



UPK REGISTRATION FORM

Sodus Central School District, 6375 Robinson Road, Sodus NY 14551, 315-483-2331

Welcome to Sodus Schools!

When the registration packet is complete and the documents described in the attached letter are collected, please bring them to the Sodus District Office, Student Services, 6375 Robinson Road, Sodus, NY 14551

Registration Checklist:

- ☐ **Completed registration packet** - Please provide an email address for parents/guardian needed for important district communications and student academics.
- ☐ **Proof of student's age** – original (Birth Certificate, Passport, Baptismal Record) Children **MUST** be 3-years old on or before December 1 of the incoming school year to enroll in the 3-year old UPK program, 4-years old on or before December 1 to enroll in the 4-year old UPK program.
- ☐ **Proof of residence within the Sodus Central School District** – one copy *If you cannot provide proof of residency in your name, please call the district office, 315-483-2331 ext. 5208 prior to registering your child.*
- ☐ **A copy of your child's current immunization record and last physical provided by your physician's office.** "My Chart" reports are not admissible. A physical dated within one year from the start of school and signed by a physician may be faxed before your registration appointment.
- ☐ **IEP** – Only applicable for students receiving special education preschool services. If your child receives special education services *by a district other than Sodus*, please provide one copy of your child's IEP.
- ☐ **Custody Papers** - If applicable.

PROOF OF AGE:

Please provide documentation establishing your child's age.

Evidence may include:

- 1) a certified transcript of a birth certificate or record of baptism (including a certified transcript of a foreign birth certificate or record of baptism) giving the date of birth.
- 2) Where such documentation is not available, a passport (including a foreign passport) may be used.

If the birth certificate or passport is not available, the District may consider certain other evidence, which has been in existence two years or more. An affidavit of age cannot be accepted as verification. Other evidence may include, but will not be limited to the following:

- official driver's license
- state or other government issued identification
- school photo identification with date of birth
- consulate identification card
- hospital or health records
- military dependent identification card
- documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement)
- court orders or other court-issued documents
- Native American tribal document
- records from non-profit international aid agencies and voluntary agencies

EVIDENCE OF IMMUNIZATIONS & PHYSICAL:

In accordance with New York State Department of Health Immunization Bureau's Immunization Requirements for School Entrance/Attendance (NYS Public Health Law), the District must receive evidence that your child has been immunized. These records are necessary to ensure your child's continued attendance.

Additionally, please provide record of the most recent physical examination your student has received. New York State mandates that each new student entering a public school is required to have a physical examination upon entering the District. A physical completed no more than twelve months before the first day of the school year in question will meet this requirement.

PROOF OF RESIDENCY:

You must be a resident of our school district and submit proof of your residency in the form of house closing papers, lease agreement or recent gas & electric bill in your name and address. If you are residing with someone who lives in the district, they need to submit a notarized letter stating that you and your children (listed by name) are living at their address and provide proof that their residence is in the Sodus CSD. If it is determined that registered students are not legal residents, the parent/guardian can be held financially responsible for educational services provided prior to the discovery of non-residence.

NOTICE OF RIGHTS REGARDING REFERRAL FOR EVALUATION FOR SPECIAL EDUCATION:

If you suspect that your child is in need of special education services or programs, you may refer your child to the District's Director of Student Services for evaluation. The referral should be made to Joseph Keeney, Director of Student Services, Sodus CSD, PO Box 220, Sodus, NY 14551. The New York State Education Department website has information regarding this process and your rights. A copy of the Parent Guide to Special Education may be obtained from the following website.

<https://www.nysed.gov/sites/default/files/programs/special-education/a-parents-guide-to-special-education.pdf>

If you have any questions with respect to the foregoing, please contact Kelley Darling, District Registrar at 315-483-5208

STUDENT SERVICES OFFICE: PO Box 220, Sodus, NY 14551 Phone: (315) 483-5208 • Fax: (315) 483-5248

• Email: Registration@soduscscsd.org • Web Site: www.soduscscsd.org

Electronic Signature and Data Correspondence Agreement

I, _____, parent/guardian of student(s) _____

authorize the Sodus Central School District to utilize my printed signature as my official digital signature for all documents relating to this registration packet under the following terms:

_____ **Electronic Signature Agreement**

By digitally entering your initials next to this statement, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this Agreement and in the packet. By initialing this section using any device, means or actions, you consent to the legally binding terms and conditions of this Agreement. You further agree that your signature on this document (hereafter referred to as you "Digital Signature") is as valid as if you signed the document in writing.

_____ **Consent to Electronic Delivery**

By digitally entering your initials next to this statement, you specifically agree to receive, obtain, and/or submit any and all documents and information electronically from the Sodus CSD. These documents and information will be collectively known as "Electronic Communications" and will include, but not be limited to, any and all current and future notices and/or disclosures concerning the SCSD, as well as such documents, statements, data, records and other communications regarding your child(ren). You accept Electronic Communications provided via email as reasonable and proper notice for the purposes of fulfilling any and all rules and regulations, and agree that such Electronic Communication fully satisfy and requirement that communications be provided to you in writing or in a form that you may keep.

STUDENT & HOUSEHOLD INFORMATION

Sodus Central School District, 6375 Robinson Road, Sodus, NY 14551, 315-483-2331

For Office Use: ☐ SODUS UPK ☐ HEADSTART UPK ☐ SPECIAL EDUCATION		
Registration Date: _____	Assigned School: _____	Grade: _____
Start Date: _____	Student ID #: _____	

STUDENT INFORMATION

Student's Full Name: <i>Last</i> _____ <i>First</i> _____ <i>Middle Initial</i> _____ <i>Nick Name</i> _____			
Student Address: Street _____ Apt. _____ Town/City _____ Zip _____		Proof of Age: ☐ Provided: Proof of Residency: ☐ Provided:	
Birth Date: <i>mm</i> / <i>dd</i> / <i>yyyy</i>	Gender:		Grade Entering:

Ethnicity NYSED & the Federal Government Department of education require each school report some enrollment data on basis of national origin or race. The Sodus CSD does not discriminate and is in compliance with the Title IX of the Education Amendments of 1972 and section 504 of the Rehabilitation Act of 1973.

Is the child Hispanic/Latino? ☐ Yes ☐ No

Is the student from one or more of these races? (Check all that apply.)

☐ American Indian-Alaskan ☐ Asian ☐ Black/African American (Not Hispanic) ☐ White

Primary Household Information		Household Phone #: _____ <i>(area code)</i>	
Complete Address: _____			
Parent/Guardian Name: <i>Last</i> _____ <i>First</i> _____ <i>Gender</i> _____ (First Contact)			
Relationship to student: ☐ Bio-Parent ☐ Legal Guardian ☐ Foster Parent ☐ Step-Parent ☐ Other _____		Phone #s: (Include Area Code) Cell:	
Email Address:		Work:	
Parent/Guardian Name: <i>Last</i> _____ <i>First</i> _____ <i>Gender</i> _____ (Second Contact)			
Relationship to student: ☐ Bio-Parent ☐ Legal Guardian ☐ Foster Parent ☐ Step-Parent ☐ Other _____		Phone #s: (Include Area Code) Cell:	
Email Address:		Work:	

SCHOOLS PREVIOUSLY ATTENDED

Name of School	City/Town/State/Country	Grade	Start Date	End Date

Is this student currently suspended from his/her most recent school? ☐ Yes ☐ No

Did the student receive free or reduced priced lunch at previous school district? ☐ Yes ☐ No

CUSTODY INFORMATION

Information of Rights of Parent from the Family Education Rights and Privacy Act (FERPA): An education 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 the rights. (Authority: 20U.S.C 1232g) Please inform your school of changes in custodial arrangements -

☐ Two parents in Home	☐ Divorced/Separated	☐ Joint Custody	☐ Single Parent	☐ Sole Custody
☐ Custody Transfer	☐ Foster Placement (DDS-2999/3424 must be provided)		☐ Unaccompanied Youth	
Custody paperwork provided during registration? ☐ Yes ☐ No				
Restrictions of contact and/or information: Custody papers/court order MUST be provided.				
☐ No Restrictions for Parents/Guardians		☐ Custody Papers Specify Restriction		☐ Order of Protection
☐ Other Documentation, specify: _____		Expiration Date: _____		
Person(s) Restricted: _____		Relationship to Student: _____		

SECONDARY HOUSEHOLD INFORMATION

Parent/Guardian Name: <i>Last</i> <i>First</i>	Relationship to student: ☐ Has permission to pick student up from school.
Complete Address:	Cell:
	Home:
	Work:
Email Address:	<i>(Include area codes.)</i> Receives mail ☐ Yes ☐ No

SIBLING INFORMATION

Siblings Residing in Primary Residence:						
Last Name	First Name	Gender		Date of Birth	Grade	School
		☐ M	☐ F			
		☐ M	☐ F			
		☐ M	☐ F			
		☐ M	☐ F			

STUDENT'S PHYSICIAN INFORMATION

Name:	Phone:
Name of Practice:	
Address:	

EMERGENCY CONTACT INFORMATION: (Please list in order of who should be contacted after parents/guardian, include area codes.)

Name:	Home #:
Relationship to student:	Cell #:
☐ Has permission to pick student up from school.	Work #:
Name:	Home #:
Relationship to student:	Cell #:
☐ Has permission to pick student up from school.	Work #:
Name:	Home #:
Relationship to student:	Cell #:
☐ Has permission to pick student up from school.	Work #:
Name:	Home #:
Relationship to student:	Cell #:
☐ Has permission to pick student up from school.	Work #:

Signature: _____ **Relationship to Student:** _____

RESIDENCY QUESTIONNAIRE

Sodus Central School District, 6375 Robinson Road, Sodus, NY 14551, 315-483-2331

Under the State Education Department's Title 1 Plan, all school districts that receive Title I funds must use a residency questionnaire that asks about a student's housing status. This form must be completed for all students seeking enrollment as well as those changing address.

Name of Local Education Agency: SODUS CENTRAL SCHOOL DISTRICT

Name of Student _____
Last First MI

Address _____
Street Town/City State Zip Code

Gender: _____ Date of Birth ____/____/____ Grade ____ ID# ____
mm dd yyyy (Preschool-12) (Optional)

Name of School _____

Is parent guardian enlisted in a branch of the United States Armed Forces ☐ Yes ☐ No

If yes, name of parent and enlistment: _____

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, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

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

- ☐ 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): _____
- ☐ In permanent housing

Presenting a false record or falsifying records is an offense under section 37.10 Penal code and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec.25.002(3)(d)

Print Name of Parent, Guardian, or
Unaccompanied Youth

Signature of Parent, Guardian, or
Unaccompanied Youth

Date

FOR OFFICE USE ONLY:

I certify that the above named student qualifies for services and the Child and Nutrition Program under the provisions of the McKinney-Vento Act.

Signature of McKinney-Vento Liaison

Date

SPECIAL EDUCATION REGISTRATION

Sodus Central School District, Student Services Office, 315-483-5208

To be completed by parent or guardian. This form, and the Release of Information, must be completed and signed before a student may enroll.

Student Name: _____ Medicaid CIN # _____

1. Is Home Language a Language Other Than English? ☐ YES (Complete Home Language Form) ☐ NO

2. Is this student classified by the Committee on Special Education? ☐ YES ☐ NO

What is students current Classification?

- | | |
|---|--|
| ☐ Learning Disability (LD) | ☐ Hearing Impairment (HH) |
| ☐ Speech or Language Impairment (SI) | ☐ Mental Retardation (MR) |
| ☐ Emotional Disturbance (ED) | ☐ Traumatic Brain Injury (TBI) |
| ☐ Autism (AU) | ☐ Deaf – Blindness (DB) |
| ☐ Multiple Disabilities (MD) | ☐ Deafness (DF) |
| ☐ Orthopedic Impairment (OI) | ☐ Preschool student w/disability (PD) |

3. What special education services did student receive? (Check all that apply)

☐ Special Education Classroom ☐ Resource Room ☐ Consultant Teacher

☐ Speech Therapy ☐ Physical Therapy ☐ Occupational Therapy ☐ Counseling

4. Did student attend a BOCES program? ☐ YES ☐ NO

Where? _____ Type of program? _____

5. Did Student attend a PRIVATE or RESIDENTIAL program outside of public school district?

Where? _____ Type of program? _____

6. Does student have a Section 504 Accommodation Plan? ☐ YES ☐ NO

If yes, please describe/list the accommodations _____

I consent to the sharing of information regarding my child, _____, between Sodus Central School District and those listed below. This information will be used to help determine educational needs.

Name Address Phone

Name Address Phone

Name Address Phone

Parent/Guardian signature

Date

PARENTAL CONSENT FOR RELEASE OF EDUCATIONAL INFORMATION FOR MEDICAID FUNDING

Sodus Central School District, Student Services Office, 315-483-5208

TERMS, RIGHTS AND RESPONSIBILITIES

By signing this application, I understand and confirm that:

- I have been fully informed in my native language or other mode of communication that the granting of my consent to share information for the purpose of obtaining the Medicaid reimbursement for the services provided per my child's individualized education program (IEP) is voluntary and may be revoked at any time and that if I revoke my consent, it does not negate (undo) an action that occurred after my consent was given and before my consent was revoked.
- If I refuse consent to allow use of Medicaid insurance to pay for special education services, the school district must still provide all required special education services at no cost to me.
- The use of Medicaid insurance for special education services will not decrease the available lifetime coverage, increase premiums or lead to the discontinuation of benefits, result in my family paying for services required for my child outside of school that would otherwise be covered by the Medicaid program or otherwise diminish my family's insured benefits under the Medicaid program.
- I will not incur an out-of-pocket expense such as payment of a deductible or co-pay amount.

I, _____ as parent/guardian of
(Print name of parent or person in parental relationship)

(Print child's name)

Medicaid CIN # (REQUIRED)

I give permission to the Sodus Central School District to use Medicaid to pay for IEP services and to such public agency and to each approved private special education school or provider who provides IEP services to my child to disclose information regarding diagnosis and procedure codes for billing Medicaid for services described in my child's IEP and for evaluations in relation to the services; and in the event of an audit, documentation required to support services reimbursed by Medicaid from my child's educational records to local, State and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for covered health-related support services for each service and for each school year in which service is provided as recommended in my child's IEP if my child is or becomes Medicaid-eligible.

I give my consent voluntarily and understand that I may withdraw that consent at any time. I also understand that my child's entitlement to free and appropriate public education (FAPE) is in no way dependent on my granting consent.

Signature: _____

Date: _____



STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lisette 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

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

ENGLISH

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:

ENGLISH



Sodus Central School District
P.O. Box 220
Sodus, New York 14551-0220
Fax (315) 483-4755



Authorization for Use or Disclosure of Protected Health Information

In order to share protected health information with the school district, your healthcare provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays in care for your child.

I, _____ authorize my child's healthcare provider(s) listed below:

Name _____	Phone _____	FAX _____
Name _____	Phone _____	FAX _____
Name _____	Phone _____	FAX _____

to release the medical records of my child, _____, DOB _____ to the district's: ☐ Medical Director ☐ School Nurse ☐ Athletic Trainer (AT) ☐ Counselor ☐ Occupational Therapist (OT) ☐ Physical Therapist (PT) ☐ Psychologist ☐ Social Worker ☐ Speech Therapist (ST) ☐ All of the above ☐ other _____

The healthcare provider may disclose the following information: (Parent/School: check all that apply)

☐ Immunizations ☐ Health Appraisals ☐ Past/Current Medical Conditions and impact on attendance, athletics, or school programming or therapy ☐ Other _____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (Parent/School: check all that apply)

☐ To develop care or therapy plans for routine and emergent school management
☐ To design appropriate educational, school, or athletic programs
☐ To assess the impact of the medical condition(s) on school programming and/or attendance
☐ To share school observations/concerns surrounding behavior
☐ To assess a medical basis for modification of transportation and/or home tutoring
☐ Medication delivery or therapy prescriptions
☐ At patient's request with no specified purpose
☐ Other _____

PARENT: Please select one:

- ☐ This authorization is valid for the duration of attendance within the school district
☐ This authorization is valid for the entire academic school year 20 - 20
☐ This authorization shall expire on ____/____/____ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building. I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

Signature of Parent/Guardian or student if over 18

Relationship

Date



Sodus Central School District
P.O. Box 220
Sodus, New York 14551-0220
Fax (315) 483-4755



HEALTH HISTORY

Name of Child _____ Date of Birth _____

Child's Physician _____ Physician's Phone _____

Has your child had any of the following? If so, please describe.

NO YES

- | | | |
|--------------------------|--------------------------|---|
| ☐ | ☐ | Allergies _____ |
| ☐ | ☐ | Asthma _____ |
| ☐ | ☐ | Diabetes _____ |
| ☐ | ☐ | Seizure Disorder _____ |
| ☐ | ☐ | Serious Illnesses _____ |
| ☐ | ☐ | Hospitalizations _____ |
| ☐ | ☐ | Serious Injuries/Surgeries _____ |
| ☐ | ☐ | Muscle/joint/bone problems (including fractures) _____ |
| ☐ | ☐ | Dizziness/fainting/chest pain _____ |
| ☐ | ☐ | Heart problems (enlarged heart, congenital defect, abnormal rhythm) _____ |
| ☐ | ☐ | Blood Pressure Issues (High or Low) _____ |
| ☐ | ☐ | Bleeding disorder _____ |
| ☐ | ☐ | Liver or spleen problem _____ |
| ☐ | ☐ | Kidney disease or absence of a kidney _____ |
| ☐ | ☐ | Knocked unconscious or had a concussion _____ |
| ☐ | ☐ | Skin problems/sores/rashes _____ |
| ☐ | ☐ | Vision/eye problems _____ |
| ☐ | ☐ | Hearing/ear problems _____ |
| ☐ | ☐ | Speech/Language Problems _____ |
| ☐ | ☐ | Is your child currently taking any medications? _____ |
| ☐ | ☐ | Is there any condition that limits classroom, playground, physical education, or vigorous activities? _____ |

Additional comments and/or concerns: _____

AUTHORIZATION BY PARENT OR GUARDIAN

I am aware that my child needs to have had a physical within the last twelve months prior to entering school. If my child doesn't have a current physical, I understand that I must schedule him/her for a physical within 30 days of enrollment. If a physical is not provided within 30 days to the school, I give permission to have an examination provided to my child by the district Medical Director. I will advise the school nurse if I want to be present during the examination.

The undersigned grants permission for the family physician/health care provider to release data & findings of this student's last physical exam and their entire immunization records to the Sodus Central School District.

Parent/Guardian Name _____ Date _____

Signature _____



Sodus Central School District
P.O. Box 220
Sodus, New York 14551-0220
"Learning, Advancing, Proud, Spartans!"



Dear Parents:

As part of our goal to recognize students and staff for their accomplishments and create a culture of celebration, we will be showcasing photographs and audio/video recordings taken at school events in school publications, newspapers, the District Website, promotional materials, television reports, Facebook, and Twitter. Pictures of students participating in school events make stories extra special to families and people in our community.

If you **DO NOT** want your child's name or photograph/video used for this purpose, we will need you to send a note to your child's principal with your request. The note should be signed by you and include a date.

Until this note is received, we will assume that you grant permission for your child's name and photograph/video be included in District communication. If you have any questions or concerns, please contact your child's Principal or me at any time.

Sincerely,

Michael Ferris
Superintendent of Schools



Sodus Central School District
P.O. Box 220
Sodus, New York 14551-0220
"Learning, Advancing, Proud, Spartans!"



SchoolTool Parent Portal

Check student grades and attendance records on the internet!
If interested in accessing this information please complete below:

Name: _____

Email address: _____
(please write clearly)

I hereby give Sodus Central School District permission to place information regarding the following student(s) in the SchoolTool Parent Portal System:

Student Name	Grade	Building

Parent/Guardian Signature: _____

Date: _____

***You will receive your first SchoolTool password through the email you have provided above.



Sodus Central School District
P.O. Box 220
Sodus, NY 14551
Transportation Department

Alternate Transportation Request

- ☐ Sodus Elementary ☐ Sodus Intermediate ☐ Sodus Jr/Sr High (Gr. 7/8)
☐ Other: (School Name) _____

Student(s) Information: (Please print)

First & Last Name	Birth Date	Grade Level
_____	_____	_____
_____	_____	_____

Home Street Address, including Zip Code

Alternate Location or Daycare Information: (Please print)

_____	_____
Street Address	Telephone number
_____	_____
Caregiver Name	Alternate telephone number

Mark
appropriate
boxes

	Mon	Tues	Wed	Thurs	Fri
To School					
From School					

Desired start date

Transportation will be arranged to/from alternate location at times marked above.

All other times student will be transported to home address in student information section above.

Parent/Guardian Information: (Please print)

_____	_____	_____
Name (print)	Home Telephone	Alternate number

New York State Education Law requires that a parent or legal guardian submit a written request for transportation to a child care provider **not later than April 1st each year**. Additional information can be found at:

<http://www.emsc.nysed.gov/schoolbus/>

My signature certifies that I am the parent/legal guardian of the above student(s) and authorized to request transportation to/from the alternate location/child care provider listed above.

Note: Retain a copy for your records

Signature

Date

Print, complete, and mail to Sodus Transportation



IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take a few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

- ☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- ☐ Work related to logging, harvesting, or initial processing of trees.
- ☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



If you answered YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____

Telephone number: (_____-_____-_____) Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____ Grade _____

Student name: _____ Age _____ Grade _____

To submit this referral please fax to 607-436-3606 or send by mail to NYS Migrant Education Program- Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ Allergies	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Asthma	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Seizures	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Diabetes	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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: ☐ Yes ☐ Not Done

Hypertension: ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:	
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥ 5 $\mu\text{g/dL}$	
Sickle Cell Screen-PRN	☐	☐			

☐ System Review Within Normal Limits

☐ Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list)

ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision Screening	With Correction ☐ Yes ☐ No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening ☐ Pass ☐ Fail					☐
Notes					
Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done
Pure Tone Screening	Right ☐ Pass ☐ Fail	Left ☐ Pass ☐ Fail	Referral ☐ Yes		☐
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		☐	☐	☐ Yes	☐
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
☐ *Family cardiac history reviewed – required for Dominic Murray Sudden Cardiac Arrest Prevention Act					
☐ Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
☐ Student is restricted from participation in:					
☐ Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
☐ Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
☐ Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
☐ Other Restrictions:					
Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.					
Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V					
☐ Other Accommodations*: Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
MEDICATIONS					
☐ Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
☐ Confirmed free of communicable disease during exam			☐ Record Attached ☐ Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					