td>M</td>
<td>F</td>
<td>Name: ___________________</td>
</tr>
<tr>
<td>Address: ___________________________________________</td>
<td></td>
<td></td>
<td>Address: ___________________________________________</td>
</tr>
<tr>
<td>Home #: ____________________________________________</td>
<td></td>
<td></td>
<td>Home #: ____________________________________________</td>
</tr>
<tr>
<td>Cell #: ____________________________________________</td>
<td></td>
<td></td>
<td>Cell #: ____________________________________________</td>
</tr>
<tr>
<td>Work #: ____________________________________________</td>
<td></td>
<td></td>
<td>Work #: ____________________________________________</td>
</tr>
</tbody>
</table>

CHILDREN IN FAMILY:  List all children in the house including Pre-School

<table>
<thead>
<tr>
<th>RELATIONSHIP TO GUARDIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: (Last, First, Middle)</td>
</tr>
<tr>
<td>___________________________________________</td>
</tr>
<tr>
<td>___________________________________________</td>
</tr>
<tr>
<td>___________________________________________</td>
</tr>
<tr>
<td>___________________________________________</td>
</tr>
</tbody>
</table>

EMERGENCY CONTACTS: * Please note that we are unable to release your child or children to any persons other than those listed on this form

<table>
<thead>
<tr>
<th>Name: (Last, First, Middle)</th>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>___________________________________________</td>
<td>__________</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>___________________________________________</td>
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<tr>
<td>___________________________________________</td>
<td>__________</td>
<td>__________</td>
<td>__________</td>
</tr>
</tbody>
</table>

Dear New Oysterponds Parent/Guardian: Please complete this form at the time of your child’s enrollment. At the end of the school year, we will be sending home a Demographic Validation Form, which you can confirm and/or update any Emergency contacts or persons to whom your child or children are authorized to be released to. Please list people other than parents or guardians as “Emergency Contacts”.
Thank you!
OYSTERPONDS UNION FREE SCHOOL DISTRICT
REGISTRATION INFORMATION FAMILY
PLEASE PRINT INFORMATION CLEARLY

MOTHER:

NAME:  (Last, First)                     NAME IF REMARRIED:  (Last, First)
_____________________________________________                  ________________________________
as it appears on the child’s birth certificate

Language mother speaks: ________________________________________________________________
E-Mail address for mother: _____________________________________________________________

FATHER:

NAME:  (Last, First)
_____________________________________________
as it appears on the child’s birth certificate

Language father speaks: ________________________________________________________________
E-Mail address for father: _____________________________________________________________

STEP PARENT:

STEP MOTHER NAME:  (Last, First)                     STEP FATHER NAME:  (Last, First)
_____________________________________________                  ________________________________

Language step parent speaks: __________________________________________________________
E-Mail address for step parent: __________________________________________________________
CHILD’S NAME: __________________________________________________ MALE _____ FEMALE ______

(Last)                                      (First)                    (Middle)

CHILD’S NAME MUST BE RECORDED AS IT APPEARS ON THEIR BIRTH CERTIFICATE OR BAPTISMAL RECORD

DATE OF BIRTH: ____________________________

IF CHILD WAS BORN OUTSIDE OF THE USA:
DATE OF ENTRY INTO USA: ___________ INTO SCHOOL IN USA: ______________

CHILD’S ETHNICITY: (Optional)
Hispanic: Yes ________ No ______________

Please check ALL that apply:
White _____ Black or African American _____ Native Hawaiian or other Pacific Islander _____
American Indian/Alaskan Native _______ Asian ______

LANGUAGE SPOKEN BY CHILD AT HOME: ____________________________ ____________________________

DOES THIS STUDENT HAVE A PARENT NOT LIVING AT THE STUDENT’S ADDRESS? IF YES:

NAME: __________________________________________________ MAILINGS: YES _____ NO _____

(Street)                                                                        (City)                                 (State)         (Zip)         (Telephone Number)

PARENTS’ MARITAL STATUS: Married Separated Divorced If divorced or separated, any legal restrictions? YES ___ NO ___

1. Has your child ever been in the Oysterponds Schools before? When: ________ Re-entry Date ________

2. Has your child ever attended a public school in New York State? Yes ____ No _____

3. Have you or your child ever registered under a different name? Yes ____ No _____

   If yes, please indicate: NAME: ____________________________ DATE: __________________

4. Has your child ever been seen by the school psychologist? Yes ____ No _____

5. Has your child ever had an independent psychological evaluation? Yes ____ No _____

6. Has your child ever been reviewed by the Committee on Special Education (CSE) Yes ____ No _____

   Or The Committee on Preschool Special Education (CPSE) and/or received any special Education service (e.g. special class, resource room, speech/language therapy, etc.)?
   If yes, please explain:

   __________________________________________________________________________________________

7. Has your child ever received remedial help in school other than what is indicated above? Yes ____ No _____

   If yes, please explain:

   __________________________________________________________________________________________

   __________________________________________________________________________________________
# Previous Schools Attended

<table>
<thead>
<tr>
<th>School</th>
<th>First School</th>
<th>Second School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of School</td>
<td>____________________________</td>
<td>____________________________</td>
</tr>
<tr>
<td>Location</td>
<td>___________________________________</td>
<td>___________________________________</td>
</tr>
<tr>
<td>Telephone #:</td>
<td>___________________________________</td>
<td>___________________________________</td>
</tr>
<tr>
<td>Dates Attended:</td>
<td>___________</td>
<td>___________</td>
</tr>
<tr>
<td>Starting Grade:</td>
<td>___________</td>
<td>Ending Grade:</td>
</tr>
</tbody>
</table>

### Third School

<table>
<thead>
<tr>
<th>School</th>
<th>Third School</th>
<th>Fourth School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of School</td>
<td>____________________________</td>
<td>____________________________</td>
</tr>
<tr>
<td>Location</td>
<td>___________________________________</td>
<td>___________________________________</td>
</tr>
<tr>
<td>Telephone #:</td>
<td>___________________________________</td>
<td>_____________________________</td>
</tr>
<tr>
<td>Dates Attended:</td>
<td>___________</td>
<td>___________</td>
</tr>
<tr>
<td>Starting Grade:</td>
<td>___________</td>
<td>Ending Grade:</td>
</tr>
</tbody>
</table>

## Important Medical Information – This section MUST be completed:

Name of Child’s Doctor: __________________________ Telephone #: __________________________

Doctor’s Address: __________________________ City: __________________________ State/Zip: __________

Does Your Child Have Any of the Following: (Optional)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Name of treating physician:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Problems:</td>
<td></td>
<td></td>
<td>___________________________</td>
</tr>
<tr>
<td>Vision Problems:</td>
<td></td>
<td></td>
<td>___________________________</td>
</tr>
<tr>
<td>Learning Problems:</td>
<td></td>
<td></td>
<td>___________________________</td>
</tr>
<tr>
<td>Speech Problems:</td>
<td></td>
<td></td>
<td>___________________________</td>
</tr>
<tr>
<td>Documented Allergies:</td>
<td></td>
<td></td>
<td>Please list any allergies:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>______________________________________________________________________</td>
</tr>
</tbody>
</table>
OYSTERPONDS UNION FREE SCHOOL DISTRICT

ALL REGISTRANTS MUST FILL OUT PART A

HOMELESS CHILD:

(A) means individuals who lack a fixed, regular and adequate nighttime residence (within the meaning of section 103(a)(1)); and

(B) (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals;
(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C); (iii) children and youth’s who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and
(iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clause (i) through (iii) {MIGRATORY CHILD.

The term “migratory child” means a child or youth who made a qualifying move in the preceding 36 months—(A) as a migratory agricultural worker or a migratory fisher; or (B) with, or to join, a parent or spouse who is a migratory agricultural worker or a migratory fisher

*Per Title IX, Part A of the Every Student Succeeds Act, “awaiting foster care placement” was removed from the definition of homeless on December 10, 2016; the only exception to his removal is that “covered states” have until December 10, 2017 to remove “awaiting foster care placement” from their definition of homeless.

McKinney-Vento Homeless Assistance Act

PART A

NAME_______________________________________ DATE __________________________

Is enrollment related to homelessness or loss of permanent housing?  Yes _____ No _____
Is enrollment related to status as unaccompanied youth?  Yes _____ No _____

(If you checked yes to either of the above, please complete section PART B)

PART B

Please indicate the living arrangements of the child or unaccompanied youth:

_____ living in a shelter

_____ living with relatives or others due to lack of housing

_____ living in an abandoned apartment/building, in a hotel/motel, camping ground, car, train/bus station, or similar situation due to lack of adequate housing

_____ temporarily housed in a shelter awaiting an OCFS permanent foster care placement

Date and School of last attendance: ___________________________________________________________

Address before child became homeless: ______________________________________________________

Are you requesting any services, such as transportation, from the District?  Yes _____ No _____
If yes, what services are you requesting? _____________________________________________________

Homeless Liaison Signature: ___________________________ Date: _______________________
FOR OFFICE USE ONLY

Please check ( ) that you have seen and taken copies of the following required paperwork:

PROOF OF AGE: (CHECK ONE) Birth Certificate: _________  Baptismal Record: _________

PRIMARY PROOF OF RESIDENCY: ________________________________________________

<table>
<thead>
<tr>
<th>TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SECONDARY #1: ________________________________________________</td>
</tr>
<tr>
<td>SECONDARY #2: ________________________________________________</td>
</tr>
</tbody>
</table>

Parent is requested to report back with additional information by: ____________________________

Parent is requested to make an appointment with the Principal: ____________________________

Application is complete and child is placed into School: ____________________________ Grade: ________________

To be completed by the School NURSE from the required documentation:

<table>
<thead>
<tr>
<th>TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Immunizations: ____________________________ Date of Physical: ____________________________</td>
</tr>
</tbody>
</table>

Nurse: ______________________________________________________________________________________

Student ID # ____________________________ ELL/ESL? YES _____ NO _____

Received?

☐ Health (Updated Exam/Immunizations)
☐ Emergency Contact Information
☐ Proof of Age
☐ Residency Requirements

Entered into ESD? ☐ Date: ____________________________

Tuition Greenport Secondary School ☐

Bus Assigned? ☐ N/A ☐

Distribution: Business Office: ☐

School Nurse Signature: ______________________________________________________________________

Administration: (Superintendent/Principal) Signature: ______________________________________________________________________

Registrar Signature: ______________________________________________________________________
Sworn Affidavits

In the event that the deed or lease where you and your children reside is NOT your name, NOTARIZED sworn affidavits are required.

Parental Affidavit – This must be filled out and notarized by the student’s parents

Homeowners Affidavit – This must be filled out and notarized by the person whose name appears on the deed. Please note that if the lease for a rental is not in your name, the homeowner’s affidavit MUST be completed by the Landlord or Management company ONLY. Notarized affidavits filled out by the building’s Superintendent will NOT be accepted.

PARENTAL AFFIDAVIT

State of New York
County of Suffolk

To: Oysterponds Union Free School District

I, __________________________________________________________ swear that my child/children_________________________________________ and I permanently reside at _______________________________________________ at the home of ________________ _____________________.

Is the tenant a relative of the homeowner?   Yes ______  No  ______

If yes, state the relationship _____________________________________________________

I am signing this affidavit with full knowledge of the laws of perjury.

_____________________________________
(Parent Signature)

Sworn to before me this ______________________
Day of ______________________________________

_____________________________________
Notary Public

IMPORTANT NOTICE

The District reserves the right to collect full tuition for false registration statements.
HOMEOWNER AFFIDAVIT

STATE OF NEW YORK
COUNTY OF SUFFOLK

TO: Oysterponds Union Free School District

I, ___________________________________, swear that _______________________________________
and her/his children _______________________________________, permanently
List Names of Children
reside at ____________________________________________________________________________.

Is the tenant a relative of the homeowner?  Yes ______  No ______
If yes, state the relationship  ________________________________.

I am signing this affidavit with full knowledge of the laws of perjury.

__________________________________________________
Homeowner Signature

Sworn to me this __________________________
day of __________________________

________________________________________
Notary Public

IMPORTANT NOTICE
The District reserves the right to collect full tuition for false registration
Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

**Student Name:**

**Date of Birth:**
- [ ] Male
- [ ] Female

**Parent/Person in Parental Relation Info:**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Relation to Student</th>
</tr>
</thead>
</table>

---

### Language Background

(Please check all that apply.)

1. What language(s) is(are) spoken in the student’s home or residence?
   - [ ] English
   - [ ] Other
   - Specify

2. What was the first language your child learned?
   - [ ] English
   - Specify

3. What is the Home Language of each parent/guardian?
   - [ ] Mother
   - Specify
   - [ ] Father
   - Specify
   - [ ] Guardian(s)
   - Specify

4. What language(s) does your child understand?
   - [ ] English
   - [ ] Other
   - Specify

5. What language(s) does your child speak?
   - [ ] English
   - [ ] Other
   - Specify
   - [ ] Does not speak
   - Specify

6. What language(s) does your child read?
   - [ ] English
   - [ ] Other
   - Specify
   - [ ] Does not read
   - Specify

7. What language(s) does your child write?
   - [ ] English
   - [ ] Other
   - Specify
   - [ ] Does not write
   - Specify

---

**THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:**

**School District Information:**

**Student ID Number in NYS Student Information System:**

<table>
<thead>
<tr>
<th>District Name (Number) &amp; School</th>
<th>Address</th>
</tr>
</thead>
</table>
8. Indicate the total number of years that your child has been enrolled in school _____________

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

<table>
<thead>
<tr>
<th>Yes*</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>*If yes, please explain: ____________________________________________</td>
</tr>
</tbody>
</table>

How severe do you think these difficulties are? □ Minor □ Somewhat severe □ Very severe

10a. Has your child ever been referred for a special education evaluation in the past? □ No □ Yes* *Please complete 10b below

10b. If referred for an evaluation, has your child ever received any special education services in the past? □ No □ Yes – Type of services received: _______________________________________________

<table>
<thead>
<tr>
<th>Age at which services received</th>
<th>(Please check all that apply):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to 3 years (Early Intervention)</td>
<td>3 to 5 years (Special Education)</td>
</tr>
<tr>
<td>6 years or older (Special Education)</td>
<td></td>
</tr>
</tbody>
</table>

10c. Does your child have an Individualized Education Program (IEP)? □ No □ Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

_________________________________________________________________________________________________________

_________________________________________________________________________________________________________

_________________________________________________________________________________________________________

12. In what language(s) would you like to receive information from the school? __________________________________________

Month: Day: Year:

________________________________________

Signature of Parent or of Person in Parental Relation

Date

Relationship to student: □ Mother □ Father □ Other: ________________________________
The Oysterponds Elementary School is continuing with the automatic calling system that will enable us to contact families about school happenings, such as closings, delayed openings or special events. Please complete the form below (one per family). Thank you.

Name of Student(s): 
____________________________________________
____________________________________________
____________________________________________
____________________________________________

Primary telephone number – this number will always be called __________________________

(area code) (telephone number)

Additional telephone numbers (cell phones, work numbers, emergency contacts), you may list up to six (6) additional numbers. Please list area code and telephone number:

____________________________________________
____________________________________________
____________________________________________
____________________________________________

Please note: this form is completed once per year. If you have any updates or telephone number changes during the school year, please notify us immediately so that we can keep up-to-date records.

Thank you for your cooperation.
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

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex:</th>
<th>M</th>
<th>F</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

School: Grade: Exam Date:

HEALTH HISTORY

<table>
<thead>
<tr>
<th>Allergies</th>
<th>☐ No</th>
<th>☐ Yes, indicate type</th>
<th>☐ Medication/Treatment Order Attached</th>
<th>☐ Anaphylaxis Care Plan Attached</th>
<th>☐ Food</th>
<th>☐ Insects</th>
<th>☐ Latex</th>
<th>☐ Medication</th>
<th>☐ Environmental</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Asthma</th>
<th>☐ No</th>
<th>☐ Yes, indicate type</th>
<th>☐ Medication/Treatment Order Attached</th>
<th>☐ Asthma Care Plan Attached</th>
<th>☐ Intermittent</th>
<th>☐ Persistent</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Seizures</th>
<th>☐ No</th>
<th>☐ Yes, indicate type</th>
<th>☐ Medication/Treatment Order Attached</th>
<th>☐ Seizure Care Plan Attached</th>
<th>☐ Type:</th>
<th>Date of last seizure:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Diabetes</th>
<th>☐ No</th>
<th>☐ Yes, indicate type</th>
<th>☐ Medication/Treatment Order Attached</th>
<th>☐ Diabetes Medical Mgmt. Plan Attached</th>
<th>☐ Type 1</th>
<th>☐ Type 2</th>
<th>☐ HbA1c results:</th>
<th>Date Drawn:</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>BMI kg/m2</th>
<th>Percentile (Weight Status Category):</th>
<th>☐ &lt;5th</th>
<th>☐ 5th-49th</th>
<th>☐ 50th-84th</th>
<th>☐ 85th-94th</th>
<th>☐ 95th-98th</th>
<th>☐ 99th and&gt;</th>
</tr>
</thead>
</table>

Hyperlipidemia: ☐ No | ☐ Yes
Hypertension: ☐ No | ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: Weight: BP:

<table>
<thead>
<tr>
<th>TESTS</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
<th>Other Pertinent Medical Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD/ PRN</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>One Functioning: ☐ Eye</td>
</tr>
<tr>
<td>Sickle Cell Screen/PRN</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>☐ Concussion – Last Occurrence:</td>
</tr>
</tbody>
</table>

Lead Level Required Grades Pre-K & K

<table>
<thead>
<tr>
<th>☐ Test Done</th>
<th>☐ Lead Elevated &gt; 10 µg/dL</th>
<th>Date</th>
</tr>
</thead>
</table>

☐ System Review and Exam Entirely Normal

Check Any Assessment Boxes **Outside** Normal Limits And Note Below Under Abnormalities

<table>
<thead>
<tr>
<th>☐ HEENT</th>
<th>☐ Lymph nodes</th>
<th>☐ Abdomen</th>
<th>☐ Extremities</th>
<th>☐ Speech</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Dental</td>
<td>☐ Cardiovascular</td>
<td>☐ Back/Spine</td>
<td>☐ Skin</td>
<td>☐ Social Emotional</td>
</tr>
<tr>
<td>☐ Neck</td>
<td>☐ Lungs</td>
<td>☐ Neurological</td>
<td>☐ Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>☐ Genitourinary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list) | ICD-10

☐ Additional Information Attached
### SCREENINGS

<table>
<thead>
<tr>
<th></th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distance Acuity</td>
<td>20/20</td>
<td>20/20</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Distance Acuity With Lenses</td>
<td>20/20</td>
<td>20/20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision – Near Vision</td>
<td>20/20</td>
<td>20/20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision – Color</td>
<td>☐ Pass ☐ Fail</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing</strong></td>
<td>Right dB</td>
<td>Left dB</td>
<td>Referral</td>
<td></td>
</tr>
<tr>
<td>Pure Tone Screening</td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td><strong>Scoliosis</strong></td>
<td>Required for boys grade 9</td>
<td>Negative</td>
<td>Positive</td>
<td>Referral</td>
</tr>
<tr>
<td>And girls grades 5 &amp; 7</td>
<td>☐</td>
<td>☐</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Deviation Degree:</td>
<td>Trunk Rotation Angle:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Recommendations:**

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

- ☐ Full Activity without restrictions including Physical Education and Athletics.
- ☐ Restrictions/Adaptations
  - ☐ No Contact Sports
  - ☐ No Non-Contact Sports
  - ☐ Other Restrictions:
    - Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
    - Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

- ☐ 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:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IMMUNIZATIONS**

- ☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

**HEALTH CARE PROVIDER**

Medical Provider Signature: ________________________________ Date: ______________

Provider Name: (please print) ________________________________

Provider Address:

Phone: ________________________________

Fax: ________________________________

Please Return This Form To Your Child’s School When Entirely Completed.
OYSTERPONDS NON-PRESCRIPTION MEDICATION PERMISSION FORM

Please review the following form regarding "over the counter medications" that will be used in the Health Office. Please indicate, in the appropriate box, whether you would or would not like the School Nurse to use these items as needed during the school year. Your choice must be marked and this form returned as soon as possible. Each child must have a copy of this form on file each school year. Please check the medications that you are comfortable with me using for your children, sign and send it back to me. This form must be signed by your medical provider in order for ANY medications to be given to your child during the school day. It can be hand delivered, faxed to 323-3713 or emailed to abennett@oysterponds.org.

Thank you,

Amy C. Bennett, RN

Students Name:____________________________Grade_____________

☐ YES, I give the School Nurse permission to administer the medications checked below when needed during the school day (form must be signed by parent AND physician below).

☐ NO, I prefer my child NOT be given any of the items listed below during the school day. (form must be signed by parent below).

The following treatments are on hand in the nurse's office to be dispensed with your permission for abrasions, stings, muscle pain, sore flu-oats, sun burn, poison ivy and mouth pain.

Cough Drops/Lozenges____ Bacitracin/Neosporin____ Calamine/Calagel____ Saline____
Anbesol _____ Anti-sting wipe _____ Aloe Gel _____ Lip Balm _____ Aquafor_____ Sunscreen _____
Hydrocortisone 0.5% Cream ___

Medications including: Motrin _____ Tylenol _____ Advil _____ Benadryl _____
Tums/Antacid _____ Cold Medicine _____

*must* be provided by the parents to the Nurse in their original container in doses appropriate for age and/or weight.

Parent/Guardian Signature: ________________________________Date: ___________

Physician/NP/PA Signature: ________________________________Date: ___________
(needed if any items are checked to approve use)
STUDENT HEALTH HISTORY FORM

Name of Child: _____________________________________________________________

Date of Birth ____________  Grade_______  Sex:  Male _____ Female _____

Allergies: Does your child have any allergies?  YES: _____  NO: _____

If YES, what is your child allergic to? (Please list with reaction below)

_________________________________________________________  REACTION: ______________________

_________________________________________________________  REACTION: ______________________

_________________________________________________________  REACTION: ______________________

_________________________________________________________  REACTION: ______________________

_________________________________________________________  REACTION: ______________________

Does your child have an Epi Pen?  YES _____  NO _____

Medication: Is your child currently taking any medication?  YES _____  NO _____

If YES, what medicine and how often? ______________________________________________________

____________________________________________________________________________________

Past Medical History: Indicate if you child has a history with any of the following:

_____ Asthma   _____ Whooping Cough

_____ Concussion/Head injury   _____ Ear Condition

_____ Diabetes   _____ Pneumonia

_____ Hart Disease   _____ Anemia

_____ Kidney Disease   _____ Reaction to vaccines

_____ Hospitalization   _____ Vision Problems

_____ Mental Health Issues   _____ Orthopedic Issues

_____ Seizures/Epilepsy   _____ Other

Please provide details for any items checked above______________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

***additional questions on the back***
Any additional health history (hospitalizations, surgeries, birth history, serious illnesses) you think the School Nurse should be aware of: ____________________________________________________

____________________________________________________________________________________________

___________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Primary care provider:

Name:_________________________________________ Phone:______________________________________

The School Nurse has permission to share information with school staff as she determines appropriate for my child's health and safety. Yes ______ No ______

The School Nurse has permission to share information about my child, as needed, with my child's health care provider: Yes ______ No ______

Parent/Guardian Signature: _________________________________________________________________

Printed Name: ___________________________________________ Date:________________________
**Dental Health Certificate- Optional**

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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)

<table>
<thead>
<tr>
<th>Child's Name:</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td></td>
</tr>
<tr>
<td>Month</td>
<td>Day</td>
</tr>
<tr>
<td>Sex:</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Will this be your child's first oral health assessment?</td>
<td>Yes</td>
</tr>
<tr>
<td>School:</td>
<td>Name</td>
</tr>
<tr>
<td>Grade:</td>
<td></td>
</tr>
<tr>
<td>Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. 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.

<table>
<thead>
<tr>
<th>Parent's Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

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

I. The dental health condition of the student listed above 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/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist'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 Cariess — Does this child have an open cavity? [At least 1/2 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.
**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL**

To be completed by the parent or guardian:

I request that my child, __________________________________________ DOB ____________ receive the medication as prescribed below by our physician. I understand that the medication is to be furnished by me, and must be in the original pharmacy labeled container and that medication and refills must be brought to school by parent, guardian or responsible adult.

Signature (Parent or Guardian): _________________________________ Date ___________________

Telephone: Home __________________ Work __________________ Cell ___________________

To be completed by physician:

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

Name of Student __________________________________________ DOB ____________________

Diagnosis: ______________________________________________________________________

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSAGE</th>
<th>FREQUENCY/TIME TO BE TAKEN</th>
<th>ROUTE OF ADMINISTRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Duration of Treatment: _____________________________________________________________
Possible Side Effects/Adverse Reactions (if any): ___________________________________
______________________________________________________________________________

Physician's Signature: _________________________________ Date: _____________________

Address: ___________________________________________ Phone: ___________________