



# 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
- ☐ 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.

- ☐ FPS  
☐ KPS  
☐ MIN

- ☐ CER  
☐ FLS  
☐ OMS  
☐ OHS

- ☐ Trinity Catholic  
☐ OCCS

Date of Entry \_\_\_\_\_

City School District of Oswego, Oswego, New York 13126

**Registration Form****Office Use Only**

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

**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 FirstResidence \_\_\_\_\_  
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. \_\_\_\_\_

Names of other adults in the child's household: \_\_\_\_\_  
Last First

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

Foster Student? ☐ Yes ☐ No DSS2999 Form? ☐ Yes ☐ NoDoes this school have updated custody documentation on file? ☐ Yes ☐ NoSpouse's Name \_\_\_\_\_  
Last FirstSpouse'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. \_\_\_\_\_

Relationship to the child: \_\_\_\_\_

**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 \_\_\_\_\_

## 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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CITY SCHOOL DISTRICT  
*Fully prepared and life ready!*

**Education Center**

One Buccaneer Boulevard, Oswego, New York 13126  
[www.oswego.org](http://www.oswego.org)

## 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:

- |                                   |   |  |  |
|-----------------------------------|---|--|--|
| <input type="checkbox"/> Academic | <input type="checkbox"/> Medical                        | <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Psychological                     |
| <input type="checkbox"/> Gifted   | <input type="checkbox"/> Committee on Special Education | <input type="checkbox"/> Social            | <input type="checkbox"/> 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

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

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

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

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

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

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

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

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

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

I am the ☐ Parent ☐ Guardian ☐ DSS Caseworker

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

\_\_\_\_\_  
Signature

☐ 1<sup>st</sup> Request

☐ 2<sup>nd</sup> Request

☐ 3<sup>rd</sup> Request



**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 themselves 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

- 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, data 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.

7314

## 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 DCS 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.



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[www.oswego.org](http://www.oswego.org)

## 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 information requested.

Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you submit a copy of your child's immunization records when you registered him/her ..... <input type="checkbox"/> <input type="checkbox"/>	Muscular dystrophy ..... <input type="checkbox"/> <input type="checkbox"/>
Has your child received a TB (tuberculosis) skin test? ..... <input type="checkbox"/> <input type="checkbox"/>	Cancer ..... <input type="checkbox"/> <input type="checkbox"/>
Has any family member or relative under the age of 50?	Physical disabilities ..... <input type="checkbox"/> <input type="checkbox"/>
had a heart attack, stroke, or died unexpectedly ..... <input type="checkbox"/> <input type="checkbox"/>	If yes, what? _____
had high blood pressure ..... <input type="checkbox"/> <input type="checkbox"/>	_____
had learning disabilities ..... <input type="checkbox"/> <input type="checkbox"/>	Mental disabilities (for example, autism, developmental delay) ..... <input type="checkbox"/> <input type="checkbox"/>
Other (please indicate below) ..... <input type="checkbox"/> <input type="checkbox"/>	If yes, what? _____
Has your child had the following illnesses?	_____
Chicken pox ..... <input type="checkbox"/> <input type="checkbox"/>	Attention deficit/hyperactivity disorder ..... <input type="checkbox"/> <input type="checkbox"/>
Red or hard measles ..... <input type="checkbox"/> <input type="checkbox"/>	Other health problems ..... <input type="checkbox"/> <input type="checkbox"/>
German or three-day measles (rubella) ..... <input type="checkbox"/> <input type="checkbox"/>	If yes what? _____
Other (please indicate below) ..... <input type="checkbox"/> <input type="checkbox"/>	_____
Does your child have any of the following health problems?	Has your child ever seen, or is your child currently seeing, a specialist (for example, cardiologist, neurologist)? ..... <input type="checkbox"/> <input type="checkbox"/>
Vision problems ..... <input type="checkbox"/> <input type="checkbox"/>	If yes, what? _____
If yes, what? _____	_____
Glasses or corrective lenses ..... <input type="checkbox"/> <input type="checkbox"/>	Has your child ever been hospitalized? ..... <input type="checkbox"/> <input type="checkbox"/>
Chronic ear infections ..... <input type="checkbox"/> <input type="checkbox"/>	If yes, for what reason? _____
Tubes in ears ..... <input type="checkbox"/> <input type="checkbox"/>	_____
Hearing aids ..... <input type="checkbox"/> <input type="checkbox"/>	Has your child ever had a serious accident (for example, broken bones, bad cuts, poisoning)? ..... <input type="checkbox"/> <input type="checkbox"/>
Hearing loss ..... <input type="checkbox"/> <input type="checkbox"/>	If yes, what? _____
Other hearing problems ..... <input type="checkbox"/> <input type="checkbox"/>	_____
If yes, what? _____	Is your child on any medication? ..... <input type="checkbox"/> <input type="checkbox"/>
Allergies to:	If yes, what? _____
Medication, What kind _____	_____
Insects, What kind _____	Has your child been seen by a physician in the last year? ..... <input type="checkbox"/> <input type="checkbox"/>
Food, What kind _____	Has your child been seen by a dentist in the last year? ..... <input type="checkbox"/> <input type="checkbox"/>
If yes, what reactions to expect? What medical procedures need to be taken? _____	_____
_____	
Asthma ..... <input type="checkbox"/> <input type="checkbox"/>	
Heart problems ..... <input type="checkbox"/> <input type="checkbox"/>	
If yes, what? _____	
Epilepsy ..... <input type="checkbox"/> <input type="checkbox"/>	
Hay fever ..... <input type="checkbox"/> <input type="checkbox"/>	
Diabetes ..... <input type="checkbox"/> <input type="checkbox"/>	
Hemophilia (free bleeding) ..... <input type="checkbox"/> <input type="checkbox"/>	
Rheumatic fever ..... <input type="checkbox"/> <input type="checkbox"/>	
Cystic fibrosis ..... <input type="checkbox"/> <input type="checkbox"/>	

**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 .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with eyes (for example, squinting, crusting lids, wandering eye) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic colds (more than 6 in one year, or a cold Lasting more than 3 weeks) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe cough .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat infection .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear infection .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tooth pain, cavities, mouth sores .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen glands or lumps .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach aches .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating or drinking too much .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating or drinking too little .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weak urinary system (frequent urination) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain or burning upon urination .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bed wetting .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusual difficulty standing or walking .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble sleeping .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiring easily .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures, convulsions, or fits .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems (for example, bruising Easily, frequent nose bleeds) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please indicate below) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please answer the following questions about the pregnancy, labor, and delivery of your child:

Did the mother have difficulties during the pregnancy, labor, or delivery of your child? ☐ Yes ☐ No  
If yes, what? \_\_\_\_\_

Did the mother visit a physician or medical clinic during her pregnancy? ☐ Yes ☐ No

Was your child born at home or at any place other than a hospital or medical clinic? ☐ Yes ☐ No  
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)? ☐ Yes ☐ No  
If yes, where? \_\_\_\_\_

Did your child weigh less than 5½ pounds at birth? ☐ Yes ☐ No  
If yes, how much did the child weigh? \_\_\_\_\_

Was your child born prematurely? ☐ Yes ☐ No  
If yes, by how many weeks? \_\_\_\_\_

Was your child born post-maturely? ☐ Yes ☐ No  
If yes, by how many weeks? \_\_\_\_\_

Was your child placed in a neonatal intensive Care nursery or high-risk nursery after birth? ☐ Yes ☐ No  
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:     /     /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first oral health assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Month    Day    Year				
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.



<b>REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM</b> <b>TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR</b> <b>IF AN AREA IS NOT ASSESSED INDICATE NOT DONE</b>					
<b>Note:</b> 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).					
<b>STUDENT INFORMATION</b>					
Name				Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
School:				DOB:	
				Grade:	
				Exam Date:	
<b>HEALTH HISTORY</b>					
<b>Allergies</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached			
<b>Asthma</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached			
<b>Seizures</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> Medication/Treatment Order Attached		Date of last seizure: <input type="checkbox"/> Seizure Care Plan Attached	
<b>Diabetes</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached			
<b>Risk Factors for Diabetes or Pre-Diabetes:</b> <i>Consider screening for T2DM if BMI% &gt; 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.</i>					
<b>BMI</b> _____ kg/m2					
<b>Percentile (Weight Status Category):</b> <input type="checkbox"/> <5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> -49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> -84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> -94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> -98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and>					
<b>Hyperlipidemia:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Done			<b>Hypertension:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Done		
<b>PHYSICAL EXAMINATION/ASSESSMENT</b>					
<b>Height:</b>		<b>Weight:</b>		<b>BP:</b>	
				<b>Pulse:</b>	
				<b>Respirations:</b>	
<b>Laboratory Testing</b>		<b>Positive</b> <b>Negative</b>		<b>Date</b>	
TB- PRN		<input type="checkbox"/>		<input type="checkbox"/>	
Sickle Cell Screen-PRN		<input type="checkbox"/>		<input type="checkbox"/>	
<b>Lead Level Required Grades Pre- K &amp; K</b>			<b>Date</b>		
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$					
<input type="checkbox"/> <b>System Review and Abnormal Findings Listed Below</b>					
<input type="checkbox"/> HEENT		<input type="checkbox"/> Lymph nodes		<input type="checkbox"/> Abdomen	
<input type="checkbox"/> Dental		<input type="checkbox"/> Cardiovascular		<input type="checkbox"/> Back/Spine	
<input type="checkbox"/> Neck		<input type="checkbox"/> Lungs		<input type="checkbox"/> Genitourinary	
				<input type="checkbox"/> Extremities	
				<input type="checkbox"/> Skin	
				<input type="checkbox"/> Neurological	
				<input type="checkbox"/> Speech	
				<input type="checkbox"/> Social Emotional	
				<input type="checkbox"/> Musculoskeletal	
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:				Diagnoses/Problems (list) ICD-10 Code*	
<input type="checkbox"/> Additional Information Attached				*Required only for students with an IEP receiving Medicaid	

Name:				DOB:	
<b>SCREENINGS</b>					
<b>Vision</b> (w/correction if prescribed)	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>	
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Near Vision Acuity	20/	20/		<input type="checkbox"/>	
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>	
Notes					
<b>Hearing</b> 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.				<b>Not Done</b>	
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Notes					
<b>Scoliosis</b> Screen Boys in grade 9, and Girls in grades 5 & 7	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b> <input type="checkbox"/> <b>Student is restricted from participation in:</b> <div style="margin-left: 20px;"> <input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.  <input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.  <input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track &amp; Field.  <input type="checkbox"/> <b>Other Restrictions:</b> </div>					
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level. <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V      Age of First Menses (if applicable) : _____					
<input type="checkbox"/> <b>Other Accommodations*:</b> (e.g. Brace, orthotics, insulin pump, prosthetic, 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.					
<b>MEDICATIONS</b>					
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School Attached</b>					
<b>IMMUNIZATIONS</b>					
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS					
<b>HEALTH CARE PROVIDER</b>					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form To Your Child's School When Completed.</b>					



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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**





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## District Warehouse

224 West Utica Street, Oswego, New York 13126  
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)				
<input type="checkbox"/> Education Center	<input type="checkbox"/> Oswego High School	<input type="checkbox"/> Oswego Middle School	<input type="checkbox"/> Frederick Leighton School	
<input type="checkbox"/> Charles E. Riley School	<input type="checkbox"/> Fitzhugh Park School	<input type="checkbox"/> Minetto School	<input type="checkbox"/> Kingsford Park School	
<input type="checkbox"/> Transportation Center	<input type="checkbox"/> District Warehouse			
Parent Name/ Staff Name:		Student Name:		
Address:				
Day Phone:		Evening Phone:	E-mail Address:	







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**Dr. Mathis A. Calvin III**  
Superintendent of Schools  
(315) 341-2001  
FAX: (315) 341-2910  
[mcalvin@oswego.org](mailto: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 evacuación/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 distrito 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	# 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

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## 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.





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

Lisette 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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	_____ specify
	<input type="checkbox"/> Guardian(s)		_____ specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> 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? \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or of Person in Parental Relation

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_  
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:





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## 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:

- ☐ I agree to release of my child's photograph
- ☐ 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. Picture ID will be required at the bus stop (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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**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