OSWEGO
CITY SCHOOL DISTRICT
Education Center
One Buccaneer Boulevard, Oswego, New York 13126
www.oswego.org

# New Student Registration Packet
# Middle School (Grades 7 – 8)

Attached is student registration forms and information for enrolling your child/dependent in the Oswego City School District.

In addition to this paperwork, you will need to provide us with the following proof:

- ☐ Copy of Birth Certificate
- ☐ Immunization Records - Present New York State Laws require that no school official shall permit any child to be admitted to school or to attend school for more than 14 days without a certificate, or other acceptable written evidence, that the child has met NYS immunization requirements. Therefore, no child shall be allowed admission to school without providing proper proof of immunization either from the school previously attended or from the student.
- ☐ Custody Papers *(if applicable) unless court papers are on file with the district, both parents will have equal access to their child(ren) and school records*
- ☐ Proof of Residency

The New Student Enrollment packet contains the following:

- ☐ Registration Form
- ☐ Student Residency Questionnaire
- ☐ Student Educational Records Release Authorization
- ☐ Emergency Go Home Form/Authorization to Release Form
- ☐ Field Trip Permission Form
- ☐ Oswego City School District Health History Survey
- ☐ School Physical Consent Form
- ☐ Dental Health Form
- ☐ Health Certificate/Appraisal Form
- ☐ Health Information Authorization Form
- ☐ Request for Pesticide Application Notification
- ☐ Potassium Iodide KI Permission form and Information
- ☐ All in One Permission Form
- ☐ Parent/Guardian Home Language Questionnaire
- ☐ Parent/Guardian Military Service Form
- ☐ Transportation Form
- ☐ Digital Equity Survey
- ☐ NYS Migrant Education Program Parent Survey (English)
- ☐ NYS Migrant Education Program Parent Survey (Español)

## Proof of Immunization

☐ Waived-Rel./Dr. Stmt.
☐ Certificate of Immunization
☐ Statement - Dr./Hlth Ct.
☐ Shot Rec. from Transfer Sch.

City School District of Oswego, Oswego, New York 13126

# Registration Form

☐ FPS ☐ CER ☐ OMS ☐ Trinity Cathlic
☐ KPS ☐ FLS ☐ OHS ☐ OCCS
☐ MIN

Date of Entry _____

## Office Use Only

☐ Out of District ☐ Proof of Residency
☐ Re-Activated
☐ Transfer Within
☐ Rec. Rq. _____ Rec. _____

## Student Data

Name _____ (Last) _____ (First) _____ (Middle)

Date of Birth _____ Type of Document _____ Gender/Sex _____ Grade _____

Physician's Name _____ Physician's Phone No. _____

Please answer questions 1 and 2:

1. Are you Hispanic/Latino? ☐ Yes ☐ No
2. Select one or more race groups that apply to your child. You must check (√) at least one box:

☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black ☐ White

## Parent/Guardian Data

Name _____ (Last) _____ (First)

Residence _____ (RD No.)

_____ (House No./ Box No.) _____ (Road or Street No.)

_____ (City) _____ (State) _____ (Zip)

Home Phone No. _____ Unlisted: ☐ Yes ☐ No

Cell Phone No. _____ email _____

Legal Relation to Child _____

Place of Employment _____

Address _____ Phone No. _____

Spouse's Name _____ (Last) _____ (First)

Spouse's Residence _____ (Leave this blank if same as parent/guardian)

_____ (House No./ Box No.) _____ (Road or Street No.)

_____ (City) _____ (State) _____ (Zip)

Home Phone No. _____ Unlisted: ☐ Yes ☐ No

Cell Phone No. _____ email _____

Legal Relation to Child _____

Spouse Place of Employment _____

Address _____ Phone No. _____

Names of other adults in the child's household: _____ (Last) _____ (First) Relationship to the child: _____

Custody Information: If separated or divorced, who has legal custody? _____

Does this school have updated custody documentation on file? ☐ Yes ☐ No

Foster Student? ☐ Yes ☐ No DSS2999 Form? ☐ Yes ☐ No

Student is currently living with: _____
Name and Relationship to Student [Examples: Mother - Father - Step-Parent - Grandparent - Foster Parent - Legal Guardian - Other (please specify)]

## Special Services

Does your child receive any special education services? ☐ Yes ☐ No

## Emergency Contact Person Other Than Parent

Name _____ Relation to Child _____ Phone No. _____

Address _____ Cell Phone No. _____

Daycare's Name _____ Address _____ Cell/Phone No. _____

## Name (Last, First, Middle), Sex, & Birthdate of Other Children Living In Home

_____ _____

_____ _____

_____ _____

## Last School Attended

Name _____ Address _____

## Parent/Guardian Signature

Parent/Guardian Signature _____ Date _____

## For Office Use Only

Pre-Kindergarten ☐ A.M. ☐ P.M. Student ID # _____ Family ID # _____

Lunch Program ☐ Free ☐ Reduced ☐ N/A Hmrm Teacher/Rm.# _____

Walker ☐ Yes ☐ No Bus Route # - To School _____ /From School _____ Pick-up/Drop-off Point _____

Enrollment Code _____

Copy Distribution - Student Academic Folder, Main Office , School Nurse, Transportation, Pupil Services

**Continue form on back**

# Housing Questionnaire

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

**Where is the student currently living?** (*please check one box*)

- ☐ In a shelter
- ☐ With another family or another person because of loss of housing or as a result of economic hardship (sometimes referred to a "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (please describe) _____

  _____

- ☐ In permanent housing

**If you are living in shared housing, please check all of the following reasons that apply:**

- ☐ Not applicable
- ☐ Loss of housing
- ☐ Economic situation
- ☐ Temporarily waiting for house or apartment
- ☐ Provide care for a family member
- ☐ Living with boyfriend/girlfriend
- ☐ Loss of employment
- ☐ Parent/guardian is deployed
- ☐ Other (please describe) _____

  _____

Would you like to speak to the Homeless Youth Coordinator about rights and other services available to families experiencing homelessness under the McKinney -Vento Act?

- ☐ Yes: please contact me via:
  - Email: _____
  - Phone: _____
- ☐ No

_____ _____

Signature of Parent/Guardian or Student (*if applicable*) Date

OFFICE USE ONLY

MV Team Notified _____ RHY Notified _____

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# Student Educational Records Release Authorization

Date _____

To: _____

_____

_____

Attn: Student Records Department

The following student, previously enrolled with you, is now residing in our school district and has enrolled in this school:

_____ (Student Name) _____ (Birth Date) _____ (Grade)

The student is anticipated to be ENROLLED on: _____
Please choose an exit date from your current district PRIOR to the above date.

*To maintain proper placement and instructional continuity, please send a transcript of all the records that apply below:

- ☐ Academic
- ☐ Gifted
- ☐ Medical
- ☐ Committee on Special Education
- ☐ Birth Certificate
- ☐ Social
- ☐ Psychological
- ☐ Custody information if applicable

*If any of these records are not at your disposal, please forward this release to the appropriate department to provide copies of these records to our school.

The Oswego City School District shall comply with the provisions of (34 CFR §99.31) - Family Educational Rights and Privacy Act of 1974 (FERPA)

**Forward all records to:**

☐ **Charles E. Riley Elementary School**
269 East Eighth Street
Oswego, New York 13126
Phone: 315-341-2800 • Fax: 315-341-2980

☐ **Frederick Leighton Elementary School**
1 Buccaneer Boulevard
Oswego, New York 13126
Phone: 315-341-2700 • Fax: 315-341-2970

☐ **Fitzhugh Park Elementary School**
195 East Bridge Street
Oswego, New York 13126
Phone: 315-341-2400 • Fax: 315-341-2940

☐ **Kingsford Park Elementary School**
275 West Fifth Street
Oswego, New York 13126
Phone: 315-341-2500 • Fax: 315-341-2950

☐ **Minetto Elementary School**
PO Box 189
Minetto, New York 13115
Phone: 315-341-2600 • Fax: 315-341-2960

☐ **Oswego Middle School**
Mark Fitzgibbons Dr.
Oswego, NY 13126
Phone: 315-341-2382 • Fax: 315-341-2930

☐ **Oswego High School**
2 Buccaneer Boulevard
Oswego, NY 13126
Phone: 315-341-2221 • Fax: 315-341-2928

☐ **Education Center**
1 Buccaneer Boulevard
Oswego, NY 13126
Phone: 315-341-2014 • Fax: 315-341-2914

☐ **Trinity Catholic School**
115 East Fifth Street
Oswego, NY 13126
Phone: 315-343-6700 • Fax: 315-342-9471

☐ **Oswego Community Christian School**
400 East Albany Street
Oswego, NY 13126
Phone: 315-342-9322 • Fax: 315-342-0268

I am the ☐ Parent ☐ Guardian ☐ DSS Caseworker

I hereby grant my permission to send the above records to the school checked above.

_____
Signature

☐ 1st Request ☐ 2nd Request ☐ 3rd Request

City School District of Oswego, Oswego, New York 13126

# Emergency Go Home/Authorization to Release Form

Student Name _____ Grade _____ Teacher _____

School Year _____ Date of Birth _____ School Attending: _____

Address _____ Parent/Guardian(s) Names (A) _____

(B) _____

(A) Home Phone _____ Work Phone _____ Place of Work _____

Cell Phone _____ Beeper # _____ Email Address _____

(B) Home Phone _____ Work Phone _____ Place of Work _____

Cell Phone _____ Beeper # _____ Email Address _____

Other Parent/Guardian Name _____

Other Parent/Guardian Address (if different from above) _____

Other Parent/Guardian Phone _____ Work _____ Cell _____

In the event it is necessary to release my child from school in an **emergency closing**, he/she has been told and instructed to do the following: (Check One Only)

☐ **Go home (someone will be there or my child can let themself in)** or if my child arrives home and no one is there, my child should walk to the following address:

_____ Resident's Name/Relation to Child _____ Address _____ Phone

☐ **Do not go home - go directly to the following address** (within your school attendance area)

_____ Resident's Name/Relation to Child _____ Address _____ Phone

_____ Bus Route # _____ Bus Stop

## Authorization to Release

To be released **ONLY** to the following individual(s) listed below: (names may be added or removed **ONLY** by written notice)

Name/Relationship _____ Phone #, Home: _____ Work: _____ Cell: _____

Name/Relationship _____ Phone #, Home: _____ Work: _____ Cell: _____

Name/Relationship _____ Phone #, Home: _____ Work: _____ Cell: _____

Name/Relationship _____ Phone #, Home: _____ Work: _____ Cell: _____

Name/Relationship _____ Phone #, Home: _____ Work: _____ Cell: _____

Name/Relationship _____ Phone #, Home: _____ Work: _____ Cell: _____

In the event that one of the persons listed above has to pick up my child(ren), **I will send in a note to the teacher**. I also know that my child(ren) **may only be released from the Main Office.**

## In Case of Emergency

Parents may notify the school by phone to have a child excused. An **identification number** or **code name** will be required to verify the request. You must provide us with **your own** identification number or code name.

I have selected the following identification number or code name: _____

Parent/Guardian Signature _____ Date _____

**Office** - **upon parental/guardian completion, make copies and route to: Nurse, Teacher, Transportation, and Parent/Guardian**

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# Field Trip Permission Form

Student:_____

I give my son/daughter permission to participate in field trips for the _____ school year.

My son/daughter has the following medical condition(s) that the chaperones should be aware of: (i.e. diabetes, allergies, migraines, seizure disorder, asthma etc.)

_____

_____

_____

***Please only list those medications which will be needed on the field trips***

He/she will be taking the following medications on field trips

Medication _____ Dosage _____ Time _____

Medication _____ Dosage _____ Time _____

Medication _____ Dosage _____ Time _____

***Medications taken at school or on a field trip must be accompanied by a medication authorization form signed by a physician and the parent.***

Parent/ Guardian Signature _____ Date _____

Address _____

Home Phone# _____ Work# _____ Cell# _____

Alternate contact in case of emergency _____

Phone:_____

***It is the parents responsibility to update the school nurse with any changes in medications or health status. This information will be shared with faculty and chaperones responsible for the field trip.***

# Important Notice to Parents/Guardians of Students with Life-threatening Health Conditions

**Definition of Life-threatening health condition:**

A condition, including a known allergy, that will put the child in danger of death during the school day if a medication or treatment order is not in place (for example; food or substance allergy, insect sting allergy, asthma, diabetes, seizure disorder, etc.).

**If your child has life-threatening health condition, please immediately contact the school Health Office/School Office.**

- The school nurse will initiate an Emergency Care Plan for your student's specific health condition.
- The school nurse may ask for additional documents completed by your child's health care provider such as:
    - An authorization for Administration of Medication in school form
    - Self-medication Release form (If applicable)

The appropriate forms and any additional information you or the licensed health provider would like to share must be completed and returned to the school for review and approval by the School Nurse as soon as possible.

**For New Registrations, New Incoming Pre-Kindergarten and Kindergarten Children**

# Oswego City School District Health History Survey

Student Name _____ Date of Birth _____

Parent/Guardian Name _____ Home Phone _____ Work Phone _____

School _____ Date _____

Please answer each question by writing a check (√) in the appropriate box providing information requested.

| | Yes | No |
|---|---|---|
| Did you submit a copy of your child's immunization records when you registered him/her . | ☐ | ☐ |
| **Has any family member or relative under the age of 50?** | | |
| had a heart attack, stroke, or died unexpectedly | ☐ | ☐ |
| had high blood pressure | ☐ | ☐ |
| had learning disabilities | ☐ | ☐ |
| Other (please indicate below) | ☐ | ☐ |
| **Has your child had the following illnesses?** | | |
| Chicken pox | ☐ | ☐ |
| COVID-19 | ☐ | ☐ |
| Date: | ☐ | ☐ |
| **Does your child have any of the following health problems?** | | |
| Vision problems | ☐ | ☐ |
| If yes, what? | | |
| Glasses or corrective lenses | ☐ | ☐ |
| Chronic ear infections | ☐ | ☐ |
| Tubes in ears | ☐ | ☐ |
| Hearing aids | ☐ | ☐ |
| Hearing loss | ☐ | ☐ |
| Other hearing problems | ☐ | ☐ |
| If yes, what? | | |
| **Allergies to:** | | |
| Medication, What kind | ☐ | ☐ |
| Insects, What kind | ☐ | ☐ |
| Food, What kind | ☐ | ☐ |
| Environmental, What kind | ☐ | ☐ |
| If yes, what reactions to expect? What medical procedures need to be taken? | | |
| Asthma | ☐ | ☐ |
| Heart problems | ☐ | ☐ |
| If yes, what? | | |
| Epilepsy | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Hemophilia (free bleeding) | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ |
| Cystic fibrosis | ☐ | ☐ |
| Muscular dystrophy | ☐ | ☐ |
| Cancer | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Physical disabilities | ☐ | ☐ |
| If yes, what? | | |
| Mental disabilities (for example, autism, developmental delay) | ☐ | ☐ |
| If yes, what? | | |
| Attention deficit/hyperactivity disorder | ☐ | ☐ |
| Other health problems | ☐ | ☐ |
| If yes what? | | |
| Has your child ever seen, or is your child currently seeing, a specialist (for example, cardiologist, neurologist)? | ☐ | ☐ |
| If yes, what? | | |
| Has your child ever been hospitalized? | ☐ | ☐ |
| If yes, for what reason? | | |
| Has your child ever had a serious accident (for example, broken bones, bad cuts, poisoning)? | ☐ | ☐ |
| If yes, what? | | |
| Is your child on any medication? | ☐ | ☐ |
| If yes, what? | | |
| Has your child been seen by a physician in the last year? | ☐ | ☐ |
| Has your child been seen by a dentist in the last year? | ☐ | ☐ |
| Has your child ever had a concussion? | ☐ | ☐ |
| How many? | | |
| Dates: | | |

**OVER**

Does your child now have, or has your child had in the last year, any of the following problems?

| | Yes, has now | Yes, in the last Year | No |
|---|---|---|---|
| Headaches | ☐ | ☐ | ☐ |
| Problems with eyes (for example, squinting, crusting lids, wandering eye) | ☐ | ☐ | ☐ |
| Chronic colds (more than 6 in one year, or a cold lasting more than 3 weeks) | ☐ | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ | ☐ |
| Severe cough | ☐ | ☐ | ☐ |
| Throat infection | ☐ | ☐ | ☐ |
| Ear infection | ☐ | ☐ | ☐ |
| Tooth pain, cavities, mouth sores | ☐ | ☐ | ☐ |
| Swollen glands or lumps | ☐ | ☐ | ☐ |
| Stomach aches | ☐ | ☐ | ☐ |
| Eating or drinking too much | ☐ | ☐ | ☐ |
| Eating or drinking too little | ☐ | ☐ | ☐ |
| Weak urinary system (frequent urination) | ☐ | ☐ | ☐ |
| Pain or burning upon urination | ☐ | ☐ | ☐ |
| Bed wetting | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ |
| Diarrhea | ☐ | ☐ | ☐ |
| Unusual diffculty standing or walking | ☐ | ☐ | ☐ |
| Trouble sleeping | ☐ | ☐ | ☐ |
| Tiring easily | ☐ | ☐ | ☐ |
| Joint pain | ☐ | ☐ | ☐ |
| Seizures, convulsions, or fits | ☐ | ☐ | ☐ |
| Bleeding problems (for example, bruising Easily, frequent nose bleeds) | ☐ | ☐ | ☐ |
| Other (please indicate below) | ☐ | ☐ | ☐ |

.....

Please answer the following questions about the pregnancy, labor, and delivery of your child:

| | Yes | No |
|---|---|---|
| Did the mother have difficulties during the pregnancy, labor, or delivery of your child? | ☐ | ☐ |
| If yes, what? ..... | | |
| Did the mother visit a physician or medical clinic during her pregnancy? | ☐ | ☐ |
| Was your child born at home or at any place other than a hospital or medical clinic? | ☐ | ☐ |
| If yes, where? ..... | | |
| Did your child have difficulties at birth or shortly after (for example, jaundice (yellow skin), breathing problems, infection, high fever, feeding problems)? | ☐ | ☐ |
| If yes, where? ..... | | |
| Did your child weigh less than 5½ pounds at birth? | ☐ | ☐ |
| If yes, how much did the child weigh? ..... | | |
| Was your child born prematurely? | ☐ | ☐ |
| If yes, by how many weeks? ..... | | |
| Was your child born post-maturely? | ☐ | ☐ |
| If yes, by how many weeks? ..... | | |
| Was your child placed in a neonatal intensive Care nursery or high-risk nursery after birth? | ☐ | ☐ |
| If yes, for how many days? ..... | | |

Please list any medications your child takes, dose, and frequency:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

*Please check to make sure you have answered every item.*
*Then, write in the space below any additional comments you have about your child's health history.*

Name of Family Physician _____ Phone _____

Name of Family Dentist _____ Phone _____

Date _____

Signature of Parent/Guardian _____

**Comments:**

_____

_____

_____

_____

_____

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# School Physical Consent Form

Student Name:_____ Grade:_____

School:_____ DOB:_____

Please read and check the correct box. Sign and return to the school nurse.

☐ I do give permission for the designated school physician or nurse practitioner to complete a physical examination as per school policy and as required by NYS Education Laws.

☐ I do not give permission for the designated school physician or nurse practitioner to complete a physical examination as per school policy and as required by NYS Education Laws. I will have a physical completed by our family physician.

This consent is valid from this date unless revoked by the parent or guardian. If custody or guardianship changes in the future, it is the responsibility of the parent or guardian to notify the school district of such a change.

_____ _____

Signature of Parent or Legal Guardian Date

# 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.

# 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:<br>☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached |
| ☐ **Asthma** | ☐ Intermittent ☐ Persistent ☐ Other:<br>☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached |
| ☐ **Seizures** | Type: Date of last seizure:<br>☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached |
| ☐ **Diabetes** | Type: ☐ 1 ☐ 2<br>☐ 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 | Lead Level Required for PreK & K | Date |
|---|---|---|---|---|---|
| TB- PRN | ☐ | ☐ | | ☐ Test Done ☐ Lead Elevated ≥5 µg/dL | |
| Sickle Cell Screen-PRN | ☐ | ☐ | | | |

☐ **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 Dominick Murray Sudden Cardiac Arrest Prevention Act

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

**<u>If Restrictions Apply</u> –** 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 <u>ONLY</u> 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.**

OSWEGO CITY SCHOOL DISTRICT
Education Center
One Buccaneer Boulevard, Oswego, New York 13126
www.oswego.org

# Authorization for Use or Disclosure of Protected Health Information

I, _____ authorize Oswego City School District to display and publish my child's life-threatening health concern listed below on the school information system (School Tool.) I understand that this information will be accessible to all Oswego City School District employees.

**The Protected Health Information may be used, disclosed or received for the following purpose(s):**
* To adhere to emergency plans of care as advised by healthcare professionals
***** to develop care or therapy plans for routine and emergent school management
*To design appropriate educational, school, or athletic programs
*To assess the impact of the medical condition(s) on school programming and/or attendance
*To share school observations/concerns
*To assess a medical basis for modification of transportation and/or home tutoring
*Medication delivery or therapy prescriptions
Other_____

Student name_____

Life Threatening Health Condition(s)_____

****This authorization is valid for the duration of attendance within the school district****

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the District Administration Building. I understand that the revocation of this authorization is not effective if the District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that Protected Health Information will not be disclosed to entities outside of the Oswego City School district. I understand that Protected Health information will be disclosed to Oswego City School district employees who have a need to know. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I give permission for the school representatives to share and disclose information as indicated above with the appropriate school district employees.

Signature of Parent/Guardian or student if over 18 Date

**Relationship**

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

**A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE ADULT PATIENT OR PARENT OF THE MINOR CHILD**

OSWEGO
CITY SCHOOL DISTRICT

District Warehouse
224 West Utica Street, Oswego, New York 13126
www.oswego.org

Dear Parent, Guardian, and School Staff:

New York State Education Law Section 409-11, effective July 1, 2001, requires all public and nonpublic elementary and secondary schools to provide written notification to all persons in parental relation, faculty, and staff regarding the potential use of pesticides periodically throughout the school year.

The Oswego City School District (or nonpublic school) is required to maintain a list of persons in parental relation, faculty, and staff who wish to receive 48-hour prior written notification of certain pesticide applications. The following pesticide applications are not prior notification requirements:

- A school remains unoccupied for a continuous 72-hours following an application;
- Antimicrobial products;
- Nonvolatile rodenticides in tamper resistant bait stations in areas inaccessible to children;
- Nonvolatile insecticidal baits in tamper resistant bait stations in areas inaccessible to children;
- Silica gels and other nonvolatile ready-to-use pastes, foams, or gels in areas inaccessible to children;
- Boric acid and disodium octaborate tetrahydrate;
- The application of EPA designated biopesticides;
- The application of EPA designated exempt materials under 40CFR152.25;
- The use of aerosol products with a directed spray in containers of 18 fluid ounces or less when used to protect individuals from an imminent threat from stinging and biting insects including venomous spiders, bees, wasps, and hornets.

If you would like to receive 48-hour prior notification of pesticide application that are scheduled to occur in your school, please complete the form below and return it to your child's school.

In the event an emergency application is necessary to protect against an imminent threat to human health, a good faith effort will be made to supply written notification to those on the 48-hour prior notification list.

Oswego City School District

**Request for Pesticide Application Notification**

(Please Print)

| | | | | |
|---|---|---|---|---|
| School Building: (Check One) | ☐ Education Center | ☐ Oswego High School | ☐ Oswego Middle School | ☐ Frederick Leighton School |
| | ☐ Charles E. Riley School | ☐ Fitzhugh Park School | ☐ Minetto School | ☐ Kingsford Park School |
| | ☐ Transportation Center | ☐ District Warehouse | | |

| | |
|---|---|
| Parent Name/ Staff Name: | Student Name: |
| Address: | |

| | | |
|---|---|---|
| Day Phone: | Evening Phone: | E-mail Address: |

OSWEGO
CITY SCHOOL DISTRICT

Education Center
One Buccaneer Boulevard, Oswego, New York 13126
www.oswego.org

Dear Parent/Guardian:

Our school building is located within the ten-mile emergency planning zone (EPZ) of the Nine Mile Point Nuclear Power Plants. The federal Nuclear Regulatory Commission and New York State have developed policies on the availability and usage of the over-the –counter drug Potassium iodide (KI) during a radiological emergency.

*Nuestro edificio de escuela está situado dentro de la zona del planeamiento de la emergencia de la diez-milla (EPZ) de las nueve plantas de energía atómica del punto de la milla. La Comisión reguladora nuclear y el estado de Nueva York federales han desarrollado políticas en la disponibilidad y el uso del excedente - el yoduro contrario del potasio de la droga (KI) durante una emergencia radiológica*

KI is an over-the-counter drug that protects the thyroid from exposure to radioactive iodine. KI only protects one organ against one radioactive substance. It is NOT an alternative to evacuation or sheltering. (Please read the attached question and answer sheet.) In fact, evacuation and sheltering remain New York's primary public protective actions in the event of an accident at any nuclear power site.

*KI es una droga over-the-counter que protege la tiroides contra la exposición al yodo radiactivo. KI protege solamente un órgano contra una sustancia radiactiva. No es un alternativa a la evacuación o a abrigar. (por favor leído la hoja unida de la pregunta y de respuesta.) En hecho, la evacuación y el abrigar siguen siendo acciones protectoras públicas primarias de Nueva York en el acontecimiento de un accidente en cualquier sitio de la energía atómica.*

Should the County and/or State Department of Health recommend the use of KI during an emergency, our school will have KI available on site for your child. KI would **only** be administered following a recommendation to do so from County or State Health Department officials, and would occur in accordance with evacuation/sheltering plans.

*Si el departamento del condado y/o del estado de la salud recomienda el uso de KI durante una emergencia, nuestra escuela tendrá KI disponible en el sitio para su niño. KI sería administrado solamente después de una recomendación de hacer así que de funcionarios del departamento de la salud del condado o del estado, y ocurriría de acuerdo con planes de evacuation/sheltering cubre.) En hecho, la evacuación y el abrigar siguen siendo acciones protectoras públicas primarias de Nueva York en el acontecimiento de un accidente en cualquier sitio de la energía atómica*

If you want the school to provide your child with KI in a radiological emergency, you **must** sign and return the enclosed form to the main office in your child's school. This permission will remain in effect as long as your child is enrolled in the Oswego City School District unless you notify us in writing that you no longer want the school to provide your child with KI. **Please note that if you do not return the enclosed form and KI is recommended by health officials, your child will not receive KI.**

*Si usted quisiera que la escuela proveiera de su niño KI en una emergencia radiológica, usted debe firmar y volver la forma incluida a la oficina principal en la escuela de su niño. Seguirá habiendo este permiso en efecto mientras alistan a su niño en el districto de la escuela de la ciudad de Oswego a menos que usted nos notifique en la escritura esa usted quisiera no más de largo que la escuela proveiera de su niño KI. Observe por favor que si usted no vuelve la forma incluida y KI es recomendado por los funcionarios de la salud, su niño no recibirá KI*

If you have any further questions about the school's program, please contact your child's school nurse or the Oswego County Emergency Management Office at 591-9150.

*Si usted tiene cualquier pregunta más otra sobre el programa de la escuela, entre en contacto con por favor la enfermera de la escuela de su niño o la oficina de la gerencia de la emergencia del condado de Oswego en 591-9150.*

Sincerely,

*Superintendent of Schools*

FACT SHEET

# Potassium Iodide (KI)

*This fact sheet is about a new policy for people, especially those who live within ten miles of a nuclear power plant, who may be exposed to radiation from a nuclear plant emergency. In December 2001, the federal Food and Drug Administration (FDA) said if there was a radiological emergency, people should take a drug that would help protect them from thyroid cancer. This drug is called potassium iodide (KI). The New York State Health Department agrees. The questions and answers below will give you more information.*

### 1. What is potassium iodide (KI) and what is it used for?

If there is a radiation emergency at a nuclear plant, large amounts of something called radioiodine could be put into the air. This could hurt your thyroid gland, or even cause thyroid cancer later on. You could breathe in the radioiodine or eat food that has some radioiodine in it. When you take the KI pill, it protects your thyroid gland from being harmed.

### 2. How does KI work?

When you take the KI pill, it fills your thyroid with a kind of iodine that prevents your thyroid gland from taking in any of the radioactive kind of iodine.

### 3. What age group has the highest risk from exposure to radioiodine?

Young children have the highest risk. We have learned this from looking at children in Russia and other areas who were exposed to the radioiodine from the Chernobyl nuclear power plant accident.

### 4. When should KI be taken?

You need to take KI before or just after you are exposed to radioiodine. You can also take it 3 or 4 hours later, but it will not be as helpful.

### 5. How will I know if I should take KI?

If there is an emergency, you will hear an announcement from your local or state health officials. Your local health department will tell you when you should start taking KI and they will also tell you when you can stop taking it.

### 6. Does KI work in all radiation emergencies?

KI will only protect you from radioactive iodine. It does not protect you from other kinds of radioactive material. KI works very well to protect your thyroid gland. However, it protects only your thyroid, not other parts of your body.

### 7. What will happen in an emergency?

You will be told what, if any, actions you should take to protect yourself. This might include leaving the area, staying inside with your windows closed and/or taking KI.

### 8. Can people have reactions to KI?

In general, most people who have taken KI have not had any reactions (side effects). If people did have a reaction, it did not last very long. In a few cases, babies had a reaction in their thyroids. Adults who had reactions had stomach problems or a rash. The federal government thinks the benefits of taking KI are much greater than the risks.

### 9. Are there some people who should not take KI?

Most people can take KI, but you should talk to your doctor **before** taking it. Talk to your doctor before an emergency occurs. It is not a good idea to take KI if you have certain medical conditions or problems. Babies need to be watched carefully if they take KI.

### 10. How much KI do I take?

The table below shows the smallest KI dose that different age groups can take which will protect the thyroid. The pill comes in both 65-mg and 130-mg tablets. Since it is hard to cut many pills, the State Health Commissioner says that, in an emergency, it is safe for children at school or day care centers to take the whole pill. It's better for children under 12 years old to take the 65-mg pill, but it is safe to take the 130-mg pill if that is the only one you have. For children or babies who cannot take pills, parents and caregivers can cut or crush the pill to make lower doses.

| Age Group | KI Dosage | #r of 65-mg tablets | # of 130-mg tablets |
|---|---|---|---|
| Adults over 18 years | 130 mg | 2 | 1 |
| Over 12 - 18 years and over 150 pounds | 130 mg | 2 | 1 |
| Over 12 - 18 years and less than 150 pounds | 65 mg | 1 | 1/2 |
| Over 3 -12 years | 65 mg | 1 | 1/2 |
| Over 1 month to 3 years | 32 mg | 1/2 | 1/4 |
| Birth -1 month | 16 mg | 1/4 | 1/8 |

### 11. Does KI come in liquid or pill form?

KI can come as a pill or a liquid. Pills are available in 65-mg or 130-mg doses. KI is also available as a liquid.

### 12. If KI has been stored for a while, is it still OK to use?

The manufacturers say KI stays "fresh" for 3-5 years. If you keep it in a dry, dark and cool place, it should last for many years.

### 13. Do you need a prescription to get KI?

No. You are allowed to get it over-the-counter.

### 14. Can KI be purchased at local pharmacies?

Yes, though it may not widely available in drugstores near you. Since it is not a prescription drug, you can buy it over the Internet. As with other drugs, make sure the KI you buy has been approved by the FDA. A supply of KI has been made available to people who live within 10 miles of a nuclear power plant in New York State. If you live within 10 miles of a nuclear power plant and did not receive KI, contact your local Office of Emergency Management.

Potassium Iodide (KI) Permission Form
Forma Del Permiso Del Yoduro Del Potasio (KI)

I understand that potassium iodide (KI) may be recommended by the County and/or State Department of Health in a radiological emergency.

*Entiendo que el yoduro del potasio (KI) se puede recomendar por el departamento del condado y/o del estado de la salud en una emergencia radiológica.*

I have read and understand the Parent/Guardian letter, Potassium Iodide (KI) Parent Q &A's and Department of Health KI information sheet.

*He leído y entiendo la letra de Parent/Guardian, los &A del padre Q del yoduro del potasio (KI) y el departamento de la hoja de la información de la salud KI.*

☐ **I DO WANT** my child to be given potassium iodide (KI) in the event of a radiological emergency.

☐ *QUISIERA que dieran mi niño el yoduro del potasio (KI) en el acontecimiento de una emergencia radiológica.*

☐ **I DO NOT WANT** my child to be given potassium iodide (KI) in the event of a radiological emergency.

☐ *No quisiera que mi recibiera mi niño el yoduro del potasio (KI) en el acontecimiento de una emergencia radiológica..*

Child's Name: _____
*Nombre Del Niño*

Date of Birth: _____
*Fecha de nacimiento*

Teacher/Homeroom Teacher: _____
*Nombre del maestro/a*

Parent/Guardian Signature:*Firma de los padres/guarda:* _____

Date: _____ Telephone number: _____
*Fecha* *Número de teléfono*

OSWEGO
CITY SCHOOL DISTRICT

Education Center
One Buccaneer Boulevard, Oswego, New York 13126
www.oswego.org

Dear Parent/Guardian:

Please complete the following form for the school year 20__ - 20__.

Child's Name _____ Grade_____
Teacher's Name_____ School_____

1. Permission for Birthday Announcements:
   I □do □do not give permission for my child's name to be announced during morning school announcements on his/her birthday.

2. Permission to Release phone number(s), email address(s), mailing address to Room Parent for Classroom Events:
   □Yes, you may share my information.
   □No, you may not share my information

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## OSWEGO CITY SCHOOL DISTRICT OPT-OUT PHOTO RELEASE

The Oswego City School District likes to celebrate the achievements of our students and staff. Throughout the year, the Public Relations Department and district staff may take photographs of students and school activities. These photographs may appear in various District materials, including the District's website (Oswego.org), newsletters, yearbooks, brochures, social media pages, district calendar, etc. We at times, may also publicize student work.

If you **DO NOT** want your child's name/photo/work publicized for these purposes you are asked to inform your child's principal, in writing. A simple, written, signed note stating: "Please do not photograph my child for use in publications and/or web", including your child's name and grade level. You may either drop off the note in person or mail it to the school your child is attending.

If you have any questions regarding this Student Photograph practice, please feel free to contact either your child's principal or the Superintendent's Office.

**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: | | | GENDER: |
|---|---|---|---|
| *Month* | *Day* | *Year* | ❑ 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: | | 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: ❑ Mother ❑ Father ❑ 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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:**

OSWEGO CITY SCHOOL DISTRICT
Education Center
One Buccaneer Boulevard, Oswego, New York 13126
www.oswego.org

# Impact Aid Registration Form

## Military Service

### (Additional data required of Parent/Guardian with present military service)

Name of Student _____ Date of Birth _____

School Enrolled In:_____ Grade_____

Home Address _____

Name of parent/guardian (A) _____

Relationship to student _____

Federal property on which parent/guardian (A) is employed _____

Name of firm, agency or uniformed services branch employing parent/guardian (A) _____

Name of parent/guardian (B) _____

Relationship to student _____

Federal property on which parent/guardian (B) is employed _____

Name of firm, agency or uniformed services branch employing parent/guardian (B) _____

If either parent is the uniformed services, please indicate:

Name of Parent _____ Rank/Unit_____

_____ _____

Signature of Parent/Guardian Date

# Oswego City School District Transportation Department

**Date:** _____

AM - Stop Location: _____ Bus #: _____
PM - Stop Location: _____ Bus #: _____

**Transportation Department Bus Registration / Student Information Update Form**

The following information is needed to assist us in assigning your child to a school bus route. This form must be completed prior to assigning new students to a bus, or changes are made for students currently assigned. The transportation office will assign students to the closest available stop upon receipt of this form. If a stop is more than .5 miles from home or if the walk route to the stop appears unsafe, a bus stop change request can be submitted. All specialized transportation needs as determined by the IEP team will be sent on the Special Needs Transportation Form. If you have any questions please contact the transportation office at (315) 341-2900.

****Note: Parent or guardian must be at the bus stop morning and afternoon for Pre-K and Kindergarten. Students will be returned to school if the adult is not at the bus stop. Parents/guardians are responsible for the supervision of students as they travel to and from bus stops and while they wait for buses to arrive.**

Check appropriate option. Information is for new student ( ) Update for current student ( )

Student Name: Legal Name: _____ Nick Name: _____

Date of Birth: _____ School: _____ Grade: _____ Teacher: _____

Parent or Guardian: _____ E-mail Address: _____

Phone: Home: _____ Work: _____ Cell/Mobile: _____

Address: _____City: _____Zip Code_____

Subdivision: _____ Cross Streets: _____ Directions to your home from zoned school:
_____

**Photograph Release: (during bus training or other bus related situations)**

I hereby release the Oswego City School District and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my child's participation:

- o I agree to release of my child's photograph
- o I do not agree to release of my child's photograph

Emergency medical information (list any health concerns or medication the driver should be aware in case of an emergency.)

**List family members or other emergency contact authorized to pick up your child if you are not available. <u>Picture ID will be required at the bus stop</u>** (use back of page if needed):

1 _____ Phone: _____ Relationship: _____
2 _____ Phone: _____ Relationship: _____
3 _____ Phone: _____ Relationship: _____

Can this student participate in any food-based treats/rewards? YES No
If yes, please list all food allergies _____

**Parent Signature:** _____

**FOR OFFICE USE ONLY**

Route #:_____ Stop Location: _____ Time: AM_____ PM _____
Parent Notified On: _____ Driver Notified On: _____ School Notified On: _____
Data entered by: _____ Route Color _____ Date completed: _____

## Digital Equity Survey

Dear Parent(s)/Guardian(s),

Collecting accurate data regarding digital resource access for our New York students will greatly help educators to better serve their students and families. In order to accomplish this, the New York State Education Department is asking parents or guardians to complete a Digital Equity survey (for each student in the family) in grades Kindergarten – Grade 12. This survey will provide information on student access to devices and internet access in their places of residence. To assist us in this process, please answer each question below and submit the form. Thank you for your time and cooperation.
Oswego City School District

**Student Name**

**Did the school district issue your child a dedicated school or district owned device for their use during the school year? (OCSD will provide all k-12 students access to a Chromebook)**

- Yes
- No

**What is the device your child uses most often to complete learning activities away from school? (Please anticipate your answer if completing for a new student, This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.)**

- Desktop
- Laptop
- Tablet
- Chromebook
- Smartphone
- No Device

**Who is the provider of the primary learning device identified in question 2? (Please anticipate your answer if completing for a new student, This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.)**

- School
- Personal
- No Device

**Is the primary learning device (identified in question 2) shared with anyone else in the household?**

- Shared
- Not Shared
- No Device

**Is the primary learning device (identified in question 2) sufficient for your child to fully participate in all learning activities away from school?**

- Yes
- No

**Is your child able to access the internet in their primary place of residence?**

- Yes
- No

**What is the primary type of internet service used in your child's primary place of residence?**

- Residential Broadband
- Cellular
- Mobile Hotspot
- Community WIFI
- Satellite
- Dialup
- DSL
- Other
- None

**In their primary residence, can your child complete the full range of learning activities, including video streaming and assignment upload, without interruptions caused by slow or poor internet performance?**

- Yes
- No

**What, if any, is the primary barrier to having sufficient and reliable internet access in your child's primary place of residence?**

- Availability
- Cost
- None
- Other

**Parent/ Guardian Name**

**Signature** **Date**

**2 - NYS / OCSD Digital Equity Survey**

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

# IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

***Please take few minutes to complete this questionnaire.***

## Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

- ☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- ☐ Work related to logging, harvesting, or initial processing of trees.
- ☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)

***If you answered YES, please provide your contact information below:***

Parent/Guardian Name: _____

Home address: _____

Telephone number: (____)-_____-_____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____Grade_____

Student name: _____ Age _____Grade_____

**To submit this referral please fax to 607-436-3606, or by mail to NYS Migrant Education Program-Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.**

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

# OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Acta de Educación Elemental y Secundaria (ESEA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, **sin importar su nacionalidad o estado legal**. Este programa **es gratuito** para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito en la escuela, excursiones, programa de verano, actividades de envolvimiento para padres, programa de emergencias y referidos a otras organizaciones o agencias.

***Por favor tome unos minutos para completar este cuestionario.***

**¿Usted o algún miembro de su familia ha trabajado o buscado trabajo en algunas de las siguientes ocupaciones en los pasados 3 años?**

- ☐ Cualquier trabajo agrícola (como plantando, seleccionando, o cosechando frutas o vegetales, cultivando o cortando flores o árboles, trabajo en lechería u otro rancho de animales, pescando, etc.)
- ☐ Trabajando en la cultivación o procesamiento de los árboles.
- ☐ Trabajando en una planta de procesamiento, empacando, lavando o cortando vegetales, frutas o carnes.

***Si usted contestó que sí, por favor complete la siguiente información:***

Nombre del Padre/Encargado: _____

Dirección Física: _____

Teléfono: (____)-_____-_____ Mejor tiempo para ser contactado _____ AM/PM

Dirección anterior: _____

Nombre del estudiante: _____ Edad_____ Grado_____

Nombre del estudiante: _____ Edad_____ Grado_____

**Para someter este referido, por favor envíelo por fax a 607-436-3606, o por correo a**
**NYS Migrant Education Program- Identification & Recruitment Office**
**100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020**