Welcome
To
Wellsville Central School

Pre K Student Checklist

- ☐ Proof of Residency in Wellsville Central School District
  - *Utility Bill **(Gas or Electric only)**
  - *Statement from landlord
  - *Tax bill
  - ***CANNOT BE A DRIVER'S LICENSE**
- ☐ Completed Registration Packet (attached)
- ☐ Copy of Birth Certificate (will not accept souvenir hand-written certificates)
- ☐ Immunization Records
- ☐ Allegany County School's health Certificate/Appraisal Form (attached)
- ☐ Parent/Guardian Photo Identification
- ☐ Copy of Custody Papers and/or Order of Protection (if applicable)
- ☐ Department of Social Services Foster Placement Form (if applicable)

There are 54 slots available for the Wellsville Elementary School Full Day Prek Program. If more than 54 students register, we will have a lottery drawing in mid-May. Any remaining students will be added to a waiting list in the order of the lottery drawing. If the Prek program is not full, out of district students will be considered for enrollment. Anyone registering after the drawing will be added to the waiting list in the order they are submitted.

Packet *Updated: 1/2020*

Our mission is to prepare our students to be successful, contributing members of their communities through excellence in education.

Wellsville Central School
Pre K Student Registration Form

Today's Date: ____________________

Student Information:

Last Name: ___________________ First Name: __________________ Middle: ______________

Nickname if any: ________________________ Gender: M F

Date of Birth: ________________________ Date of first polio vaccination: __________________

Social Security #: __________________________(optional)

Residence Address:

Street: ______________________________

Town: _____________________Zip:______

Telephone # _____________________

Mailing Address: (if different than residence)

P.O. Box/Street: _______________________________

Town: ________________________ Zip: ___________

Ethnic Group: (please select one)

- ❑ White (not Hispanic origin)
- ❑ Black (not Hispanic origin)
- ❑ Hispanic
- ❑ Asian or Pacific Islander
- ❑ American Indian or Alaskan Native

Please check all that Apply:

❑ Residing in the Wellsville School District

❑ Eligible for Free and Reduced Lunch

❑ Currently in Foster Care
Agency Responsible for placement: ________________________
Actual Home School District: ____________________________

❑ Migrant

❑ Immigrant/Refugee:
Date entered US:__________
Country of Birth: ______________ Home Language ___________

Homeless Designation:

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

1. Living with an adult who does not have legal custody
2. Living in a motel, hotel or camping grounds
3. Your family is living with a relative or friends
4. Awaiting foster placement
5. Or other similar situations due to the lack of alternative, adequate housing

You must check one of the following:

___ I am currently living in one of the above eligible conditions, and I am interested in learning more about my educational rights. If this box is checked the office must immediately notify the homeless liaison for a review of the case.

___ The above conditions do not apply to me

___ I wish to maintain my privacy

Parent/Guardian Information: Please complete ALL information below:
***Note: We presume both NATURAL parents share custody in divorce or legal separation agreements unless and until we receive a copy of the court order or separation agreement that pertains to the child's custody. Non-custodial parents are legally able to obtain school records unless otherwise noted in court documents.**

Mother's Name: ____________________ Student resides with: Yes No

Address: ____
RD, PO Box AND/OR Street, Town, State, Zip, County

Home Telephone Number: ____________________ Cell phone: ____________________

Employer: ________________________________ Employer Phone: _______________

E-Mail Address: ____

Father's Name: ____________________ Student resides with: Yes No

Address: ____
If different from above **RD, PO Box AND/OR Street, Town, State, Zip, County**

Home Telephone Number: _____________________ Cell phone: _____________________

Employer: ________________________________ Employer Phone: ________________

E-Mail Address: __________________________________

Step Parent or Legal Guardian: _________________ Student resides with: Yes No

Address: ____
RD, PO Box AND/OR Street, Town, State, Zip, County

Home Telephone Number: _____________ Cell phone: _______________

Employer: _____________________ Employer Phone: ____________

E-Mail Address: _____________________________________

Parents Are:

Married____ Divorced_____

Separated: Legally__________ No Legal Agreement_________

Custody: Joint_________________ One parent has custody*__________

***We will need a copy of the custody agreement**

Custody Papers on File? Yes No Order of Protection on File? Yes No

Comments: ____

____

Names, ages, birth dates and grades of siblings:

___________ ___ _______ ___ ___________ ___ _______ ___

___________ ___ _______ ___ ___________ ___ _______ ___

Additional Emergency Contacts: (List at least one)

Name: ____________________ Name: __________________

Relationship: ________________ Relationship: ______________

Address: ___________________ Address: _________________

___________________ _________________

Home Phone: ________________ Home Phone: ______________

Cell Phone: _________________ Cell Phone: ________________

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Previous School This Child Attended: (Headstart, Montessori, etc)

School Name: ____

School Address: ____

____

Phone Number: (___) ______________

Dates of Attendance at this School:

Start Date: _______________________

Withdrawal Date: ______________

My Child Received the Following Early Intervention Services:

- ❑ Refer to CSE
- ❑ Was your child classified under the Committee of Special Education? Yes No
- ❑ Special Education Services (please specify program):
  - Self-contained classroom ____
  - 504 Plan ____
- ❑ Speech Therapy
- ❑ Occupational Therapy
- ❑ Physical Therapy
- ❑ Visual Therapy
- ❑ Counseling
- ❑ Other (please specify):_______________________________________

Comments: ____

I hereby certify that the student listed on this registration form actually resides at the address specified on Page 2 within the Wellsville Central School District boundaries. I further certify that all the information I have provided on this registration form is true and correct. I understand that I must immediately notify the Wellsville Central School District if the residency of the student changes from the address listed on this registration form.

I authorize the request of student records from previous schools and give permission to the Wellsville Central School District to verify telephone numbers, addresses, and employment. I understand that if the district believes that the information on this form is no longer correct or that the child being registered no longer lives at the address provided, the Wellsville Central School District has the right under New York State Law to investigate and to withdraw the child from the Wellsville Central School District

Please be advised that the provision of false information on this registration form could constitute a crime. In addition, the Wellsville Central School District reserves its right to recover from parents, legal guardians or other responsible parties the entire actual cost of educating a student, plus related costs, for the entire period that any non-resident student is enrolled in the Districts schools with authorization and/or under false pretenses. I HAVE READ AND UNDERSTAND THIS NOTICE

Parent (Guardian) Signature: ____

Date: _____________________

WELLSVILLE CENTRAL SCHOOL DISTRICT
126 WEST STATE STREET
WELLSVILLE, NEW YORK 14895

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Student Name ____ Birthdate _________________

Primary Healthcare Provider ___________________________________ Phone ___________________

Address ____ Fax _____________________

Healthcare Provider ____ Phone ___________________

Address ____ Fax _____________________

I hereby authorize my child's physician(s) listed above as well as Zahi Kassas, MD, acting school physician, to exchange the following information with Wellsville Central school staff, including:

☐ School Nurse
☐ Physical Therapist
☐ Occupational Therapist
☐ Speech Therapist
☐ Audiologist
☐ Vision Department
☐ Admissions Officer
☐ School Psychologist
☐ School Social Worker
☐ Other ____

☐ Immunizations/physical exams to comply with NYS regulations
☐ Social History
☐ Psychological evaluations/reports
☐ Medical clearances, as needed, following an injury or change in condition
☐ Medical orders required for therapy needs; evaluations
☐ Authorization for medications during the school day or on school trips
☐ Medical condition/treatment plans that may have an impact in the school environment
☐ Physician referral for services (OT, PT)

This information will be used to provide a safe and healthful environment and develop an appropriate program for this student at school. Enrollment is not contingent upon obtaining this release; however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment. This release expires on the last day of the enrollment of the above student in school and may be revoked at any time by sending the request to cancel this permission in writing to the address above. Such revocation will not affect any disclosure made prior to its receipt. Protected health information will not be disclosed without consent per FERPA regulations. **A copy of this release has been provided to me and will be sent to the appropriate provider when requests are made.**

☐ **I waive my right to receive a copy of this notice.**

____________________________ ____________________

(Signature of Parent/Guardian/ or Student- if over 18 years old)** (Date)

**If a student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is signing authority to act on student's behalf: ____

This form complies with all HIPAA regulations. Revised 10/10 KLDH

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Wellsville Elementary Universal Pre-K/ Kindergarten Health History

Name______________________ Date of Birth_____________

Birth Weight _____ Birth Length _____ Type of Delivery: Vaginal / Cesarean and Full term / Premature

Any pregnancy Yes No If Yes, please explain_______________________________________

Childs Physician	_______________	Phone number	_______	Last visit	_____________
Childs Dentist	_______________	Phone number	____________	Last visit	_____________
Childs Eye Dr.	_______________	Phone number	____________	Last visit	_____________
Childs ENT	_______________	Phone number	____________	Last visit	_____________
Other Dr.	_______________	Phone number	____________	Last visit	_____________

Has your child ever been hospitalized? Yes No Where?____________________________

When _____________ Why?____

Has your child had surgery? Yes No If yes, please list: _______________________________

Does your child have any allergies? Yes No Please list: ______________________________

What is the reaction? _________________________ Does your child have an Epi-Pen? Yes No

Please mark any of the following your child may have experienced and please explain.

- ❑ Ear infections____
- ❑ Frequent colds____
- ❑ Chicken pox____
- ❑ Measles ____
- ❑ Vision problems? ____
- ❑ Does your child wear glasses? Yes No ________________________________
- ❑ Nose bleeds____
- ❑ Pneumonia____
- ❑ Seizures____
- ❑ Unconsciousness ____
- ❑ Mumps____
- ❑ Diabetes____
- ❑ Hearing problems____
- ❑ Speech problems____
- ❑ Asthma____
- ❑ Diagnosed ADD or ADHD____
- ❑ Physical disabilities____
- ❑ Bleeding disorders____

Does your child take any medication? Yes No If yes, please specify what it is and what it's for_______

____

Did your child attend day care or preschool? Yes No Where? __________________________

May WES contact previous school for information regarding your child? Yes No

Please describe the following for your child:

Eating habits_____________________ Sleep habits/bedtime _______________ Stays dry at night? _________

Independent in bathroom? _____ Needs help? ________________ Can your child dress him/herself? _______

How does your child handle anger? ____

How does your child relate to other children? ____

How does your child relate to adults? ____

What are your child's fears? ____

Describe your child's personality____

____

Please attach any additional information that you think we should know.

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Wellsville Central School

126 West State Street

Wellsville, NY 14895

Dear Parent/Guardian:

As a part of your child's requirements for school, as of 07/01/2018, a physical examination is required for students in Prekindergarten or Kindergarten, and in Grades 1, 3, 5, 7, 9 and 11. A law was recently enacted that expands health screenings to include the **dental health** of students in New York State.

We would like to request that your child have a physical examination and we will be requesting a **dental certificate,** as well. On the reverse side is a certificate available for you to take to your child's dentist. Once it is completed, it should be returned to the School Nurse as it will be filed in your child's Cumulative Health Record.

Thank you for your cooperation in this new health endeavor. Our students benefit when we work together to promote the health and achievement of all students.

Please call the school's Health Office if you have any questions or concerns. These forms may also be found on the school's website at http://www.wellsvilleschools.org/domain/91.

Sincerely,

Hope Gilfert, RN
Secondary School Nurse, Grades 9-12
Phone: 585-596-2167
Fax: 585-596-2130

Kathy Darrow-Holla, RN
Secondary School Nurse, Grades 6-8
Phone: 585-596-2147
Fax: 585-596-2130

Heather Hoffman, RN
Elementary School Nurse, Grades 3-5
ICS Nurse
Phone: 585-596-2117
Fax: 585-596-2114

Rose Mary Vossler, RN
Elementary School Nurse, Grades Pre-K-2
Phone: 585-596-2107
Fax: 585-596-2120

Revised 02/01/18

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 ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

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

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

Diabetes ☐ No ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type ☐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	Other Pertinent Medical Concerns
PPD/ PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
Sickle Cell Screen/PRN	☐	☐		☐ Concussion – Last Occurrence: ______________
Lead Level Required Grades Pre- K & K			**Date**	☐ Mental Health: ______________
☐ Test Done	☐ Lead Elevated ≥ 10 µg/dL			☐ 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:	Diagnoses/Problems (list)	ICD-10 Code
	______________	________
	______________	________
	______________	________
☐ Additional Information Attached	______________	________

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.

WELLSVILLE CENTRAL SCHOOLS
DENTAL HEALTH CERTIFICATE

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, Pre-K or K, 1, 3, 5, 7, 9 & 11. 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 dentist for an assessment. If your child had a dental check-up before he/she started school, ask your dentist to fill out Section 2. Return the completed form to the school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / (Month Day Year)

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School Name:

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

Parent's Signature: ______________________ Date: ____________

Section 2. To be completed by the Dentist

I. The Dental Health condition of ______________________ on ____________ (date of exam)

NOTE: The date of the exam 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 name and address (please print or stamp)	**Dentist'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 filing (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 1/2mm 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): ______________________

III. 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.

2020-2021 Pre-K TRANSPORTATION INFORMATION

Student(s) Name: ____ DOB: _______________

Parent/Guardian Name: ____

Phone Number: ____

Address: ____

______ My child will be self-transported **TO** school

______ My child will be self-transported **FROM** school

______ My child needs to ride a bus (answer questions below)

- Will your child be getting on the bus in the morning at the above address? YES ____ NO ____
- Will your child be getting off the bus in the afternoon at the above address? YES ____ NO ____

If you answered NO to either question above, please continue with the rest of this form.

Morning Pickup information:

Name: ____ Phone: __________________________

Relationship: ____

Address: ____

Afternoon Drop Off information:

Name: ____ Phone: ________________________

Relationship: ____

Address: ____

Wellsville Central School Transportation Building

Attn: Aprille Little

2407 County Road 44, Wellsville, NY 14895

Or by email to: alittle@wlsv.org

Please call 585-593-5450 with any questions. Thank you

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