Oakfield-Alabama Central School District
7001 Lewiston Road, Oakfield, NY 14125
Phone: (585) 948-5211
Fax: (585) 948-8913

Kindergarten Registration Requirements

WELCOME TO THE OAKFIELD-ALABAMA CENTRAL SCHOOL DISTRICT

In order to register your child(ren) you must complete all of the information in the enclosed registration packet and turn it into Mrs. Fisher in the Elementary Office. Each child must have a registration packet completed.

Proof of Residency (2 forms are required)
To register your child, you must be a resident of the Oakfield-Alabama Central School District. Examples of proof of residency include a lease agreement, a signed purchase offer, a utility bill (gas, electric, phone, cable), a current bank statement, a current computer printed pay stub, NYS Drivers' License, NYS Certificate of Title, and/or NYS Registration Document with your name and address.

Birth Certificate
Birth certificates for all students born in the United States are required.

Citizenship
If your child is not a citizen of the United States, please bring your child's I-94 form or alien registration card (green card).

Are both natural parents living at the same address as the student?
If there has been a divorce or separation, a copy of a signed document stating the custody and the primary residence of the child(ren) is required. The District must comply with all legal arrangements set forth by the Court and/or agreements made by both the natural parents.

Records of Immunization
We must have each child's complete up to date shot history from your physician or previous school at the time of registration. These must be signed by a doctor and will need to be reviewed by our School Nurse.

Physical
We must have each child's complete up to date physical from your physician or previous school at the time of registration. These must be signed by a doctor and will need to be reviewed by our School Nurse.

Dental Appraisal
We must have each child's complete, up to date dental appraisal from your family dentist or previous school at the time of registration. These must be signed by a dentist and will need to be reviewed by our School Nurse.

Health History Form
This form is enclosed and is requested for the student's health file. This information will be helpful to the nurse in determining illness should your child go to the Health Office for assistance.

Student Information or Registration Form
This form is enclosed and required for parental contact, emergency contact, and emergency transportation information.

Home Language Questionnaire
This form is enclosed and needs to be completed to determine how well your child understands, speaks, reads and writes English.

Free/Reduced Meal Application (only 1 per family needed)
This form is available on our website under Lunch Payment and needs to be completed if you wish to know if your child qualifies for free/reduced meals.

Transportation Information Form
This form is available on our website under Transportation and is required to be completed and signed by a parent.

OAKFIELD-ALABAMA CENTRAL SCHOOL DISTRICT
7001 Lewiston Road Oakfield, New York 14125 – Phone (585)948-5211 Fax (585)948-8913
NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH APPRAISAL FORM

Name: _____ Date of Birth: _____

School: _____ Gender: ☐ M ☐ F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: _____
PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____
Dental Referral ☐ Yes ☐ No ☐ Not done Date: _____

Significant Medical/Surgical History: ☐ See attached _____

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

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

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

				Referral
Body Mass Index: _____ _____ . _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th	Vision - Near Point	R	L	
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher	Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: _____

Eyes____ Ears____ Nose____ Throat/Tonsils____ Teeth/Gums____ Lymph Glands____ Thyroid____ Lungs____ Breast____

Heart____ Genito-Urinary____ Hernia____ Orthopedic____ Nervous System____ Epilepsy____ Skin____ Nutrition_____

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.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ **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 ☐ Other: _____

(Stamp below)

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 10/3/07*

Oakfield-Alabama Central School

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 the 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) 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 filling (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 ½ mm 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.

Oakfield Alabama CSD

STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age: Grade:	Gender: ☐M ☐F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Dental Injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition
  (depression, eating disorder, anxiety, OCD, ODD, etc.)
- ☐ Scoliosis
- ☐ Single Organ (☐kidney, ☐testicle)
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Urinary Condition

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	

Continues on back page

Oakfield Alabama CSD

During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

; there any condition that would prevent your child from participating in physical education or sports?

☐No ☐Yes:_____

lease list any additional concerns: (use back of sheet if necessary)_____

_____

'arent/Guardian Signature:_____Date:_____

Oakfield-Alabama Central School
7001 Lewiston Road
Oakfield, NY 14125
(585) 948-5211

Student Information Form

Please list the student and all children, to age 21, living in the home.

	Name	Social Security Number	DOB (mm/dd/yyyy) Location	Gender (circle)	Ethnicity (circle see below)	Grade (PreK-12)	Services (circle)
STUDENT		- -	/ /	Male Female	A B H I P W		CSE 504
Siblings/Other children		- -	/ /	Male Female	A B H I P W		CSE 504
		- -	/ /	Male Female	A B H I P W		CSE 504
		- -	/ /	Male Female	A B H I P W		CSE 504
		- -	/ /	Male Female	A B H I P W		CSE 504

A=Asian, B=African-American, H=Hispanic, I=American Indian/Alaskan Native, P=Native Hawaiian or other Pacific Islander, W=White

Student Information:

Address: _____

Mailing Address (if different from above): _____

Student Resides With: _____ (circle one if different): Guardian #1 Guardian #2 Both Joint Custody Other: _____

If parents are divorced or separated, who has legal custody? _____ ***Court documentation must be provided.***

Guardian #1 Information:

Guardian #1's Full Name: _____

Relationship to Child: _____

Guardian #1's Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

Guardian #1's Land Line Phone: _____

Guardian #1's Cell Phone: _____

Guardian #1's Employer: _____

Guardian #1's Work Phone: _____

Guardian #1's Email: _____

Guardian #2's Information:

Guardian #2's Full Name: _____

Relationship to Child: _____

Guardian #2's Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

Guardian #2's Land Line Phone: _____

Guardian #2's Cell Phone: _____

Guardian #2's Employer: _____

Guardian #2's Work Phone: _____

Guardian #2's Email: _____

In the event of an emergency, parents will be contacted first. If parents are not available, list additional emergency contacts in the order they should be contacted.

Emergency Contact #1

Last Name, First Name	Relationship to Child	Phone	Phone Type:

Emergency Contact #2

Last Name, First Name	Relationship to Child	Phone	Phone Type:

Emergency Contact #3

Last Name, First Name	Relationship to Child	Phone	Phone Type:

The above will be authorized to pick up your child in case of early dismissal due to illness, injury, inclement weather or any other emergency situation. The above will only be used if parents cannot be reached.

If school is dismissed early or evacuated for any reason and ALL students will be bused, please indicate below where your child should be sent. ***(Must be in the Oakfield-Alabama School District).***

Location (circle one): Home Other Location

Name: _____

Address: _____

Phone: _____

The questions below are intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

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

If you answered YES to the above questions, please complete the remainder of this form. If you answered NO, you may stop here.

Where is the student presently living? (circle) Motel Shelter With more than one family in a house/apartment Moving from place to place Car/Park/Campsite

Street	City	State	Zip	( ) Home Phone	Email Address

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 others costs. TEC Sec. 25.002(3)(d).

Signature of Parent/Legal Guardian	Date

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

McKinney-Vento Liaison Signature	Date

The University of the State of New York • The State Education Department • Office of Bilingual Education
Albany, New York 12234

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 English. Your assistance in answering these questions is greatly appreciated.

Thank You

TO BE COMPLETED BY SCHOOL PERSONNEL

Please print or type clearly

DISTRICT

SCHOOL GRADE

STUDENT NAME

DATE OF BIRTH
Month: Day: Year:

STUDENT IDENTIFICATION NUMBER

COUNTRY OF BIRTH / ANCESTRY

NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.

NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION

DETERMINATION: ❑ Possible LEP ❑ English Proficient

(✔ boxes that apply)

1. What language(s) is spoken in the student's home or residence? ❑ **English** ❑ **Other** _____ *specify*
2. What language(s) are spoken most of the time to the student, in the home or residence? ❑ **English** ❑ **Other** _____ *specify*
3. What language(s) does the student understand? ❑ **English** ❑ **Other** _____ *specify*
4. What language(s) does the student speak? ❑ **English** ❑ **Other** _____ *specify*
5. What language(s) does the student read? ❑ **English** ❑ **Other** _____ *specify* ❑ **Does Not Read**
6. What language(s) does the student write? ❑ **English** ❑ **Other** _____ *specify* ❑ **Does Not Write**
7. In your opinion, how well does the student understand, speak, read and write English?

	Very well	*Only a little*	*Not at all*
Understands English	❑	❑	❑
Speaks English	❑	❑	❑
Reads English	❑	❑	❑
Writes English	❑	❑	❑

Signature of Parent/Guardian/Other

Month: Day: Year:
Date