BOQUET VALLEY
CENTRAL SCHOOL DISTRICT

Dear Families of Incoming Kindergarten Students,

We hope this letter finds you well. As we gear up for another exciting academic year, we want to inform you about the Kindergarten screening process. Kindergarten screening is a valuable opportunity for us to get to know your child better and tailor our educational approach to meet their needs effectively.

What is Kindergarten Screening?
Kindergarten screening is an assessment process designed to provide us with insights into your child's readiness for kindergarten. It helps us understand their developmental strengths and areas where additional support may be beneficial. This screening is a collaborative effort between our dedicated educators and your child's future teachers and related service providers.

When is Kindergarten Screening?
Kindergarten Screening is scheduled for May 29 & May 30, 2024. Please mark these dates on your calendar as attendance is crucial for your child's successful transition into kindergarten. Once we receive this completed packet back at school, we will schedule you and your child for a one hour time slot.

What to Expect During Kindergarten Screening:
During the screening process, your child will engage in various activities and tasks that allow us to observe their skills and abilities. These activities are designed to be engaging and developmentally appropriate. Some examples of activities your child may participate in include: Fine motor skills assessment (e.g., drawing, cutting), language and literacy activities (e.g., letter recognition, storytelling), math readiness tasks (e.g., counting, sorting), and social interaction and communication exercises (e.g., group activities, following directions).

Parent/Guardian Involvement:
While the screening is focused on evaluating your child's readiness for kindergarten, we understand that this process can sometimes evoke questions or concerns. We welcome your involvement and are available to address any queries or discuss any aspect of the screening process. Please feel free to reach out to me personally if you have any questions or require further clarification.

Yours in Education,

Lee Kyler

Mr. Lee Kyler
Principal, Lake View Campus
Boquet Valley Central School District
Office Phone: (518) 962-8244

BOQUET VALLEY CENTRAL SCHOOL DISTRICT

Joshua R. Meyer Superintendent of Schools

District Office
@ Mountain View Campus
P.O. Box 158
Elizabethtown, NY 12932
Ph (518) 873-6371

Student Residency Questionnaire

Name of Student: _____Sex: _____

Birth Date: ____/_____/_____ Age:_____ Social Security #:_____

This questionnaire is 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.

1. Is your current address a temporary living arrangement? _____Yes _____No
2. Is this temporary living arrangement due to loss of housing or economic hardship? _____Yes _____No
3.

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? (*check one box*)

- ☐ In a motel
- ☐ In a shelter
- ☐ With more than one family in a house or apartment
- ☐ Moving from place to place
- ☐ In a place not designed for ordinarysleeping accommodations such as a car, park, or campsite

Name of Parent(s)/Legal Guardian(s)_____
Address _____Zip_____Phone_____

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).

Signature of Parent/Legal Guardian _____Date:_____
Please send a copy to _____ at the Central Office.
Fax:_____

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

Date:_____ _____
(McKinney-Vento Liaison Signature)

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

Elisa Alvarez, Associate 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 Person in Parental Relation:
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.

STUDENT NAME:		
First	*Middle*	*Last*
DATE OF BIRTH:		GENDER:
Month	*Day*	*Year* ❑ Male ❑ Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to*

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?	❑ Parent 1 *specify*	❑ Parent 2 *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:*	

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: ❑ **Parent** ❑ **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:

BOQUET VALLEY CENTRAL SCHOOL
KINDERGARTEN REGISTRATION FORM

STUDENT INFORMATION

Last Name:_____First Name:_____Middle Name:_____

__ Date of Birth:____/_____/_____Place of Birth:_____, _____

(City) (State)

Physical Address: _____

Mailing Address:_____

PARENT OR LEGAL GUARDIAN INFORMATION

Mother's Last Name:_____Home Phone Number: ( )_____-_____

Mother's First Name:_____Cell Phone Number: ( )_____-

Country Born:_____Work Phone Number: ( ) _____

Mother's Email Address: _____

Mother's Occupation: _____

Father's Last Name:_____Home Phone Number: ( )_____ - _____

Father's First Name:_____Cell Phone Number: ( )____-_____

Country Born:_____Work Phone Number: ( )_____-_____

Father's Email Address: _____

Father's Occupation: _____

Emergency Contact person(s) and Phone Number- (If Parent/Guardian cannot be reached)

Please list all of your children (oldest to youngest):

Last Name	First Name	D.O.B	Sex : M/F	Living at Home	Living Away

The student lives with- (Please check those that apply)

_____Mother _____Father _____Grandmother _____Aunt

_____Step Father _____Grandfather _____Uncle

_____Step Mother

Other:_____

Are student's parents: (Please circle one)

Married Separated Divorced Widowed: Mother deceased/Father deceased

Please list any agencies aiding your family:

_____

Language spoken at home: _____

Did your child participate in a Pre-School, Pre-K or Head Start program?

_____Pre-School List any problems there: _____

_____Pre-K List any problems there: _____

_____Head Start List any problems there: _____

If not, did your child participate in daycare? _____

Was the daycare registered? Yes / No / I don't know

Does your child have an IEP through CPSE or early education services?

_____

Is your child Left Handed, Right Handed, Both

How many hours of TV does your child watch per day? _____

Does your child get exercise regularly? (Describe the activities)

_____

_____

Do you feel that your child has an issue with any of the following?

_____Following directions

_____Self Control

_____Social Pay

_____Motor Coordination

_____Remembering

_____Gaining Independence

_____Language Skills/Speech

_____Other: _____

Has your child had any of the following behaviors that might concern you?

_____Bowel/Bladder problems

_____Difficulty Sleeping

_____Nail biting

_____Nightmares

_____Shyness

_____Temper Tantrums

_____Thumb Sucking

_____Over activeness

_____Other: _____

Please describe methods of discipline used in your family:

_____

_____

Which parent typically disciplines the child? _____

How would you describe the child's relationship with his/her siblings? _____

_____

Describe the students typical:

Breakfast:_____

Lunch:_____

Dinner:_____

Does your child have any food allergies? (Please list)

_____

Is the child a "picky" eater? _____

What time does your child go to bed? _____

How often does your child brush his/her teeth? _____

Does the student floss his/her teeth? _____

PRENATAL

Were there any complications or problems during the pregnancy, labor, or delivery of the child?

_____

Did the child have any complications at birth? _____

_____

Was the child born prematurely? _____

DEVELOPMENTAL MILESTONES

Do you have any concerns regarding your child's development? Please explain.

_____

_____

Have the parents been separated during the child's life?_____Yes_____No

Age of the child during the time of separation: _____

Have there been any circumstances in the child's life that you believe were hard for the child and you think would better help us understand him/her? Please explain.

_____

_____

_____

Has the child received any professional counseling? If so, where?

_____

Does anyone in the family (other than the child) have a history of?

_____Allergies	_____Arthritis	_____Asthma
_____Cancer	_Cerebral Palsy	_Diabetes
_____Emotional problems	_Hearing problems	_Heart disease
_____Hepatitis	_Kidney disease	_Tuberculosis
_____Learning disability	_Mental Retardation	_Bad Headaches
_____Seizures or Convulsions	_Speech Problems	___Visual Problems

Chronic Illness (be specific) _____

Does anyone in the home smoke cigarettes, pipes, or cigars? Please specify:

_____

STUDENT'S HISTORY

Has the child had any of the following?

_____Allergies	_____Measles
_____Anemia	_____Meningitis
_____Arthritis	_____Mumps
_____Asthma	_____Orthopedic Problems
_____Bee Sting Allergy	_____Rheumatic Fever
_____Birth Defects	_____Seizures or Convulsions
_____Chicken Pox	_____Severe Headaches
_____Diabetes	_____Whooping Cough
_____Heart Disease	_____other

HISTORY RELATIVE TO THE EAR

How many colds or sore throats does the child have per year? _____

Has the child had more than two ear infections in the past year? _____

Does the child sneeze a lot or have a stuffy nose frequently? _____

Does the child watch your mouth when you talk to him/her? _____

Does the child stand close to the Television or to you when you speak? _____

Does the child respond when you call him/her from another room? _____

Has the child ever had discharge from his/ear ears or had issues with ear wax? _____

Has the child been to an Ear, Nose, and Throat Specialist? _____

If so, Dr's Name:_____Date:_____

Results: _____

HISTORY RELATIVE TO THE EYE

Does the child experience excessive rubbing, blinking, or squinting? _____

Does the child have trouble seeing close up?_____Far away? _____

Does the child have a history of crossed eyes?_____Recurring sties? _____

Does the student complain of itching or burning? _____

Other:_____

Does the student sit close to the TV? _____

Does the student complain of dizziness or headaches? _____

Has the student been seen by an eye specialist? _____

If so, Dr.'s Name:_____Date:_____

Results: _____

HISTORY RELATIVE TO ALLERGY/ASTHMA

Has the student been tested for allergies? _____

If so, Dr.'s Name:_____Date:_____

Results:_____

List of Allergies: _____

Is the student receiving medications, allergy shots, or other treatments? _____

Using an inhaler or nebulizer? _____

Name of medication and dosage: _____

What triggers an allergy/asthma attack in the student? _____

_____

Please check the child's typical allergic symptoms:

____Chronic Fatigue	____Nasal Congestion
____Dark circles under eyes	____Rashes
____Headaches	____Restlessness
____Hyperactivity	____Sensitive Eyes
____Insomnia	____Shortness of Breath
____Mood Swings	____Other

Please list any accidents or hospitalizations the student has had:

Date	Accident/Hospitalization	Injury/Illness

CURRENT MEDICAL CARE

Pediatrician name and Facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

Last date seen: _____

Name of Dentist: _____

Address: _____

Phone Number: _____ Fax Number: _____

Last date seen: _____

Are there any other medical personnel treating the student? _____

List any medications your child is currently taking on a daily basis, including vitamins:

_____

Is the student allergic to any medication? _____

HOUSEHOLD INCOME SURVEY

Boquet Valley Central School District participates in the federal lunch program. This information is collected to ensure continuation of resources and supports. Your participation will help in bringing necessary services to our district.

Number in household? _____

Household income:

_____ 0 - $11,770	_____ $11,771 - $15,930	_____ $15,931 - $20,089
_____ $20,090 - $24,249	_____ $24,250 - $24,809	_____ $24,810 - $32,569
_____ $32,570 - $36,729	_____ $36,730 - $40,889	_____ $40,890 - $45,049
_____ $45,050 - $49,203	_____ $49,204 - Or more	

_____ _____

Parent/Guardian Signature *Date*

BOQUET VALLEY
CENTRAL SCHOOL DISTRICT

Joshua R. Meyer Superintendent of Schools

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@ Mountain View Campus
P.O. Box 158
Elizabethtown, NY 12932
Ph. (518) 873-6371

BEE STING ALLERGY FORM

Student Name: _____ Date: _____

- My child is allergic to stings by (Please check those that are applicable)
  - _____ Bees
  - _____ Yellow Jackets
  - _____ Hornets/Wasps

- My child is allergic but has a local reaction ONLY (at the site of a sting) and requires treatment as follows:

  _____

  _____

- My child is SEVERELY allergic to stings and requires treatment as follows:

  _____

  _____

_____ _____

Parent/Guardian Signature Date

PLEASE NOTE: If your child requires medication of any kind, the School Nurse must have:

1. Written parental permission to administer specified medication
2. Doctor's written authorization to give specified medication.
3. Medication in its ORIGINAL bottle or package with the prescription attached.

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Physical Examination & Dental Health Certificates Information for Parents/Guardians

Dear Parents/Guardians,

New York State law requires a health examination for all students **entering the school district for the first time and for CSE Triennial Reviews when entering Pre-K or K, 1st, 3rd, 5th, 7th, 9th and 11th grade**. A New York State licensed physician, physician assistant or nurse practitioner must complete the examination.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time. The school will provide you with a list of dentists and registered dental hygienists who offer dental services on a free or reduced cost basis if you ask for it.

- A copy of the health examination must be provided to the school before your child starts at the school, and when your child starts pre-K or K, 1st, 3rd, 5th, 7th, 9th or 11th grades.
- If your child has an appointment for an exam during the school year that is after the first 30 days of school, please notify the Health Office with the date.
- For your convenience, a physical exam form and dental certificate for your health care provider is enclosed.
- Communication between providers and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with the school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the time of your child's appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office. Forms may also be faxed to the number provided below.

Sincerely,

School Nurse: Carol Schwoebel RN
School: Boquet Valley Central School – Lake View Campus
Phone #: 518-962-8244
Fax #: 518-962-4571
Email: cschwoebel@boquetvalleycsd.org

Dental Health Certificate - Optional

Parent/Guardian: Please complete Section 1 and take the form to your dentist/dental hygienist for an assessment. Request your dentist/dental hygienist to fill out Section 2. Return the completed form to your child's teacher 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

Section 2. To be completed by the Dentist/Dental Hygienist

I. 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**

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

II. Treatment Needs (check all that apply)

☐ **No need for Treatment**

☐ **Urgent Treatment –** abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care –** amalgams, composites, crowns, etc.

☐ **Preventive Care** – sealants, fluoride treatment, prophylaxis, mouthguard etc.

☐ **Other** – periodontal, orthodontic treatments

Please note _____

The Dental Health condition of _____ on _____ (date of exam) Check one:

☐ **Yes, The student listed above *is* in fit condition of dental health to permit him/her attendance at the public schools.**

☐ **No, The student listed above *is not* in fit condition of dental health to permit him/her attendance at the public schools.**

Dentist's Name and Address (Please Print or Stamp):

Dentist/Dental Hygienist Signature:

Date of Exam: / /

* The dental health condition of the student when the exam is made and the date of exam shall not be more than 12 months prior to the commencement of the school year in which the exam is requested.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY 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

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code
_____	_____
_____	_____
_____	_____
_____	_____

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** — **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** — **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

STUDENT EMERGENCY FORM

Please supply all information requested below and return this form to the school. This form will be kept on file in the district office for the school year. If more than one form is needed per family, please contact the office for additional forms.

Student Information:

Student Name:	**Date of Birth:**	**Grade:**
Mailing Address:	**City:**	**Zip:**
Physical Address:	**City:**	**Zip:**
Home Phone:	**Cell Phone:**	
Email Address:		

Parent/Guardian Information: *To serve your child in case of accident, sudden illness, emergency closing and/or other occurrence requiring immediate parental notification; it is necessary that you furnish the following information for emergency calls.*

Mothers Name:	
Business Address:	
Business Phone:	**Cell Phone:**
Email Address 1:	**Email Address 2:**

Father's Name:	
Business Address:	
Business Phone:	**Cell Phone:**
Email Address 1:	**Email Address 2:**

Emergency Contacts: *Please designate two emergency contacts who will assume temporary care of your child, if you cannot be reached in the event of an accident, sudden illness, emergency closing and/or other occurrence requiring immediate parental notification.*

Contact #1:		**Relationship to Student:**
Address:		
Home Phone:	**Cell Phone:**	**Work Phone:**

Contact #2:		**Relationship to Student:**
Address:		
Home Phone:	**Cell Phone:**	**Work Phone:**

Medical Information:

Physician (Full Name):	
Address:	**Phone Number:**
Hospital/Dr. Office:	

I, the undersigned, do here authorize officials of the Boquet Valley Central School District to contact directly the persons named on this form and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this card or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement, for the health of said child.

I will not hold the school district financially responsible for the emergency care and/or transportation of the child.

Date _____ **Signature of Parent or Guardian** _____

BOQUET VALLEY CENTRAL SCHOOL DISTRICT

Joshua R. Meyer Superintendent of Schools

District Office
@ Mountain View Campus
P.O. Box 158
Elizabethtown, NY 12932
Ph: (518) 873-6371

PROVIDER ATTESTATION AND PARENT PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name:_____ **DOB:**_____

Health Care Provider Permission for Independent Use and Carry
I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This oder applies to the medications checked below:
This student is diagnosed with:

- ☐ Allergy and requires Epinephrine Auto-injector
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ☐ _____(state diagnosis) which requires rapid administration of _____(Medication Name)

Signature:_____ **Date:**_____

Parent/Guardian Permission for Independent Use and Carry
I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Signature:_____ **Date:**_____

Please return to School Nurse:

School Nurse:	School:

Phone #:	Fax:	Email: