CANASTOTA CENTRAL SCHOOL DISTRICT

220 N. Peterboro Street, Canastota, New York 13032 • 315-697-2027 • Fax 315-697-6355

PETERBORO STREET ELEMENTARY SCHOOL
Jennifer L. Carnahan, *Principal*

Shawn D. Bissetta
Superintendent of Schools

February 1, 2024

Dear Future Kindergarten Parents/Caregivers:

We would like to welcome you to the beginning of a wonderful adventure, kindergarten! In order to make this a special time for you and your child, we will have several events planned that lead up to the first day of school. The first one is kindergarten registration, which will be held on Tuesday, March 5th, with a "snow date" of Monday, March 11th. You must have an appointment to register your child. Daytime appointments between 8am-3pm will be held in the High School Guidance Office @ 120 Roberts Street. Afternoon appointments between 3:30-5:30pm will take place at Peterboro Street Elementary School at 220 N. Peterboro Street. In order to schedule an appointment, please call Mrs. Amanda Snyder, District Registrar, at 315-697-6326. **Please note: A resident parent must register his/her child in person, but the child does not need to be present.**

We have put together the enclosed packet of information in order to guide you through the registration process. In the packet, you will find forms that need to be filled out in order to register your child for kindergarten. In an effort to save you time during registration, we are asking you to complete **ALL** of the forms in the green folder ahead of time. If you have any questions regarding the forms, please call District Registrar, Ms. Amanda Snyder, at (315) 697-6326, and she will help you.

On the day you register your child, please bring the following items. You may use this as a checklist if you like.

- ❑ Resident parent must have photo identification with him/her on the day of registration
- ❑ Green folder with all forms completed
- ❑ Kindergarten Screening Parent Questionnaire. If you would like to elaborate on any of the information you have shared on this important form, Mrs. Schlegel, our School Psychologist, will be available and can give you a call during screening, the week of April 29th if you so indicate on your form.
- ❑ Copy of your child's birth certificate
- ❑ Copy of your child's immunizations record (as of that date)
- ❑ Copy of your child's Health Examination Form (physical form)
- ❑ Custodial adult's proof of residency in the Canastota Central School District (ie. signed lease agreement with name and address, utility bill) Please note: This proof must be recent and a Canastota Post Office box cannot be used as proof of residency.
- ❑ Custodial papers and any court-issued custody documents (if applicable)
- ❑ Date/time available to bring your child to Peterboro Street Elementary for Kindergarten Screening on May 1st or May 2nd between the hours of 8am and 2pm. Time slots will be in increments of one (1) hour. You will sign up for this appointment as part of the registration process, so please bring your calendar with you to registration. **Please note: copies of the required documents can be made on-site if need be.**

We look forward to meeting and working with you and your child at Peterboro Street, where we root for each other and watch each other grow!

Sincerely,

Ms. Jennie Carnahan

Principal

Canastota Central School District
STUDENT REGISTRATION FORM

Student Information:

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Sex: _____Grade _____ Student ID # _____ Date Registered _____

Residential Address (include Apt. #) Mailing Address (if different)

_____ _____

_____ _____

Ethnicity: **(Choose one)**
Is student Hispanic, Latino or of Spanish origin ? ☐ Yes Hispanic ☐ No Non-Hispanic
(means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race)

Race: **(Choose one or more, regardless of Ethnicity)**
☐ American Indian or Alaska Native (origins to original peoples of North America and who maintains cultural identification)
☐ Asian (origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent)
☐ Native Hawaiian or Other Pacific Islander (origins of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands)
☐ Black (origins in any of the black racial groups of Africa)
☐ White (origins in any of the original peoples of Europe, North Africa, or the Middle East)

Parental/Guardian Information: **(relationship: natural parent, step parent, guardian, foster parent, other)**

Male Guardian: _____ Employer: _____ Work Phone: _____

Relationship: _____ Email: _____ Cell Phone: _____

Residential Address: Mailing Address: Home Phone: _____

_____ _____

_____ _____

Female Guardian: _____ Employer: _____ Work Phone: _____

Relationship: _____ Email: _____ Cell Phone: _____

Residential Address: Mailing Address: Home Phone: _____

_____ _____

_____ _____

Any special information regarding CUSTODY that office staff needs to be aware of (example: Order of Protection, notifications (report cards/mailings) need to be sent to a 2nd parent- please provide address

2nd Parent Name: _____ Address: _____

_____

Custodial Information: _____

Emergency Contacts

Emergency Contact: _____ Relationship: _____ Phone #: _____

Child Care Provider: _____ Address: _____ Phone #: _____

Siblings at Same Address (who are school age or younger)

Full Name	Date of Birth	Grade (if in School)	School Attending

COMPLETE THIS BOX ONLY IF 1: IT REFLECTS YOUR CHILD'S CURRENT LIVING SITUATION OR
2: YOUR LIVING SITUATION - IF YOU ARE A YOUTH NOT LIVING WITH A PARENT OR GUARDIAN

Check one box if you are living:

☐ in a shelter ☐ with relatives or others due to lack in housing ☐ at a train/bus station, park or in car
☐ in a motel/hotel, camping ground or other similar situation due to lack of alternative, adequate housing
☐ in an abandoned apartment/building ☐ temporarily housed in a shelter awaiting permanent foster care

Language(s) spoken at home other than English

Parent _____ Child _____ Need Interpreter _____

School History

Has student previously attended Canastota Central Schools? Yes ____No ____ When _____

Pre-School Attended: _____ When: _____

Last School Attended: Name of School : _____ Phone #: _____

When: 20__ to 20 __ Grade: ____ Address of School: _____

Were AIS/Title I Services Provided? Math: Yes _____ No ____ Reading: Yes: _____ No: ____ Other : _____

Does your Child have an IEP? Yes: _____ No: _____ 504 Accommodation Plan? Yes: _____ No: _____

If Child has IEP , what program/services ? Special Class Type ____ Resource ____ Adaptive Physical Ed ____

Speech Therapy ____ Occupational Therapy ____ Physical Therapy ___ Other _____

Involvement of Outside Agencies (Social Services, Probation, Counseling, Etc.)

_____

****

Registering Parent/Guardian's Name _____ Parent/Guardian Identification _____

Registering Parent/Guardian's Signature _____ Date of Registration _____

CANASTOTA CENTRAL SCHOOLS
PRE-REGISTRATION RESIDENCY/CUSTODIAL FORM
(updated 28-Jan-16)

Student Name: _____ Date of Registration: _____

LEGAL CUSTODY

List **ALL** who have legal custody of the child. Please provide documentation if separated or divorced.

_____ _____
Name Relationship

_____ _____
Name Relationship

PHYSICAL CUSTODY

Canastota Household Members: List who has **physical custody** of student. (Address of student's primary residency)

_____ _____
Father Parent/Guardian Name Mother Parent/Guardian Name

_____ _____
Address of Above Address of Above

_____ _____
City/State/Zip City/State/Zip

( ) Natural Father _____ ( ) Natural Mother _____
( ) Stepfather _____ ( ) Stepmother _____
( ) Legal Guardian _____ ( ) Legal Guardian _____
( ) Other _____ ( ) Other _____

Documentation Given – All Forms Attached - Filled in by Office Staff Only

____ Birth Certificate
____ **Shot Record** (in health perm – not attached)
____ Proof of Residency - Documentation Provided/Date _____
____ Custodial - Type and Date of Form _____
(Custodial Forms below must be completed and approved before registration)

Date Received		**Approved/Disapproved**
_____	Affidavit of Emancipation	_____
_____	Residency Application	_____
_____	Custodial Affidavit	_____
_____	Parent Affidavit	_____
_____	Other	_____

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

Lissette Colon-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:
☐ Male
☐ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence? ☐ English ☐ Other *specify*
2. What was the first language your child learned? ☐ English ☐ Other *specify*
3. What is the Home Language of each parent/guardian? ☐ Mother *specify* ☐ Father *specify* ☐ Guardian(s) *specify*
4. What language(s) does your child understand? ☐ English ☐ Other *specify*
5. What language(s) does your child speak? ☐ English ☐ Other *specify* ☐ Does not speak
6. What language(s) does your child read? ☐ English ☐ Other *specify* ☐ Does not read
7. What language(s) does your child write? ☐ English ☐ Other *specify* ☐ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** ☐ *No* ☐ *Not sure* ☐ *If yes, please explain:_____

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

10a. Has your child ever been ***referred*** for a special education evaluation in the past? ☐ No ☐ Yes* **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever ***received*** any special education services in the past?
☐ No ☐ Yes – Type of services received:_____

Age at which services received *(Please check all that apply):*
☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ☐ No ☐ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation *Date*

Relationship to student: ☐ Mother ☐ Father ☐ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF QUALIFIED 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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Canastota Central School District

Request for NEW Student Transportation

Student Name: _____

PSES SSES RSES High School BOCES Program GED Grade: _____ (AM/PM if Pre-K)

Health Issues/Accommodation Driver should be aware of: _____

Home Address - Location #1

Parent/Guardian(s): _____ Relationship: _____

House #: _____ Apt. #: _____ Home Phone: _____

Street/Road Name: _____ Cell Phone: (Male) _____ (Female) _____

City/Town: _____ Work Phone: (Male) _____ (Female) _____

Location #2 – Alternate Address

Parent/Guardian(s) : _____ Relationship: _____

House #: _____ Apt. #: _____ Home Phone: _____

Street/Road Name: _____ Cell Phone: (Male) _____ (Female) _____

City/Town: _____ Work Phone: (Male) _____ (Female) _____

The Transportation Department will only accommodate pick up and drop off schedules that are consistent. An example of consistent schedule would be:

Pick up and drop off will be at home Monday, Tuesday and Friday
Wednesday and Thursday pick up and drop off will be at the sitters

The Transportation Department cannot SAFELY accommodate multiple pick up and drop off points throughout the week.

Pick-up & Drop-off Request

Please indicate at which location *(use #1 or #2 from above)* the student is to be picked up or dropped off at in the appropriate box for the day of the week.

	Monday	Tuesday	Wednesday	Thursday	Friday
Pick-up Location (AM)					
Drop-off Location (PM)					

Is student a walker: Yes No Effective Date: _____

Parent/Guardian Signature: _____ Date: _____

For office use only:

Date Received: _____ Signature: _____

Date Completed: _____ Signature: _____

Canastota Central School District

220 N. Peterboro St., Canastota, NY 13032 • 315.697.2027

Peterboro Street Elementary School

Jennifer L. Carnahan
Principal

Shawn D. Bissetta
Superintendent of Schools

Dear PSES Parent/Caregiver,

I would like to take this opportunity to officially welcome you and your family to Peterboro Street Elementary School. I would also like to provide you with some information in regards to our Health Office.

According to New York State law, it is necessary for our school district to provide all newly enrolled students with certain health screenings. These include hearing, near/far vision and color perception. I conduct these health screenings in the health office during the school day. Should any abnormal or questionable results arise, a referral slip will be sent home including the specific results and a recommendation to follow up with a physician.

All students entering the Canastota Central School District are required to submit documentation of a school health examination (physical) within **30 days** of their first day of school. The date of the exam should be no more than 12 months prior to the first day of school. **Please submit a copy of your child's most recent health exam as soon as possible.**

- **Health Exams are required by New York State for all students entering the district and new entrants in PK or K and in 1st, 3rd, 5th, 9th and 11th grade.**
- **Immunization Requirements for Kindergarten: (See reverse side for requirements)**

All immunizations must also be up-to-date before entering school. NYS offers a 14 day grace period from the first day of school to complete required vaccinations. After 14 days, students are prohibited from attending school until sufficient proof of vaccination is submitted.

The CCSD recommends students also have routine annual dental health screenings. Please submit copies of all dental health certificates to the school health office.

All health related forms are available on our district website.

Thank you in advance for your attention and cooperation in these student health requirements. If you have any questions or concerns, please contact me by phone at 315-697-6350 or email mryan@canastotacsd.org at any time.

Sincerely,
Meghan Ryan RN
Peterboro Street Elementary School Nurse

Please check with your health care provider as soon as possible to make sure that your child has all the needed immunizations.

Immunization requirements for students entering *Pre-K*

Immunization	Number of Doses
Polio	3 doses
Hepatitis B (Hep B)	3 doses
Diphtheria/Tetanus/Pertussis (DTaP)	4 doses
Measles/Mumps/Rubella (MMR)	1 dose
Varicella	1 dose
Haemophilus influenzae Type B Conjugate (HiB)	1-4 (# of doses determined by MD based on age when series was started)
Pneumococcal Conjugate (PCV)	1-4 (# of doses determined by MD based on age when series was started)

Immunization requirements for students entering *kindergarten* and *1st grade*

Immunization	Number of Doses
Polio	4 doses or 3 doses if the 3rd dose is received at 4 years or older
Hepatitis B (Hep B)	3 doses
Diphtheria/Tetanus/Pertussis (DTaP)	5 or 4 doses if the 4th dose is given at 4 years of age or older Or 3 doses if 7 years or older and series started at age 1 or older
Measles/Mumps/Rubella (MMR)	2 doses
Varicella	2 doses

Proof of immunization may include any of the documents listed below:

- An immunization certificate signed by your healthcare provider
- Immunization Registry report (NYSIIS) from your healthcare provider or the DOH
- Serologic evidence of Measles, Mumps or Rubella antibodies via lab report with an interpretation from an MD.
- Serologic evidence of Polio antibodies with MD interpretation if the test was performed prior to 9-1-2019 and all 3 serotypes are positive.
- Serologic evidence of Varicella antibodies, lab confirmation of varicella disease or a diagnosis from an MD, PA or NP that your child has had varicella (chicken pox) disease.
- Positive blood test for Hepatitis B surface antibody

If you have questions or concerns about immunizations, please contact the school nurse. Proof of immunization must be submitted to the School Health Office within 14 days of the first day of school in order to avoid exclusion for incomplete vaccination.

Meghan Ryan RN
PSES Nurse
Phone (315) 697-6350
Fax (315) 951-2711
mryan@canastotacsd.org

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

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

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors:Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

Percentile (Weight Status Category): ☐ < 5th ☐ 5th- 49th ☐ 50th- 84th ☐ 85th- 94th ☐ 95th- 98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date
TB-PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	

Lead Level Required for PreK & K	Date
☐ Test Done ☐ Lead Elevated ≥5 µg/dL	

☐ **System Review Within Normal Limits**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

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

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.			**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed** – required for Dominic Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process 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.

CANASTOTA CENTRAL SCHOOL DISTRICT

120 Roberts Street. Canastota. New York 13032 • 315-697-2025 • Fax 315-697-6368

DISTRICT OFFICE
Tracy L. Leone, *Business Manager*

Shawn D. Bissetta
Superintendent of Schools

Dear Parent/Caregiver,

The Canastota Central School District requests that families submit a copy of their child's dental health exam to the School Health Office annually. Preventing tooth decay and identifying concerns early with daily brushing, flossing and routine dental exams is imperative to overall health and wellness.

Thank you for your cooperation in this community health endeavor. All of our students benefit when we work together to promote the health, well being and achievement of each student.

Local providers:

Smile Solutions	118 South Main Street Canastota, NY 13032	315-697-9287
Camden Dental	337 North Peterboro Street Canastota, NY 13032	315-697-3535
Dr. Charles Choi DDS	3167 Seneca Tpke. Canastota, NY 13032	315-697-9321
Dr. Colocotronis	121 South Peterboro Street Canastota, NY 13032	315-697-2259

Providers accepting Medicaid insurance plans:

Fayetteville Smiles Dentist 315-329-5146	5009 Campuswood Dr. Fayetteville, NY 13057
Grant BLVD Dental 315-472-3414	1500 Grant BLVD Syracuse, NY 13208
Valley Dental 315-982-9590	4825 Commercial Dr. New Hartford, NY 13413
Wilson Dental 315-871-0068	224 S. Geddes St. Syracuse, NY 13204

Sincerely,

School Nurses
Meghan Ryan RN PSES (315) 697-6350
Joanne Vaccaro RN SSES (315) 697-6362
Michelle Marsello RN RSES (315) 697-6341
Roseann Gardinier RN CHS (315) 697- 6315

Canastota Central School District

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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 oral health assessment? 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/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment 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/ Dental Hygienist's name and address

(please print or stamp) **Dentist's/Dental Hygienist'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):_____

II. 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.

(3/2018)

Student Health Inventory

___ PSES (PK-1) ___ SSES (2-3) ___ RSES (4-6) ___ CHS (7-12) School Year: 20____-20 ____

The following is a brief heath form that must be returned to your child's school nurse annually. This information will be reviewed by the school nurse and used to meet you child's health needs at school.

Student's Name: _____ Date of Birth: _____

Gender assigned at birth: Male _____ Female _____ Grade: _____ Teacher: _____

Please list student's current medications: _____

The School Nurse may treat my child with the following first aid medications consistent with their label usage: Triple antibiotic ointment, 1% hydrocortisone cream, caladryl, aloe gel, bee sting wipes, antiseptic wound cleaner/towelettes ___ Yes ___ No **Signature** _____

Please check below any conditions that applies to your child:

___ **My child has no health conditions**

___ ADD/ADHD (see below)	___ Diabetes (see below)	___ Migraine Headaches	___ Sickle Cell Anemia
___ Allergies (see below)	___ Down Syndrome	___ Neuromuscular Disease	___ Tympanostomy (PE) Tubes
___ Asthma (see below)	___ Epilepsy/Seizures (see below)	___ Muscular Dystrophy	___ Ulcers/ Gastric Reflux
___ Autism	___ Heart Problems (see below)	___ Orthopedic Disability	___ Vision Concern
___ Cerebral Palsy	___ Hemophilia/Bleeding disorder	___ Psychiatric Condition	___ Glasses
___ Concussion, Date: ___	___ Hospitalization (see below)	___ Renal/Kidney Disease	___ Contact lenses
___ Cystic Fibrosis	___ Leukemia/Cancer	___ Recent Surgery	

For conditions listed above, please provide additional information below:

ADD/ADHD	Does your child require medication (for this condition) to be taken at school: ___ Yes* ___ No
Allergies	Does your child have any of the following allergies: ___ Bees ___ Food ___ Medication ___ Seasonal ___ Other If yes, please list specific allergen and reaction (hives, swelling, vomiting, difficulty breathing, etc.): _____ Date of last allergic reaction: _____ Is emergency medication required at school? ___ Yes* ___ No
Asthma	Date of last asthma episode: _____ Is medication or treatment required at school? ___Yes* ___ No List medications used to treat asthma episodes: _____
Diabetes	Which type? ___ Type 1 ___Type 2 How is it controlled? ___ Oral medication ___ Insulin ___ Diet Is medication treatment required at school? ___ Yes* ___ No
Seizures	Date of last seizure: _____ Type of seizures: _____ Is student aware of impending seizure? ___ Yes ___ No Is rescue medication required at school? ___ Yes* ___ No
Heart Problems	Check type: ___ Functional heart murmur ___ Heart Valve condition ___ Other (please list) _____ Is exercise limited? ___ Yes* ___ No
Neuromuscular Disease/ Orthopedic Disability	Name of condition: _____ School concerns: _____
Other Health Concerns/Disability	Name of condition: _____ School concerns: _____
	***Indicates that additional physician documentation may be required. See School Nurse for information and forms.**

I understand that in a health or safety emergency involving my child school officials may share confidential health information with appropriate and necessary health, safety or welfare officials.

Signature of parent of guardian: _____ **Date:** _____

CANASTOTA Central School District

Striving for Excellence

Release of Information

I give the Kindergarten Screening Team at Peterboro Street Elementary School permission to contact and receive records for my child regarding his/her pre-school experience.

_____

Child's Name

_____

Pre-School Name

_____

Pre-School Address

_____

Pre-School Phone Number

This signed form provides my consent for the K-Screening team to have access to my child's pre-school.

☐ My child did not attend a formal pre-school

_____ _____

Date Parent/Guardian Signature

Peterboro Street Elementary School
Kindergarten Screening Parent Questionnaire

Questionnaire completed by: _____ Relation: _____

Child's name: _____ Date of Birth: _____

Child's Nickname: _____ Gender: _____

Father/Guardian's name: _____ Year of birth: _____

Mother/Guardian's name: _____ Year of birth: _____

Occupation: _____ _____

Father Mother

Step Parent: _____ Occupation: _____

Step Parent: _____ Occupation: _____

****

I. Developmental/Medical History:

1. Were there any problems during pregnancy with your child? (e.g. German measles, toxemia, bleeding, RH incompatibility)

_____

_____

2. What was the child's condition at birth? (normal weight, breathing difficulties, etc.)

_____

3. Developmental milestones (mo/yr): Roll: _____

Sit: _____ Walk: _____

Talk (words): _____ Talk (sentences): _____

Potty trained: _____

4. Does your child have any difficulty with speech, hearing or sight? _____

_____

_____

II. Description of Child:

1. Has your child received any special services? (e.g. EI., speech, OT, PT, counseling, etc.)

_____

_____

2. Does your child have any significant medical issues? Please explain: _____

_____

3. Please use a few words to describe your child's personality.

4. What are his/her strengths? What does he/she do best? What does he/she like to do?

5. What are the most difficult areas for your child?

6. Do you feel your child has any special needs? Please explain:

7. How does your child get along with others?

III. Educational History:

1. Did your child attend a preschool program? YES _____ NO _____

Where: _____ How many years: _____

IV. Family History:

1. Have there been any events in your family which have affected your child? (family move, death, divorce, birth of a sibling) Please explain.

2. Is your family history significant for any medical or learning issues? Please explain.

**** Is there anything else you think we should know about your child?

Check if appropriate: _____ I would like School Psychologist, Mrs. Amanda Schlegel, to call me regarding something I shared on this form. My name is _____ and the best number to reach me at is _____. Thank you!

For Staff Use Only