Lansing Central School District

284 Ridge Road, Lansing, NY 14882 607-533-3020 x 4412

Welcome Families! 2022/2023 School Year Registration Packet

PARENTS/GUARDIANS, PLEASE PRESENT THE FOLLOWING DOCUMENTS TO THE REGISTRAR:

- **Completed Registration Packet**
    - **Proof of Age** (**ONE** of the following)— **Copies are acceptable please do not mail original documents**
    - Original Birth Certificate
    - Passport and/or VISA
    - Baptismal Certificate with date of birth indicated

- **Proof of Residency in the Lansing Central School District** (**TWO** of the following)
    - Contract to purchase a primary residence*
    - Contract to build a primary residence*
    - Certificate of occupancy
    - Lease agreement
    - Utility bill or statement of service (only one utility bill will be accepted)
    - Driver's license
    - Paycheck stub
    - Voter registration card
    - School tax bill
    - Moving company receipt

    *District Policy states that you must reside in the district within 90 days

- **Immunization & Health Records** Include a copy of the most recent physical and immunizations (dated within the last year at the time of registration). Also include a health history form (included in the packet).

- IF APPLICABLE:
- **Legal Documents**
    - Custody agreement
    - Court Order of Protection
    - Form DSS-2999 for foster placement

- **Student Name Changes** Provide proof of name change (must have two: adoption certificate, court order, social security card, health insurance card)

Please direct any questions regarding the registration process to the district registrar at x4412 or LDavis@LCSD.K12.NY.US

Lansing Central School District
Student Registration

Date Received : ____________________
(OFFICE USE)

Grade ______ Age ______ Date of Birth ________________

Birthplace City State Country

Student Legal Name Last First Middle

Gender ☐ Male ☐ Female ☐ Non Binary

Home Address Street

Preferred Pronouns ____________________

State ZIP City

Student resides with ☐ Both Parents ☐ One Parent
☐ Legal Guardian

Transferring from District/School

____

____

If parents do not reside in same household, please check.
Custody is ☐ Sole ☐ Joint
☐ Court Protection Order

Last Day Attended __________ Grade Completed______

Has your child ever attended Lansing Schools in the past? ☐ Yes ☐ No If yes, please provide dates/grades: ____________________

Primary Parent/Guardian *(residing with student)*

Name ____________________

Employer ____________________
Active Duty Military Personnel ☐ Yes ☐ No

Phone # Priority 1 ____________________ (Home, Cell, Work)
Priority 2 ____________________ (Home, Cell, Work)
Priority 3 ____________________ (Home, Cell, Work)

Email ____________________
Relationship to student ☐ Mother ☐ Father ☐ Step-parent
☐ Legal Guardian ☐ Other ____________________

Secondary Parent/Guardian *(residing with student)*

Name ____________________

Employer ____________________
Active Duty Military Personnel ☐ Yes ☐ No

Phone # Priority 1 ____________________ (Home, Cell, Work)
Priority 2 ____________________ (Home, Cell, Work)
Priority 3 ____________________ (Home, Cell, Work)

Email ____________________
Relationship to student ☐ Mother ☐ Father ☐ Step-parent
☐ Legal Guardian ☐ Other ____________________

Lansing Central School Policy states both parents have equal access to their children and school records. If access is denied, court papers must be on file with the District giving specific instructions regarding custody of student and access to records. Complete information for both parents is required if Joint Custody exists or there are no court documents.

Parent not Residing with Student

Name ____________________

Employer ____________________

Address Street City State ZIP
Receive Mail ☐ Yes ☐ No
Active Duty Military Personnel ☐ Yes ☐ No
In Case of Emergency can this person be contacted ☐ Yes ☐ No ☐ Only if all other contacts can not be reached

Phone # Priority 1 ____________________ (Home, Cell, Work)
Priority 2 ____________________ (Home, Cell, Work)

Email ____________________
Relationship to student ☐ Mother ☐ Father ☐ Step-parent

Lansing Central School District
Student Registration

Student's Name ______________________________

PLEASE ANSWER QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) Check (√) the box that best describes your child.] Check (√) only ONE box.

1. Is student Hispanic, Latino, or of Spanish origin? A person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race. ☐ **YES, Hispanic** ☐ **Not Hispanic**

2. Select one or more races from the following five racial groups [For question (2) Check (√) all groups that apply to your child; check (√) **at least** ONE box.]:

☐ **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and maintain tribal affiliation or community attachment

☐ **Asian:** A person having origins in any of the original peoples of Far East, Southeast Asia, or Indian subcontinent (i.e. Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands,Thailand or Vietnam)

☐ **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Island

☐ **Black or African American:** A person having origins in any of the Black racial groups of Africa

☐ **White:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East

Siblings residing with student at same address:

Grade	Name	Sex	Birth date
______	______________ Last / First / MI	______	______
______	______________ Last / First / MI	______	______
______	______________ Last / First / MI	______	______
______	______________ Last / First / MI	______	______

Will your child require English as Second Language Services? ◻ **Yes** ◻ **No**

Parent/Guardian is Migrant Worker ◻ **Yes** ◻ **No**

What is the primary language spoken at home? ____________________ What language does your child primarily speak? ____________________

Is your child **currently** receiving English as a Second Language services? ◻ **Yes** ◻ **No**

Foster Care Placement Please provide the **Form DSS-2999** at time of registration along with the following information:

Name of Case Worker ______________________________ Phone ____________________

Is this student considered Neglected / Delinquent? ◻ **Yes** ◻ **No**

Parent / Guardian Statement

I understand that proof of New York State required immunizations for polio, mumps, measles, diphtheria, hepatitis, and rubella from a physician or clinic is required for admission to school. If there is a medical or religious exemption, statements of such must be presented. Failure to file either proof of immunization or exemptions will result in the exclusion of the pupil until such time as an appropriate immunization statement is submitted.

Permission is hereby granted to Lansing Central Schools to obtain all heath and scholastic records from the above listed school as well as transfer records to a new school in the event of a move to another district or state. I understand that all reports and screening test results will be treated confidentially; and certify that the information provided is accurate to the best of my knowledge and that I have legal custody of the above named child.

Signature ______________________________ **Date** ____________________

Lansing Central School District

Student Registration

Student's Name ____________________

Authorized Emergency Contacts (in addition to student's parents/guardians)
Please indicate which phone number goes with which contact when household members are listed

Name ____________________

____
Address Street City State ZIP

Phone # Priority 1 ____________ (Home, Cell, Work) Priority 3 ____________ (Home, Cell, Work)
Priority 2 ____________ (Home, Cell, Work) **Relationship to student:** ____________

Name ____________________

____
Address Street City State ZIP

Phone # Priority 1 ____________ (Home, Cell, Work) Priority 3 ____________ (Home, Cell, Work)
Priority 2 ____________ (Home, Cell, Work) **Relationship to student:** ____________

Name ____________________

____
Address Street City State ZIP

Phone # Priority 1 ____________ (Home, Cell, Work) Priority 3 ____________ (Home, Cell, Work)
Priority 2 ____________ (Home, Cell, Work) **Relationship to student:** ____________

Name ____________________

____
Address Street City State ZIP

Phone # Priority 1 ____________ (Home, Cell, Work) Priority 3 ____________ (Home, Cell, Work)
Priority 2 ____________ (Home, Cell, Work) **Relationship to student:** ____________

Name ____________________

____
Address Street City State ZIP

Phone # Priority 1 ____________ (Home, Cell, Work) Priority 3 ____________ (Home, Cell, Work)
Priority 2 ____________ (Home, Cell, Work) **Relationship to student:** ____________

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

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

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

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

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:
❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background

(Please check all that apply.)

Question			
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:

Lansing Central School District
Student Registration

Student's Name ______________________

Date of Birth: ______________________

Additional Services Information

Is your child currently receiving ***Section 504 Support Services*** (Accommodation Plan)? ☐ **YES** ☐ **NO**

Does your child have an ***Individualized Education Program*** (IEP)? ☐ **YES** ☐ **NO**

Is your child currently receiving ***Academic Intervention Services*** (AIS)? ☐ **YES** ☐ **NO**

If **yes**, please indicate which subject area: ☐ **Math** ☐ **ELA**

Residency Information

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

Parent/Guardian Signature ______________________ Date ______________

Lansing Central School District

KINDERGARTEN STUDENT QUESTIONNAIRE

Student's Name ______________________________ Date of birth________________________

Please help our teachers get to know your student a little better.

1. Has your child been to preschool or in a day care with other children? Where?

2. Is your child able to play by themselves?

3. What does your child enjoy doing? What makes them happy?

4. What activities does your child like to do alone? With others?

5. How does your child get along with friends/siblings?

6. How does your child react to frustration or anger?

7. How does your child respond when hurt or upset?

8. Does your child have any fears or phobias?

9. Is your child fully potty trained? Do they use the bathroom independently?

10. Describe your child's self help skills (getting dressed, tying shoes, personal care, etc.)

11. Has your child ever received special services?

12. Does your child have any gross motor (running, hopping, etc.) or fine motor (writing, cutting, etc.) challenges?

13. Please share anything else you would like us to know about your child:

THANK YOU FOR SHARING THIS INFORMATION. WE LOOK FORWARD TO WATCHING YOUR STUDENT LEARN AND GROW!

Required Health Paperwork for Registration

Parents/Guardians are required to provide the following health paperwork:

- **Health History completed**
- **Physical exam by a NYS provider** (within the past year)-must be provided by the 30th day of school.
- **Complete immunization record**-student must be fully immunized by the 14 day of school or the student will be excluded.

If any of the above health paperwork is not provided at the time of registration, the parent/guardian must contact the building school nurse.

School Nurse contact information is below:

Kelly Bell, RN BSN
Elementary School Nurse
P: (607) 533-3020 Ext. 1113
F: (607) 533-4829

Melissa O'Neill, RN BSN
Elementary School Nurse
P: (607) 533-3020 Ext. 1113
F: (607) 533-4829

Diane Marabella, RN BSN
Middle School Nurse
P: (607) 533-3020 Ext. 2140
F: (607) 533-4851

Tracie Larkin RN
High School Nurse
P: (607-533-3020 Ext. 3111
F: (607) 533-3456

Please feel free to have your healthcare provider fax the recent physical exam and immunizations to the school nurse, **but you must follow up with the nurse** to ensure the required paperwork was received. Contact the building nurse with any questions or concerns.

Thank you

Name_______________________________________ **Date of NEXT EXAM** ____________________

Date of Birth______________________Gender________Grade______ **Primary Care Physician** ______________________________________

Medications and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____

Do you have any allergies? ☐Yes ☐No   If **yes**, please identify specific allergy: ☐ Medicine   ☐ Pollens   ☐ Food   ☐ Stinging Insect

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐Asthma ☐Anemia ☐Diabetes ☐Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐High blood pressure ☐ A heart murmur ☐High cholesterol ☐A heart infection ☐Kawasaki disease Other:		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first period?		
54. How many periods have you had in the last 12 months?		
COVID HISTORY		
55. Has your child ever tested + for COVID-19? Provide dates		
56. Was your child symptomatic?		
57. Did your child see a healthcare provider for their symptoms?		
58. Did your child have any cardiac symptoms or HCP diagnosed cardiac condition? If yes, provide additional details.		
59. Was your child hospitalized? If so provide details.		
60. Has your child been vaccinated for COVID 19? If yes, provide vaccine record.		

I give consent for my child's health information to be shared with appropriate school personnel:

Parent Signature: ____ **Date:** ____________

Adapted from the ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment. HE0503 9-2681/0410

Release Form

2022-2023
AUTHORIZATION AND RELEASE FOR PUBLICATION OF STUDENT WORK AND STUDENT PHOTOGRAPHIC/VIDEO IMAGES

Dear Parents/Guardians/Eligible Students:

We are proud of our students and the work that they create throughout the school year. Such work includes, by way of example, writings, artwork, photographic/video/digital images, and instrumental and vocal recordings. We like to showcase our students and their work beyond the classroom and school buildings through publication in a variety of calendars, the district, school and classroom websites, and local and national newspapers, television stations, and radio broadcasts.

Please complete and return the attached form to your child's teacher/ school as soon as possible so we can understand your wishes with regard to publication of your child's work and/or photographic and video image.

Thank you for your cooperation.

□ **Yes – I hereby consent.** I grant permission for my child to participate and appear in audio recordings, films, photographs, written articles, or on websites and social media sites. This consent includes the use of my child's image, voice, and name in media projects by LCSD to print, broadcast or Internet media outlets, such as Newspapers, radio, television, and websites.

As authorized above, I hereby release, discharge and hold the School District and its representatives harmless from any and all claims that may arise by reason of the publication of such works and/or images.

□ **No – I do not consent.** I do not grant permission for my child to participate and appear in audio recordings, films, photographs, written articles, or on websites and social media sites. This consent includes the use of my child's image, voice, and name in media projects by LCSD to print, broadcast or Internet media outlets, such as Newspapers, radio, television, and websites.

Child's Name ________________________________ Grade __________

Parent/Guardian Name ____

Parent/Guardian Signature ____________________________ Date __________

Note: for eligible students (i.e., those who are 18 or older), the right to consent or withhold permission for publication is yours. References to "my child" refer to you, the student, directly and you should check your preferences above and then sign in the Parent/Guardian sections provided.

Failure to return this form grants permission to use student work/ images/ recordings as noted above.

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. 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.

IDENTIFICATION & RECRUITMENT OFFICE
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 answer 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.