Welcome to
Lyndonville Central School
Guidance/Registrar's Office
585-765-3157
585-765-2106 FAX

Registration of Students

Please bring these items when you come in to register:

1. The child's original birth certificate or a certified copy.

2. A copy of a completed immunization record & a physical within the last year.

3. Parent/Guardian Picture Identification (such as a driver's license).

4. Proof of Residency: Driver's license, utility bill – gas, electric, or water, notarized landlord statement, mortgage deed, change of address document from DSS.

5. Proof of custody: Court documents if parents are not married, separated or divorced which must reflect joint custody with residential custody being with the registering parent or full custody being with registering parent/guardian), Legal Guardianship document, DSS-2999 Form if in foster care.

If you have any questions, please call Kim Bow at the above number.

As a parent (guardian), you have the right to refer your child for special education evaluation, and programs and services.
Please see A Parent's Guide to Special Education at the NYSED website:*http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm*,
or contact Mrs. Anne Marie Holland, Director of Special Programs and CSE/CPSE Chairperson, at (585) 765-3107.

Lyndonville Central School

Housel Avenue, P.O. Box 540
Lyndonville, NY 14098
Tel (585) 765-3157
Fax (585) 765-2106

Jeff Kingsbury
Counselor for 9-12

Kimberly Nealon
Counselor PK-8

Date:

RECORDS RELEASE:
The following student is presently enrolled at Lyndonville Central School

Name _____

Grade _____

D.O.B. _____

Please send the following information by email or fax to the number and email address below:

Withdrawal date/grades	**Official transcript of grades**	Key to your grading system
Achievement/Ability Test results	Psychological reports	**IEP/Phase I & II**
Special services information	**Complete health records**	Attendance record
NYS Assessment Scores	Discipline Record	AIS Plan

Lyndonville Central School
Guidance Office
Housel Avenue, PO Box 540
Lyndonville, NY 14098
ATTN: KIM BOW
kbow@lcsdk12.org
Fax: 585-765-2106

Name and address of school that records are requested from:

_____

_____

_____

Lyndonville Central School District – Registrar's Office
25 Housel Ave., P.O. Box 540
Lyndonville, NY 14098
(585) 765-3157 – Phone (585) 765-2106 - Fax

LYNDONVILLE CENTRAL SCHOOL DISTRICT REGISTRATION FORM

Please PRINT all information and complete BOTH sides of this form

Student Name: _____ Male: _____ Female: _____

Physical Address: _____ Apt. #: _____ Zip: _____

Mailing Address(if different from physical): _____ P.O. Box: _____

Phone: Household _____ Cell _____ D.O.B.: _____ Grade: _____ Age: _____

Ethnicity (circle all that apply):

White Black Hispanic American Indian/Alaskan Native Asian (Far East, Southeast Asia or Indian sub-continent) Native Hawaiian/Pacific Islander (Hawaii, Guam, Samoa)

Parent/Guardian Information (lives in household with child)

1. Name: _____ Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐

Address: _____

Phone Numbers: Home Phone: _____ Work Phone: _____ Cell: _____

Email Address: _____ Relationship to Student: Mother ☐ Father ☐ Step-Parent ☐

Permission to pick up student ☐ **Yes** ☐ **No** Other – Please Explain: _____

2. Name: _____ Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐

Address: _____

Phone Numbers: Home Phone: _____ Work Phone: _____ Cell: _____

Email Address: _____ Relationship to Student: Mother ☐ Father ☐ Step-Parent ☐

Permission to pick up student ☐ **Yes** ☐ **No** Other – Please Explain: _____

Parent/Guardian who <u>does NOT</u> live with child but will receive mailings:

Name: _____ Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐

Address: _____

Phone Numbers: Home Phone: _____ Work Phone: _____ Cell: _____

Email Address: _____ Relationship to Student: Mother ☐ Father ☐ Step-Parent ☐

Permission to pick up student ☐ **Yes** ☐ **No** Other – Please Explain: _____

Brothers and Sisters (Birth Age to 21)

Name – Last, First	M/F	DOB	Grade	Lives at Home Y or N

Emergency Contact – OTHER THAN PARENT

Name	Relationship to Student/Permission to Pick Up	Day Phone Number
	Yes No	
	Yes No	
	Yes No	

School History

Name of Last School Attended: _____

Address of School: _____

Has student ever repeated a grade? Yes_____ No _____ If yes, which grade? _____

What year did your child enter Grade 9?: _____ Has student ever attended Lyndonville Schools?: Yes _____ No _____

What language is spoken in the student's home? English _____ Other: _____

What is the student's COUNTRY of birth: _____

Is the student an immigrant? Yes _____ No _____ (if yes, what did did he/she enter the U.S.) _____

Has the student been classified by the Committee of Special Education (have an IEP?) Yes _____ No _____

Is the student currently receiving and special education services? Yes _____ No _____

Please circle any special program that your child has been assigned:

504 Plan Consultant Services Resource Room Remedial (AIS) Special Classes (Self-Contained)

Occupational Therapy Physical Therapy Speech Therapy Counseling ESL Services

Other (please explain): _____

As a parent (guardian), you have the right to refer your child for special education evaluation, and programs and services. Please see A Parent's Guide to Special Education at the NYSED website: http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm, or contact Mrs. Anne Marie Holland, Director of Special Programs and CSE/CPSE Chairperson, at (585) 765-3107

SIGN HERE PLEASE! 

Parent/Guardian: _____ Date: _____

Signature

Lyndonville Central School District

STUDENT RACIAL AND ETHNIC IDENTIFICATION

FORM **SREI**

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.

English Only

Name of School: **Lyndonville Primary, Elementary & Intermediate School (PK-6)**
L.A. Webber Middle-High School (7-12)

School District Student Identification Number: 332-940

Date of Birth (Month/Day/Year): / /

Student Name: Last, First, Middle:

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**

2. Select one **or more races from the following five racial groups.**
If you select "Multiracial" you must select at least two choices from this list.

☐ **AMERICAN INDIAN OR ALASKA NATIVE**: A person having origins in any of the original peoples of North America 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

☐ **MULTIRACIAL**

Signature of Parent/Guardian/Other _____ Date _____

Relationship to Student (please check one box below):

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify): _____

See reverse for important message to Parents/Guardians and Confidentiality Procedures and Regulations.

Lyndonville Central School District

FORM **SREI**

SAMPLE SCHOOL DISTRICT
STUDENT RACIAL AND ETHNIC IDENTIFICATION

To the Parent/Guardian: The *SAMPLE SCHOOL DISTRICT* has adopted a policy which requires the collection and recording of the ethnic identity of students in the *SAMPLE SCHOOL DISTRICT* 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 on the back of this page. Put a check (√) in the box for the category or categories which best describe your child. The *SAMPLE SCHOOL DISTRICT* 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 the 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

Please complete the form on the reverse side of this page

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

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

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

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

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:
❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

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

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

SCHOOL DISTRICT INFORMATION:

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: ❑ **Mother** ❑ **Father** ❑ **Other:** _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

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

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

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

****DATE OF INDIVIDUAL INTERVIEW:** _____ (MO / DAY / YR.)

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

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. / DAY / YR.)

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

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

Lyndonville Central School District
CUSTODY DISCLOSURE FORM

The District Registration Office is responsible for registration, **not** in determining which parent or guardian may check a child in/out of school etc. If custodial or guardianship issues exist when you register your child in the Lyndonville Central School District, it is your responsibility to provide custodial documentation to the Registration Office and a copy will be forwarded to your child's counseling office. **NOTE:** A current legal court document must be provided to ensure compliance with custody orders.

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

Information of Rights of Parents from the Family Education Rights and Privacy Act (FERPA)

An educational agency or institution shall give full rights under the Act to either parent, unless the agency or institution has been provided with evidence that there is a court order, State statute, or legally binding document relating to such matters as divorce, separation, or custody that specifically revokes the rights. (Authority: 20 U.S.C. 1232g)

Please check the current custody/guardianship arrangement (check all that apply):

- ☐ Parents/Guardians are together residing in the same residence
- ☐ Single parent (father and mother **ARE** listed on the birth certificate
- ☐ Single parent (father **IS NOT** listed on the birth certificate
- ☐ Parents/Guardians divorced/separated – joint custody
- ☐ Parents/Guardians divorced/separated – sole custody
- ☐ Parents have never been married and have no legal custody papers
- ☐ Parent is remarried with a step-parent in the house
- ☐ Custody/Guardianship is transferred by the courts to _____
- ☐ Custody/Guardianship is transferred by District Notarized Affidavit to _____
- ☐ Restricted Pickup (legal documentation must be provided) _____

Child's Primary residence is with _____

Please check all that apply:

- ☐ I have disclosed my current custody/guardianship arrangement.
- ☐ I have attached a copy of those pages of the legal documents that describe custody arrangements.
- ☐ I understand that it is my responsibility to update my child's school counseling office secretary of changes in custody.

Student Name (please print): _____

_____

Signature of Parent/Guardian Date

LYNDONVILLE CENTRAL SCHOOL HOUSING/RESIDENCY QUESTIONNAIRE

Name of LEA: Lyndonville Central School District

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female

Date of Birth: _____/_____/_____
Month Day Year

Grade: _____

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 as residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

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

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "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

LYNDONVILLE CENTRAL SCHOOL DISTRICT

Student Health Services Information

Parent/Guardian: Please complete and sign the information below

STUDENT'S NAME: _____ Grade: _____

DATE OF BIRTH: _____ SEX: M___ F____

PHYSICIAN'S NAME: _____ PHONE #: _____

DENTIST'S NAME: _____ PHONE#: _____

Does This Student:

Have an ALLERGY to bee, wasp, or insect stings, medication or foods? Yes___No_____
Need medication for his or her reaction? EXPLAIN: _____

_____

Have ASTHMA or Reactive Airway Disease? Yes___No_____
Use an inhaler? If yes, name of inhaler _____
Have a history of shortness of breath while exercising? Yes_____No_____
Have a history of fainting, dizziness, heat intolerance or seizure disorder? Yes___No_____
Have any serious disease, injury to, loss or absence of an organ? Yes___No_____
Have any disability or chronic conditions? Yes___No_____
Have Diabetes? Yes___No_____
Have a history of heart problems, murmurs, extra beats or high blood pressure? Yes___No_____
If you answered yes to any of the above questions please explain:_____

_____

_____

(a clearance letter from the treating physician MAY be required)

Is this student currently taking any medication? Yes___No_____
If yes, please list and include dose: _____

_____

If student requires any medicine at school, please obtain the appropriate form from the Health Office.

Other health information or concerns? _____

_____

_____

SIGN HERE

_____

Parent/Guardian Signature Daytime Phone Number Date

It is the parent's responsibility to notify the bus garage/driver of any medical conditions your child has.

LYNDONVILLE CENTRAL SCHOOL DISTRICT

PHYSICAL EXAMINATION/HEALTH APPRAISAL

Dear Parent/Guardian:

Physical examinations are required by the Lyndonville Central School District according to the New York State School Health Law (Section 903). The following students are required to have a physical examination:

- All new entrants to the district, regardless of grade level
- Students in Grade Pre-K, K, 2, 4, 7, 10
- Special Education students are required to have a physical examination every three years
- Sports and working permits

A Health Appraisal Form is available if the examination is to be given by your Primary Health Care Provider. This form should be **submitted within 30 days after the student's entrance** and is valid for one year through the last day of the month of the date on the health certificate.

Please inform us if your child has had an exam, or if an appointment is scheduled with your Health Care Provider for a physical examination by completing and returning this form.

NOTE: If a required health certificate is not submitted, your child will be scheduled to have an in-school physical. You may contact the health office personnel at (585) 765-3124 if you have any questions or concerns. Thank you.

Please check the appropriate box below, sign your name, and return this completed form to your child's school Health Office personnel.

☐ I have already submitted an examination form from my child's Health Care Provider.
Exam was given on _____(date) by _____(name).

☐ My child is scheduled for a physical examination by our Health Care Provider on _____(date) by _____(name). I will return the completed physical exam health form ASAP.

☐ My child may receive a school physical examination by the School Physician.

_____

Student Name (please print) Grade Teacher

_____

Parent/Guardian Name (please print)

_____

Parent/Guardian Signature Date

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

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

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

STUDENT INFORMATION

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

HEALTH HISTORY

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

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

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

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

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

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

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

PHYSICAL EXAMINATION/ASSESSMENT

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

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

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

☐ **System Review and Exam Entirely Normal**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:	DOB:

SCREENINGS

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

Recommendations:

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

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

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

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

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

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

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

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

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

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

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

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

HEALTH CARE PROVIDER

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

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

Lyndonville Central Schools Health Office

585-765-3124
585-765-3190 (fax)

NEW INFORMATION PLEASE READ

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 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 school health examination. A sample of school districts will be selected to take part in a survey by the New York State Department of Health. If our school is selected to be part of the survey, we will be reporting to New York State Department of Health about our students' 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 summary report.

The information sent to New York State Department 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 this year, please print and sign your name below and return this form to:

Lyndonville Central School District
25 Housel Ave.
Lyndonville, NY 14098
ATTN: HEALTH OFFICE

Please do **NOT** include my child's weight status information in the school survey.

If you don't have a preference, please disregard this form.

Print Child's Name _____ Date _____

Print Parent's Name _____ Parent's Signature _____

IMPORTANT NOTICE TO PARENTS/PERSONS IN PARENTAL RELATION 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 a life-threatening health condition please immediately contact the School Health Office/School Office for a "Life-threatening Health Condition Packet" which includes the following:

[ ] Student Emergency Care Plan for the student's specific health condition;

[ ] Authorization for Administration of Medication in School;

[ ] Self-Medication Release Form.

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.

Reminder:

It is the parent/person in parental relation's responsibility to alert other school programs that their child has a health condition and/or a care plan in place.

Please report immediately any changes needed in emergency contact information, medication, health status, etc. to the School Office.

If you have any questions or concerns, please contact the Principal or the School Nurse assigned to your child's school.

Thank you for your assistance in helping us to provide a safe school experience for your child.

This form should be given to all parents/persons in parental relation at the time of registration or when school staff is notified that a student has a life-threatening health condition.