



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, 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 Central Registration Office

6917 West Bergen Road, Bergen, NY 14416

Phone (585) 494-1220 Fax (585) 494-2613

Email: aorologio@bbschools.org or 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

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

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:

--

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

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

Date



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STUDENT REGISTRATION INFORMATION

Student: _____
Last Name First Name Middle

Birthdate: _____ ☐ Male ☐ Female ☐ Non-Binary

Student resides with:	<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.

Relationship to Student:	<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:

<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

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.

Signature of Parent/Guardian

Date

If necessary, I authorize the school to call:

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.

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: _____



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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: _____



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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.*

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

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.

STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
		<input type="checkbox"/> Male
Month	Day	Year
<input type="checkbox"/> Female		
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

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

Month: Day: Year:

Signature of Parent or of Person in Parental Relation

Date

Relationship to student: ☐ Parent ☐ Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME:

POSITION:

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

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

NAME:

POSITION:

ORAL INTERVIEW NECESSARY: ☐ No ☐ Yes

**DATE OF INDIVIDUAL
INTERVIEW:

MO

DAY

YR.

OUTCOME OF
INDIVIDUAL
INTERVIEW:

☐ ADMINISTER NYSITELL

☐ ENGLISH PROFICIENT

☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME:

POSITION:

DATE OF NYSITELL
ADMINISTRATION:

MO.

DAY

YR.

PROFICIENCY LEVEL
ACHIEVED ON
NYSITELL:

☐ ENTERING

☐ EMERGING

☐ TRANSITIONING

☐ EXPANDING

☐ COMMANDING

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



Byron-Bergen Central School District

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STUDENT HEALTH HISTORY

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



Provider and Parent Permission to **Administer Medication** at School/School Sponsored Events

To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

Parent/Guardian Signature

Date

Email

Phone Where We Can Reach You ☐ Check if Cell

To Be Completed By Health Care Provider-Valid for 1 Year

Diagnosis _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations _____ ICD Code _____

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

☐ **Per MEDICAID requirements, frequency & duration as indicated "per" IEP when appropriate.**

☐ **Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)**

NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

Name/Title of Prescriber (Please Print)

Date

Prescriber's Signature

Phone

Email

Stamp

Return to:

School Nurse: _____ School: _____

School Address: _____

Phone: () _____ Fax: () _____ Email _____



Dental Health Certificate- Optional

Parent/Guardian: New York State Law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To Be Completed by Parent or Guardian (Please Print)

Child's Name:

Birth Date:

Month Day Year

Sex: ___ Male

___ Female

Will this be your child's first oral health assessment? Yes ___ No ___

School:

Grade:

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? Yes ___ No ___

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature

Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ on _____ (date of assessment)
The date of the assessment needs to be within 12 months of the start of the school year in which it is requested.

Check one:

- ☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.
☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/Dental Hygienist's name and address
(please print or stamp)

Dentist's/Dental Hygienist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here.

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

___ Yes ___ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

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

___ Yes ___ No **Dental Sealants Present**

Other problems (Specify): _____

II. Treatment Needs (check all that apply)

- ☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.



Byron-Bergen Student Acceptable Use Policy

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.

Please print your name, sign and date below:

Print Name

Signature

Date



Byron-Bergen Central School District

DIGITAL EQUITY SURVEY

Collecting accurate data regarding digital resource access for our New York students will greatly help educators to better serve their students and families. In order to accomplish this, the New York State Education Department is asking parents or guardians to complete a Digital Equity survey (for each student in the family) in grades Kindergarten-Grade 12. This survey will provide information on student access to devices and internet access in their places of residence. To assist us in this process, please answer each question below.

Thank you for your time and cooperation.

Name of Student:	
-------------------------	--

1. Did the school district (or will the school district) issue your child a dedicated school or district owned device for their use during the school year?
☐ Yes ☐ No
2. What is the device your child uses **most often** to complete learning activities away from school? (This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.)
☐ Desktop ☐ Chromebook ☐ Tablet
☐ Laptop ☐ Smartphone ☐ No Device
3. Who is the provider of the primary learning device identified in question 2? (This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.)
☐ School ☐ Person ☐ No Device
4. Is the primary learning device (identified in question 2) shared with anyone else in the household?
☐ Shared ☐ Not Shared ☐ No Device
5. Is the primary learning device (identified in question 2) sufficient for your child to fully participate in all learning activities away from school?
☐ Yes ☐ No
6. Is your child able to access the internet in their primary place of residence?
☐ Yes ☐ No
7. What is the primary type of internet service used in your child's primary place of residence? (**Select ONE**)
☐ Residential Broadband ☐ Community Wi-Fi ☐ Cellular ☐ DSL ☐ None
☐ Mobile Hotspot ☐ Satellite ☐ Dial Up ☐ Other
8. In their primary residence, can your child complete the full range of learning activities, including video streaming and assignment uploads, without interruptions caused by slow or poor internet performance?
☐ Yes ☐ No
9. What, if any, is the primary barrier to having sufficient and reliable internet access in your child's primary place of residence?
☐ Availability ☐ Cost ☐ None ☐ Other

Effective Date of this Change: _____

Student's Name: _____	Grade: _____
Student's Name: _____	Grade: _____
Student's Name: _____	Grade: _____
Student's Name: _____	Grade: _____

Home Address: _____

OFFICE USE ONLY:

☐ 1st Request

Date Received: _____

☐ 2nd Request

Home Route: _____

Intramural:s _____

Sitter Route: _____

JumpStart: _____

Band/Chorus: _____

☐ School Tool

☐ Route sheet

Date: _____

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

BYRON-BERGEN **ELEMENTARY CHILD** LEARNING INVENTORY

Please take a few minutes to complete this form if your child is in Elementary School. 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. Thank you, in advance, for your assistance.

Name of Student:	
Parent/Guardian <i>(person completing the form):</i>	
Relationship to the child:	

My child usually approaches learning... <input type="checkbox"/> with curiosity <input type="checkbox"/> with confidence <input type="checkbox"/> with anxiety <input type="checkbox"/> with reluctance <input type="checkbox"/> without interest	My child learns best... <input type="checkbox"/> by listening <input type="checkbox"/> by watching <input type="checkbox"/> by doing <input type="checkbox"/> other, please explain: <hr/> <hr/>	My child finds it challenging to... <input type="checkbox"/> pay attention <input type="checkbox"/> follow directions <input type="checkbox"/> behave appropriately <input type="checkbox"/> speak in front of others <input type="checkbox"/> other, please explain: <hr/> <hr/>
My child's favorite classroom subjects include: <input type="checkbox"/> math <input type="checkbox"/> science <input type="checkbox"/> social studies <input type="checkbox"/> reading <input type="checkbox"/> writing	How would you describe your child's reading habits? <input type="checkbox"/> enjoys reading with others <input type="checkbox"/> enjoys reading alone <input type="checkbox"/> reads well, but is reluctant to read <input type="checkbox"/> does not read on their own <input type="checkbox"/> does not enjoy reading books	My child's special talents, abilities, interests and hobbies include... <hr/> <hr/> <hr/> <hr/>

Please rank your child on a scale of 1-5.

(Scale indicates: 1 = Needs to Improve to 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	Shares toys with others	1 2 3 4 5
Enjoys listening to stories	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
Relates easily to and cooperates with adults	1 2 3 4 5	Shows an interest in numbers and counting	1 2 3 4 5
Is enthusiastic and curious about new activities	1 2 3 4 5	Is able to button and zip his/her own clothing (UPK – Grade 1 students)	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		

~OVER~

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).
