Cairo-Durham Central School District

Cairo-Durham District Office	Cairo-Durham Elementary School	Cairo-Durham Middle School	Cairo-Durham23 High School
PO Box 780 424 Main Street Cairo, NY 12413 Phone: 518-622-8534 Fax: 518-622-9566	PO Box 1090 424 Main Street Cairo, NY 12413 Phone: 518-622-3231 Fax: 518-622-9060	PO Box 1139 1301 Rt. 145 Cairo, NY 12413 Phone: 518-622-0490 Fax: 518-622-0493	PO Box 598 1301 Rt. 145 Cairo, NY 12413 Phone: 518-622-8543 Fax: 518-622-8856

Dear Pre-K Families,

Welcome to the Cairo-Durham Central School District. To register a student the documentation listed below **is required** along with the completed registration forms.

1. **Proof of Residency – NEED TO SUPPLY 2 PROOFS OF RESIDENCY**

Must contain the parents/guardians name & physical address and be dated within the previous 30 days.

- Deed or lease to house or apartment;
- A **notarized** statement by a landlord, owner or tenant from whom the parent(s)/guardian(s) lease from or live with;
- Such other **notarized** statements by a third party establishing the physical presence of the Parent(s)/guardians in the school district;
- Pay Stub;
- Income tax form;
- Utility bill;
- Membership documents such as library cards-based upon residency;
- Voter registration document;
- Official driver's license, learner's permit or non-driver ID;
- State or other government issued ID.

2. **Proof of Age of Student** -

- Birth Certificate
- Baptismal record
- Passport
- Federal, State or other Local-issued identification;
- School photo identification with date of birth;
- Hospital or health records;
- Military dependent identification card;
- Court orders or other court-issued documents;
- Native American tribal documents;
- Records from non-profit international aid agencies and voluntary agencies.

3. **Immunization Record & Health Certificate Appraisal Form (signed by physician or clinic staff)**

4. **Picture ID of Parent/Guardian Registering Student.**

Please take the time to review and fill out all the necessary forms and bring them with you when you register. Having all papers with you and carefully filled out will move the process along greatly.

Cairo-Durham Elementary School

Pre-K Preference Form
2025/2026

Student's Name: _____

Parent's Name: _____

Please fill out and hand in this form ranking what your preference for our 25/26 Pre-K Program would be.

*** Number from 1-3 in order of preference.**

_____ **Half-Day Morning Program - 9:00 a.m. - 11:30 a.m.**

_____ **Half-Day Afternoon Program - 12:45 p.m. - 3:15 p.m.**

_____ **Full-Day Program - 9:00 a.m. - 3:20 p.m.**

***Please note that we will do our best to accommodate everyone's request but that a lottery for the programs may occur.**

Cairo-Durham Central School District Registration Form

For: Elementary School Pre-Kindergarten-5th Grade

Student's Legal Name: _____
Last First Middle

Date of Birth:_____ Age:_____ Gender: _____ Grade:_____

Physical Address: _____

Mailing Address: _____

Father's Name: _____ Email: _____ Occupation:_____

Cell #_____ Work #_____ Home # _____

Mother's Name: _____ Email: _____ Occupation:_____

Cell #_____ Work #_____ Home # _____

Marital Status of Parents: ( ) Married ( ) Separated ( ) Divorced ( ) Never Married

Student's Legal Guardian is: ( ) Mother & Father ( ) Father ( ) Mother ( ) *Other

* If other, please give name, telephone # and provide court documents.

Legal Guardian's Name: _____

Home # _____ Cell #_____ Work #_____

Stepfather's Name: _____ Contact #_____

Stepmother's Name: _____ Contact #_____

Members of Household:

Name	Date of Birth	Relationship to Student

List Name & Phone Number of two adults, other than yourselves, that can be contacted in case of an emergency when you are not available:

Name	Phone Number	Relationship to Student

Has student ever attended Cairo-Durham Central School District before? ( ) Yes ( ) No

If yes, when: _____

Does student receive Special Education Services? Yes ____ No _____

Did Student Attend Pre K? ( ) Yes ( ) No If yes, Where:_____

Is this student living in a foster home? ( ) Yes ( ) No

If yes, what is the student's home school district? _____

Name of Foster Agency: _____

*If the student is currently living in foster care, all forms must be completed and signed by the student's case worker. Foster parents are not permitted to register students.

Medical History

Is your child on any regular medication? ( ) Yes ( ) No

What?_____

Why?_____

_____

Does your child have any known allergies? ( ) Yes ( ) No

(For example: medications, latex, bee stings, peanuts)

If yes, please identify allergy and reaction exhibited: _____

_____

Prescribing Physician: _____

Date of last Physical? _____ Physician who performed Physical? _____

Has your child been examined by a Specialist? ( ) Yes ( ) No

If yes, please indicate which:

Family Doctor ____ Pediatrician ____ Ophthalmologist ____ Optometrist ____ Psychologist ____ Psychiatrist ____

Speech Clinic ____ Other: _____

High Fever? ( ) Yes ( ) No When?_____ Why? _____

Seizures? ( ) Yes ( ) No When? _____ Why? _____

Has your child had a serious illness or hospitalization? Yes or No If yes, please explain: _____

_____

Frequent:

Colds	( ) Yes ( ) No	Earaches	( ) Yes ( ) No
ENT Surgery	( ) Yes ( ) No	Sore Throat	( ) Yes ( ) No
Hearing Difficulty	( ) Yes ( ) No		

Accidents: (Example – Stitches, Fractures, Surgery)

_____

_____

Family Physician **Phone** **Address**

_____

Family Dentist **Phone** **Address**

_____

Family allergies? ( ) Yes ( ) No Who? _____

What? _____

Chronic Family Illness? ( ) Yes ( ) No Who? _____

What? _____

Important

Under public health law 2164, no child may be admitted to school in New York State unless they can show proof of having been immunized against the communicable diseases of: Polio Myelitis, Mumps, Measles, Diphtheria, Rubella, Hepatitis B and Varicella. It is the responsibility of the parents to furnish such proof of immunizations to the admitting school within 14 days of initial entry.

_____ _____

Parent/Guardian Signature Date

Interval Health History

Student Name:	DOB:
School Name:	Age:
Grade:	Limitations: ☐ NO ☐ YES
	Date of last Health Exam:
	Date form completed:

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.

Since your child's last health exam – Has your child?

General Health	No	Yes
Been restricted by a health care provider from sports participation for any reason?	☐	☐
Had surgery?	☐	☐
Spent the night in a hospital?	☐	☐
Been diagnosed with mononucleosis within the last month?	☐	☐
Has only one functioning kidney?	☐	☐
Has or had a bleeding disorder?	☐	☐
Having problems with hearing or have congenital deafness?	☐	☐
Having problems with vision or only have vision in one eye?	☐	☐
Been diagnosed with a new medical condition?	☐	☐
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Other:		
Developed Allergies?	☐	☐
If yes, check all that apply ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Other: ☐ Pollen		
Had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐
Had or has groin pain, a bulge, or a hernia?	☐	☐
Devices / Accommodations	**No**	**Yes**
Uses a brace, orthotic, or another device?	☐	☐
Has special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wears protective eyewear, such as goggles or a face shield?	☐	☐
Wears a hearing aid or cochlear implant?	☐	☐
Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.		

Since your child's last health exam – Has your child?

Brain/Head Injury History	No	Yes
Has or had a hit to the head that caused headache, dizziness, nausea, or confusion, or been told they had a concussion?	☐	☐
Received treatment for a seizure disorder or epilepsy?	☐	☐
Has or had headaches with exercise?	☐	☐
Has or had migraines?	☐	☐
Breathing	**No**	**Yes**
Complained of getting extremely tired or short of breath during exercise?	☐	☐
Used or carries an inhaler or nebulizer?	☐	☐
Has or had wheezing or coughing frequently during or after exercise?	☐	☐
Been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐
Digestive (GI) Health	**No**	**Yes**
Has or had stomach or other GI problems?	☐	☐
Has an eating disorder?	☐	☐
Has a special diet or need to avoid certain foods?	☐	☐
Do you have concerns about your child's weight?	☐	☐
Injury History	**No**	**Yes**
Been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Had an injury, pain, or joint swelling caused them to miss practice or a game?	☐	☐
Has or had a bone, muscle, or joint that bothers them?	☐	☐
Has or had joints that become painful, swollen, warm, or red with use?	☐	☐
Been diagnosed with a stress fracture?	☐	☐
Females Only	**No**	**Yes**
Change in period frequency related to female athlete triad?	☐	☐

Student Name:	DOB:

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?		
MALES ONLY	**NO**	**YES**
Has only one testicle?	☐	☐
SKIN HEALTH	**NO**	**YES**
Has any rashes, pressure sores, or other skin problems?	☐	☐
Has a herpes or MRSA skin infection?	☐	☐
COVID-19 INFORMATION	**NO**	**YES**
Child tested positive for COVID-19?	☐	☐
NO, STOP and go to Family Heart Health History. If **YES,** answer the questions below:		
Date of positive COVID test:		
Was your child symptomatic?	☐	☐
Did your child see a healthcare provider for their COVID-19 symptoms?	☐	☐
Was your child hospitalized for COVID?	☐	☐
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	☐	☐

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?		
HEART HEALTH	**NO**	**YES**
Had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Has or had lightheadedness or dizziness during or after exercise?	☐	☐
Has or had chest pain, tightness, or pressure during or after exercise?	☐	☐
Has or had fluttering in the chest, skipped heartbeats, heart racing?	☐	☐
Been told by a healthcare provider they have or had a heart or blood vessel problem?	☐	☐

If yes, check all that apply:

- ☐ Chest Tightness or Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ New fast or slow heart rate
- ☐ Heart Infections
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Kawasaki Disease
- ☐ Has implanted cardiac defibrillator (ICD)
- ☐ Had a pacemaker implanted
- ☐ Other:

SINCE YOUR CHILD'S LAST HEALTH EXAM - CHECK ANY **NEW** FAMILY HEART HEALTH HISTORY

A relative had or is currently experiencing any of the following:
Check all that apply:

- ☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
- ☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
- ☐ Heart rhythm problems: long or short QT interval?
- ☐ Structural heart abnormality, repaired or unrepaired?
- ☐ Brugada Syndrome?
- ☐ Catecholaminergic Ventricular Tachycardia?
- ☐ Marfan Syndrome (aortic rupture)?
- ☐ Heart attack at age 50 or younger?
- ☐ Pacemaker or implanted cardiac defibrillator (ICD)?
- ☐ Known heart abnormalities or sudden death before age 50?
- ☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

If you answered **NO** to ***all*** questions, **STOP**. Sign and date below.
GO to page 3 if you answered **YES** to a question.

☐ Information on this form is NEW information since my child's last health examination.

Parent/Guardian Signature:	Date:

Student Name:	DOB:

If you answered YES to any questions, give details. Sign and date below.

Parent/Guardian Signature:	Date:

Cairo-Durham
CENTRAL SCHOOL DISTRICT

Enrollment Residency Questionnaire

Name of Student: _____
First Middle Last

Grade: _____ Date of Birth: _____ Gender: _____

Address: _____

Phone: _____

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)*

___ In a shelter

___ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")

___ In a hotel/motel

___ In a car, park, bus, train or campsite

___ Other temporary living situation (Please describe):

_____

___ In permanent housing

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

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

_____
Date

If the student is <u>NOT</u> 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. <u>After</u> the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

Cairo-Durham
CENTRAL SCHOOL DISTRICT

Transportation Request

Please check which school your child needs transportation to/from:
Elementary School _X___ Middle School ____ High School____

Student _____ **Date of Birth** _____ **Grade** _____

_____

_____

_____

_____

Parent/Guardian: _____
Home #: _____
Cell #: _____
Work #: _____

Physical Address: _____

Mailing Address: _____

Bus Pick-Up Location: (*Please describe exact street address, color of house, etc.)*

AM Pickup: _____
_____

PM Drop-off: _____
_____

Do you plan to send your student to a babysitter on a regular basis? Yes ___ No ___
(If yes, please provide exact location and weekly schedule on the back of this form.)

Parent/Guardian Signature: _____

For emergency purposes, it is important that the information being requested on this form be returned as soon as possible. If you have any questions or concerns, please contact the Transportation Department at (518) 622-2236.

Office Use Only:
Start Date: _____
Bus Route: _____
AM Pick-Up Time: _____
PM Drop-Off Time: _____

Cairo-Durham
CENTRAL SCHOOL DISTRICT

Student Racial and Ethnic Identification

To Parent/Guardian:

As per Federal Regulations, Cairo-Durham Central School District is required to collect and record the ethnic identity of our students in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and Federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Study the movement of students in different ethnic groups as they move from school to school.
- Analyze differences in academic performance, attendance and completion of school.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions. Check each category which best describes your child. Cairo-Durham CSD understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

Confidentiality Procedures and Regulations:
To School Staff: This form will be filed in the student's permanent record as confidential information.
To Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

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

Name of School: (Please check one)
( ) Cairo-Durham Elementary School ( ) Cairo-Durham Middle School ( ) Cairo-Durham High School

Student Name: _____

Date of Birth: _____ Grade Level: _____

Directions to Parent/Guardian: Please answer questions 1 and 2. Please read them before you respond.

(For question 1, check the box that best describes your child . Check only one box.)

1. **Is the student Hispanic, Latino, or of Spanish origin?** Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.
   ____ **YES, Hispanic** ____ **NO, not Hispanic**

(For question 2, check ALL groups that apply to your child. Check at least one box.)

2. **Select one or more races from the following five racial groups**

_____ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North American and who maintains cultural identification through tribal affiliation or community recognition. e.g. Cherokee, Mohawk, Inuit.
_____ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
_____ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
_____ **BLACK:** A person having origins in any of the black racial groups of Africa.
_____ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Parent/Guardian Signature: _____ Date: _____
Relationship to Student: (Please check one) Mother ___ Father___ Guardian ___ Other___(Specify)_____

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

Elisa Alvarez, Associate 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 Person in Parental Relation:
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.

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*

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?	❑ Parent 1 *specify*	❑ Parent 2 *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:

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

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

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

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

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

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

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

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

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

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

Relationship to student: ❑ Parent ❑ 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 ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Cairo-Durham
CENTRAL SCHOOL DISTRICT

Health Office

Protocol 2025-2026

Medication Administration:

The guidelines for administration of medication in school issued by the NY State Education Dept. requires the following: Medication must be brought to the school by an adult. It may not be transported on the bus by a student. Medication must be in the original container with the student's name and pharmacy label intact. **A written request to administer the medication by a parent is required. A written order from their physician indicating frequency, side effects, dosage, time, and length of time of medication is to be given.** Any over the counter medications, including topically used items, also need parental written consent and a specific physician order to use on a student in school. If a student is found to be carrying medication in a school, prescription or over the counter, it will be taken from him/her and the parent will have to come in and pick it up.

Absences:

If your student is absent, please notify the health office if it is related to illness or injury. Further instructions will be given by the nurse depending on the nature of the illness or injury. All absences should be followed up with a note from home or a doctor's excuse note. If absent 3 or more consecutive days a doctor's note is required.

Gym Excuses:

A written note from a parent will be accepted on two occasions per month. Excuses for more than two days per month must be written by a doctor.

Leaving School Due to Illness:

Keeping your child home from school when they are sick is crucial for preventing the spread of germs and illness. If your student has a fever, is vomiting, or has diarrhea, it is required that they stay home for 24 hours after their temperature has returned to normal without the use of analgesics (Tylenol/Motrin). The same rule applies to vomiting, diarrhea, and the use of antibiotics. They may return 24 hours after their last episode of vomiting or diarrhea. If your student is prescribed antibiotics they are also required to stay home for 24 hours after the medicine is started. If your student gets sick while at school, all early dismissal for illness or injury has to be released via the health office. If your student is sent home for illness they are not permitted to attend any after school hosted activities. The nurse will not give early release passes for students who chose to call their parents independently.

COVID-19:

For COVID Guidelines, please visit the Cairo Durham website or call the health office for the most current guidelines.

Physical Exams:

Upon entry the NYS public health law requires new students, and grades Pre-K, K, 1, 3, 5, 7, 9 and 11 to have a physical on file in the health office. A current physical exam is required for sports participation. A physical is current for 1 year. Parents are encouraged to have this done with their child's pediatrician or family physician. Any student in need of a physical will be expected to have one with the school physician at the time of his visit, if they have not obtained one by their family physician. **Parents need to complete the Interval Health History forms as NY State requirements have changed. If Interval Health History forms are not completed students will be excluded from physical education, sports, playground, and work.** Any physical performed on or after 7/1/21 must be on the Required NYS Health Examination or EHR equivalent form.

Health Office

Protocol 2025-2026

Immunizations:
All immunizations must be up to date for grade level and age. Please review the NYS Immunization Requirements for School Entrance/Attendance with your child's doctor's office. **Students entering: grade 6 require T-Dap vaccination, grade 7 requires first meningococcal and grade 12 require second meningitis immunization.**

Vision/Hearing Screening and Health Referrals: Distance and near acuity screening is required for new entrants and grades Pre K, K, 1,3, 5, 7, and 11. Color screening for all new entrants. This screening is often done at your doctor's office as part of the annual physical exam. If these assessments are missing, the health office will provide these assessments and provide referrals if needed. A copy of the further evaluation is needed for the school health cumulative record.

Scoliosis:
Scoliosis (spinal curvature) screening for students in grade 9, boys only. Grade 5 and 7, girls only. If this assessment is missing, the health office will provide this assessment and provide a referral if needed.

Dental Certificates:
Requested for all newly entering students and students in Grades Pre-K, K,1,3,5,7,9 & 11.

Infectious Diseases: All infectious diseases in a household should be reported to the school nurse. These include but are not limited to:
COVID-19, Measles, German Measles, Strep Throat, Chicken Pox, Mumps, Whooping Cough, Scabies, Head Lice, Scarlatina, Pink Eye, Scarlet Fever, Flu, Impetigo

Health Notes:
It is not the school's policy to provide transportation other than regular bus service. If it is necessary for your child to go home during the day, parents must provide transportation.

If you are a working parent or guardian, the school must know the name and phone number of your place of employment so you can be reached if necessary.

The name and phone number of at least two relatives or friends, who will care for your child if you cannot be reached, must be given to the school. At least one of these individuals must live in the school district.

If your child has suffered an injury requiring medical attention, we need a note from your doctor as soon as possible with the following information:

Type of injury
Limitations of activity (physical education and/or recess)
When he/she can return to activity

It is important that we know of any physical limitations your child might have so we can provide for his/her safety.

Cairo-Durham Central School District
Health Office
Administration of Medication in School

Please check appropriate school:		
(X) C-D Elementary School	( ) C-D Middle School	( ) C-D High School

To be completed by parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication will be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/ her own medication.

_____ _____
Signature of Parent/Guardian Date

Telephone: Cell _____ Work _____

To be completed by the licensed health care prescriber:

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

Name of Student _____ Date of Birth _____

Diagnosis _____

Medication _____

Prescribed Dosage, Frequency and Route of Administration _____

_____

Time to be Taken During School Hours _____

Duration of Treatment _____

Possible Side Effects and Adverse Reactions (if any)

_____

Other Recommendations _____

_____
Name of Licensed Prescriber and Title (Please Print)

_____ _____
Signature of Prescriber Date

Cairo-Durham Central School District
Health Office

BMI Information

Please check appropriate school:		
(X) C-D Elementary School	**( ) C-D Middle School**	**( ) C-D High School**

As part of a required school health examination, a student is weighed and his/her height is measured. These numbers are used to figure out the student's body mass index or "BMI". The BMI helps the doctor or nurse know if the student's weight is in a healthy range or is too high or too low. Recent changes to the New York State Education Law require that BMI and weight status group be included as part of the student's health examination. A sample of school districts will be selected to take part in the survey, we will be reporting to New York State Department of Health. If our school is selected to be a part of the survey, we will be reporting to New York State Department of Health information about our student's weight status groups. Only summary information is sent. No names and no information about individual students are sent. However, you may choose to have your child's information excluded from this survey report.

The information sent to the NYS Dept. of Health will help health officials develop programs that make it easier for children to be healthier.

If you **do not** wish to have your child's weight status group information included as part of the Health Department's survey, please print and sign your name below and return this form to:

Sarah Brown, RN & Bonnie Diamond, RN- Cairo Durham Elementary – 518-622-3231 ext. 37000

Please **DO NOT** include my child's weight status information on the NYS Dept. of Health's 2025-2026 survey.

_____ _____

Print Child's Name Child's Grade/Teacher

_____ _____

Print Parent's Name Parent's Signature

_____

Date

HEALTH OFFICE

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to share protected health Information with the school district, your healthcare provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please sign and give the form to your healthcare provider and/or to your school nurse to avoid delays in the care of your child.

I, _____ authorize my child's healthcare provider(s) listed below to release the medical records of my child _____, Date of Birth _____ to the district's Medical Director ___ School Nurse ___ Athletic Trainer ___ Counselor ___ Occupational Therapist ___ Physical Therapist ___ Psychologist ___ Social Worker ___ Speech Therapist ___ Other _____

Name:_____ Phone:_____ Fax:_____

Name:_____ Phone:_____ Fax:_____

Name:_____ Phone:_____ Fax:_____

Name:_____ Phone:_____ Fax:_____

The healthcare provider may disclose the following protected health information: (Parent/School: Check all that apply)

_____ Immunizations
_____ Health Appraisals
_____ Past/Current Medical Condition and Impact on Attendance, Athletics, School Programing or Therapy
_____ Other

The Protected Health Information may be used, disclosed or received for the following purpose(s): (Parent/School: Check all that apply)

_____ To develop care of 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 surrounding behavior
_____ To assess a medical basis for modification of transportation and/or home tutoring
_____ Medication delivery and/or therapy prescriptions
_____ At patient's request with no specified purpose
_____ Other _____

PARENT/ GUARDIAN: Please select one

_____ This authorization is valid for the entire academic school year 20____ - 20_____.
_____ This authorization is valid for the duration of attendance within the school district.
_____ This authorization shall expire on _____ (month, day, year).

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building. I understand that the revocation of the authorization is not effective if the Healthcare Provider or 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 redisclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those that governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the healthcare provider listed.

_____ _____ _____

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.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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

BMI_____kg/m2

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

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

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

☐ Assessment/Abnormalities Noted/Recommendations: Diagnoses/Problems (list) ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision	**With Correction** ☐ Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/		☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed** – required for Dominick Murray Sudden Cardiac Arrest Prevention Act

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

If Restrictions Apply – Complete the information below

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

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

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

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

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

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

2025-2026 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
All children must be age-appropriately immunized to attend school in NYS. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the "ACIP-Recommended Child and Adolescent Immunization Schedule." Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]	**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses or 2 doses** of **adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9, 10 and 11: 1 dose**	**2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019, and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
   c. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 9: 10 years; minimum age for grades 10, 11, and 12: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2023-2024, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 9; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 10, 11, and 12.
   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a pollovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 10: 10 years; minimum age for grades 11 and 12: 6 weeks).
   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.
   f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. PCV is not required for children 5 years or older.
   f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

Cairo-Durham
CENTRAL SCHOOL DISTRICT

Media Permission Opt-Out

Return this form ONLY if you oppose the following:

As part of the district's efforts to recognize student achievements and share school activities with our community, student directory information such as names and photographs may be used on the district's website, social media pages, school publications, or released to the media. Examples include but are not limited to:

- Honor roll or other recognition lists
- Class projects and activities
- A playbill showing your student's role in a drama production
- Sports activity sheets and rosters

Cairo-Durham CSD has designated and historically released the following directory information when appropriate to highlight student accomplishments and educational programs:

- Student's name
- Grade level
- Photograph
- Courses of study

If you **DO NOT** want your child's photo, name, etc. published, please sign this form and return it to the school's main office. If it is acceptable for the district to publish your child's photo, name, etc. to share student achievements or school activities, no response is necessary.

_____ I do **NOT** give permission for my child _____, to have his/her **photograph** published for educational and/or educationally-related purposes.

_____ I do **NOT** give permission for my child, _____, to have his/her **name** published for educational and/or educationally-related purposes.

Building (check one): ____ Elementary School ____ Middle School ____ High School

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Cairo-Durham
CENTRAL SCHOOL DISTRICT

Student Computer Take-Home Agreement

As part of your student's education, Cairo-Durham Central School District is providing a laptop computer for his/her individual use. Like a textbook, this computer is purchased by the district and remains the property of the district.

The computer will be assigned at the start of the school year, collected at the end of the year and returned to your student (or replaced) at the beginning of the following school year. In some cases, the computer may also be borrowed during the summer.

While some wear-and-tear is reasonable and expected, the laptop must be returned in good working order. If the equipment is not returned or if it has been damaged, the district may bill the family. See below for additional details.

Please note that the equipment remains the property of the school district. If the student graduates or transfers to another school, the equipment must be returned. Failure to do so may result in the equipment being reported as stolen.

When Damage or Loss Occurs

If accidental damage, loss or theft occurs, it must be reported to the Information Technology Department (I.T.) as soon as possible. Arrangements will be made to get the device repaired or replaced as quickly as possible so that no learning time is lost.

Technical Support

The I.T. Department can be contacted by any of these methods:

- Email help@cairodurham.org
- Call (518) 622-8543, extension 59500
- Ask the school office and/or a teacher to assist

Intentional Damage/Continual Damage:

If damage is done intentionally or continual accidental damage occurs the student will be given an older device to use at the discretion of the IT department and the School Administration. All damage is tracked per student and continued damage may result in loss of computer use privileges or take-home privileges. Such damage may also result in students not having the same model as classmates. Device may be removed at the discretion of the School Administrator for behavior issues or damage and the student may face disciplinary consequences.

Lost Devices

The district has tools for recovering devices which are lost or stolen. If a device is reported as lost, the district will activate these tools and work with law enforcement officials to recover the device. If it us recovered, the family will not be charged. **If your student 's device is missing, please report it to the school as soon as you know.**

Parent/Guardian: (Print) (Sign) (Date)

Student: (Print) (Sign) (Date)

Cairo-Durham
CENTRAL SCHOOL DISTRICT

Authorization for Release of Information

Cairo-Durham Central School District
Fax: 518.622.9060
jcleary@cairodurham.org

This student has registered in our school district. Please send all records including:

- Academic Records (Including Standardized Test Scores, Transcripts, Report Cards)
- Health Records
- Attendance, Suspension & Discipline Records
- Individualized Education Plan or 504 Plan
- CSE/Psychological Records
- Birth Certificate
- Custody Information
- Science Required Investigations (Grades 3-8)

Student: _____

Grade: _____ Date of Birth: _____

Previous School: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I hereby grant permission for the release of the requested records:

_____ _____
Signature of Parent/Guardian **Date**

Please send records to:

Cairo-Durham Elementary School PO Box 1090 424 Main Street Cairo, NY 12413 Phone: 518-622-3231 **Fax: 518-622-9060**	**Cairo-Durham Middle School** PO Box 1139 1301 Rt. 145 Cairo, NY 12413 Phone: 518-622-0490 **Fax: 518-622-8856**	**Cairo-Durham High School** PO Box 598 1301 Rt. 145 Cairo, NY 12413 Phone: 518-622-8543 **Fax: 518-622-8856**

In accordance with the Family Education Rights and Privacy Act, this is authorization to release a copy of student records, including complete transcripts of the school record, standardized test results, health records and psychological reports.

(For Cairo-Durham Elementary Students ONLY)

Field Trip Information

Several times during the course of the school year, classes arrange for approved field trips to coincide with the academic curriculum, which necessitates transporting students to and from the district. Other student groups such as the student council, chorus and band have occasion to leave the building for rehearsals or other student activities.

We are requesting that parents sign and return this permission slip at the beginning of the school year to cover all trips away from the district during the year. We will, of course, notify you in advance of any activity which would involve transporting your child from the building.

Several times in the past children have not been permitted to accompany their class on a field trip simply because they "forgot" their permission slip and we were unable to contact the parents. Having a permission slip on file for each student would eliminate last minute confusion and disappointment. If at any time you did not want your child to participate in a field trip, you need only notify the school in writing.

FIELD TRIPS

Student's Legal Name _____

Grade/Teacher _____

I hereby give permission for my child to attend approved field trips and student activities requiring transportation from the Cairo-Durham Central School District.

( ) Yes ( ) No

_____ _____

Parent/Guardian's Signature Date

Cairo-Durham School District

SCHOOLTOOL PARENT PORTAL

Dear Cairo-Durham Families,

Our school district student database system is called "Schooltool". Parents/guardians will be able to access their child/children's information such as contact information, grades, attendance and discipline records all on-line via our "Parent Portal."

You must have an e-mail address to set up your account. Please fill out the following form and return to school so your account can be created. (Please use one form per person requesting access to the parent portal.) Please see the "Parent Portal Tutorial" for a reference guide. This document can be found on our website: cairodurham.org

Cairo-Durham

Central School District

PARENT PORTAL ACCESS FORM

Information request for Parent Portal Access

Please use one (1) form per parent requesting access to Parent Portal

Please use this form to amend an e-mail address for any contact with Parent Portal access as this information will affect log-in status.

Name of Parent/Guardian requesting access: _____

Name(s) of Student(s): _____

Relationship to Individual(s): _____

Email address to be used for Parent Portal access: _____ @ _____

NOTE:

- This form must be completed in its entirety and returned to the school in order for access to the parent portal to be granted.
- Without a Parent/Guardian signature below, NO authorization to the parent portal will be granted.

PARENTAL AUTHORIZATION TO ADD PORTAL ACCESS

Parent/Guardian SIGNATURE: _____ Date: _____

PRINT Parent/Guardian name: _____

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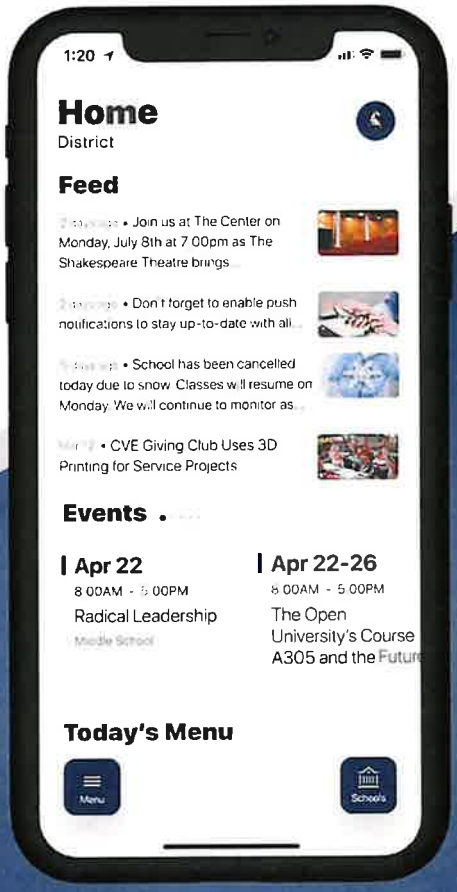

Cairo-Durham CSD

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