



CORNWALL
CENTRAL SCHOOL DISTRICT

STUDENT REGISTRATION OFFICE
www.cornwallschools.com

Welcome to the Cornwall Central School District!

Please complete the online Cornwall Pre-Registration form: <https://st-cw.mhric.org/Cornwall/onlinepreregistration/>

Attached is the Cornwall Central School District enrollment packet for you to complete.

The following documents are **required** at time of registration:

- 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
- most recent report card (Please contact your child's school to obtain a copy)
- disciplinary records (if applicable)
- immunizations up-to-this date
- Your child will need a physical completed in **New York State** within one 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.

You can either scan in an email or mail the documents to the address on the bottom on this page. If you do not have access to a printer please call or email the Registrar. You may also hand deliver the forms to the High School between the hours of 8:30 am and 1:30 pm – Monday thru Friday.

Crystal O'Brien
Central Registrar
Cornwall Central High School
10 Dragon Drive
New Windsor, NY 12553
Phone: 845-534-8009 x7803 Fax: 845-458-7975
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	ATTENDED: 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? _____

CORNWALL CENTRAL SCHOOL DISTRICT

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

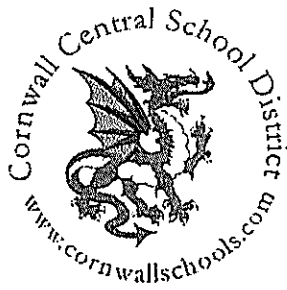
Relationship

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



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

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

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

Home Language Questionnaire (HLQ)

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

STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
Month	Day	Year
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1 _____ <i>specify</i>	<input type="checkbox"/> Parent 2 _____ <i>specify</i>
	<input type="checkbox"/> Guardian(s) _____ <i>specify</i>	
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> 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:
Cornwall Central School District Cornwall, NY	
<small>District Name (Number) & School: Address:</small>	

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: <u>Crystal O'Brien</u>	POSITION: <u>Central Registrar</u>
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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <small>MO DAY YR.</small>	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <small>MO. DAY YR.</small>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> 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: _____

DOB: _____ First _____ Middle _____ Last _____ 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
Ext. 5010

Middle School
Ext. 4010

Cornwall on Hudson Elementary
Ext. 1010

Cornwall Elementary
Ext. 2010

Willow Avenue Elementary
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 ever had the following Communicable Diseases:

	<u>Yes</u>	<u>No</u>	<u>Date</u>		<u>Yes</u>	<u>No</u>	<u>Date</u>
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 ANY 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 _____

Family Physician: _____
Name City/State Phone #

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

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

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

_____ **Cornwall Central Middle School**
122 Main Street
Cornwall, NY 12518
Fax: 845-534-7115

_____ **Willow Avenue Elementary School**
67 Willow Avenue
Cornwall, NY 12518
Fax: 845-534-3474

_____ **Cornwall on Hudson Elem. School**
234 Hudson Street
Cornwall on Hudson, NY 12520
Fax: 845-534-2284

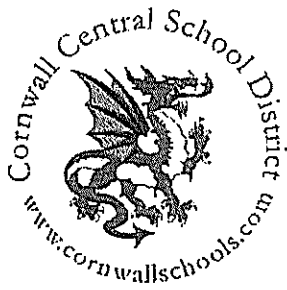
_____ **Office of Pupil Personnel Services**
10 Dragon Drive
New Windsor, NY 12553
Fax: 845-314-8640

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 HEALTH CARE 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; working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

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

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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: No Yes Not Done **Hypertension:** No Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)	
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Lead Level Required Grades Pre- K & K	Date			
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$				
<input type="checkbox"/> System Review and Abnormal Findings Listed Below				
<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

Assessment/Abnormalities Noted/Recommendations: _____ **Diagnoses/Problems (list)** _____ **ICD-10 Code*** _____

Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name: _____ DOB: _____

Vision & Hearing SCREENINGS - Required for Pre-K or K, 1, 3, 5, 7, & 11

Vision (w/correction if prescribed)	Right	Left	Referral	Not Done
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Near Vision Acuity	20/	20/		
Color Perception Screening	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	
Notes				
Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	Negative <input type="checkbox"/>	Positive <input type="checkbox"/>	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	Not Done

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

- Student may participate in all activities without restrictions.
- 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 Age of First Menses (if applicable) : _____

Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

Order Form for Medication(s) Needed at School Attached

IMMUNIZATIONS

Record Attached Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature: _____
 Provider Name: (please print) _____
 Provider Address: _____
 Phone: _____ Fax: _____

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