Education Center
OSWEGO City School District
Fully prepared and life ready!
One Buccaneer Boulevard, Oswego, New York 13126
www.oswego.org

New Student Registration Packet

Attached is student registration forms and information for enrolling your son/daughter in the Oswego City School District.

In addition to this paperwork, you will need to provide us with the following proof:

- ☐ Original Birth Certificate
- ☐ Immunization Records - Present New York State Laws require that no school official shall permit any child to be admitted to school or to attend school for more than 14 days without a certificate, or other acceptable written evidence, that the child has met NYS immunization requirements. Therefore, no child shall be allowed admission to school without providing proper proof of immunization either from the school previously attended or from the student.
- ☐ Custody Papers *(if applicable)*
- ☐ Proof of Residency

The New Student Enrollment packet contains the following:

- ☐ Registration Form
- ☐ Student Residency Questionnaire
- ☐ Student Educational Records Release Authorization
- ☐ Emergency Go Home Form/Authorization to Release Form
- ☐ Educational Internet Account Form (Signed/Initialed by Student)
- ☐ Field Trip Permission Form
- ☐ Oswego City School District Health History Survey
- ☐ School Physical Consent Form
- ☐ Dental Health Form
- ☐ Health Certificate/Appraisal Form
- ☐ Health Information Authorization Form
- ☐ Request for Pesticide Application Notification
- ☐ Potassium Iodide KI Permission form and Information
- ☐ All in One Permission Form
- ☐ Every Student Succeeds Act Notification to Parents
- ☐ Parent/Guardian Home Language Questionnaire
- ☐ Parent/Guardian Military Service Form
- ☐ Transportation Form
- ☐ HIPPA Form

Proof of Immunization

☐ Waived-Rel./Dr. Stmt.
☐ Certificate of Immunization
☐ Statement - Dr./Hlth Ct.
☐ Shot Rec. from Transfer Sch.

City School District of Oswego, Oswego, New York 13126

Registration Form

☐ FPS ☐ CER ☐ OMS ☐ Trinity Catholic
☐ KPS ☐ FLS ☐ OHS ☐ OCCS
☐ MIN

Date of Entry _____

Office Use Only

☐ Out of District ☐ Proof of Residency
☐ Re-Activated
☐ Transfer Within
☐ Rec. Rq. _____ Rec. _____

Student Data

Name _____
Last First Middle

Date of Birth _____ Type of Document _____ Gender/Sex _____ Grade _____

Physician's Name _____ Physician's Phone No. _____

Please answer questions 1 and 2:
1. Are you Hispanic/Latino? ☐ Yes ☐ No
2. Select one or more race groups that apply to your child. You must check (√) at least one box:
☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black ☐ White

Parent/Guardian Data

Name _____
Last First

Residence _____
RD No.

_____
House No./ Box No. Road or Street No.

_____
City State Zip

Home Phone No. _____ Unlisted: ☐ Yes ☐ No

Cell Phone No. _____ email _____

Legal Relation to Child _____

Place of Employment _____

Address _____ Phone No. _____

Spouse's Name _____
Last First

Spouse's Residence _____
(Leave this blank if same as parent/guardian)

_____
House No./ Box No. Road or Street No.

_____
City State Zip

Home Phone No. _____ Unlisted: ☐ Yes ☐ No

Cell Phone No. _____ email _____

Legal Relation to Child _____

Spouse Place of Employment _____

Address _____ Phone No. _____

Names of other adults in the child's household: _____ Relationship to the child: _____
Last First

Custody Information: If separated or divorced, who has legal custody? _____

Does this school have updated custody documentation on file? ☐ Yes ☐ No

Foster Student? ☐ Yes ☐ No DSS2999 Form? ☐ Yes ☐ No

Special Services

Does your child receive any special education services? ☐ Yes ☐ No

Emergency Contact Person Other Than Parent

Name _____ Relation to Child _____ Phone No. _____

Address _____ Cell Phone No. _____

Daycare's Name _____ Address _____ Cell/Phone No. _____

Names & Birthdates of Other Children That Live at Home

_____ _____
_____ _____
_____ _____

Last School Attended

Name _____

Address _____

Parent/Guardian Signature

Parent/Guardian Signature _____ Date _____

For Office Use Only

Pre-Kindergarten ☐ A.M. ☐ P.M. Student ID # _____ Family ID # _____

Lunch Program ☐ Free ☐ Reduced ☐ N/A Hmrm Teacher/Rm.# _____

Walker ☐ Yes ☐ No Bus Route # - To School _____ /From School _____ Pick-up/Drop-off Point _____

Enrollment Code _____

Copy Distribution - Student Academic Folder, Main Office , School Nurse, Transportation, Pupil Services

Continue form on back ⇩

Student Residency Questionnaire

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? *(Please check one box)*

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "double-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (please describe):_____

  _____
- ☐ In permanent housing

_____

Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____

Date

Office Use Only

Please send a copy to the Runaway Homeless Youth (RHY) Coordinator at Oswego High School.

If the student is **NOT** living in permanent housing, proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. The district's LEA liaison is required to assist the student in obtaining any necessary documents, including immunization or school records after the student has been enrolled.

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

_____

Runaway Homeless Youth Signature

_____

Date

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Student Educational Records Release Authorization

Date _____

To: _____

_____

_____

Attn: Student Records Department

The following student, previously enrolled with you, is now residing in our school district and has enrolled in this school:

_____ _____ _____
(Student Name) (Birth Date) (Grade)

The student is anticipated to be ENROLLED on: _____
Please choose an exit date from your current district PRIOR to the above date.

*To maintain proper placement and instructional continuity, please send a transcript of all the records that apply below:

- ☐ Academic
- ☐ Gifted
- ☐ Medical
- ☐ Committee on Special Education
- ☐ Birth Certificate
- ☐ Social
- ☐ Psychological
- ☐ Custody information if applicable

*If any of these records are not at your disposal, please forward this release to the appropriate department to provide copies of these records to our school.

The Oswego City School District shall comply with the provisions of (34 CFR §99.31) - Family Educational Rights and Privacy Act of 1974 (FERPA)

Forward all records to:

☐ **Charles E. Riley Elementary School**
269 East Eighth Street
Oswego, New York 13126
Phone: 315-341-2800 • Fax: 315-341-2980

☐ **Frederick Leighton Elementary School**
1 Buccaneer Boulevard
Oswego, New York 13126
Phone: 315-341-2700 • Fax: 315-341-2970

☐ **Fitzhugh Park Elementary School**
195 East Bridge Street
Oswego, New York 13126
Phone: 315-341-2400 • Fax: 315-341-2940

☐ **Kingsford Park Elementary School**
275 West Fifth Street
Oswego, New York 13126
Phone: 315-341-2500 • Fax: 315-341-2950

☐ **Minetto Elementary School**
PO Box 189
Minetto, New York 13115
Phone: 315-341-2600 • Fax: 315-341-2960

☐ **Oswego Middle School**
Mark Fitzgibbons Dr.
Oswego, NY 13126
Phone: 315-341-2382 • Fax: 315-341-2930

☐ **Oswego High School**
2 Buccaneer Boulevard
Oswego, NY 13126
Phone: 315-341-2221 • Fax: 315-341-2928

☐ **Education Center**
1 Buccaneer Boulevard
Oswego, NY 13126
Phone: 315-341-2014 • Fax: 315-341-2914

☐ **Trinity Catholic School**
115 East Fifth Street
Oswego, NY 13126
Phone: 315-343-6700 • Fax: 315-342-9471

☐ **Oswego Community Christian School**
400 East Albany Street
Oswego, NY 13126
Phone: 315-342-9322 • Fax: 315-342-0268

I am the ☐ Parent ☐ Guardian ☐ DSS Caseworker

I hereby grant my permission to send the above records to the school checked above.

_____
Signature

☐ 1st Request ☐ 2nd Request ☐ 3rd Request

City School District of Oswego, Oswego, New York 13126

Emergency Go Home/Authorization to Release Form

Student Name _____ Grade _____ Teacher _____

School Year _____ Date of Birth _____ School Attending: _____

Address _____ Parent/Guardian(s) Names (A) _____

_____ (B) _____

(A) Home Phone _____ Work Phone _____ Place of Work _____

Cell Phone _____ Beeper # _____ Email Address _____

(B) Home Phone _____ Work Phone _____ Place of Work _____

Cell Phone _____ Beeper # _____ Email Address _____

Other Parent/Guardian Name _____

Other Parent/Guardian Address (if different from above) _____

Other Parent/Guardian Phone _____ Work _____ Cell _____

In the event it is necessary to release my child from school in an **emergency closing**, he/she has been told and instructed to do the following: (Check One Only)

☐ **Go home (someone will be there or my child can let themself in)** or if my child arrives home and no one is there, my child should walk to the following address:

_____ Resident's Name/Relation to Child _____ Address _____ Phone

☐ **Do not go home - go directly to the following address** (within your school attendance area)

_____ Resident's Name/Relation to Child _____ Address _____ Phone

_____ Bus Route # _____ Bus Stop

Authorization to Release

To be released **ONLY** to the following individual(s) listed below: (names may be added or removed **ONLY** by written notice)

Name/Relationship _____ Phone #, Home: _____ Work: _____ Cell: _____

Name/Relationship _____ Phone #, Home: _____ Work: _____ Cell: _____

Name/Relationship _____ Phone #, Home: _____ Work: _____ Cell: _____

Name/Relationship _____ Phone #, Home: _____ Work: _____ Cell: _____

Name/Relationship _____ Phone #, Home: _____ Work: _____ Cell: _____

Name/Relationship _____ Phone #, Home: _____ Work: _____ Cell: _____

In the event that one of the persons listed above has to pick up my child(ren), **I will send in a note to the teacher**. I also know that my child(ren) **may only be released from the Main Office.**

In Case of Emergency

Parents may notify the school by phone to have a child excused. An **identification number** or **code name** will be required to verify the request. You must provide us with **your own** identification number or code name.

I have selected the following identification number or code name: _____

Parent/Guardian Signature _____ Date _____

Office - **upon parental/guardian completion, make copies and route to: Nurse, Teacher, Transportation, and Parent/Guardian**

Educational Internet Account - Student

through

Oswego City School District, Oswego, New York 13126

Computers, networks and on-line access are used to support learning and to enhance instruction. These tools and connections to the Internet allow communications with millions of users through hundreds of thousands of networks. Your application for an Internet account indicates you will comply with the attached "Acceptable Use Policy" and regulations (Policy #7314- Student Use of Computerized Information Resources, Regulation #6470R, which are found on the reverse side of this form, and will be a responsible, efficient and ethical user. Failure to adhere to the policies and guidelines will result in the revocation of the use privileges.

Date: _____

Name: _____ Home Phone: _____ ☐ Oswego High School ☐ Oswego Middle School

Home Address: _____

Please check/complete the appropriate student information:

1. Date of Birth: _____ Current Grade Level: _____

2. I have been provided staff development or training on the appropriate use of the internet by:

Name of Trainer/Teacher: _____ Date of Instruction: _____

Items 3 - 5 must be initialed by the student
(Regulations are found on the reverse side of this form)

3. I have read the Oswego Board of Education Policy #7314 and Regulation #6470R and will comply with them.

☐ YES ☐ NO (**Please initial appropriate box**)

4. I understand that any violation of the "Acceptable Use Policy" may result in loss of access, personal payment of any fees incurred and possible prosecution.

☐ YES ☐ NO (**Please initial appropriate box**)

5. I understand that the use of the Internet as part of an educational program is a privilege, not a right and inappropriate use will result in a cancellation of these privileges.

☐ YES ☐ NO (**Please initial appropriate box**)

With connections to computers and people all over the world also comes the availability of material that may not be considered to be of appropriate educational value. On a global network, it is impossible to restrict access to all controversial materials. It is the responsibility of the student to ensure that access to telecommunication networks and computers provided by the educational system is not abused.

Students and Parents/Guardian: Complete this box

By placing my signature on this document, I am confirming I have read, understand, and will abide by Student Policy #7314 and Student Regulation #6470R, which are found on the reverse side of this form.

Signature of Student: _____ Date: _____

The District has taken considerable steps to electronically block inappropriate materials and sites. Unfortunately though, and by the very nature of the Internet, I understand that my son/daughter may be able to gain access to services on the Internet which the District has not authorized for educational purposes. I also understand that communications on the Internet are not censored by the District. Further, I understand that my son/daughter may gain access to information and communications which I may find inappropriate, offensive, or controversial. I assume this risk by consenting to allow my son/daughter to participate in the use of the Internet. I understand that my child may keep this access throughout the school year as long as the procedures, policies and guidelines are followed, and the child is a student in good standing with the school.

Signature of Parent/Guardian: _____ Date: _____

Parent/Guardian email: _____

Please print or type Parent/Guardian's name: _____

Signature of Teacher/Trainer for Internet Use: _____

STAFF AND STUDENT USE OF COMPUTERIZED INFORMATION RESOURCES

The following comprise the rules and regulations relating to the use of the district's computer network system:

Administration

1) The Superintendent of Schools shall designate a computer coordinator to over see the district's computer network.
2) The computer coordinator shall monitor and examine all network activities as deemed appropriate to ensure proper use of the system.
3) He/she shall disseminate and interpret district policy and regulations governing use of the district's network at the building level with all network users.
4) He/she shall provide employee training for proper use of the network and will ensure that staff supervising students using the district's network provide similar training to their students, including copies of district policy and regulations governing use of the district's network.
5) He/she shall ensure that all disks and software loaded onto the computer network have been scanned for computer viruses.
6) All student agreements to abide by district policy and regulations shall be kept on file in the district office.

System Access

The following individuals may be designated as members with access to the computer network system:

1) Middle and secondary students may be granted an account for up to one academic year at a time.
2) Teachers may apply for a class and/or individual account.
3) Other district employees as deemed necessary.
4) Community members as deemed necessary.Procedures for Proper Use

Procedures for Proper Use

1) The district's computer network shall be used only for educational purposes consistent with the district's mission and goals.
2) The individual in whose name an account is issued is responsible at all times for its proper use.
3) Network users will be issued a log-in name and password. Passwords must be changed every 90 days.
4) Only those network users with written permission from the designated computer coordinator may access the district's system from off-site (e.g. from home).
5) Network users identifying a security problem on the district's system must notify the appropriate teacher, administrator or computer coordinator. Do not demonstrate the problem to anyone.
6) Student account information will be maintained in accordance with applicable education records law and district policy and regulations 5500.
7) Copyrighted material may not be placed on any computer connected to the district's network without the author's permission. Only staff specifically authorized may upload copyrighted material to the network.
8) Network users may download copyrighted material for their own use. Copyrighted material shall be used in accordance with the fair use doctrine and district policy and regulations 8650.
9) Any network user identified as a security risk or having a history of violations of district computer use guidelines may be denied access to the district's network.
10) Only instructional materials approved by the District Computer Coordinator and the District Software Review Committee may be loaded on the District network and machines.

Prohibitions

The following is a list of prohibited actions concerning use of the district's computer network. Violation of any of these prohibitions may result in discipline or other appropriate penalty, including suspension or revocation of a user's access to the network.

1) There must be no sharing of passwords without written permission from the teacher/administrator of computer coordinator, as appropriate.
2) Attempts to read, delete, copy or modify the electronic mail of other system users is prohibited as is deliberate interference with the ability of their system users to send/receive electronic mail. Forgery or attempted forgery of electronic mail messages is prohibited.
3) No personal software or disks may be loaded onto the district's computers and/or network, without permission of the computer coordinator.
4) Attempts by a student to log on to the district's system in the name of another individual, with or without the individual's password, is prohibited.
5) System users shall not encourage the use of tobacco, alcohol or controlled substances or otherwise promote any other activity prohibited by district policy, state or federal law.
6) Use of computer access to data and access to secure areas other than for educational purposes is prohibited.
7) System users shall not evade, change or exceed resource quotas as set by the administration. A user who continues to violate disk space quotas after seven calendar days of notification may have their file removed by the system coordinator. Such quotas may be exceeded only by requesting to the appropriate administrator or system coordinator that disk quotas be increased and stating the need for the increase.
8) Transmission of material, information or software in violation of any district policy or regulation, local, state or federal law or regulation is prohibited.
9) Vandalism will result in cancellation of system use privileges. Vandalism is defined as a malicious attempt to harm or destroy district equipment or materials, including software and related print material, date of another user of the district's system or any of the agencies or other networks that are connected to Internet. This includes, but is not limited to, the uploading, downloading or creating of computer viruses.
10) Tampering with or misuse of the computer system or taking any other action inconsistent with this policy and regulation will be viewed as a security violation.

Any user of the Districts Computer system (DCS) that accesses another network or other computer resources shall be subject to that network's acceptable use policy.

Sanctions

The computer coordinator will report inappropriate behavior to the staff member's supervisor who will take appropriate disciplinary action. Any other reports of inappropriate behavior, violations or complaints will be routed to the staff member's supervisor for appropriate action. Violations may result in a loss of access to the DCS and/or disciplinary action. When applicable, law enforcement agencies may be involved.

Notification

All staff will be given a copy of the District's policies on staff and student use of computerized information resources and the regulations established in connection with those policies. Each staff member will sign an acceptable use agreement (Refer to Form #6470F) before establishing an account or continuing their use of the DCS.

STUDENT USE OF COMPUTERIZED INFORMATION RESOURCES POLICY

The Board of Education will provide access to various computerized information resources through the District's computer system ("DCS" hereafter) consisting of software, hardware, computer networks and electronic communications systems. This may include access to electronic mail, so-called "on-line services" and the "Internet." It may include the opportunity for some students to have independent access to the DCS from their home or other remote locations. All use of the DCS, including independent use off-school premises, shall be subject to this policy and accompanying regulations. Further, all such use must be in support of education and/or research and consistent with the goals and purposes of the School District.

One purpose of this policy is to provide notice to students and parents/legal guardians that, unlike most traditional instructional or library media materials, the DCS will allow student access to external computer networks not controlled by the School District where it is impossible for the District to screen or review all of the available materials. Some of the available materials may be deemed unsuitable by parents/legal guardians for student use or access. This policy is intended to establish general guidelines for acceptable student use. However, despite the existence of such District policy and accompanying guidelines and regulations, it will not be possible to completely prevent access to computerized information that is inappropriate for students. Furthermore, students may have the ability to access such information from their home or other locations off school premises. Parents/legal guardians of students must be willing to set and convey standards for appropriate and acceptable use to their children when using the DSC or any other electronic media or communications. The District respects the right of each family to decide whether or not to apply for independent computer access.

Student use of the DCS is conditioned upon written agreement by all students and their parents/legal guardians that student use of the DCS will conform to the requirements of this policy and any regulations adopted to insure acceptable use of the DCS. All such agreements shall be kept on file in the District Office.

Generally, the same standards of acceptable student conduct which apply to any school activity shall apply to use of the DCS. This policy does not attempt to articulate all required and/or acceptable uses of the DCS; nor is it the intention of this policy to define all inappropriate usage. Administrative regulations will further define general guidelines of appropriate student conduct and use, as well as proscribed behavior.

District students shall also adhere to the laws, policies and rules governing computers including, but not limited to, copyright laws, rights of software publishers, license agreements, and student rights of privacy created by federal and state law.

Students who engage in unacceptable use may lose access to the DCS and may be subject to further discipline under the District's school conduct and discipline policy and the Student Discipline Code of Conduct. The District reserves the right to pursue legal action against a student who willfully, maliciously or unlawfully damages or destroys property of the District. Further, the District may bring suit in civil court against the parents/legal guardians of any student who willfully, maliciously or unlawfully damages or destroys District property pursuant to General Obligations Law Section 3-112.

Student data files and other electronic storage areas will be treated like school lockers. This means that such areas shall be considered to be School District property subject to control and inspection. The computer coordinator may access all such files and communications to insure system integrity and that users are complying with the requirements of this policy and accompanying regulations. Students should NOT expect that information stored on the DCS will be private.

The Superintendent or his/her designee is authorized to establish regulations as necessary to implement the terms of this policy.

Adopted: 10/2000

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Field Trip Permission Form

Student:_____

I give my son/daughter permission to participate in field trips for the _____ school year.

My son/daughter has the following medical condition(s) that the chaperones should be aware of: (i.e. diabetes, allergies, migraines, seizure disorder, asthma etc.)

_____

_____

_____

Please only list those medications which will be needed on the field trips

He/she will be taking the following medications on field trips

Medication _____ Dosage _____ Time _____

Medication _____ Dosage _____ Time _____

Medication _____ Dosage _____ Time _____

Medications taken at school or on a field trip must be accompanied by a medication authorization form signed by a physician and the parent.

Parent/ Guardian Signature _____ Date _____

Address _____

Home Phone# _____ Work# _____ Cell# _____

Alternate contact in case of emergency _____

Phone:_____

It is the parents responsibility to update the school nurse with any changes in medications or health status. This information will be shared with faculty and chaperones responsible for the field trip.

Important Notice to Parents/Guardians of Students with Life-threatening Health Conditions

Definition of Life-threatening health condition:

A condition, including a known allergy, that will put the child in danger of death during the school day if a medication or treatment order is not in place (for example; food or substance allergy, insect sting allergy, asthma, diabetes, seizure disorder, etc.).

If your child has life-threatening health condition, please immediately contact the school Health Office/School Office.

- The school nurse will initiate an Emergency Care Plan for your student's specific health condition.
- The school nurse may ask for additional documents completed by your child's health care provider such as:
  - An authorization for Administration of Medication in school form
  - Self-medication Release form (If applicable)

The appropriate forms and any additional information you or the licensed health provider would like to share must be completed and returned to the school for review and approval by the School Nurse as soon as possible.

For New Registrations, New Incoming Pre-Kindergarten and Kindergarten Children

Oswego City School District Health History Survey

Student Name _____ Date of Birth _____

Parent/Guardian Name _____ Home Phone _____ Work Phone _____

School _____ Date _____

Please answer each question by writing a check (√) in the appropriate box providing infornation requested.

	Yes	No
Did you submit a copy of your child's immunization records when you registered him/her	☐	☐
Has you child received a TB (tuberculosis) skin test?	☐	☐
Has any family member or relative under the age of 50?		
had a heart attack, stroke, or died unexpectedly	☐	☐
had high blood pressure	☐	☐
had learning disabilities	☐	☐
Other (please indicate below)	☐	☐
Has your child had the following illnesses?		
Chicken pox	☐	☐
Red or hard measles	☐	☐
German or three-day measles (rubella)	☐	☐
Other (please indicate below)	☐	☐
Does your child have any of the following health problems?		
Vision problems	☐	☐
If yes, what? _____		
Glasses or corrective lenses	☐	☐
Chronic ear infections	☐	☐
Tubes in ears	☐	☐
Hearing aids	☐	☐
Hearing loss	☐	☐
Other hearing problems	☐	☐
If yes, what? _____		
Allergies to:		
Medication, What kind _____		
Insects, What kind _____		
Food, What kind _____		
If yes, what reactions to expect? What medical procedures need to be taken? _____		
Asthma	☐	☐
Heart problems	☐	☐
If yes, what? _____		
Epilepsy	☐	☐
Hay fever	☐	☐
Diabetes	☐	☐
Hemophilia (free bleeding)	☐	☐
Rheumatic fever	☐	☐
Cystic fibrosis	☐	☐

	Yes	No
Muscular dystrophy	☐	☐
Cancer	☐	☐
Physical disabilities	☐	☐
If yes, what? _____		
Mental disabilities (for example, autism, developmental delay)	☐	☐
If yes, what? _____		
Attention deficit/hyperactivity disorder	☐	☐
Other health problems	☐	☐
If yes what? _____		
Has your child ever seen, or is your child currently seeing, a specialist (for example, cardiologist, neurologist)?	☐	☐
If yes, what? _____		
Has your child ever been hospitalized?	☐	☐
If yes, for what reason? _____		
Has your child ever had a serious accident (for example, broken bones, bad cuts, poisoning)?	☐	☐
If yes, what? _____		
Is your child on any medication?	☐	☐
If yes, what? _____		
Has your child been seen by a physician in the last year?	☐	☐
Has your child been seen by a dentist in the last year?	☐	☐

OVER ☛

Does your child now have, or has your child had in the last year, any of the following problems?	Yes, has now	Yes, in the last Year	No
Headaches	☐	☐	☐
Problems with eyes (for example,squinting, crusting lids, wandering eye)	☐	☐	☐
Chronic colds (more than 6 in one year, or a cold Lasting more than 3 weeks)	☐	☐	☐
Shortness of breath	☐	☐	☐
Severe cough	☐	☐	☐
Throat infection	☐	☐	☐
Ear infection	☐	☐	☐
Tooth pain, cavities, mouth sores	☐	☐	☐
Swollen glands or lumps	☐	☐	☐
Stomach aches	☐	☐	☐
Eating or drinking too much	☐	☐	☐
Eating or drinking too little	☐	☐	☐
Weak urinary system (frequent urination)	☐	☐	☐
Pain or burning upon urination	☐	☐	☐
Bed wetting	☐	☐	☐
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Unusual diffculty standing or walking	☐	☐	☐
Trouble sleeping	☐	☐	☐
Tiring easily	☐	☐	☐
Joint pain	☐	☐	☐
Seizures, convulsions, or fits	☐	☐	☐
Bleeding problems (for example, bruising Easily, frequent nose bleeds)	☐	☐	☐
Other (please indicate below)	☐	☐	☐

_____

_____

_____

_____

Please answer the following questions about the pregnancy, labor, and delivery of your child:	Yes	No
Did the mother have difficulties during the pregnancy, labor, or delivery of your child?	☐	☐
If yes, what? _____		
Did the mother visit a physician or medical clinic during her pregnancy?	☐	☐
Was your child born at home or at any place other than a hospital or medical clinic?	☐	☐
If yes, where? _____		
Did your child have difficulties at birth or shortly after (for example, jaundice (yellow skin), breathing problems, infection, high fever, feeding problems)?	☐	☐
If yes, where? _____		
Did your child weigh less than 5½ pounds at birth?	☐	☐
If yes, how much did the child weigh?		
Was your child born prematurely?	☐	☐
If yes, by how many weeks? _____		
Was your child born post-maturely?	☐	☐
If yes, by how many weeks? _____		
Was your child placed in a neonatal intensive Care nursery or high-rish nursery after birth?	☐	☐
If yes, for how many days? _____		

Please check to make sure you have answered every item. Then, write in the space below any additional comments you have about your child's health history.

Name of Family Physician _____ Phone _____

Name of Family Dentist _____ Phone _____

Date _____

Signature of Parent/Guardian _____

Comments:

_____

_____

_____

_____

_____

_____

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School Physical Consent Form

Student Name:_____ Grade:_____

School:_____ DOB:_____

Please read and check the correct box. Sign and return to the school nurse.

- ☐ I do give permission for the designated school physician or nurse practitioner to complete a physical examination as per school policy and as required by NYS Education Laws.

- ☐ I do not give permission for the designated school physician or nurse practitioner to complete a physical examination as per school policy and as required by NYS Education Laws. I will have a physical completed by our family physician.

This consent is valid from this date unless revoked by the parent or guardian. If custody or guardianship changes in the future, it is the responsibility of the parent or guardian to notify the school district of such a change.

_____ _____

Signature of Parent or Legal Guardian 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)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ 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/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment 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 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):_____

II. 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.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

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

IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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

STUDENT INFORMATION

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

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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

BMI_____kg/m2

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

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

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL				

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

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

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

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

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

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

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

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

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

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

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

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

MEDICATIONS

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

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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

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Authorization for Use or Disclosure of Protected Health Information

I, _____ authorize Oswego City School District to display and publish my child's life-threatening health concern listed below on the school information system (School Tool.) I understand that this information will be accessible to all Oswego City School District employees.

The Protected Health Information may be used, disclosed or received for the following purpose(s):
* To adhere to emergency plans of care as advised by healthcare professionals
* to develop care or therapy plans for routine and emergent school management
*To design appropriate educational, school, or athletic programs
*To assess the impact of the medical condition(s) on school programming and/or attendance
*To share school observations/concerns
*To assess a medical basis for modification of transportation and/or home tutoring
*Medication delivery or therapy prescriptions
Other_____

Student name_____

Life Threatening Health Condition(s)_____

This authorization is valid for the duration of attendance within the school district*

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the District Administration Building. I understand that the revocation of this authorization is not effective if the District has used the authorization for disclosure of the Protected Health Information before receiving 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 and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that Protected Health Information will not be disclosed to entities outside of the Oswego City School district. I understand that Protected Health information will be disclosed to Oswego City School district employees who have a need to know. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I give permission for the school representatives to share and disclose information as indicated above with the appropriate school district employees.

_____
Signature of Parent/Guardian or student if over 18 Date

_____
Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE ADULT PATIENT OR PARENT OF THE MINOR CHILD

District Warehouse

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www.oswego.org

Dr. Mathis A. Calvin III
Superintendent of Schools
(315) 341-2001
FAX: (315) 341-2910
mcalvin@oswego.org

David M. Crisafulli
Director of Facilities III
(315) 341-2906
FAX: (315) 341-2919
dcrisafu@oswego.org

Dear Parent, Guardian, and School Staff:

New York State Education Law Section 409-11, effective July 1, 2001, requires all public and nonpublic elementary and secondary schools to provide written notification to all persons in parental relation, faculty, and staff regarding the potential use of pesticides periodically throughout the school year.

The Oswego City School District (or nonpublic school) is required to maintain a list of persons in parental relation, faculty, and staff who wish to receive 48-hour prior written notification of certain pesticide applications. The following pesticide applications are not prior notification requirements:

- A school remains unoccupied for a continuous 72-hours following an application;
- Antimicrobial products;
- Nonvolatile rodenticides in tamper resistant bait stations in areas inaccessible to children;
- Nonvolatile insecticidal baits in tamper resistant bait stations in areas inaccessible to children;
- Silica gels and other nonvolatile ready-to-use pastes, foams, or gels in areas inaccessible to children;
- Boric acid and disodium octaborate tetrahydrate;
- The application of EPA designated biopesticides;
- The application of EPA designated exempt materials under 40CFR152.25;
- The use of aerosol products with a directed spray in containers of 18 fluid ounces or less when used to protect individuals from an imminent threat from stinging and biting insects including venomous spiders, bees, wasps, and hornets.

If you would like to receive 48-hour prior notification of pesticide application that are scheduled to occur in your school, please complete the form below and return it to your child's school.

In the event an emergency application is necessary to protect against an imminent threat to human health, a good faith effort will be made to supply written notification to those on the 48-hour prior notification list.

Oswego City School District

Request for Pesticide Application Notification

(Please Print)

School Building: (Check One)	☐ Education Center ☐ Charles E. Riley School ☐ Transportation Center	☐ Oswego High School ☐ Fitzhugh Park School ☐ District Warehouse	☐ Oswego Middle School ☐ Minetto School	☐ Frederick Leighton School ☐ Kingsford Park School
Parent Name/ Staff Name:			Student Name:	
Address:				
Day Phone:	Evening Phone:		E-mail Address:	

Education Center

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Dr. Mathis A. Calvin III
Superintendent of Schools
(315) 341-2001
FAX: (315) 341-2910
mcalvin@oswego.org

Dear Parent/Guardian:

Our school building is located within the ten-mile emergency planning zone (EPZ) of the Nine Mile Point Nuclear Power Plants. The federal Nuclear Regulatory Commission and New York State have developed policies on the availability and usage of the over-the –counter drug Potassium iodide (KI) during a radiological emergency.

Nuestro edificio de escuela está situado dentro de la zona del planeamiento de la emergencia de la diez-milla (EPZ) de las nueve plantas de energía atómica del punto de la milla. La Comisión reguladora nuclear y el estado de Nueva York federales han desarrollado políticas en la disponibilidad y el uso del excedente - el yoduro contrario del potasio de la droga (KI) durante una emergencia radiológica

KI is an over-the-counter drug that protects the thyroid from exposure to radioactive iodine. KI only protects one organ against one radioactive substance. It is NOT an alternative to evacuation or sheltering. (Please read the attached question and answer sheet.) In fact, evacuation and sheltering remain New York's primary public protective actions in the event of an accident at any nuclear power site.

KI es una droga over-the-counter que protege la tiroides contra la exposición al yodo radiactivo. KI protege solamente un órgano contra una sustancia radiactiva. No es un alternativa a la evacuación o a abrigar. (por favor leído la hoja unida de la pregunta y de respuesta.) En hecho, la evacuación y el abrigar siguen siendo acciones protectoras públicas primarias de Nueva York en el acontecimiento de un accidente en cualquier sitio de la energía atómica.

Should the County and/or State Department of Health recommend the use of KI during an emergency, our school will have KI available on site for your child. KI would **only** be administered following a recommendation to do so from County or State Health Department officials, and would occur in accordance with evacuation/sheltering plans.

Si el departamento del condado y/o del estado de la salud recomienda el uso de KI durante una emergencia, nuestra escuela tendrá KI disponible en el sitio para su niño. KI sería administrado solamente después de una recomendación de hacer así que de funcionarios del departamento de la salud del condado o del estado, y ocurriría de acuerdo con planes de evacuation/sheltering cubre.) En hecho, la evacuación y el abrigar siguen siendo acciones protectoras públicas primarias de Nueva York en el acontecimiento de un accidente en cualquier sitio de la energía atómica

If you want the school to provide your child with KI in a radiological emergency, you **must** sign and return the enclosed form to the main office in your child's school. This permission will remain in effect as long as your child is enrolled in the Oswego City School District unless you notify us in writing that you no longer want the school to provide your child with KI. **Please note that if you do not return the enclosed form and KI is recommended by health officials, your child will not receive KI.**

Si usted quisiera que la escuela proveiera de su niño KI en una emergencia radiológica, usted debe firmar y volver la forma incluida a la oficina principal en la escuela de su niño. Seguirá habiendo este permiso en efecto mientras alistan a su niño en el districto de la escuela de la ciudad de Oswego a menos que usted nos notifique en la escritura esa usted quisiera no más de largo que la escuela proveiera de su niño KI. Observe por favor que si usted no vuelve la forma incluida y KI es recomendado por los funcionarios de la salud, su niño no recibirá KI

If you have any further questions about the school's program, please contact your child's school nurse or the Oswego County Emergency Management Office at 591-9150.

Si usted tiene cualquier pregunta más otra sobre el programa de la escuela, entre en contacto con por favor la enfermera de la escuela de su niño o la oficina de la gerencia de la emergencia del condado de Oswego en 591-9150.

Sincerely,

Dr. Mathis A. Calvin III
Superintendent of Schools

FACT SHEET

Potassium Iodide (KI)

This fact sheet is about a new policy for people, especially those who live within ten miles of a nuclear power plant, who may be exposed to radiation from a nuclear plant emergency. In December 2001, the federal Food and Drug Administration (FDA) said if there was a radiological emergency, people should take a drug that would help protect them from thyroid cancer. This drug is called potassium iodide (KI). The New York State Health Department agrees. The questions and answers below will give you more information.

1. What is potassium iodide (KI) and what is it used for?

If there is a radiation emergency at a nuclear plant, large amounts of something called radioiodine could be put into the air. This could hurt your thyroid gland, or even cause thyroid cancer later on. You could breathe in the radioiodine or eat food that has some radioiodine in it. When you take the KI pill, it protects your thyroid gland from being harmed.

2. How does KI work?

When you take the KI pill, it fills your thyroid with a kind of iodine that prevents your thyroid gland from taking in any of the radioactive kind of iodine.

3. What age group has the highest risk from exposure to radioiodine?

Young children have the highest risk. We have learned this from looking at children in Russia and other areas who were exposed to the radioiodine from the Chernobyl nuclear power plant accident.

4. When should KI be taken?

You need to take KI before or just after you are exposed to radioiodine. You can also take it 3 or 4 hours later, but it will not be as helpful.

5. How will I know if I should take KI?

If there is an emergency, you will hear an announcement from your local or state health officials. Your local health department will tell you when you should start taking KI and they will also tell you when you can stop taking it.

6. Does KI work in all radiation emergencies?

KI will only protect you from radioactive iodine. It does not protect you from other kinds of radioactive material. KI works very well to protect your thyroid gland. However, it protects only your thyroid, not other parts of your body.

7. What will happen in an emergency?

You will be told what, if any, actions you should take to protect yourself. This might include leaving the area, staying inside with your windows closed and/or taking KI.

8. Can people have reactions to KI?

In general, most people who have taken KI have not had any reactions (side effects). If people did have a reaction, it did not last very long. In a few cases, babies had a reaction in their thyroids. Adults who had reactions had stomach problems or a rash. The federal government thinks the benefits of taking KI are much greater than the risks.

9. Are there some people who should not take KI?

Most people can take KI, but you should talk to your doctor **before** taking it. Talk to your doctor before an emergency occurs. It is not a good idea to take KI if you have certain medical conditions or problems. Babies need to be watched carefully if they take KI.

10. How much KI do I take?

The table below shows the smallest KI dose that different age groups can take which will protect the thyroid. The pill comes in both 65-mg and 130-mg tablets. Since it is hard to cut many pills, the State Health Commissioner says that, in an emergency, it is safe for children at school or day care centers to take the whole pill. It's better for children under 12 years old to take the 65-mg pill, but it is safe to take the 130-mg pill if that is the only one you have. For children or babies who cannot take pills, parents and caregivers can cut or crush the pill to make lower doses.

Age Group	KI Dosage	#r of 65-mg tablets	# of 130-mg tablets
Adults over 18 years	130 mg	2	1
Over 12 - 18 years and over 150 pounds	130 mg	2	1
Over 12 - 18 years and less than 150 pounds	65 mg	1	1/2
Over 3 -12 years	65 mg	1	1/2
Over 1 month to 3 years	32 mg	1/2	1/4
Birth -1 month	16 mg	1/4	1/8

11. Does KI come in liquid or pill form?

KI can come as a pill or a liquid. Pills are available in 65-mg or 130-mg doses. KI is also available as a liquid.

12. If KI has been stored for a while, is it still OK to use?

The manufacturers say KI stays "fresh" for 3-5 years. If you keep it in a dry, dark and cool place, it should last for many years.

13. Do you need a prescription to get KI?

No. You are allowed to get it over-the-counter.

14. Can KI be purchased at local pharmacies?

Yes, though it may not widely available in drugstores near you. Since it is not a prescription drug, you can buy it over the Internet. As with other drugs, make sure the KI you buy has been approved by the FDA. A supply of KI has been made available to people who live within 10 miles of a nuclear power plant in New York State. If you live within 10 miles of a nuclear power plant and did not receive KI, contact your local Office of Emergency Management.

Potassium Iodide (KI) Permission Form
Forma Del Permiso Del Yoduro Del Potasio (KI)

I understand that potassium iodide (KI) may be recommended by the County and/or State Department of Health in a radiological emergency.

Entiendo que el yoduro del potasio (KI) se puede recomendar por el departamento del condado y/o del estado de la salud en una emergencia radiológica.

I have read and understand the Parent/Guardian letter, Potassium Iodide (KI) Parent Q &A's and Department of Health KI information sheet.

He leído y entiendo la letra de Parent/Guardian, los &A del padre Q del yoduro del potasio (KI) y el departamento de la hoja de la información de la salud KI.

☐ **I DO WANT** my child to be given potassium iodide (KI) in the event of a radiological emergency.

☐ *QUISIERA que dieran mi niño el yoduro del potasio (KI) en el acontecimiento de una emergencia radiológica.*

☐ **I DO NOT WANT** my child to be given potassium iodide (KI) in the event of a radiological emergency.

☐ *No quisiera que mi recibiera mi niño el yoduro del potasio (KI) en el acontecimiento de una emergencia radiológica..*

Child's Name: _____
Nombre Del Niño

Date of Birth: _____
Fecha de nacimiento

Teacher/Homeroom Teacher: _____
Nombre del maestro/a

Parent/Guardian Signature:*Firma de los padres/guarda:* _____

Date: _____ Telephone number: _____
Fecha *Número de teléfono*

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Dear Parent/Guardian:

Please complete the following form for the school year 20__ - 20__.

Child's Name _____ Grade_____
Teacher's Name_____ School_____

1. Permission for Birthday Announcements:
   I □do □do not give permission for my child's name to be announced during morning school announcements on his/her birthday.

2. Permission to Release phone number(s), email address(s), mailing address to Room Parent for Classroom Events:
   □Yes, you may share my information.
   □No, you may not share my information

OSWEGO CITY SCHOOL DISTRICT OPT-OUT PHOTO RELEASE

The Oswego City School District likes to celebrate the achievements of our students and staff. Throughout the year, the Public Relations Department and district staff may take photographs of students and school activities. These photographs may appear in various District materials, including the District's website (Oswego.org), newsletters, yearbooks, brochures, social media pages, district calendar, etc. We at times, may also publicize student work.

If you **DO NOT** want your child's name/photo/work publicized for these purposes you are asked to inform your child's principal, in writing. A simple, written, signed note stating: "Please do not photograph my child for use in publications and/or web", including your child's name and grade level. You may either drop off the note in person or mail it to the school your child is attending.

If you have any questions regarding this Student Photograph practice, please feel free to contact either your child's principal or the Superintendent's Office.

Oswego High School

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mcalvin@oswego.org

Patrick Wallace
Principal
(315) 341-2200
FAX: (315) 341-2920
pwallace@oswego.org

NOTIFICATION TO PARENTS

Pursuant To the federal *Every Student Succeeds Act* signed into law in December 10, 2010, the school district must disclose to military recruiters and institutions of higher learning, upon request, the names, addresses and telephone numbers of our high school students. However, the district must also notify parents of their rights and the rights of their children to request, in writing, that the district **NOT** release such information if it is requested.

Parents, or students who are at least 18 years old, wishing to exercise their option to withhold their consent to the release of the above information to military recruiters and institutions of higher learning must sign and return the form attached below to the High School Principal.

Patrick Wallace
Principal

TO: Patrick Wallace
Principal

RE: Reservation of Consent for the Release of certain student information under the *Every Student Succeeds Act*

I do **not** wish to have my child's name, address or phone number released to military recruiters and/or institutions of higher learning:

(Print name of student on above line)	(Class of)
(Parent Signature)	(Date)
(Student Signature, if 18 years old or older)	(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:			**GENDER:**
Month	*Day*	*Year*	❑ 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:

Education Center
OSWEGO
CITY SCHOOL DISTRICT
Fully prepared and life ready!
One Buccaneer Boulevard, Oswego, New York 13126
www.oswego.org

Impact Aid Registration Form

Military Service

(Additional data required of Parent/Guardian with present military service)

Name of Student _____ Date of Birth _____

School Enrolled In:_____ Grade_____

Home Address _____

Name of parent/guardian (A) _____

Relationship to student _____

Federal property on which parent/guardian (A) is employed _____

Name of firm, agency or uniformed services branch employing parent/guardian (A) _____

Name of parent/guardian (B) _____

Relationship to student _____

Federal property on which parent/guardian (B) is employed _____

Name of firm, agency or uniformed services branch employing parent/guardian (B) _____

If either parent is the uniformed services, please indicate:

Name of Parent _____ Rank/Unit_____

_____ _____

Signature of Parent/Guardian Date

Oswego City School District Transportation Department

Date: _____

AM - Stop Location: _____ Bus #: _____
PM - Stop Location: _____ Bus #: _____

Transportation Department Bus Registration / Student Information Update Form

The following information is needed to assist us in assigning your child to a school bus route. This form must be completed prior to assigning new students to a bus, or changes are made for students currently assigned. The transportation office will assign students to the closest available stop upon receipt of this form. If a stop is more than .5 miles from home or if the walk route to the stop appears unsafe, a bus stop change request can be submitted. All specialized transportation needs as determined by the IEP team will be sent on the Special Needs Transportation Form. If you have any questions please contact the transportation office at (315) 341-2900.

****Note: Parent or guardian must be at the bus stop morning and afternoon for Pre-K and Kindergarten. Students will be returned to school if the adult is not at the bus stop. Parents/guardians are responsible for the supervision of students as they travel to and from bus stops and while they wait for buses to arrive.**

Check appropriate option. Information is for new student ( ) Update for current student ( )

Student Name: Legal Name: _____ Nick Name: _____

Date of Birth: _____ School: _____ Grade: _____ Teacher: _____

Parent or Guardian: _____ E-mail Address: _____

Phone: Home: _____ Work: _____ Cell/Mobile: _____

Address: _____City: _____Zip Code_____

Subdivision: _____ Cross Streets: _____ Directions to your home from zoned school:

_____

Photograph Release: (during bus training or other bus related situations)

I hereby release the Oswego City School District and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my child's participation:

- o I agree to release of my child's photograph
- o I do not agree to release of my child's photograph

Emergency medical information (list any health concerns or medication the driver should be aware in case of an emergency.)

List family members or other emergency contact authorized to pick up your child if you are not available. <u>Picture ID will be required at the bus stop</u> (use back of page if needed):

1 _____ Phone: _____ Relationship: _____
2 _____ Phone: _____ Relationship: _____
3 _____ Phone: _____ Relationship: _____

Can this student participate in any food-based treats/rewards? YES No
If yes, please list all food allergies _____

Parent Signature: _____

FOR OFFICE USE ONLY

Route #:_____ Stop Location: _____ Time: AM_____ PM _____
Parent Notified On: _____ Driver Notified On: _____ School Notified On: _____
Data entered by: _____ Route Color _____ Date completed: _____

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One Buccaneer Boulevard, Oswego, New York 13126
www.oswego.org

AUTHORIZATION FOR DISCLOSURE AND USE
OF PROTECTED HEALTH INFORMATION
AND CONSENT FOR DISCLOSURE OF EDUCATION RECORDS

Student's Name: _____
Address: _____
Date of Birth_____

Description of the information which is to be disclosed:

_____
_____

Information is to be disclosed BY:
OSWEGO CITY SCHOOL DISTRICT, [*insert medical provider's name*]_____
_____

Information is to be disclosed TO: OSWEGO CITY SCHOOL DISTRICT, [*insert medical provider's name*]

Purpose(s) of disclosure or use: Health care collaboration and/or special education, including student assessments and services

Date or event on which this authorization expires *(initial one):*
____ When the student is no longer an Oswego City School District student
____ Other specified date or event: _____

Acknowledgements:

This Authorization may be revoked in writing at any time, except to the extent that the entity disclosing the information has already relied upon it. Signing this Authorization is not a condition for treatment, payment, enrollment, or eligibility for benefits. I understand that if this Authorization allows protected health information to be disclosed to a recipient that is not a health care provider or a health plan, the information disclosed may no longer be protected under the HIPAA Privacy Rule.

PARENT / GUARDIAN SIGNATURE	**Date signed:**
_____	_____
_____	_____
Printed name of parent/guardian	Relationship to student