



## DOLGEVILLE CENTRAL SCHOOL DISTRICT PRE-K-12 ENROLLMENT FORM

### NEW STUDENT ENROLLMENT – RECORD REQUEST AUTHORIZATION

Parent/Guardian Signature Authorization

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**Student Name**

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**Date of Birth**

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**Grade**

**Previous School Information:**

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School Name

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Phone Number

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Fax Number

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School Address

**By signing below:**

- I give permission for Dolgeville Central School to request all transfer records and pertinent information from my child's former school.
- I certify that the student has had polio, diphtheria (DPT), MMR, and varicella vaccines.
- I certify that the information contained in this enrollment form is true and current to the best of my knowledge.

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**Parent/Guardian Signature**

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**Date**



# DOLGEVILLE CENTRAL SCHOOL DISTRICT

## PRE-K-12 ENROLLMENT FORM

### NEW STUDENT REGISTRATION

**District Registrar use only**

**Student ID:** \_\_\_\_\_

**Enter Date:** \_\_\_\_\_

**Placement:**  Prekindergarten  Dolgeville Elementary K-6  James A. Green High School  
 Other: \_\_\_\_\_

**Grade:** \_\_\_\_\_ **Homeroom Teacher (PK-6 only):** \_\_\_\_\_

#### Documentation:

Proof of Age/Birth Certificate  Proof of Residency  New Student  Returning Student  
 School Records Received  Foster Care  CSE  CSE Records Received  
 Immunization Records  Physician Physical  Guardianship/custody paperwork (if applicable)

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### STUDENT INFORMATION

Last (legal name only)	First	Middle	Gender
_____	_____	_____	<input type="checkbox"/> Not Specified <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary
Date of Birth	Place of Birth		

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### PARENT/GUARDIAN INFORMATION

<b>Parent/Guardian #1</b>	<input type="checkbox"/> Primary Residence	<b>Parent/Guardian #2</b>	<input type="checkbox"/> Primary Residence
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Name	Relationship to Student	Name	Relationship to Student
_____	_____	_____	_____

Address	Address
_____	_____

Mailing Address (if different)	Mailing Address (if different)
_____	_____

Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Cell _____	Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Cell _____
Email _____	Email _____
Place of Employment _____	Place of Employment _____

Education/Highest grade completed \_\_\_\_\_

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**EMERGENCY CONTACTS**

Person or relative who we can contact if you are not reachable by phone.

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Name

Relationship to Student

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Address

Phone



# DOLGEVILLE CENTRAL SCHOOL DISTRICT PRE-K-12 ENROLLMENT FORM

## STUDENT RESIDENCY QUESTIONNAIRE

**Note:** The questions in this section are used to help identify students in homeless situations as required by the McKinney-Vento Homeless Assistance Improvements Act, 42U.S.C. 11453. Answers to this residency information help determine the services the student may be eligible to receive.

Is your current address a temporary living arrangement?  No  Yes

Is this temporary living arrangement due to loss of housing or economic hardship?  No  Yes

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
- In a hotel/motel
- In a car, park, bus, train, or campsite
- Another living situation (please explain): \_\_\_\_\_
- In permanent housing

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PRINT Name of Parent, Guardian, or Unaccompanied Homeless Youth

Signature of Parent, Guardian, or Unaccompanied Homeless Youth

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**SIBLINGS** (Be sure to include any future Blue Devils that are not currently enrolled!)

Name	* Gender	Date of Birth	Grade	Residence
				<input type="checkbox"/> Home <input type="checkbox"/> Other
				<input type="checkbox"/> Home <input type="checkbox"/> Other
				<input type="checkbox"/> Home <input type="checkbox"/> Other
				<input type="checkbox"/> Home <input type="checkbox"/> Other
				<input type="checkbox"/> Home <input type="checkbox"/> Other
				<input type="checkbox"/> Home <input type="checkbox"/> Other
				<input type="checkbox"/> Home <input type="checkbox"/> Other

\* Gender: Not Specified, Female, Male, Non-Binary

### OTHERS IN HOUSEHOLD

Name	Date of Birth	Relationship to Student

*Continued on next page*

**FOSTER CARE PLACEMENT** – Please complete this section only if the student is in foster care.

Foster Parent Name	Relationship to Student
<hr/>	
Address	Mailing Address (if different)
Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Cell	<hr/> Email
<hr/>	
Student's District of Origin	Agency placing student
<hr/>	
School Last Attended	Caseworker Name
<hr/>	
Date student was placed	Phone



## DOLGEVILLE CENTRAL SCHOOL DISTRICT PRE-K-12 ENROLLMENT FORM

### EDUCATION/SCHOOL BACKGROUND

**Previous School Attended**

Entry Date: \_\_\_\_\_

Grade: \_\_\_\_\_

Left Date: \_\_\_\_\_

Grade: \_\_\_\_\_

**Previous School Attended**

Entry Date: \_\_\_\_\_

Grade: \_\_\_\_\_

Left Date: \_\_\_\_\_

Grade: \_\_\_\_\_

**Previous School Attended**

Entry Date: \_\_\_\_\_

Grade: \_\_\_\_\_

Left Date: \_\_\_\_\_

Grade: \_\_\_\_\_

**Previous School Attended**

Entry Date: \_\_\_\_\_

Grade: \_\_\_\_\_

Left Date: \_\_\_\_\_

Grade: \_\_\_\_\_

Did your child attend preschool or pre-kindergarten?  No  Yes  Enrolling this school yearHas your child ever been retained?  No  Yes Grade: \_\_\_\_\_ Year: \_\_\_\_\_Does your child have a IEP or 504 Plan?  No  Yes, please explain \_\_\_\_\_**CHAPTER 53, EDUCATION LAW of 1980 - SCREENING**

According to Chapter 53, Education Law of 1980, all new entrants to public schools in New York State must be screened for possible handicapping conditions (such as learning disabilities, sensory deficits, physical impairments, etc.) or for giftedness (students who are capable of high academic aptitude, leadership, or special talent in one of more of the arts). Your child will be screened in areas of physical development, speech and language, motor abilities and cognitive development.

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Parent/Guardian Signature

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Date**RELEASE OF STUDENT ACCOMPLISHMENTS**

The Dolgeville Central School District is pleased to celebrate the accomplishments of our children. As a result, student artwork, writing, photographs, videos, and/or audio clips and quotes may be used in the Dolgeville Central School's printed and electronic publications or by the media. Please select one option below regarding the sharing of your child's accomplishments:

- I give permission to use my child's photos, works, and words in promotional publications for the Dolgeville Central School District (district website, Facebook page, ParentSquare, etc.).
- I do not want the district to share my child's photos, works, or words published in any form.

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Parent/Guardian Signature

---

Date



## DOLGEVILLE CENTRAL SCHOOL DISTRICT PRE-K-12 ENROLLMENT FORM

### MEDICAL INFORMATION

- To Be Completed By Parent/Guardian

Last (legal name only)

First

Middle

Gender

- Not Specified
- Female
- Male
- Non-Binary

Grade

Date of Birth

Place of Birth

Phone:  Home  Cell

Student Address:

Parent/Guardian #1 Name

Parent/Guardian #2 Name

Physician Name

Address

Phone

Dentist Name

Address

Phone

Emergency Contact Name #1

Phone

Relationship

Emergency Contact Name #2

Phone

Relationship

**Immunizations:** Please attach a copy of your child's most recent immunization records from their physician.

### HEALTH HISTORY

*Please complete the following as accurately as possible.*

Allergies (food, drugs, bees, animals, environmental)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Type of Allergy:	Medication Taken:
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If yes, indicate dates and explain:

Hay fever, asthma, wheezing	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Eczema or frequent skin rashes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Convulsions or seizures	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Heart trouble or murmurs	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

If yes, indicate dates and explain:

Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Pneumonia	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Frequent colds, sore throat, or ear aches	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Rheumatic fever / scarlet fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Mononucleosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Chicken Pox	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Measles/Mumps/Rubella	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Meningitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Strep Infections	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Speech problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Bowel or urinary problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Nutrition or weight problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Behavior, developmental or maturity problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Social adjustment problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Severe accidents or injuries	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Hospitalizations	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Surgeries	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Known vision problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Known hearing problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Pain in legs, arms, back or joints	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Limp or unusual walk	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Balance issues or unexplained sudden movements	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Other:	<input type="checkbox"/> No <input type="checkbox"/> Yes	

**Medications**

Is your child taking any medications? (If a child needs medication administered in school, a medication request form must be completed and signed by a physician before medication can be given at school).  No  Yes

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Name of medication and dosage

Reason for medication

**Prenatal History**

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Child's birth weight

Duration of pregnancy

Prenatal difficulties

Did the child have difficulties at birth?  No  Yes, please explain

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**Physical Activity**

Does your child have any physical difficulty that would prevent them from participating in the normal physical education class or other activities? (If your child is unable to participate in physical education class, then a physician's certificate is required.)

No  Yes, please explain

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**Annual Physical Examinations**

The New York State Education Law requires a physical examination before entrance to school and routinely at grades Pre-K, K, 2, 4, 7, and 10. All athletes, and those with physical disabilities, are examined yearly.

Student to be examined:

In school  
 By family physician

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Parent/Guardian Signature

---

Date



## DOLGEVILLE CENTRAL SCHOOL DISTRICT PRE-K-12 ENROLLMENT FORM

### DENTAL HEALTH CERTIFICATE

- Optional

New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, and 10. 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 complete Section 2. The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Return the form to the school nurse as soon as possible.

### SECTION 1. TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name	First	Middle	Grade
Gender: <input type="checkbox"/> Not Specified <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary			

Date of Birth

Will this be your child's first dental visit?  No  Yes

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

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### SECTION 2. TO BE COMPLETED BY THE DENTIST

The Dental Health condition of \_\_\_\_\_ on \_\_\_\_\_ (date of exam – should be within 12 months of the start of the school year).

- Is in fit condition of dental health to permit his/her attendance at public school.
- Is not in fit condition of dental health to permit his/her attendance at public school.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with the students 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.)**

\_\_\_\_\_

**Date**



# DOLGEVILLE CENTRAL SCHOOL DISTRICT

## REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

- TO BE COMPLETED 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					
Child's Last Name	First	Middle	Date of Birth		
Gender: <input type="checkbox"/> Not Specified <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary					
Date of Exam	<input type="checkbox"/> Prekindergarten <input type="checkbox"/> Dolgeville Elementary K-6 <input type="checkbox"/> James A. Green High School				
Grade					
HEALTH HISTORY					
If yes to any diagnoses below, check all that apply and provide additional information.					
<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached				
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached				
<input type="checkbox"/> Seizures	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached				
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached				
<b>Risk Factors for Diabetes or Pre-Diabetes:</b> 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/m <sup>2</sup>					
Percentile (Weight Status Category): <input type="checkbox"/> <5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> -49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> -84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> -94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> -98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and >					
Hyperlipidemia: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Done			Hypertension: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Done		
PHYSICAL EXAMINATION/ASSESSMENT					
Height:	Weight:	BP:	Pulse:	Respirations:	
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done	
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Lead Elevated > 5 µg/dL	
<input type="checkbox"/> System Review Within Normal Limits					
<input type="checkbox"/> Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)					
<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech	
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional	
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal	
Assessment/Abnormalities Noted/Recommendations:			Diagnoses/Problems (list) ICD-10 Code*		
<input type="checkbox"/> Additional Information Attached			*Required only for students with an IEP receiving Medicaid		

Continued on next page

Child's Last Name

First

Middle

Date of Birth

**SCREENINGS**

Vision &amp; Hearing Screenings Required for PreK or K, 1, 3, 5, 7, &amp; 11

Vision Screening	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>

**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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes	<input type="checkbox"/>
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**Notes:**

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	Negative	Positive	Referral	Not Done
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>

**Notes:****FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS\*/PLAYGROUND/WORK**

\*Family cardiac history reviewed - required for Dominick 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 ONLY 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: (please print)

Provider Address:

Phone:  Fax:

**Please Return This Form to Your Child's School Health Office When Completed.**



## DOLGEVILLE CENTRAL SCHOOL DISTRICT PRE-K-12 ENROLLMENT FORM

### ELIGIBILITY SCREEN FOR MIGRANT EDUCATION SERVICE

Migrant Education Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed.

Has your family moved to a different school district in the last three years?  No  Yes

In the last three years, has the parent or guardian of the child enrolling done farm work as a paid job? (Did they work on a dairy farm planting, picking/harvesting vegetables or fruits, food processing or packaging, logging or tree farming?)  No  Yes

If yes, what farm did you work on? \_\_\_\_\_

Where? \_\_\_\_\_

Dates of Work: \_\_\_\_\_

**If you can answer YES to BOTH of the above questions, your family MAY qualify for Migrant Education services. To be contacted by a staff member regarding possible services, please complete the information for your children below:**

Name of Child(ren)	* Gender	Date of Birth	Grade

\* Gender: Not Specified, Female, Male, Non-Binary

#### PARENTS/GUARDIANS INFORMATION

Parent/Guardian #1

Name \_\_\_\_\_

Address \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

Phone:  Home  Cell \_\_\_\_\_  
 Work  Cell \_\_\_\_\_

Parent/Guardian #2

Name \_\_\_\_\_

Address \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

Phone:  Home  Cell \_\_\_\_\_  
 Work  Cell \_\_\_\_\_

# It's everything Dolgeville CSD, in your pocket.



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Documents



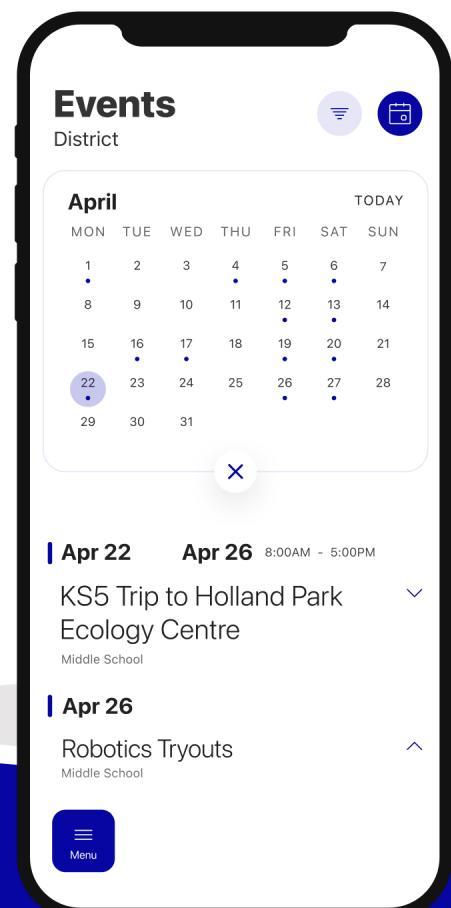
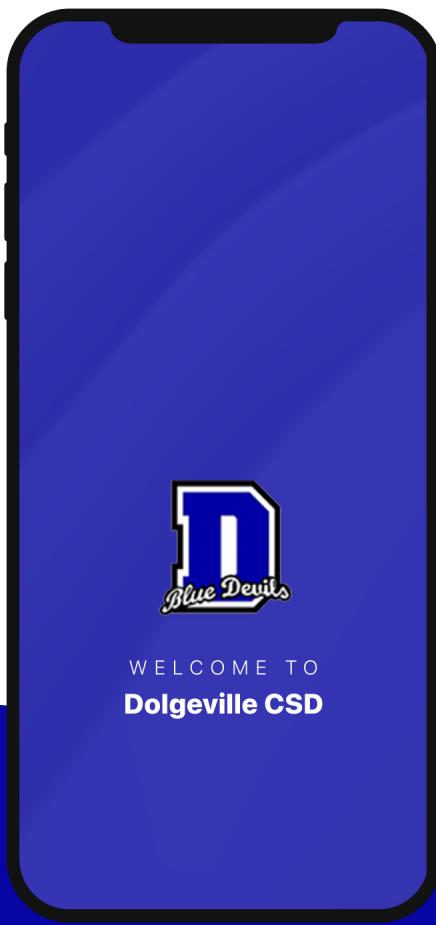
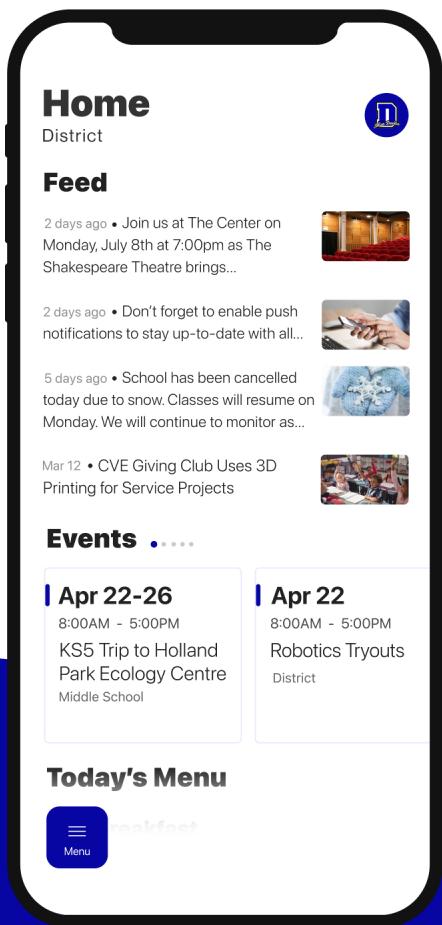
Staff



Notifications



Dining



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