



## Byron-Bergen Central School District Student Registration

6917 W. Bergen Road, Bergen, NY 14416

Phone: (585) 494-1220 ext. 2229

Fax: (585) 494-2613

# Registration Procedures for New Students

*Welcome to the Byron-Bergen Central School District*

**For Students in 1st - 12th Grade:** Parent/Guardian completes registration in the District Office.

**For Students in Universal PreKindergarten (UPK) or Kindergarten:** Parent/Guardian completes registration in the Elementary School Office.

In order to complete the registration process, the District requests the following information:

- **Completed Registration Forms**

Complete the following pages or register online using link below:

<https://edutech.schooltool.com/ByronBergen/onlinepreregistration/>

- **Proof of a Student's Address**

Some examples include a lease or mortgage statement, recent utility bill, bank statement, or pay stub. Please contact the registration office for other examples of acceptable proof.

- **Documentation of Student's Age**

Some examples include an original birth certificate, record of baptism, or passport. Please contact the registration office for other examples of acceptable proof.

- **Record of Student Immunizations, Health Records, Dental Exam**

- **Custody / Guardianship / Adoption documents, if applicable**

**Contact the registration office at (585) 494-1220 ext. 2229 if you have any questions.**

These documents have been revised to comply with the Amendment of the Regulations of the Commissioner of Education (Subdivision (y) of section 100.2) as adopted by the Board of Regents on December 16, 2014.

Complaints concerning enrollment and registration can be submitted to the OAG by mail to 120 Broadway, 23<sup>rd</sup> Floor, New York, NY 10271, by phone to (212) 416-8250, or by email to [civil.rights@ag.ny.gov](mailto:civil.rights@ag.ny.gov).

# Committee on Preschool Special Education Referral Form

Date of Referral to CPSE:

Child's Date of Birth:

Child's Name:

Names of Parents/Legal Guardians:

Home Address:

Mailing Address (If different from home):

Phone Number:

Email Address:

Attends Preschool/Daycare? (Circle one)      Yes                      No

If yes-

Name of Program:

Location:

Days/Hours Attended:

Please circle any areas of concern you have about your child:

Motor

Cognitive

Language/Communication

Adaptive

Social Emotional/Behavioral

Physical

Please see back



This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.



# Byron-Bergen Central School District Central Registration Office

6917 West Bergen Road, Bergen, NY 14416  
Phone (585) 494-1220 Fax (585) 494-2613  
Email: [aorologio@bbschools.org](mailto:aorologio@bbschools.org) or [kbrown@bbschools.org](mailto:kbrown@bbschools.org)

## **AUTHORIZATION FOR RELEASE OF INFORMATION**

*(Please fax, mail, or email the student records to the address above)*

Date: \_\_\_\_\_

\_\_\_\_\_  
*(Name of school student(s) will be transferring from)*

\_\_\_\_\_  
*(Address)*

\_\_\_\_\_  
*(City, State, Zip)*

\_\_\_\_\_  
*(Phone Number)*

\_\_\_\_\_  
*(Fax)*

\_\_\_\_\_  
*(Email)*

**I/we authorize the release/exchange of information between the above agency and the Byron-Bergen Central School District for the following student(s):**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

**Please send the following records:**

- ☐ **Permanent Record Information and Home Language Questionnaire**  
*Including, but not limited to, birth certificate, social security # (optional), most recent report card, all standardized testing, any state testing, high school transcript.*

☐ **Health Record Information**  
*Including, but not limited to, Hepatitis B verification, most recent immunizations, last physical exam.*

☐ **Confidential Reports**  
*Including, but not limited to, CPSE/CSE records, 504 records, psychological testing, related service (OT, PT, Speech).*

\_\_\_\_\_  
*Signature of Parent/Legal Guardian*

\_\_\_\_\_  
*Date*

Relationship to Student (please check): ☐ Mother ☐ Father ☐ Guardian ☐ Other (specify): \_\_\_\_\_

\_\_\_\_\_  
*Signature of Witness/Requesting Officer*, Residency Clerk

\_\_\_\_\_  
*Date*



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## ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

<b>Name of LEA:</b>	Byron-Bergen Central School District		
<b>Name of School:</b>			
<b>Name of Student:</b>			
<b>Date of Birth:</b>			
<b>Grade:</b>			
<b>Gender:</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Non-Binary
<b>Student Address:</b>			

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

- ☐ In permanent housing
- ☐ 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:

--

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

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

---

**Date**



# Byron-Bergen Central School District

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## STUDENT REGISTRATION INFORMATION

**Student:** \_\_\_\_\_  
Last Name First Name Middle

**Birthdate:** \_\_\_\_\_ ☐ Male ☐ Female ☐ Non-Binary

<b>Student resides with:</b>	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Stepmother	<input type="checkbox"/> Stepfather
	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Group Home	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Other
<i>If checked other, please specify:</i> _____				

### PRIMARY - Parent/Legal Guardian #1

**Name:** \_\_\_\_\_  
Last Name First Name Middle

☐ Male ☐ Female ☐ Non-Binary ☐ Not Specified -- ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.

<b>Relationship to Student:</b>	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Stepmother	<input type="checkbox"/> Stepfather
	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Group Home	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Other
<i>If checked other, please specify:</i> _____				

Physical Address: \_\_\_\_\_ County: \_\_\_\_\_

Mailing Address (if different from physical address): \_\_\_\_\_

Telephone Numbers: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ (Work Phone) \_\_\_\_\_

## Parent/Legal Guardian #2

**Name:** \_\_\_\_\_  
Last Name First Name Middle

☐ Male    ☐ Female    ☐ Non-Binary    ☐ Not Specified    --    ☐ Mr.    ☐ Mrs.    ☐ Ms.    ☐ Miss    ☐ Dr.

**Relationship to Student:**

☐ Mother☐ Father☐ Stepmother☐ Stepfather☐ Foster Parent☐ Group Home☐ Legal Guardian☐ Other

If checked other, please specify: \_\_\_\_\_

Physical Address: \_\_\_\_\_ County: \_\_\_\_\_

Mailing Address (if different from physical address): \_\_\_\_\_

Telephone Numbers: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ (Work Phone) \_\_\_\_\_

**Please list child's sisters, brothers, and other persons living in the home:**

[illegible]

## EMERGENCY INFORMATION:

In the event of an emergency and the parent or guardian cannot be reached, I authorize the transport of my child to the nearest Emergency First Aid Station by ambulance, if necessary. I realize that the school district cannot assume responsibility for the payment of medical fees or expenses incurred. I authorize the School Nurse to obtain immunization, physical examination, injury, and/or illness information from my child's physician.

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**Signature of Parent/Guardian**

**Date**

*If necessary, I authorize the school to call:*

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*Child's Physician*

*Phone #*

**Preferred Hospital:** \_\_\_\_\_

**Child's Dentist:** \_\_\_\_\_

*Name*

*Phone #*

## EMERGENCY CONTACT NAME and INFORMATION:

If my child has to be taken home because of a minor illness and the parent or guardian cannot be reached, an emergency contact will be called. Please indicate emergency contacts below:

1. \_\_\_\_\_

<i>Name</i>	<i>Relationship to Student</i>	<i>Phone Number</i>
	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Not Specified	

2. \_\_\_\_\_

<i>Name</i>	<i>Relationship to Student</i>	<i>Phone Number</i>
	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Not Specified	

3. \_\_\_\_\_

<i>Name</i>	<i>Relationship to Student</i>	<i>Phone Number</i>
	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Not Specified	

4. \_\_\_\_\_

<i>Name</i>	<i>Relationship to Student</i>	<i>Phone Number</i>
	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Not Specified	



**NOTIFICATIONS (Phone, Email and Text Messaging):**

The Byron-Bergen Central School District uses the ParentSquare messaging system to contact families to notify them of school closings, emergency notifications, and event reminders. In the spaces below, please provide the name of phone numbers you would like to receive the notifications:

	Name	Phone Number	Email
1			
2			
3			

**MEDIA RELEASE:**

Throughout the year, district staff write feature articles and/or news stories on the students, staff, and/or programs within our district. It is not unusual for photographs and/or video clips of our students to accompany these articles and may be included in printed newsletters, eNewsletters, website features, or social media.

For your child's safety, minors' full names do not accompany photographs on the website or social media. Exceptions include announcing the valedictorian/salutatorian and are not posted without specific parent/guardian permission.

I give permission for my child, \_\_\_\_\_, to be interviewed, photographed, and/or videotaped by faculty, staff, outside new media representatives for press or media purposes as indicated above.

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**Parent/Guardian** (Print Name)

**Parent/Guardian Sign**

***\*If opting out, please fill out a Media DO NOT release form available in the District Office.***

**I attest that the information completed by me on this form is current, true, and accurate.**

**Signature of Parent/Guardian:** \_\_\_\_\_

Date: \_\_\_\_\_



# Byron-Bergen Central School District

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## CUSTODY DISCLOSURE FORM

The Registration Office is responsible for registration, **not** 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 Byron-Bergen 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 school principal.

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

#### Information of Rights of Parent 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 these rights**.  
(Authority: 20 U.S.C. 1232g)

#### Student Legal Name:

\_\_\_\_\_

Last Name

\_\_\_\_\_

First Name

\_\_\_\_\_

Middle

#### Please check the current custody/guardianship arrangement:

- ☐ Parents/Guardians are together residing at the same residence
- ☐ Single parent (father and mother **ARE** listed on the birth certificate)
- ☐ Single parent (i.e. 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 no legal custody papers
- ☐ Custody/Guardianship is transferred by courts
- ☐ Restricted pickup (**legal documentation must be provided**)
- ☐ Student is **emancipated** – (**legal documentation must be provided**)

#### Please check all that apply:

- ☐ I have disclosed my current custody/guardianship arrangement
- ☐ I have attached a copy of those pages of the legal current court documents that describe custody arrangements
- ☐ No legal documents that describe custody arrangements exist

***I understand that it is my responsibility to update my child's school of changes in custody.***

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_



## Byron-Bergen Central School District

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### Student Racial and Ethnic Identification

**To the Parent/Guardian:** The BYRON-BERGEN CENTRAL SCHOOL DISTRICT has an Administrative Regulation which requires the collection and recording of the ethnic identity of students in the BYRON-BERGEN CENTRAL 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 describes your child.

The BYRON-BERGEN CENTRAL 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.*



# Byron-Bergen Central School District

## Student Racial and Ethnic Identification

*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.*

<b>Byron-Bergen Central School</b> (please check):	
<input type="checkbox"/> ELEMENTARY SCHOOL (UPK - 5th Grade)	<input type="checkbox"/> JR/SR HIGH SCHOOL (6th - 12th Grade)
<b>Student Name (Last, First, Middle):</b>	<b>Date of Birth (Month/Day/Year):</b> / /
<b>School District Student Identification Number:</b>	<b>Grade Level:</b>

### PLEASE ANSWER THE FOLLOWING QUESTIONS:

#### 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

For this question, Check (✓) only ONE box. Check (✓) the box that best describes your child.

☐ Yes, Hispanic

☐ No, not Hispanic

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

For this question, check (✓) all groups that apply to your child. Please check (✓) at least ONE box.

- ☐ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North and South America (including Central America) who maintains cultural identification through tribal affiliation or community recognition.
- ☐ **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 OR AFRICAN AMERICAN:** 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.

\_\_\_\_\_  
Signature of Parent/Guardian

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



**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.*

<b>STUDENT NAME:</b>		
First	Middle	Last
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
		<input type="checkbox"/> Male
Month	Day	Year
<input type="checkbox"/> Female		
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	<input type="checkbox"/> Parent 2	_____
	<input type="checkbox"/> Guardian(s)		_____
			specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak
			specify
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
			specify
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write
			specify

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

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT  
INFORMATION SYSTEM:

District Name (Number) & School:

Address:

## Home Language Questionnaire (HLQ)—Page Two

### Educational History

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

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

Yes\*    No    Not sure

☐    ☐    ☐    \*If yes, please explain: \_\_\_\_\_

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

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

10b. **\*If referred for an evaluation**, has your child ever **received** any special education services in the past?

☐ No    ☐ Yes – Type of services received: \_\_\_\_\_

Age at which services received (Please check all that apply):

☐ Birth to 3 years (Early Intervention)    ☐ 3 to 5 years (Special Education)    ☐ 6 years or older (Special Education)

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

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

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

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

Month:    Day:    Year:

\_\_\_\_\_  
Date

Relationship to student: ☐ 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:



# Byron-Bergen Central School District

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## STUDENT HEALTH HISTORY

<b>Name of Student:</b>			
<b>Date of Birth:</b>			
<b>Grade:</b>			
<b>Sex Assigned at Birth:</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
<b>Gender Identity:</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Non-Binary
<b>Parent/Guardian</b> <i>(person completing the form):</i>			
<b>Phone:</b>	Home Phone:		Cell Phone:

Has your child ever:	Yes	No	If yes, please explain and include date:
Had an ongoing medical condition	<input type="checkbox"/>	<input type="checkbox"/>	
Seen a medical specialist	<input type="checkbox"/>	<input type="checkbox"/>	
Had allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other: _____
Been hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	
Had an operation	<input type="checkbox"/>	<input type="checkbox"/>	
Had an injury requiring a visit to the Emergency Room	<input type="checkbox"/>	<input type="checkbox"/>	
Missed more than 5 days of school in a row due to illness/injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a bone/muscle injury	<input type="checkbox"/>	<input type="checkbox"/>	
Passed out and had a concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a convulsion/seizure	<input type="checkbox"/>	<input type="checkbox"/>	
Had a vision problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	
Had a hearing problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	
Worn dental bridge, braces or mouthpiece	<input type="checkbox"/>	<input type="checkbox"/>	

**Check all that apply to your child:**

<input type="checkbox"/> ADHD	<input type="checkbox"/> GI Conditions ( <i>Ulcer, reflux, IBS</i> )	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Asthma/trouble breathing	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Single Organ <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
<input type="checkbox"/> Autism/Asperger	<input type="checkbox"/> Heart Conditions	
<input type="checkbox"/> Dental Injuries	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental Health Condition ( <i>depression, eating disorder, anxiety, OCD, ODD, etc</i> )	<input type="checkbox"/> Speech Condition
<input type="checkbox"/> Ear Infections		<input type="checkbox"/> Urinary Condition
<p><i>Please use this space to elaborate or share additional information:</i></p>		

Current Medications	Yes	No	Please list name, dose, time(s)
To be given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
Assistive Equipment	Yes	No	Please check all that apply:
During or Outside of School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other: _____
Treatments	Yes	No	
During or Outside of School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Insulin/Blood Glucose Monitoring <input type="checkbox"/> Inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> Special Diet <input type="checkbox"/> Other: _____

**Is there any condition that would prevent your child from participating in physical education or sports?**

☐ No      ☐ Yes    *Please explain:* \_\_\_\_\_

**Please list any additional concerns:** \_\_\_\_\_

\_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_