CORNWALL
CENTRAL SCHOOL DISTRICT

STUDENT REGISTRATION OFFICE

www.cornwallschools.com

Welcome to the Cornwall Central School District!

Attached is the Cornwall Central School District enrollment packet for you to complete. (One per child)

Along with this packet, the following documents are **required** at time of registration:

- Online Pre Registration – must be completed prior to submitting any registration paperwork.
  Please visit the link below to create a new student account (top left of page)
  https://st-cw.mhric.org/Cornwall/onlinepreregistration/
- Proof of residency:
  - If you **own** your home, provide a current tax bill **OR** a current mortgage statement **AND** a current utility bill.
  - If you **rent** your home, provide a current lease **AND** a current utility bill.
  - If you are residing with family, please call the Registrar for a CCSD Resident Affidavit.
- Birth Certificate (the registrar will make a copy)
- Most recent report card
- Immunizations up-to-this date
- Your child will need a physical completed in **New York State** within the year of starting school.
  Your child has 15 days after his/her first day of school to provide a **NYS** physical to the school nurse.

If you have any questions, do not hesitate to call or email me.

Crystal O'Brien
Central Registrar
Cornwall Central High School
10 Dragon Drive
New Windsor, NY 12553
Phone: 845-534-8009 x7803
cobrien@cornwallschools.com

CORNWALL CENTRAL SCHOOL DISTRICT
ENROLLED STUDENT INFORMATION FORM

STUDENT'S NAME: _____ **GRADE:** _____
First Middle Last

DATE OF BIRTH: _____ **GENDER**: ☐ **Male** ☐ **Female**

PLACE OF BIRTH: _____
City & State / Country if not USA

DATE OF ENTRY INTO THE USA: _____ **YEARS IN USA SCHOOLS:** _____

IS EITHER PARENT OR LEGAL GUARDIAN AN ACTIVE DUTY MEMBER OF THE ARMED FORCES? IF YES, PLEASE SPECIFY BELOW:

Name: _____ **Branch of Service:**_____ **Entry Date:**_____ **Exit Date:** _____

Name: _____ **Branch of Service:**_____ **Entry Date:**_____ **Exit Date:** _____

ETHNICITY: ☐ **Yes**, Hispanic/Latino ☐ **No**, Not Hispanic/Latino
Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South America, or other Spanish culture or origin, regardless of race.

RACE: ***You may choose one or more***

☐ **Am Indian/Alaska Native -** A person having origins in North America and who maintains cultural identification through tribal affiliation or community recognition. e.g. Cherokee, Mohawk, Inuit.
☐ **Asian -** A person having origins in any of the origins of the Far East, Southeast Asia, or the Indian subcontinent.
☐ **Native Hawaiian/Pacific Islander -** A person having origins in Hawaii, Guam, Samoa, or other Pacific Islands.
☐ **Black/African American -** A person having origins in any of the Black racial groups of Africa.
☐ **White -** A person having origins in Europe, North Africa or the Middle East.

_____ _____
Signature of Parent / Guardian *Date*

**This information is gathered pursuant to New York State and Federal requirements, but is not used to make a determination with respect to a student's right to register and enroll in the Cornwall Central School District.*

CORNWALL CENTRAL SCHOOL DISTRICT

STUDENT REGISTRATION OFFICE – 10 DRAGON DRIVE, NEW WINDSOR, NY 12553
PHONE: 845-534-8009 x7803

STUDENT'S NAME _____ **GENDER:** MALE ☐ FEMALE ☐ **GRADE:** _____
First Middle Last

DATE OF BIRTH: _____

PARENT MARITAL STATUS _____ **Is there a custody issue with this child?** _____ **If yes, who has custody?** _____

ORDER OF PROTECTION _____ ***If an order of protection exists, please submit a copy to your child's principal at time of student enrollment.***

SIBLINGS RESIDING AT HOME			
NAME OF SIBLING	**DATE OF BIRTH**	**GRADE**	**SCHOOL ATTENDING**

STUDENT'S EDUCATIONAL BACKGROUND		
SCHOOL NAME	**CITY/STATE**	**ATTTENDED: GRADE / YEAR**

Has your child been retained (repeated a grade)? ☐ Yes ☐ No **If yes, what grade?** _____

Has your child received: ☐ Counseling ☐ Speech ☐ Remedial Math ☐ Remedial Reading ☐ Other _____

Does your child have an Individual Education Plan (IEP)? Yes _____ **No** _____ **At what were services provided?** _____

EMERGENCY CONTACTS: Local person who have agreed to care for your child in an emergency when parents cannot be reached:
In an emergency situation, Administration will take any action it deems necessary and appropriate, including taking your child to the hospital.

#1_____ _____ _____
Name ***Relationship to child*** *City/State* ***(MUST BE LOCAL)***

_____ _____ _____ _____
Home Phone # *Cell Phone #1* *Cell Phone #2* *Work Phone #*

#2_____ _____ _____
Name ***Relationship to child*** *City/State* ***(MUST BE LOCAL)***

_____ _____ _____ _____
Home Phone # *Cell Phone #1* *Cell Phone #2* *Work Phone #*

_____ _____ _____
Signature of Parent, Guardian ***Relationship*** ***Date***

_____ *Check here (and provide details) if student lives in a shelter, abandoned apartment/building, motel/hotel, camp ground, car, or train/bus station; if the student lives with relatives or others due to lack of housing or other similar situation; or if the student is temporarily housed in a shelter awaiting permanent foster care placement_____ (living arrangements). If box is checked, please complete STAC-202 form. The answer you give 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 do not 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.*

Is this a foster placement: _____ Yes _____ No If yes, name of county: _____
If yes, copy of DSS 2999 Form required

Cornwall Central School District

COMPUTER USE AND PHOTO PERMISSION FORM

Cornwall Central School District wishes to provide students, educators and community with a useful computer information system. Our computer network, e-mail system, internet access policy and district website serve to help our staff and students conduct research, produce material and communicate. All Students have access to this system. Abuse or misuse of the computer system may subject a student to have use rights removed as per the Code-of-Conduct.

To highlight the accomplishments and or engagement of our students, there are often occasions when a building administrator or teacher will want to publish photographs and/or videos of students engaged in school-related activities while on School District property or at School District sponsored functions to the School District's website or to select social media sites monitored and edited by the School District such as Facebook or Twitter. **Student's name will not be included**.

If you do not want the District to use your child's image or likeness on the District's website or sponsored social media sites, please sign and return the slip below.

If you have any questions or concerns, please contact your child's principal.

_____ **NO, I do not want my child's picture to be posted on the School District's website, district sponsored social media forums i.e., Facebook, Twitter**

_____ **YES, I give CCSD permission to post my child's picture.**

_____ _____ _____

CHILD'S NAME **BUILDING** **DATE**

_____ _____

PRINT PARENT / GUARDIAN'S NAME **PARENT / GUARDIAN SIGNATURE**

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234

Elisa Alvarez, Associate Commissioner Office of Bilingual Education and World Languages

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

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

Home Language Questionnaire (HLQ)

Dear Parent or Person in Parental Relation:

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

Thank you.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:

❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to*

HOME LANGUAGE CODE

Language Background

(Please check all that apply.)

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

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: ❑ Parent ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ **POSITION:** _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

****DATE OF INDIVIDUAL INTERVIEW:** _____
MO DAY YR.

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: **POSITION:**

DATE OF NYSITELL ADMINISTRATION: _____
MO. DAY YR.

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

CORNWALL CENTRAL SCHOOL DISTRICT

SCHOOL TRANSPORTATION REQUEST FORM – PUBLIC SCHOOL

Today's Date: _____ **SCHOOL YEAR:** _____ **START DATE**: _____

Student's Name: _____
First Middle Last

DOB: _____ Gender: _____ M _____ F

Home Address: _____
(Street address, city, state, zip code)

Mailing Address (if different from above): _____
(Street address, city, state, zip code)

Parent/ Guardian Name(s): _____

Home Phone: _____ Cell/Work: _____

Email: _____

School: HS ◯ MS ◯ CES ◯ WAE ◯ COH ◯ Grade: _____

❑ NEW STUDENT ☐ NEW ADDRESS **(SEE BELOW)** ☒ NEW CHILDCARE ☐ CHANGE IN SCHOOL

❑ OTHER (please explain): _____

CHANGE OF ADDRESS WILL REQUIRE PROOF OF RESIDENCY AND MUST BE PRESENTED TO:
Central Registrar, Crystal O'Brien PH: 845-534-8009 x7803 Email address: cobrien@cornwallschools.com

REQUEST:

_____ Transportation to/from **HOME** address.
_____ Transportation with **CHILDCARE** arrangements.
_____ **WALKER/PARENT TRANSPORT** - transportation not required.

CHILDCARE TRANSPORTATION (within CCSD)

A.M. PICK UP:

Check: _____Home _____Childcare Provider _____Walker

Providers Name: _____

Providers Address: _____

_____

Providers Phone: _____

Days: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri

P.M. DROP OFF:

Check: _____Home ☐ Childcare Provider _____Walker

Providers Name: _____

Providers Address: _____

_____

Providers Phone: _____

Days: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs. ☐ Fri

Does your child have any medical concerns we should know about, ie, allergies, etc.? Please explain:

_____

Parent Signature: _____ **Date:**

Return to: Transportation Coordinator

PH: 845-534-8009 x7100 FAX: 845-534-9032 Email address: transportation@cornwallschools.com **** PLEASE NOTE TRANSPORTATION CHANGES TAKE APPROX 48 HOURS or longer during the first week of school****

FOR OFFICE USE ONLY: NEW STUDENT: _____ (YES OR NO) STUDENT ID#: _____ Parent Notified: _____

BUS RUN #: _____ A.M. P/U TIME: _____ Location: _____ P.M. D/O TIME: _____ Location: _____

Cornwall Central School District

STUDENT HEALTH OFFICES

(845) 534-8009

High School	Middle School	Cornwall on Hudson Elementary	Cornwall Elementary	Willow Avenue Elementary
Ext. 5010	**Ext. 4010**	**Ext. 1010**	**Ext. 2010**	**Ext. 3010**

Student's Name: _____Gender: _____ Date of Birth: _____

Parent email: _____ Grade: _____

Home Address: _____ Home phone #: _____

Parent/Guardian: _____Cell #:_____ Work #:_____

Parent/Guardian: _____ Cell #:_____ Work#: _____

Student's Medical History

Has your child <u>ever</u> had the following Communicable <u>Diseases</u>:

	Yes	No	Date		Yes	No	Date
Chicken Pox	____	____	_____	Scarlet Fever	____	____	_____
Mumps	____	____	_____	Whooping Cough	____	____	_____
German Measles	____	____	_____				

1) Is your child presently under treatment for any physical problem? Yes_____ No_____

If so, explain: _____

---

2) Does your child take medication on a regular basis? Yes_____ No_____

If so, name of medication and reason_____

If your child needs to take medication during the school day, you must contact the Health office in person. Specific forms must be filled out and signed by your Physician before <u>ANY</u> medication can be administered.

3) Has your child ever had surgery? Yes_____ No_____ Explain: _____

4) Has your child had any serious medical problems? Yes_____ No_____ Explain: _____

5) Has your child had a serious accident or injury? Yes_____ No_____ Explain: _____

6) Has your child ever been hospitalized? Yes_____ No_____ Explain: _____

7) Does your child have any allergies to food, medication or insects/bee stings? Yes_____ No_____

If yes, please list: _____

8) Does your child wear glasses or contacts? Yes_____ No_____ Other visual difficulties, please explain:

_____

9) Does your child have any:

Ear problems?	Yes_____	No_____
Hearing loss?	Yes_____	No_____
Frequent ear infections?	Yes_____	No_____
Tubes in ears?	Yes_____	No_____ At what age? _____

Explain: _____

10) Does your child have any speech difficulties? Yes_____ No_____ If yes, please explain: _____

_____

11) Does your family have any history of diabetes or tuberculosis? Yes_____ No_____

<u>Family Physician</u>: _____

Name City/State Phone #

<u>In emergency situations, Administration will take any action it deems necessary & appropriate, including taking your child to the hospital.</u>

Parent / Guardian Signature: _____Date:_____

CORNWALL CENTRAL SCHOOL DISTRICT - CORNWALL, NY

** REQUEST FOR STUDENT RECORDS **

District Phone Number (845) 534-8009

PRIOR SCHOOL: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

Student's Name: _____ **Student's DOB:** _____

The above named student has enrolled in the Cornwall Central School District. Please forward to us the items listed below and any other pertinent information which will assist us in placing and supporting this student. Thank you.

- **Official Transcript**
- **Health / Immunization Records**
- **Standardized Test Scores**
- **School Profile**
- **Course Selections/Recommendations for the new school year**
- **Discipline Records**
- **RCT Scores**
- **Copy of last Report Card**
- **Graduation Requirements**
- **Withdrawal Grades for current year**
- **Copy of I E P**
- **Behavior Intervention Plan or 504**
- **Psychological Reports (if any)**
- **Speech Evaluations (if any)**
- **OT / PT Evaluations (if any)**
- **Vision Evaluation (if any)**
- **Other:**_____

Please send records listed above to the attention of _____

_____**Cornwall Central High School**
10 Dragon Drive
New Windsor, NY 12553
Fax: 845-565-4931
Email: csaldanha@cornwallschools.com

_____ **Cornwall Elementary School**
99 Lee Road
Cornwall, NY 12518
Fax: 845-534-0569

_____**Cornwall Central Middle School**
122 Main Street
Cornwall, NY 12518
Email: amilani@cornwallschools.com

_____ **Willow Avenue Elementary School**
67 Willow Avenue
Cornwall, NY 12518
Fax: 845-314-9424

_____**Cornwall on Hudson Elem. School**
234 Hudson Street
Cornwall on Hudson, NY 12520
Fax: 845-534-2284
Email: pshilling@cornwallschools.com

_____ **Office of Pupil Personnel Services**
10 Dragon Drive
New Windsor, NY 12553
Fax: 845-314-8640

I hereby authorize the release of the records listed above.

_____ _____ _____

Signature of Student (if over 18) ***Signature of Parent / Guardian*** ***Date***

Cornwall Central School District

Terry Dade
Superintendent of Schools

Harvey Sotland
Assistant Superintendent for Business

Megan Argenio
Assistant Superintendent for Instruction

THIS FORM MUST BE RETURNED WITH PHOTO IDENTIFICATION

Dear Parent / Guardian:

The Cornwall Central School District is introducing the Parent Portal of our SchoolTool Student Management Information System to Parents/Guardians. You will have access to view the following information for your child: emergency contact information, schedule, attendance, report card grades including progress reports, past assessment scores/past exam grades.

To create an account for viewing this information, please complete the bottom portion of this letter and either bring it to the main office of your child's school or return the form to school with a copy of your current photo ID with your child. Once the form is received at the school and processed, an account will be created. You will receive an email with your first SchoolTool password and instructions on how to access your portal account. Please note that this process only needs to be completed once, not every year. One form will cover all children in your family. SchoolTool is a secure internet site; however, parents/guardians are responsible for protecting their password.

If you have any questions or concerns, please contact the main office your child's building.

_ _

Please keep top portion of this letter for your records.

Parents/Guardians must provide valid picture identification. Accounts will not be created without proper identification.

Name of Parent/Guardian: ____

Parent/Guardian **email address**: ____

PLEASE PRINT LEGIBLY

Name of child(ren):

Child's name	Grade/School	Child's name	Grade/School
Child's name	Grade/School	Child's name	Grade/School

Signature of Parent/Guardian: ____

BUILDING VERIFICATION

Type of Photo ID: ____________________ Date: ________

Date form received: ______________

Photo ID received by: ______________________________

Date account created: ____________

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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

Notes

Hearing 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***: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

*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.