



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

NEW STUDENT ENROLLMENT – RECORD REQUEST AUTHORIZATION

Parent/Guardian Signature Authorization

Student Name

Date of Birth

Grade

Previous School Information:

School Name

Phone Number

Fax Number

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.

Parent/Guardian Signature

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)

STUDENT INFORMATION

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

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1	<input type="checkbox"/> Primary Residence	Parent/Guardian #2	<input type="checkbox"/> Primary Residence
_____	_____	_____	_____
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 _____		Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell _____	
<input type="checkbox"/> Work <input type="checkbox"/> Cell _____		<input type="checkbox"/> Work <input type="checkbox"/> Cell _____	
_____		_____	
Email		Email	
_____		_____	
Place of Employment		Place of Employment	
_____		_____	
Education/Highest grade completed		Education/Highest grade completed	

EMERGENCY CONTACTS

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

<hr/> Name	<hr/> Relationship to Student
<hr/> Address	<hr/> Phone
<hr/> Name	<hr/> Relationship to Student
<hr/> Address	<hr/> Phone
<hr/> Name	<hr/> Relationship to Student
<hr/> Address	<hr/> Phone
<hr/> Name	<hr/> Relationship to Student
<hr/> Address	<hr/> 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

PRINT Name of Parent, Guardian, or Unaccompanied Homeless Youth

Signature of Parent, Guardian, or Unaccompanied Homeless Youth

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

Address

Mailing Address (if different)

Phone: ☐ Home ☐ Cell

☐ Work ☐ Cell

Email

Student's District of Origin

Agency placing student

School Last Attended

Caseworker Name

Date student was placed

Phone



DOLGEVILLE CENTRAL SCHOOL DISTRICT PRE-K-12 ENROLLMENT FORM

EDUCATION/SCHOOL BACKGROUND

Previous School Attended**Address**

Entry Date: _____ Grade: _____ Left Date: _____ Grade: _____

Previous School Attended**Address**

Entry Date: _____ Grade: _____ Left Date: _____ Grade: _____

Previous School Attended**Address**

Entry Date: _____ Grade: _____ Left Date: _____ Grade: _____

Previous School Attended**Address**

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.

Parent/Guardian Signature**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.

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 <input type="checkbox"/> Not Specified <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary
_____ Grade	_____ Date of Birth	_____ Place of Birth	
_____ Student Address:		Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell	_____
_____ 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:

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

Name of medication and dosage

Reason for medication

Prenatal History

Child's birth weight

Duration of pregnancy

Prenatal difficulties

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

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

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

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

Date of Birth Gender: ☐ Not Specified ☐ Female ☐ Male ☐ Non-Binary

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

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.)

Dentist Signature

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	
Date of Exam		Gender: <input type="checkbox"/> Not Specified <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary			
		<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 Date of last seizure: <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				
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): <input type="checkbox"/> <5 th <input type="checkbox"/> 5 th -49 th <input type="checkbox"/> 50 th -84 th <input type="checkbox"/> 85 th -94 th <input type="checkbox"/> 95 th -98 th <input type="checkbox"/> 99 th 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"/> Dental <input type="checkbox"/> Mental Health	<input type="checkbox"/> Lymph nodes <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Lungs	<input type="checkbox"/> Abdomen <input type="checkbox"/> Back/Spine/Neck <input type="checkbox"/> Genitourinary	<input type="checkbox"/> Extremities <input type="checkbox"/> Skin <input type="checkbox"/> Neurological	<input type="checkbox"/> Speech <input type="checkbox"/> Social Emotional <input type="checkbox"/> Musculoskeletal	
<input type="checkbox"/> 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
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SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 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"/>
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					
<input type="checkbox"/> *Family cardiac history reviewed - required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions. <u>If Restrictions Apply</u> - Complete the information below <input type="checkbox"/> Student is restricted from participation in: <ul style="list-style-type: none"> <input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. <input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball. <input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. <input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> Other Accommodations*: Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.): <div style="font-size: small;">*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.</div>					
MEDICATIONS					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> 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.
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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

Parent/Guardian #2

Name

Name

Address

Address

Mailing Address (if different)

Mailing Address (if different)

Phone: ☐ Home ☐ Cell _____
☐ Work ☐ Cell _____

Phone: ☐ Home ☐ Cell _____
☐ Work ☐ Cell _____

Migrant Education services are offered through Herkimer-Fulton-Hamilton-Otsego BOCES,
352 Gros Boulevard, Herkimer, NY 13350.

It's everything Dolgeville CSD, in your pocket.



News



Events



Documents



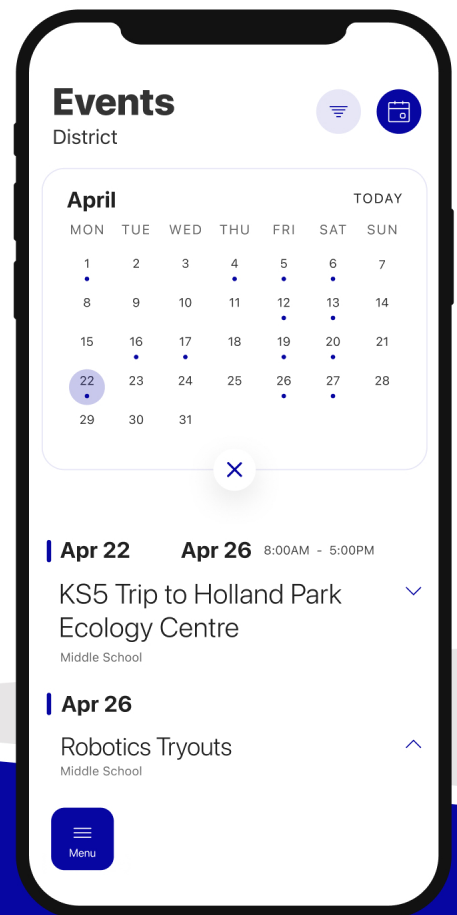
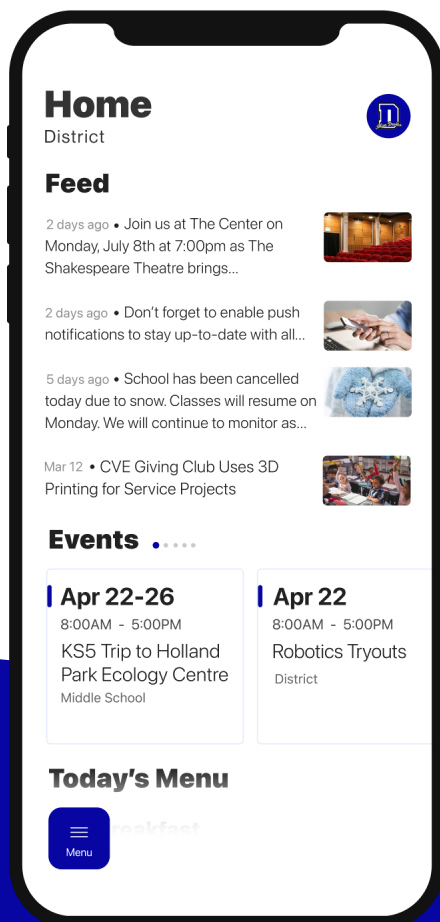
Staff



Notifications



Dining



Download the **Dolgeville CSD** app from the iOS App Store or Android Play Store and enable Notifications.