Gates Chili Central School District

3 Spartan Way
Rochester, New York 14624

Nichole Valdez
Registration/Census Clerk

TEL: (585) 247-5050 Ext. 12224
FAX: (585) 340-5580
EMAIL: nichole_valdez@gateschili.org

Dear Parent(s)/Guardian(s):

Welcome to the Gates Chili Central School District. The enclosed Registration Packet is the First Step in completing the registration process. Please take the time to read the forms carefully and fill them out completely. When completed please turn the packet and all your documents to the Administration Building. or email them to the Registrar.

	For Office Use Only	
Registration Packet Forms – Please fill out completely and sign and date all pages.	Date Rec'd	Initialed
Proof of Residency Checklist		
Custody Disclosure Form		
Student Registration Form (Complete both sides)		
Student Health History		
Health Appraisal Form		
Dental Health Certificate		
HIPAA Form		
Student Records Request		

Include copies of your original documents			
When registering your student, you need to present Proof of Residency. **Please provide ONE item from Category 1 and ONE from Category 2. If an item from Category 1 is unavailable, please provide at least TWO from Category 2.**			
Residency Proof Category 1	Mortgage Statement; School or Property Tax Receipt; Lease Agreement; Homeowner's/Renter's insurance policy; a statement by a third-party landlord, owner or tenant from whom you lease or with whom you share property within the district; or other statement by a third-party that establishes your physical presence in the District.		
Residency Proof Category 2	• Pay stub • Income Tax Form • Voter registration document(s) • Utility or other bills • Membership documents (e.g., library cards) based upon residency • Official driver's license, learner's permit, non-driver identification, vehicle insurance • State or other government issued identification • Documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement) • Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers		
Proof of Age	Birth or baptismal certificate; If not available, then a Passport **If not available, then one of the following:** • Official driver's license • State or other government issued identification • School photo identification with date of birth • Consulate identification card • Hospital or health records • Military dependent identification card • Documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement) • Court orders or other court-issued documents • Native American tribal document • Records from non-profit international aid agencies and voluntary agencies		
Immunization Record signed by Doctor's Office (not required for registration)			
Most recent physical (not required for registration)			
IEP - Individual Education Plan (if classified) or Declassification Plan or 504 Plan (if applicable)			
Custody or Guardianship Papers (if applicable)			

Only completed Registration Packets with all the required documents will be processed. If you have any questions, please call between 8:00 a.m. and 3:30 p.m. Registration Office 247-5050 ext. 12224. We look forward to working with you during this enrollment process.

Rev. 9/21/2021 CV

Gates Chili Central School District

Residency Checklist

Student(s)' Name:_____

In-District Address:_____
House # Street Name Apt. #

Date Registered:_____

These questions are intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help to determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? _____ Yes _____ No
2. Is this temporary living arrangement due to loss of housing or economic hardship? _____ Yes _____ No

If you answered YES to the above questions, where is the student presently living? (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

NOTE: If the student is **not** living in permanent housing, **proof of residency** and other documents normally needed for enrollment **are not required**. Families who are homeless are not required to complete the remaining forms.

Residency Proofs for each family registering students are required by the Gates Chili School District.

Check the box that represents your Residency Status and provide Residency Proofs as listed below.

☐ **Homeowner — Please provide ONE item from Category 1 and ONE from Category 2. If an item from Category 1 is unavailable, please provide at least TWO from Category 2.**

Category 1: Mortgage Statement; School or Property Tax Receipt; Homeowner's insurance policy. (If building new home, Copy of Builder Sales Contract indicating purchaser name, address and tentative completion date.)

Category 2:

- Pay stub
- Income Tax Form
- Utility or other bills
- Voter registration document(s)
- Membership documents(e.g., library cards) based upon residency
- Official driver's license, learner's permit, non-driver identification, or vehicle insurance
- State or other government issued identification
- Documents issued by federal, state or local agencies(e.g., local social service agency, federal Office of Refugee Resettlement)
- Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers

☐ **Renter — Please provide ONE item from Category 1 and ONE from Category 2. If an item from Category 1 is unavailable, please provide at least TWO from Category 2.**

Category 1: Lease Agreement; Renter's insurance policy, statement from landlord or other third-party that establishes physical address in the District.

Category 2:

- Pay stub
- Income Tax Form
- Utility or other bills
- Voter registration document(s)
- Membership documents(e.g., library cards) based upon residency
- Official driver's license, learner's permit, non-driver identification or vehicle insurance
- State or other government issued identification
- Documents issued by federal, state or local agencies(e.g., local social service agency, federal Office of Refugee Resettlement)
- Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers

☐ **Shared Housing: Sharing Single Family Home or Apartment with Another Family.** **(This section will be completed when the shared housing is not due to loss of residence because of hardship.)*

Primary Resident: Person(s) whose name **is** on the mortgage or lease.

Individual Residing At or Moving In: Person(s) whose name **is not** on the mortgage or lease.

BOTH the "Primary Resident" and the "Individual Residing At or Moving In" must provide Residency Proofs as listed on the back of the Shared Housing Certificate and sign the Shared Housing Certificate.

District Registration/Census Office *Gates Chili Central School District*
Phone: 247-5050 ext. 12224 *3 Spartan Way*
Fax: 340-5504 *Rochester, NY 14624*

CUSTODY DISCLOSURE FORM

The Registration Office is responsible for registration, **not** in determining which parent or guardian may check a child in/out of school, etc. If custodial or guardianship issues exist when you register your child in the Gates Chili Central School District, it is your responsibility to provide custodial documentation to the Registration Office and a copy will be forwarded to your child's school principal.

Please inform your child's school of changes in custodial arrangements.

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 to 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)

Please check the current custody/guardianship arrangement:

- ☐ 1. Parents/guardians are together residing at the same residence
- ☐ 2. Single parent (father and mother **are** listed on the birth certificate)
- ☐ 3. Single parent (father **is not** listed on the birth certificate)
- ☐ 4. Parents/guardians divorced/separated – joint custody
- ☐ 5. Parents/guardians divorced/separated – sole custody
- ☐ 6. Parents have never been married and have no legal custody papers
- ☐ 7. Custody/guardianship is transferred by courts
- ☐ 8. *Restricted* pickup ***(legal documentation must be provided)*** _____
- ☐ 9. Student is *emancipated (legal documentation provided if available)*

Please check all that apply:

- ☐ I have disclosed my current custody/guardianship arrangement.
- ☐ I have attached a copy of those pages of the legal court documents that describe custody arrangements.
- ☐ No legal documents that describe custody arrangements exist.
- ☐ I understand that it is my responsibility to update my child's school principal of changes in custody.

Student Name (please print): _____

_____ _____

Signature of Parent/Guardian Date

GATES CHILI CENTRAL SCHOOL DISTRICT REGISTRATION FORM

Please *PRINT* all information and complete *BOTH* sides of this form

Student Name: _____ Male _____ Female_____
Last First Middle

Address: _____ Apt. # ____ Zip *146*

Primary Phone# _____ Listed( ) Unlisted( ) Date of Birth _____ Age: _____

Parent/Guardian

☐**Mr.** ☐**Mrs.** ☐**Ms.** ☐**Miss** ☐**Dr.** ☐**Other**

Name:_____
Last First MI

Address:_____
Street

_____
City State Zip

Home Phone#:_____ Pager#:_____

Cell Phone#:_____ Work #:_____

Email Address:_____

Employer:_____

Occupation:_____

Marital Status: ☐Single ☐Married ☐Separated ☐ Divorced ☐Widowed

Relationship to Student: ☐Mother ☐Father ☐Step Mother ☐Step Father ☐Foster Parent ☐Group Home Contact ☐Guardian ☐Other

Parent/Guardian

☐**Mr.** ☐**Mrs.** ☐**Ms.** ☐**Miss** ☐**Dr.** ☐**Other**

Name:_____
Last First MI

Address:_____
Street

_____
City State Zip

Home Phone#:_____ Pager#:_____

Cell Phone#:_____ Work #:_____

Email Address:_____

Employer:_____

Occupation:_____

Marital Status: ☐Single ☐Married ☐Separated ☐ Divorced ☐Widowed

Relationship to Student: ☐Mother ☐Father ☐Step Mother ☐Step Father ☐Foster Parent ☐Group Home Contact ☐Guardian ☐Other

Brothers and Sisters (Birth to Age 21)

Name:(Last) (First) (MI)	**Sex**	**Birth Date**	**Grade**	**Living at Home**	
				Yes	**No**
				Yes	**No**
				Yes	**No**
				Yes	**No**
				Yes	**No**

Others in Home:	
Name:	**Relationship to Student**

Below for Office Use Only

ID# _____ **Building**_____ **Grade** _____ **Registration Date** _____

Records: Date Requested _____ **Date Received** _____

PLEASE COMPLETE BOTH SIDES

School History

Kindergarten Students Only:

Did your child attend nursery school? (Circle One) **Yes** **No** If yes, for how long? _____

Where? _____
(Name and address of School)

Has your child ever been tested and/or received services for Occupational Therapy___ Physical Therapy___ Speech ___ Other ___

ALL OTHERS:

Name of Last School Attended: _____ Last Grade Attended _____

School Address and Phone # _____

List Other Schools Attended _____

Has child ever played a sport at another Section V school? YES _____ NO _____

If yes, what school/sport/level _____ List years _____

Has Student ever repeated a grade? YES ____ NO _____ If yes, which grade? _____

What year did your child **first** enter grade nine? _____

Has Student ever received special help in: Reading _____ Math _____ Speech _____ Other _____

Has student ever been placed in Special Education with an IEP? YES ____ **NO** ____ If yes, when? _____

Does student have a 504 Plan **YES** ____ **NO** ____

For more information regarding your rights to special education services, please visit the New York State Education Department's website relating to a parent's guide to special education in New York for children ages three through 21
http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm

Emergency Information

If your child stays with a sitter before and/or after school:

Name of person who cares for student _____ Phone _____

Address _____

If we are unable to reach parents or sitter in an emergency:

Name of Emergency Contact: _____ Phone _____

Address _____ Relationship _____

IF THESE TELEPHONE NUMBERS OR THOSE ON THE FRONT OF THIS FORM ARE CHANGED DURING THE YEAR, PLEASE NOTIFY US IMMEDIATELY.

This is to confirm that all of the above information is accurate and that I am a resident of the Gates Chili School District.

_____ _____
Parent/Guardian Signature Date

Additional Student Identification

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

Student Name: _____

Please answer all questions. 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 and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **BLACK OR AFRICAN AMERICAN:** A person having origins in any of the Black racial groups of Africa.

☐ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

3. **Is the student considered an Immigrant Child or Youth?** The term "immigrant children and youth" refers to individuals who:
   - are ages 3 through 21;
   - have not been attending school in any state for more than three full academic years; and
   - were not born in any state.

Immigrant Status: Yes ___ No ___ if yes, Date arrived in United States: _____ Country of Origin:_____

4. **Is the student considered a Migrant Child?**
   Has anyone in your family worked, or looked for work at the following occupations during the past 3 years? (Please check all that apply.)
   - □ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
   - □ Work related to logging, harvesting, or initial processing of trees.
   - □ Work at a food processing plant, (such as meat or poultry processing plants, packaging fruits or vegetables, etc.)

Migrant Status: Yes ____ No ____

Signature of Parent/Guardian_____ Date_____

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

Lissette Colon-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:

❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other _____ *specify*	
2. What was the first language your child learned?	❑ English	❑ Other _____ *specify*	
3. What is the Home Language of each parent/guardian?	❑ Mother _____ *specify*	❑ Father _____ *specify*	
	❑ Guardian(s) _____ *specify*		
4. What language(s) does your child understand?	❑ English	❑ Other _____ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other _____ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other _____ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other _____ *specify*	❑ Does not write

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

SCHOOL DISTRICT INFORMATION:	**STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:**
District Name (Number) & School *Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

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

Yes ***No*** ***Not sure***
❑ ❑ ❑ ***If yes,** please explain:_____

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

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

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

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

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

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

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

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ Mother ❑ Father ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ **POSITION:** _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

****DATE OF INDIVIDUAL INTERVIEW:** _____
MO DAY YR.

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:** _____

DATE OF NYSITELL ADMINISTRATION: _____
MO. DAY YR.

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

GATES CHILI CENTRAL SCHOOL DISTRICT

Student Health History

Student Name _____ Sex_____ Date of Birth_____

Physician's Name _____ Physician Address_____

Has your child ever had any of the following? If "yes" please comment,

	No	Yes	
Allergies			
Asthma			
Diabetes			
Seizures			
Bleeding Tendencies			
Heart Disease			
Tuberculosis Contact			
Rheumatic Fever			
Severe Headaches			
Chicken Pox			
Cancer			
Leukemia			
Vision Problems			
Hearing Problems			
Speech Problems			
Orthopedic Problems			
Other			

Approximate date of the most recent physical examination _____Exam

Does your child have any allergies to medicine? Yes/No _____
If "Yes" – Type of Reaction

Has your child had any operations (including tonsillectomy)? Yes/No When?_____

Explain _____

Has your child had any serious accidents or injuries? Yes/No When?_____

Explain _____

Is your child now or has he/she ever been on any regular medications? Yes/No When?_____

Explain _____

Does your child have any special health problems or restrictions? Yes/No

Explain_____

Does your child have any allergy to foods? Yes/No (if yes what?)

Explain_____

Does your child have any dietary restrictions? Yes/No (if yes what?)

Explain_____

I give permission for the above health history information to be shared with appropriate school personnel as necessary to promote the health and education of my child.

_____ _____

Date Parent/Guardian Signature

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

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

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

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

Diabetes ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code
_____	_____
_____	_____
_____	_____
_____	_____

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** — **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** — **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

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

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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

Dental Health Certificate

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.

Gates Chili Central School District

3 Spartan Way
Rochester, New York 14624

Jackie Dennison, P.N.P.
Nurse Practitioner

TEL: (585) 247-5050 x 21210
FAX: (585) 340-5545
www.gateschili.org

Dear Parent or Guardian

A physical examination, **performed by a health care provider in New York State**, is required by law for new students entering our district. The examination may be done either by your private physician or by our district nurse practitioner.

Please complete the form below regarding your intentions and it will be forwarded to your child's school health office. An examination will be scheduled with our district nurse practitioner if this form is not completed at the time of registration.

Thank you for your cooperation.

Very Sincerely Yours,

Jackie Dennison
Nurse Practitioner for the Gates Chili School District

NEW STUDENT PHYSICAL

_____ _____
Child's Name School and Grade

_____ I prefer to have my child examined by our private physician. The date of the appointment is _____.

_____ My child's examination is dated not more than one year prior to their start date. I will have the physician complete the Health Appraisal form and I will return it to my child's school Health Office within 30 days.

_____ I prefer to have my child examined by the district nurse practitioner.

_____ _____
Date Parent/Guardian Signature

Gates Chili School District

3 Spartan Way
Rochester, NY 14624
(585) 247-5050

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your health care provider will require the release of information form below to share Protected Medical Information with the school district. Please read and sign below.

I, _____, authorize my child's health care provider(s) listed below to release the medical records (including immunizations, health appraisals, and past/current medical conditions and their impact on attendance, school programming, and/or PT/OT/ST needs) of my child, _____, date of birth _____ to the school district's medical officer, physical/ occupational/speech therapist, counselor, social worker, psychologist and/or school nurse.

HC Provider_____Phone_____

HC Provider_____Phone_____

HC Provider_____Phone_____

HC Provider_____Phone_____

The Protected Health Information may be used, disclosed, or received for the purposes of developing care or therapy plans for school management, designing appropriate educational programs, assessing school observations/concerns surrounding behavior and/or student health, assessing a medical basis for modification of transportation and/or tutoring (home or district-based), and medication delivery and/or therapy prescriptions for PT/OT/ST.

This authorization for release of information shall be in force and effect until no longer a student in the Gates Chili School District, at which time this authorization expires.

- I acknowledge that I have the right to revoke this authorization at any time by sending written notification to my health care provider and to the District Administration Building.
- I understand that the revocation of this authorization is not effective if the health care provider or district has used the authorization for the disclosure of Protected Health Information before my written revocation notice.
- I understand that any Protected Health Information disclosed as a result of this authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.
- I understand that my child's treatment, payment, enrollment or eligibility for benefits is not dependent on my agreement to release or withhold information.

_____	_____	_____
Date	Signature of parent or guardian, or student over 18	Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION. If you choose *not* to give authorization, please initial here _____ Date _____

Request For Records From The Gates Chili Central School District

LAST SCHOOL ATTENDED:_____ DATE:_____

ADDRESS:_____ PHONE #_____

_____ FAX #_____

PERMISSION TO RELEASE INFORMATION AS INDICATED BELOW ON THE FOLLOWING STUDENT(S):

Name of Student	Date of Birth	Grade Attended

REQUESTING THE FOLLOWING INFORMATION:

- Permanent Record Information
- Health Record Information
- Psychological Reports (if applicable)
- Achievement Test Scores
- Discipline Record
- Any Other Pertinent Information

Signature of Parent/Guardian Date

Signature of Employee Requesting Records Date Requested

PLEASE FAX OR MAIL THE REQUESTED INFORMATION TO THE SCHOOL/OFFICE INDICATED BELOW.

	NEIL ARMSTRONG ELEMENTARY SCHOOL LISA MCGARY, Principal	3273 Lyell Road, Rochester, New York 14606 TEL: (585)247-3190 FAX: (585)340-5550
	FLORENCE BRASSER ELEMENTARY SCHOOL TIM YOUNG, Principal	1000 Chili Center Coldwater Road, Rochester, New York 14624 TEL: (585)247-1880 FAX: (585)340-5577
	WALT DISNEY ELEMENTARY SCHOOL ELAINE DAMELIO, Principal	175 Coldwater Road, Rochester, New York 14624 TEL: (585)247-3151 FAX: (585)340-5567
	PAUL ROAD ELEMENTARY SCHOOL PETER HENS, Principal	571 Paul Road, Rochester, New York 14624 TEL: (585)247-2144 FAX: (585)340-5571
	GATES CHILI MIDDLE SCHOOL LISA BUCKSHAW, Principal	2 Spartan Way, Rochester, New York 14624 TEL: (585)247-5050 FAX: (585)340-5555 EMAIL:sandra_gladney@gateschili.org
	GATES CHILI HIGH SCHOOL KENNETH HAMMEL, Principal	1 Spartan Way, Rochester, New York 14624 TEL: (585)247-5050 FAX: (585)340-5594
	GATES CHILI STUDENTS WITH DISABILITIES OFFICE DANIELLE LATORE: Pupil Services Coordinator, Grades K-6 JULIE STARK: Pupil Services Coordinator, Grades 6-12	3 Spartan Way, Rochester, New York 14624 TEL: (585)247-5050 FAX: (585)247-1072