Welcome
To
Wellsville Central School

K Student Checklist

- ❑ Proof of Residency in Wellsville Central School District
  - *Utility Bill **(Gas or Electric only please)**
  - *Statement from landlord
  - *Tax bill
  - ***CAN NOT BE A DRIVERS LICENSE**
- ❑ Completed Registration Packet (attached)
- ❑ Copy of Birth Certificate (will not accept souvenir hand written certificates)
- ❑ Immunization Records
- ❑ Allegany County Schools 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)

Wellsville Central School
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. Student 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:

_____ ____ _____ ____ _____ ____ _____ ____

_____ ____ _____ ____ _____ ____ _____ ____

Emergency Contacts:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

_____ _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

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: _____

Previous School This Child Attended:

School Name: _____

School Address: _____

_____

Phone Number: (_____) _____

Dates of Attendance at this School:

Start Date: _____ Withdrawal Date: _____

My Child Received the Following Services:

- ❑ Academic Intervention Services (AIS)
  If so, for what subjects: _____
- ❑ Was your child classified under the Committee of Special Education? Yes No
- ❑ Special Education Services (please specify program):
  - Self-contained classroom _____
  - Resource Room _____
  - 504 Plan _____
- ❑ Speech Therapy
- ❑ Occupational Therapy
- ❑ Physical Therapy
- ❑ Visual Therapy
- ❑ Counseling
- ❑ Other (please specify):_____

Comments: _____

_____

I certify that the information provided above is true to the best of my knowledge.

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 _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

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
- ☐ _____
- ☐ 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)
- ☐ Other _____

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 student over 18 or Parent/Guardian)** (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

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

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 complication? 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_____
- ❑ Measeles_____
- ❑ Vision problems? _____
- ❑ Does your child wear glasses? Yes No _____
- ❑ Nose bleeds_____
- ❑ Pneumonia_____
- ❑ Seizures_____
- ❑ Unconsciencsness_____
- ❑ 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.

Transportation Information

Please complete and return this form to the Elementary School

BY AUGUST 1st

50-98 School St. Wellsville, NY 14895

___My child(ren) will be self-transported to school

___My child(ren) will be self-transported from school

___My child(ren) needs to ride a bus (complete form below)

Student(s) Name: _____

Parent/Guardian Name: _____

Phone: _____

Address: _____

___My address has changed

- 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 fill out the remainder of this form

Alternative **morning** pick up information

Name: _____Phone:_____

Relationship: _____

Address: _____

Alternative **afternoon** drop off information

Name: _____Phone:_____

Relationship: _____

Address: _____

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

Wellsville Central School
126 West State Street
Wellsville, NY 14895

Dear Parent/Guardian:

As a part of your child's requirements for school, a physical examination has been required for students in Prekindergarten or Kindergarten, and in Grades 2, 4, 7 and 10. A law was recently enacted that expands health screenings to include the **dental health** of students in New York State.

Currently and in the future, when we require that your child have a physical examination, 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.

Sincerely,

Hope Gilfert, R.N.
High School Nurse
Phone: 585-596-2167
Fax: 585-596-2130

Kathy Darrow-Holla, R.N.
Middle School Nurse
Phone: 585-596-2147
Fax: 585-596-2130

Rebecca Joyce, R.N.
Elementary School Nurse
Phone: 585-596-2117
Fax: 585-596-2120

Rose Mary Vossler, R.N.
Elementary School Nurse
Phone: 585-596-2107
Fax: 585-596-2120

(OVER)

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, K, 2, 4, 7, & 10. 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's medical director or 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

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

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.

ALLEGANY COUNTY SCHOOLS
HEALTH CERTIFICATE / APPRAISAL FORM

NYSED requires an annual physical exam for new entrants, students in Grades Universal Pre-K or K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

Student: _____ Date of Birth: _____
School: _____ Gender: ☐ M ☐ F Grade: _____
Student's Primary Doctor/Physician: _____

IMMUNIZATIONS / HEALTH HISTORY

☐ **Please attach current immunizations.**

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: _____
PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____
Elevated Lead: ☐ Positive ☐ Negative ☐ Not done Date: _____
Dental Referral: ☐ Positive ☐ Negative ☐ Not done Date: _____

Significant Medical/Surgical History: ☐ See attached _____
_____

Allergies: ☐ **LIFE THREATENING** ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____
☐ Seasonal ☐ Medication: _____

DATE OF PHYSICAL EXAM: _____

Height: _____ Weight: _____ Urinalysis: _____
Temperature: _____ Pulse: _____ Respirations: _____ Blood Pressure: _____
Referral

Body Mass Index: _____ _____. _____
Weight Status Category (BMI Percentile):
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

Vision – without glasses/contact lenses	R	L	
Vision – with glasses/contact lenses	R	L	
Vision – Near Point	R	L	
Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: _____
Specify any abnormality (use reverse of form, if needed): _____
_____
_____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form
Name: _____ Dosage/Time: _____
Name: _____ Dosage/Time: _____
If AM dose is missed at home: _____
I assess this student to be self-directed: ☐ Yes ☐ No Student may self-carry and self-administer medication: ☐ Yes ☐ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school, or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball, soccer, basketball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, rifleman, weight train, crew, dance, track, run, walk, rope jump, roller skating.
☐ **Specify medical accommodations needed for school:** _____ ☐ None
☐ **Known or suspected disability:** _____ ☐ Please monitor
☐ **Restrictions:** _____ ☐ Please monitor
☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Helmet ☐ Other:

ADDITIONAL INFORMATION, if known

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension ☐ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)
Provider's Name/Address: _____ Fax: _____
Parent's Signature: _____ Date: _____

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