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
- 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.

### City School District of Oswego, Oswego, New York 13126

#### Registration Form

<table>
<thead>
<tr>
<th></th>
<th>FPS</th>
<th>KPS</th>
<th>CER</th>
<th>OMS</th>
<th>Trinity Catholic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Entry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Office Use Only
- Out of District
- Proof of Residency
- Re-Activated
- Transfer Within
- Rec. Req.
- Rec.

### Student Data

<table>
<thead>
<tr>
<th>Name</th>
<th>Last</th>
<th>First</th>
<th>Type of Document</th>
<th>Gender/Sex</th>
<th>Grade</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Physician's Name</th>
<th>Physician's Phone No.</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Last</th>
<th>First</th>
<th>Spouse’s Name</th>
<th>Last</th>
<th>First</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Residence</th>
<th>RD No.</th>
<th>House No./ Box No.</th>
<th>Road or Street No.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Phone No.</th>
<th>Unlisted: [ ] Yes [ ] No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Cell Phone No.</th>
<th>email</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Legal Relation to Child</th>
<th>Spouse’s Residence</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Place of Employment</th>
<th>Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone No.</th>
</tr>
</thead>
</table>

Names of other adults in the child’s household:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Relationship to the child:</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Relation to Child</th>
<th>Phone No.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Cell Phone No.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Daycare’s Name</th>
<th>Address</th>
<th>Cell/Phone No.</th>
</tr>
</thead>
</table>

### Names & Birthdates of Other Children That Live at Home

<table>
<thead>
<tr>
<th>Name</th>
<th>Relation to Child</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

### Last School Attended

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
</table>

### Parent/Guardian Signature

<table>
<thead>
<tr>
<th>Parent/Guardian Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

### For Office Use Only

<table>
<thead>
<tr>
<th>Pre-Kindergarten</th>
<th>A.M.</th>
<th>P.M.</th>
<th>Student ID #</th>
<th>Family ID #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Lunch Program</th>
<th>Free</th>
<th>Reduced</th>
<th>N/A</th>
<th>Hrmr Teacher/Rm.#</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Walker</th>
<th>Yes</th>
<th>No</th>
<th>Bus Route # - To School</th>
<th>/From School</th>
<th>Pick-up/Drop-off Point</th>
</tr>
</thead>
</table>

Enrollment Code

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 certificates. 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
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
- [ ] Psychological
- [ ] Social
- [ ] 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, New York 13126
  Phone: 315-341-2382 • Fax: 315-341-2930

- [ ] Oswego High School
  2 Buccaneer Boulevard
  Oswego, New York 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
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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you submit a copy of your child’s immunization records when you registered him/her?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your child had a TB (tuberculosis) skin test?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has any family member or relative under the age of 50?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>had a heart attack, stroke, or died unexpectedly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>had high blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>had learning disabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please indicate below)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 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                                                         |     |    |

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?

- 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 difficulty 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:

- 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?
- If yes, where?

- 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-risk 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:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
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)

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>School:</td>
<td>Name</td>
<td>Grade</td>
<td></td>
</tr>
<tr>
<td>Have you noticed any problem in the mouth that interferes with your child’s ability to chew, speak or focus on school activities?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

☐ 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. Oral Health Status (check all that apply).

☐ Yes ☐ No 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

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex: □ M □ F</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Exam Date:</td>
</tr>
</tbody>
</table>

### HEALTH HISTORY

<table>
<thead>
<tr>
<th>Allergies □ No □ Yes, indicate type</th>
<th>Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Medication/Treatment Order Attached □ Anaphylaxis Care Plan Attached</td>
<td></td>
</tr>
<tr>
<td>Asthma □ No □ Yes, indicate type</td>
<td></td>
</tr>
<tr>
<td>□ Intermittent □ Persistent □ Other:</td>
<td></td>
</tr>
<tr>
<td>□ Medication/Treatment Order Attached □ Asthma Care Plan Attached</td>
<td></td>
</tr>
<tr>
<td>Seizures □ No □ Yes, indicate type</td>
<td></td>
</tr>
<tr>
<td>□ Type:</td>
<td></td>
</tr>
<tr>
<td>□ Intermittent □ Persistent □ Other</td>
<td></td>
</tr>
<tr>
<td>□ Medication/Treatment Order Attached □ Seizure Care Plan Attached</td>
<td></td>
</tr>
<tr>
<td>Diabetes □ No □ Yes, indicate type</td>
<td></td>
</tr>
<tr>
<td>□ Type: □ 1 □ 2</td>
<td></td>
</tr>
<tr>
<td>□ Medication/Treatment Order Attached □ Diabetes Medical Mgmt. Plan Attached</td>
<td></td>
</tr>
</tbody>
</table>

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

**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

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
<th>BP:</th>
<th>Pulse:</th>
<th>Respiration:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory Testing</td>
<td>Positive</td>
<td>Negative</td>
<td>Date</td>
<td>List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)</td>
</tr>
<tr>
<td>TB-PRN</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Screen-PRN</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Level Required</td>
<td>Grades Pre-K &amp; K</td>
<td>Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Test Done □ Lead Elevated &gt; 5 µg/dL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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:

□ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

2020  Page 1 of 2
### SCREENINGS

<table>
<thead>
<tr>
<th>Vision (w/correction if prescribed)</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
<td>20/</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Near Vision Acuity</td>
<td>20/</td>
<td>20/</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Color Perception Screening</td>
<td>☐ Pass</td>
<td>☐ Fail</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Pure Tone Screening</th>
<th>Right</th>
<th>☐ Pass</th>
<th>☐ Fail</th>
<th>☐ Yes</th>
<th>☐ No</th>
<th>☐</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Left</td>
<td>☐ Pass</td>
<td>☐ Fail</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes**

**Scoliosis** Screen Boys in grade 9, and Girls in grades 5 & 7

<table>
<thead>
<tr>
<th>Negative</th>
<th>Positive</th>
<th>Referral</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

### 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.
  - ☐ 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, 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.

### 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.*
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.

_________________________________________ Date

Signature of Parent/Guardian or student if over 18

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
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:
- 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:
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.

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.

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.

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.

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.

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 radiiodine could be put into the air. This could hurt your thyroid gland, or even cause thyroid cancer later on. You could breathe in the radiiodine or eat food that has some radiiodine 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 radiiodine 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 radiiodine. 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.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>KI Dosage</th>
<th># of 65-mg tablets</th>
<th># of 130-mg tablets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults over 18 years</td>
<td>130 mg</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Over 12 - 18 years and over 150 pounds</td>
<td>130 mg</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Over 12 - 18 years and less than 150 pounds</td>
<td>65 mg</td>
<td>1</td>
<td>1/2</td>
</tr>
<tr>
<td>Over 3 - 12 years</td>
<td>65 mg</td>
<td>1</td>
<td>1/2</td>
</tr>
<tr>
<td>Over 1 month to 3 years</td>
<td>32 mg</td>
<td>1/2</td>
<td>1/4</td>
</tr>
<tr>
<td>Birth - 1 month</td>
<td>16 mg</td>
<td>1/4</td>
<td>1/8</td>
</tr>
</tbody>
</table>

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.
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 leido 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.

☐ **QUIISIERA 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
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:
   □ 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.
Dear Parent or Guardian:

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

Please write clearly when completing this section.

**STUDENT NAME:**

First               Middle               Last

**DATE OF BIRTH:**

Month               Day               Year

**GENDER:**

☐ Male  ☐ Female

**PARENT/PERSON IN PARENTAL RELATION INFO:**

Last Name               First Name               Relation to Student

---

**HOME LANGUAGE CODE**

---

**Language Background**

(Please check all that apply.)

1. What language(s) is(are) spoken in the student’s home or residence?

☐ English  ☐ Other  specify

2. What was the first language your child learned?

☐ English  ☐ Other  specify

3. What is the Home Language of each parent/guardian?

☐ Mother  specify  ☐ Father  specify  ☐ Guardian(s)  specify

4. What language(s) does your child understand?

☐ English  ☐ Other  specify

5. What language(s) does your child speak?

☐ English  ☐ Other  specify  ☐ Does not speak

6. What language(s) does your child read?

☐ English  ☐ Other  specify  ☐ Does not read

7. What language(s) does your child write?

☐ English  ☐ Other  specify  ☐ Does not write

---

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

**SCHOOL DISTRICT INFORMATION:**

District Name (Number) & School

Address

**STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:**
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*  □ Not sure

   *Please complete 10b below

10b. "If referred for an evaluation, has your child ever received any special education services in the past?  □ No  □ Yes  □ Not sure

   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:**

□ ENTERING  □ EMERGING  □ TRANSITIONING  □ EXPANDING  □ COMMANDING

---

**NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL**

NAME: __________________________  POSITION: __________________________

DATE OF NYSITELL ADMINISTRATION: __________________________

□ ENTERING  □ EMERGING  □ TRANSITIONING  □ EXPANDING  □ COMMANDING

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

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_________


Data entered by: ____________ Route Color ____________ Date completed: ______________
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

______________________________ _____________________________

______________________________ _____________________________

______________________________ _____________________________