**Byron-Bergen Central School District**
**Central Student Registration**
6917 W. Bergen Rd., Bergen, NY 14416
Phone (585) 494-1220 ext. 2229
Fax (585) 494-2613

# Registration Procedures for New Students
## Grades 1-5

Welcome to the Byron-Bergen Central School District. Parents/legal guardians will register all school-aged children in Central Registration (located in the District Office).
In addition to the forms that follow this cover page, the District requests the following information:

**Proof of a Student's Address** (*fill out the Residency Questionnaire on pg. 2*)
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 Age**
Some examples include an original birth certificate, record of baptism, passport. Please contact the registration office for other examples of acceptable proof.

**Record of Immunization and Health Records**

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

**Contact the registration office at (585) 494-1220 ext. 2229 if you have any questions.**
Office hours: 7:30 a.m. to 3:30 p.m. (M-Th) and 7:30 a.m. to 3:00 p.m. (F)
*Summer hours: 7:30 a.m. to 1:30 p.m. (M-Th) and 7:30 a.m. to 1:00 p.m. (F)*

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, 23rd Floor, New York, NY 10271, by phone to (212) 416-8250, or by email to civil.rights@ag.ny.gov.

**Byron-Bergen Central School District**
**6917 W. Bergen Rd., Bergen, NY 14416**
**Phone (585) 494-1220**
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## ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: Byron-Bergen Central School District

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____ /____ /____ Grade: ____ ID#: _____
*Month Day Year (preschool-12) (optional)*

Current Address: _____ Phone: _____

The answer you give below will help the District determine what services your child may be able to receive under the McKinney-Vento Act.

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

☐ In permanent housing

Temporary living situation:

☐ 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): _____

Address resided at during loss of housing _____

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

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

_____**Date**

# Byron-Bergen Central School District

**6917 W. Bergen Rd., Bergen, NY 14416**
**Phone (585) 494-1220 Fax (585) 494-2613**

## 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.*

**Please complete this form and return the form to the Main Office.**

# Byron-Bergen Central School District

**6917 W. Bergen Rd., Bergen, NY 14416**
**Phone (585) 494-1220 Fax (585) 494-2613**

## 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.

**Byron-Bergen Central School (please check):**

☐ ELEMENTARY SCHOOL (Pre-K-6) ☐ JR. HIGH SCHOOL (7-8) ☐ SR.HIGH SCHOOL (9-12)

| **School District Student Identification Number:** | **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.**
   For question (2) check (✓) all groups that apply to your child. 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:** 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

Lissette Colón-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: | | | GENDER: |
| *Month* | *Day* | *Year* | ❑ 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: | | 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? _____

_____ 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 ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

# 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)**

*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

*Students Legal Name (Please Print)* *Last* *First* *Middle*

*Parent/Guardian Signature* *Date*

**BYRON-BERGEN CENTRAL SCHOOL DISTRICT**

***Student:*** _____ **Student ID #:** _____ **Class of*:*** _____
Last Name First Name Middle

**Male** _____ **Female** _____ **Birthdate** _____ **Birth Location:** _____
City State Country

---

***PRIMARY - Parent /Legal Guardian #1:***_____

**Relationship to Student:** ☐ **Mother** ☐ **Father** ☐ **Step-parent** ☐ **Guardian/Other**

**Physical Address:** _____

**Mailing Address** ***(if different from physical address)*** _____

**Telephone Numbers: (Home)** _____ **(Cell)** _____

**Email Address**: _____

**Place of Employment:** _____ **(Work Phone Number)** _____

**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** **Spouse**_____
(Name)

**Child's sisters, brothers, and other persons living in the home:**

| **Name** | **Relationship** | **Date of Birth** | **School** | **Grade** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

***Parent/Legal Guardian #2:***_____

**Relationship to student:** ☐ **Mother** ☐ **Father** ☐ **Step-parent** ☐ **Guardian/Other**

**Physical Address:** _____

**Mailing Address** ***(if different from Physical Address)*****:**_____

**Telephone Numbers: (Home)** _____ **(Cell)**_____

**Email Address**: _____

**Place of Employment:** _____ **(Work Phone Number)** _____

**Marital Status: Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Spouse:** _____

**INSTANT CONNECT** (Electronic Phone Messaging): The Byron-Bergen Central School District uses an electronic phone messaging system to contact families by phone of school closings, emergency notifications and event reminders. In the spaces below, please provide the phone number(s) you would like to receive calls at.

**1.** _____ **2.** _____
(Name) (Phone Number) (Name) (Phone Number)

**3.** _____
(Name) (Phone Number)

**EMERGENCY CONTACT 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.

_____
Signature of Parent/Guardian Date

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

_____
Family Physician Address Phone #

***If my child has to be taken home because of <u>minor illness</u> and the parent or guardian cannot be reached, please contact*:**

Emergency name contact phone number(s)

**1.**_____
Name Relationship to Student Phone Number

**2.**_____
Name Relationship to Student Phone Number

**3.**_____
Name Relationship to Student Phone Number

*Other emergency related information:

Preferred Hospital _____
Hospital Name Address Phone #

Family Dentist _____
Name Address Phone #

***If applicable, please complete the following*:**

My child has the following allergies**:** _____

My child has the following condition which requires special handling: _____

_____

List serious illnesses, injuries, operations in the last year**:** _____

_____

Are there any hearing difficulties? _____

Does your child have tubes in his/her ears? _____

Does your child wear glasses? _____

When are glasses to be worn? _____

Are there any eye or visual difficulties? _____

My child routinely takes the following medication(s):_____

_____

Were there any immunizations given in the last year the Health Office was not informed of? _____

Give exact dates**:** _____

**Media Release**

Periodically district staff writes feature articles or news stories on the students, staff, 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 print 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, or outside news media representatives for press or media purposes as indicated above.

_____

Parent/Guardian (Print Name) Parent/Guardian (Signature)

- ***If opting out please fill out a Media DO NOT Release form, available in 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**
**Central Registration Office**
**6917 West Bergen Rd, Bergen, NY 14416 Phone**
**(585) 494-1220, ext. 2229**
**Fax (585) 494-2613**
**Registrar Email: Skuszlyk@bbschools.org**

# AUTHORIZATION FOR RELEASE OF INFORMATION

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

Date: _____

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

_____
*(Address)*

_____
*(City, State, Zip)*

Phone (  )_____ Fax (  )_____

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

Student: _____ DOB: _____ Grade: _____

Student: _____ DOB: _____ Grade: _____

Student: _____ DOB: _____ Grade: _____

Student: _____ DOB: _____ Grade: _____

Student: _____ DOB: _____ Grade: _____

**Permanent Record Information**

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, all/any related service information (OT, PT, Speech), outside evaluations.

Signature of Legal Guardian/Parent: _____

Relationship to Student(s): _____ Date Signed: _____

Witness & Requesting Officer: _____, Residency Clerk

# *BYRON-BERGEN ELEMENTARY CHILD LEARNING INVENTORY*

Please take a few minutes to complete this form. Completing the Child Learning Inventory will assist in planning a positive and successful school year for your child. Check the responses that apply to your child. You may check more than one for each answer. Feel free to add comments. This survey will be kept confidential. Thank you, in advance, for your assistance. PLEASE DO NOT REQUEST A SPECIFIC TEACHER. ***Please return this form to your child's teacher in his/her report card envelope.***

Child's Name_____ Person completing form_____

Relationship to child_____

| My child usually approaches learning… | My child learns best… | My child finds it challenging to… |
|---|---|---|
| ___ with curiosity<br>___ with confidence<br>___ with anxiety<br>___ with reluctance<br>___ without interest | ___ by listening<br>___ by watching<br>___ by doing<br>___ other, please explain | ___ pay attention<br>___ follow directions<br>___ behave appropriately<br>___ speak in front of others<br>___ other, please explain |
| **My child's favorite classroom subject(s) is (are)…** | **How would you describe your child's reading habits? My child…** | **My child's special talents, abilities, interests and hobbies include…** |
| ___ math<br>___ science<br>___ social studies<br>___ reading<br>___ writing | ___ enjoys reading with others<br>___ enjoys reading alone<br>___ reads well, but is reluctant to read<br>___ does not read on his/her own<br>___ does not enjoy reading books | _____<br>_____<br>_____<br>_____ |

For students entering Kindergarten, please rank your child on a scale of 1-5: 1 = needs to improve, 5 = excels

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Makes friends easily | 1 | 2 | 3 | 4 | 5 | Stays focused on the task at hand | 1 | 2 | 3 | 4 | 5 |
| Interacts well with other children | 1 | 2 | 3 | 4 | 5 | Enjoys listening to stories | 1 | 2 | 3 | 4 | 5 |
| Shares toys with others | 1 | 2 | 3 | 4 | 5 | Follows simple verbal directions | 1 | 2 | 3 | 4 | 5 |
| Shows an interest in letters and words | 1 | 2 | 3 | 4 | 5 | Is comfortable in new situations | 1 | 2 | 3 | 4 | 5 |
| Shows an interest in numbers and counting | 1 | 2 | 3 | 4 | 5 | Is able to button and zip his/her own clothing | 1 | 2 | 3 | 4 | 5 |
| Relates easily to and cooperates with adults | 1 | 2 | 3 | 4 | 5 | Is enthusiastic and curious about new activities | 1 | 2 | 3 | 4 | 5 |
| Is able to deal with frustration caused by not being able to do as he/she wishes | 1 | 2 | 3 | 4 | 5 | | | | | | |

Please complete second page

What is the most important issue to be considered in your child's placement?_____

Please list any additional information or concerns that will assist us in knowing about your child and his/her abilities/ needs that will allow us to help with his/her learning (i.e. social, emotional, physical, academic, other).

# Byron-Bergen Elementary School
## Nurse's Questionnaire

6971 West Bergen Rd., Bergen, NY 14416, (585) 494-1220

**Please complete this questionnaire and return it to school. Thank you for being prompt.**

Student Name _____ Date of Birth _____

Street Address _____ Place of Birth _____

Town & Zip _____ Phone Number _____

Father's Name and Birthplace _____

Mother's Name and Birthplace _____

Guardian's Name (if different from above) _____

Physician's Name _____ Dentist's Name _____

**Please check and explain if the following pertains to your child:**

- ☐ Allergies _____
- ☐ Anemia _____
- ☐ Asthma _____
- ☐ Birth Defect _____
- ☐ Bowel/Bladder Incontinence _____
- ☐ Chicken Pox _____
- ☐ Clotting Disorder _____
- ☐ Croup _____
- ☐ Diabetes _____
- ☐ Ear Infections _____
- ☐ Epilepsy _____
- ☐ GI Reflux _____
- ☐ Headaches _____
- ☐ Heart _____
- ☐ Kidney Problems _____
- ☐ Nose Bleeds _____
- ☐ Operations _____
- ☐ Pneumonia _____
- ☐ Premature _____
- ☐ Serious Injuries _____
- ☐ Sinus Infections _____
- ☐ Skin Conditions _____
- ☐ Sore Throat _____
- ☐ Other _____

| | |
|---|---|
| Is your child color blind? | Yes ____ No ____ |
| Does your child have hearing problems? | Yes ____ No ____ |
| Does you child have tubes in their ears? | Yes ____ No ____ |
| Does your child wear glasses? | Yes ____ No ____ |
| Does your child have diet restrictions/modifications? | Yes ____ No ____ |

If yes, please explain: _____

_____

Please indicate what medication(s) your child takes: _____

_____

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

# Byron-Bergen Central School
# **Medication Administration Request**

Dispensing medication in school is contrary to statutory regulations under the Nurse Practice Act and New York State Education Law. We realize, however, that it is sometimes necessary for a student to take internal medication during school hours. **Certain requirements <u>MUST</u> be met for the administration of medication in school.**

1. A written request from the physician indicating the frequency and dosage of the prescribed medication.
2. A written request from the parent to administer the medication
3. Medication must be in the original and properly labeled container. (Request a separate container for school use if necessary.)
4. Medication must be delivered to school by the parent/guardian. Should problems arise, parents should contact the school nurse for assistance.

## To Be Completed by the Physician

_____ is under my care and it is necessary that he/she be given the following medication during school hours.

Diagnosis: _____

Medication: _____

Dosage: _____ Time: _____

Possible Reactions: _____

Date: _____ Physician's Signature: _____

## To Be Completed by the Parent/Guardian

I hereby request that my child, _____ be given the medication as prescribed by his/her physician.

Date: _____ Parent/Guardian Signature: _____

**<u>MEDICATION REQUEST MUST BE RENEWED YEARLY</u>**
**<u>FOR LONG TERM MEDICATION</u>**

# 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.**

# Byron-Bergen Central School

**6917 West Bergen Rd.**
**Bergen, NY 14416**
***Dental Examination Certificate***
**High/Middle School Fax No. 585-494-2613**
**Elementary Fax No. 585-494-2433**

**To be completed by the parent (please print):**

| Student's Name: Last | First | Middle | Birth Date: (Month/Day/Year) / / |
|---|---|---|---|
| Address: Street | City | Zip Code | Telephone: |
| Name of School: | Grade Level: | | |
| Parent or Guardian: | Address (of parent/guardian): | | |

**To be completed by dentist:**

**Oral Health Status (check all that apply)**

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience/Restoration History –** A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries –** At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

**Treatment Needs (check all that apply)**

☐ **No problem seen**

☐ **Urgent Treatment –** abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care –** amalgams, composites, crowns, etc.

☐ **Preventive Care –** sealants, fluoride treatment, prophylaxis

☐ **Other –** periodontal, orthodontic

Please note_____

Signature of Dentist_____ Date_____

Address_____ Telephone_____
Street City Zip Code

# Instructional Computer Network- Acceptable Use Policy

Amended 5/27/10

*(Please read, sign, and return page 2)*

The Board of Education is committed to the development and establishment of a quality, equitable, and cost-effective computer network. The purpose of the network shall be for the advancement and promotion of learning and teaching, and administration and management purposes.

The network will provide a forum for learning various software applications and will significantly enhance educational experiences and provide statewide, national, and global communications opportunities for staff and students.

The District has established rules and regulations governing the use and security of the District's computer network. Failure to comply with District policy and regulations for the use of the network may result in suspension and/or revocation of computer access. Additionally, student violations may result in discipline up to and including suspension. Staff violations may also result in discipline up to and including dismissal.

## *Prohibitions*

***The following is a list of prohibited actions concerning use of the District's computer network. Violation of any of these prohibitions may result in discipline or other appropriate penalty, including suspension or revocation of a user's access to the District's system.***

a. There must be no sharing of passwords without written permission from the teacher/administrator or District Coordinator, as appropriate.
b. Transmission of material, information or software in violation of any District policy or regulation, local, state, or federal law or regulation is prohibited.
c. No personal software or disks may be uploaded on to the District's computer and/or network.
d. Attempts to read, delete, copy, or modify the electronic mail of other system users is prohibited, as is deliberate interference with the ability of other system users to send/receive electronic mail. Forgery or attempted forgery of electronic mail messages is prohibited.
e. System users shall not engage in or encourage activities prohibited by District policy, State or Federal law.
f. Attempts by a user to log on to the District's system in the name of another individual, with or without the individual's password, is prohibited.
g. The use of software or hardware to circumvent security protocols, enter or alter District records, or destroy or impair computer use in the District is prohibited.
h. Copy or install software that is not authorized by proper licensing.

## Privacy Rights

Staff data files and electronic storage areas shall remain District property, subject to District control and inspection. The IT Support Specialist II/Coordinator of Computer Instruction may access all such files and communications with prior notice to ensure system integrity and that users are complying with requirements of this policy and accompanying regulations. Staff should NOT expect that information stored on the District computer system will be private, including but not limited to staff email and websites visited.

## Internet

Byron-Bergen Central School District **DOES NOT HAVE CONTROL OF THE INFORMATION ON THE INTERNET.** Some sites accessible via the Internet may contain material that is inappropriate for educational use in a PreK-12 setting. The District does not condone the use of such materials and will not permit usage of such in the school environment. The District also denies any responsibility for the accuracy or quality of information obtained through its Internet accounts.

### *Acceptable Uses*

a. Use consistent with the mission of the Byron-Bergen Central School District.
b. Use that encourages efficient, cooperative methods to perform the user's job duties or educational tasks.
c. Use in support of research and education.
d. To provide resources and promote collaborative projects.

### *Unacceptable Uses*

a. Use of technology resources for a commercial, political, or as a profit-making enterprise.
b. Accessing or distributing inappropriate material; i.e., obscene, abusive, threatening, harassing (religious, sexual, racial), or any material specifically prohibited by Federal, State, or local law.
c. Attempt to illegally access files, data, or accounts.
d. Activities which interfere with student and staff access to network resources.
e. Working (or attempting to work) from network accounts not assigned to you.
f. Sharing your password or account with others.
g. Deliberately or intentionally damaging hardware or software.
h. Use of technology resources for social networking, on-line shopping, or other non-school related uses.

## Other

a. Users must comply with all existing District policies as they may be interpreted to apply to technology resources, including, but not limited to the following: Student Conduct and Discipline, Copyright, Selection Policy, and Sexual Harassment.
b. Network Security Protocols - Changing Passwords: All staff that has an account on the District's computer network is required to change his/her password at announced times and dates. Staff is encouraged to use good password protocols that call for a password to be a random series of numbers, letters, and symbols with some of the elements capitalized.
c. Users must sign a consent form indicating they are aware of this policy and will abide in accordance with it.

**NOTE: Byron-Bergen Central School District's *Acceptable Use Policy* is subject to change.**

# Byron-Bergen Central School
# Acceptable Use Agreement
# Student and Parent Permission Form

Your son/daughter is granted access to the Byron-Bergen computer network. This access includes connection to the Internet, which would connect your child with educational resources all over the world. A student and parent must sign and date an Acceptable Use Agreement. In accepting an account, your child accepts the responsibility of using the network in an appropriate manner.

As a user of the Byron-Bergen Central School District Computer Network, I have read and agreed to comply with the *Acceptable Use Policy*.

Student Signature: _____ Date: _____

Student Name (please print): _____

Year of Graduation: _____

As parent/legal guardian of the student signing above, I grant permission for my child. I understand that some materials on the Internet may be objectionable; therefore I agree to accept responsibility for guiding my child, and conveying to him/her appropriate standard for selecting, sharing and/or exploring information and media.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (please print): _____

**Please complete this form and return to your child's school.**

**For School Use Only – DO NOT WRITE below this line**

Students must sign each year to renew acknowledgement of *Acceptable Use Policy*:

| Date | Name | Date | Name |
|---|---|---|---|
| _____ | | _____ | |
| _____ | | _____ | |
| _____ | | _____ | |
| _____ | | _____ | |

# BYRON-BERGEN CENTRAL SCHOOL
# TRANSPORTATION REQUEST FORM

**TRANSPORTATION COORDINATOR**
**Phone: 585-494-1220 EXT 5112**
**Email: transportation@bbschools.org**
**Fax: 585-494-0173**

*This form is for the **CURRENT SCHOOL YEAR** and should be updated annually for transportation to a location other than home.*

Effective Date of this Change: _____

Student's Name: _____ Grade: _____

Student's Name: _____ Grade: _____

Student's Name: _____ Grade: _____

Student's Name: _____ Grade: _____

**OFFICE USE ONLY:**

☐ 1st Request
☐ 2nd Request

Date Received: _____

Home Route: _____ Intramural:s _____

Sitter Route: _____ JumpStart: _____

Band/Chorus: _____

☐ School Tool ☐ Route sheet Date: _____

Home Address: _____

## PICK-UP

Select one: ☐ Home ☐ Childcare ☐ Parent Transport

Complete the following if address is somewhere other than home.

_____
Name of Caregiver

_____
Address (**consistent location Monday - Friday**)

_____
Phone

## DROP-OFF

Select one: ☐ Home ☐ Childcare ☐ Parent Transport

Complete the following if address is somewhere other than home.

_____
Name of Caregiver

_____
Address (**consistent location Monday - Friday**)

_____
Phone

**This form must be filled out in it's entirety to maintain proper communication between staff and student.**
**Please complete all sections of this page.**

_____ _____ _____
Signature of Parent or Guardian | Today's Date | Daytime Phone

To submit this via email, save it and send it as an attachment transportation@bbschools.org.