Registration Checklist – 5th through 12th grades:

_____ Birth Certificate (official one with raised seal)

_____ Proof of Residency (driver's license, lease agreement, utility bill, etc.)

_____ Immunization Records

Waverly Central Schools

15 Frederick Street • Waverly, New York 14892-1294
(607) 565-2841 • Fax (607) 565-4997

To: Waverly Central School District Parents/Guardians

From: Mr. Jeffrey DeAngelo, Director of Special Programs

Date: February 19, 2015

New York State law requires school districts to notify every parent, or person in parental relation, of their rights regarding the referral and evaluation of their child for the purposes of special education services or programs. If you have a preschool or school-age student (ages 3-21) that you suspect has a disability which affects his or her learning, you may ask the school district to evaluate your child to determine if he or she needs special education services. The Waverly Central School District, like all districts in New York State, operates two teams of specialists that will conduct those evaluations and then make recommendations on your child's abilities and needs. For students aged 3-5, that team is called the Committee on Preschool Special Education (CPSE). For students aged 5-21, the team is called the Committee on Special Education (CSE). I supervise, and facilitate, both teams. You are a key member of both teams.

If you suspect that your child has a disability and you would like to make a written referral to the CPSE or CSE for evaluation, please contact me at 607.565.8101 x 1014 or at jdeangelo@gstboces.org. I will be happy to help you though the process and explain each step.

You may also access a helpful New York State Education Department document called, *Special Education in New York State for Children Ages 3-21: A Parent's Guide.* Go to www.nysed.gov. Under "Quick Links", click on "Special Education". In the search box, enter "Parent's Guide".

Please don't hesitate to contact me if I can be of help.

Waverly Central School District

___ **Lincoln Street Elementary School**, 45 Lincoln Street, Waverly, NY 14892 (607-565-8176)
Grades Pre-K, Kindergarten & 1
___ **Elm Street Elementary School**, 145 Elm Street, Waverly, NY 14892 (607-565-8186) Gr. 2-4
___ **Waverly Intermediate School**, 1 Frederick Street, Waverly NY 14892 (607-565-8101) Gr. 5-6
___ **Waverly Middle School**, 1 Frederick Street, Waverly, NY 14892 (607-565-8101) Gr. 7-8
___ **Waverly High School**, 1 Frederick Street, Waverly, NY 14892 (607-565-8101) Gr. 9-12

Waverly Central School District Registration Checklist

The following documents are needed for enrollment:

_____ Request For Records

_____ Enrollment Form/Residency Questionnaire

_____ Family/Student Information Form

_____ Emergency Contact Form

_____ Student Racial and Ethnic Identification Form

_____ Transportation Request (If needed)

_____ Special Education Transfer/Student Intake Form (if applicable)

_____ Residency Questionnaire

_____ Student Photo

_____ Items from Nurse's Office

Parent/Guardian is responsible to provide the following:

_____ Birth Certificate or equivalent

_____ Immunization Records

_____ Proof of Residency
(Mail at premises, lease/rental agreement, proof of purchase of house)

_____ Proof of Custody (if applicable)

_____ Individualized Education Plan or Section 504 Plan (if applicable)

Waverly Central Schools

1 Frederick Street Waverly NY 14892
(607)565-8101 Fax (607)565-3718
School Counseling Department
Middle and Senior High School

RELEASE OF INFORMATION

Permission is granted to Waverly Central Schools to obtain information from, or release information to, the sources listed below for the following child.

Please include all educational records, current marks, health records, psychological reports, IEP, discipline records, data, etc.

I hereby authorize: _____

_____

_____

_____

To release the school records of:

Name: _____ Date of Birth: _____

Present Grade: _____

To: School Counseling Office
Waverly Middle/Senior High School
Attn: Denise Chambers, School Counseling Secretary
1 Frederick Street
Waverly, NY 14892

email: dchamber@gstboces.org
Fax: 607-565-3718

_____ _____

Signature of Parent or Guardian Date

Waverly Central Schools – Office / Nurse Emergency Information

Child's Name:_____ ☐ Male ☐ Female
Grade ____ Homeroom _____ Date of Birth: _____Student ID#_____
ADDRESS: Street_____Town/City_____State ____Zip_____
Home Phone _____Parent/Guardian Cell Phone _____
(*Note: Home Phone and/or Parent/Guardian Cell Phone will be used for contact information in the District's Rapid Notify system.)

Father's (Step) Name _____ Phone _____
ADDRESS: Street_____Town/City_____State ____Zip_____
Place of Employment _____Work Phone_____

Mother's (Step) Name:_____ Phone _____
ADDRESS: Street_____Town/City_____State ____Zip_____
Place of Employment _____Work Phone_____
(If parent addresses are different, should mailings be sent to both names listed above ☐ Yes ☐ No)
Name of Parent/Guardian with Whom the Student Resides _____
Home Email Address (Optional) _____

In case there is no one home during the school day, please give us the name(s) of a relative or a reliable neighbor with a telephone whom will come for and take care of your child should he/she become ill during the day.
Name:_____Relationship:_____Address:_____Phone:_____
Name:_____Relationship:_____Address:_____Phone:_____

Please identify any siblings attending school in the district.

Brother(s)	Age	Grade	School	Sister(s)	Age	Grade	School

(Front of Card)
(Back of Card)
Does your child have:

1. Allergies to medication/food/environment/bees?_____
2. If allergic to bees, what happens and what is school personnel to do?_____
3. If allergic to any foods, what happens and what is school personnel to do?_____
4. Any illness/injury since last year?_____
5. Any medical conditions (diabetes, seizures, asthma, etc.)?_____
6. Daily medications taken at home (including inhalers):_____
7. In order to keep your child safe while at school, can above information be shared with staff as needed: Yes_____ No_____
8. Does your child have health care insurance?: Yes_____ No_____
9. If no, can an outside agency contact you to help you apply for health care insurance?: Yes_____ No _____

If divorced or separated:

1. Who has custody?_____
2. Are custody papers on file at school?_____
3. Who may pick up the child after school? _____
   _____

Is there any additional information about your child that the school should be aware of (ie: faints easily, frequent colds, etc.)? _____
_____
_____
_____

Excuse Signature Form

The parent or guardian of_____, directs school authorities to accept the name(s) below as authorized signatures for excuses. No other names will be accepted other than those signed below. (Each person must sign his/her own name.)

_____

_____

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: _____ /_____ /_____ Grade: _____ ID#: _____
Month Day Year *(preschool-12)* *(optional)*

Address: _____ Phone: _____

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

_____ _____
Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____
Date

WAVERLY CENTRAL SCHOOL DISTRICT

SPECIAL EDUCATION TRANSFER/STUDENT INTAKE FORM

Student Name:_____ Parent Name:_____

DOB:_____ Address:_____

Grade:_____ _____

Does the student have a current Individual Education Plan? Yes or No

Does the student have a Section 504 Plan? Yes or No

If so, please provide a copy.

Is the student receiving services from:

Special Education Teacher	Yes or No
Occupational Therapist	Yes or No
Physical Therapist	Yes or No
Speech/Language Pathologist	Yes or No
School Counselor/Social Worker	Yes or No
Nurse	Yes or No

Prior School District:_____

Contact Person:_____

I request that all records be sent to:
Waverly Central School District
Attention: Holly Wright
1 Frederick Street
Waverly, NY 14892

_____ Date: _____
Parent Signature

Parent Phone: _____ Parent E-mail: _____

WAVERLY CENTRAL SCHOOL HC-16

TEMPORARY PLACEMENT AND PERMISSION TO EVALUATE FORM

A. CHILD'S NAME: _____

DATE OF BIRTH: _____

SCHOOL ENROLLING IN: _____

(Lincoln St., Elm St., Intermediate, MS, HS)

GRADE: _____

B. My child has the following handicaps:

_____ 1. Mentally Retarded
_____ 2. Autistic
_____ 3. Emotionally Disturbed
_____ 4. Speech Impaired
_____ 5. Deaf
_____ 6. Hard of Hearing
_____ 7. Visually Impaired
_____ 8. Deaf-Blindness
_____ 9. Orthopedically Impaired
_____ 10. Other Health Impaired
Explain: _____
_____ 11. Multiple Disabled
Explain: _____
_____ 12. Learning Disabled
_____ 13. Traumatic Brain Injury

C. My child received the following services at his/her previous school:

Name of previous School: _____ Phone No.: _____

1. Remedial Reading _____
2. Remedial Math _____
3. Speech Therapy _____
4. Resource Room _____
5. Special Class _____
6. Other _____
Explain: _____

D. I request that the Waverly Central School District provide services similar to what he/she received until the staff has an opportunity to examine my child's records. In addition, I hereby give permission to the Waverly Central School District to evaluate my child in order to secure an appropriate educational program.

_____ _____

Parent's Signature Date

_____

Address

_____

Phone No.

WAVERLY CENTRAL SCHOOL DISTRICT
STUDENT RACIAL AND ETHNIC IDENTIFICATION FORM

Dear Parent/Guardian:

The Waverly Central School District, in accordance with standards set by the U.S. Department of Education regarding the collection and reporting of racial and ethnic data by educational institutions, has adopted a procedure which requires the collection and recording of the ethnic identity of students in the Waverly Central School District. The information collected will be used to:

- ✓ Report information to the State and Federal Education Departments.
- ✓ Plan educational programs and make sure that they are readily available to all students.
- ✓ Study the movement of students in different ethnic groups as they move from school to school.
- ✓ Analyze differences in academic performance, attendance and completion of school.

In order to accomplish this task, we need your help. Please review the Racial/Ethnic definitions below and place a check in the box for the category or categories which best describe your child. The School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a school or district administrator will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

Name of School: _____ Grade:_____

Student Name: _____ _____ _____
(Last) (Middle) (First)

" Note: All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex. Citizenship, handicapping condition or immigration status."

DIRECTIONS:

PLEASE ANSWER BOTH QUESTIONS 1 AND 2. PLEASE READ BEFORE YOU RESPOND. You must respond to both questions

1. Is the student Hispanic, Latino or of Spanish Origin? Hispanic, Latino or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American or other Spanish culture or origin, regardless of race.

   ☐ YES, Hispanic

   ☐ NO, 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 ALASKAN NATIVE: A person having origins in any of the original peoples of 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 original peoples of the Far East, Southeast Asia or the Indian subcontinent, including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

   ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

   ☐ BLACK: 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.

_____ _____
Signature of Parent/Guardian /Other Date

Waverly Central Schools Middle/High School Health History

(To be filled out by parent)

Name of Student_____ Grade_____
Date of Birth_____ Age_____ Sex □ F □M School last attended _____
Mother/Guardian's Name_____
Father/Guardian's Name_____
Physician_____ Town/City_____ Hospital_____
Dentist_____ Town/City_____

HEALTH CONDITIONS (check those that apply)

	ADD/ADHD		Frequent Colds/Sore Throat
	Allergies-Environmental or Seasonal		G.I. Disorder (Stomach/Intestinal)
	Arthritis/Connective Tissue		Genetic Disorder
	Asthma/Reactive Airway		Headaches/Migraines
	Anxiety/Behavioral/Psychological		Hearing Impaired Hearing Aide: Yes or No
	Blood Disorder		High Blood Pressure
	Dental		Immunizations: Religious or Medically Exempt
	Brain/CNS Disorder		Musculoskeletal Disorders/Scoliosis
	Diabetes		Operations/Surgeries
	Eating Disorder		Prosthesis
	Cancer		Seizure Disorder
	Cardiovascular (Heart/Blood Disease)		Serious Injuries
	Endocrine Disease		Skin Disease
	Cerebral Palsy		Urinary/Kidney Disease
	Cystic Fibrosis		Visually Impaired: Glasses Yes or No
	Epilepsy		
	Faints Easily		Other Conditions Not Listed:

Please fully explain any answers checked above:

_____

_____

Please list any medications/dosages student takes on a regular basis:

_____

_____

SEVERE ALLERGIES

BEE STING: Yes or No LATEX: Yes or No
FOOD/PEANUT/NUT: Yes or No MEDICATION: Yes or No
OTHER ALLERGIES NOT LISTED:_____
Reaction to above:_____Medication/Treatment:_____

In order to keep your child safe while at school, can this information be shared with staff as needed? YES or NO

**If your child requires medication while at school, a physician's written order and parent/guardian's written consent is required to be on file at the school. Children are allowed to carry Epi-pens and inhalers, as they are rescue medications.
Please provide the school with the necessary paperwork and medication! **

WAVERLY CENTRAL SCHOOL DISTRICT

Dear Parents/Guardians,

New York State law requires a health examination for all students who are entering the school district for the first time, receiving special education/resource room services or entering Pre-K, Kindergarten, 1st, 3rd, 5th, 7th, 9th and 11th grades. The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner. A dental certificate which state your child has been seen by a dentist or dental hygienist is also requested at the same time.

New York State Health Department also requires that students are immunized according to the law. If your child has a medical exemption a written document must be provided each year by his/her healthcare provider. If your child has a religious exemption a request must be submitted to the Superintendent of Schools for approval. If you need a form for religious exemption for your child please let the staff know when you are entering him/her to the school district.

Thank you –

School Nurse's Office

****Take this packet home for your reference when scheduling appointments****

WAVERLY CENTRAL SCHOOL DISTRICT

Student's name: _____

I understand that the information I give to the school nurse is important for the school staff to understand and help the health and education of my child. All information will be kept confidential by the school staff.

Signature of Parent/Guardian: _____

PERMISSION FOR EXAMINATIONS AND SCREENINGS

I give permission for my child to receive physicals and screenings as provided by the school health services of the Waverly School District while he/she is enrolled in the district. I understand NYS law requires:

- Physicals Examinations for grades PK, K, 1, 3, 5, 7, 9 and 11; students in OT, PT, Speech and resource room. All new students to the district at any grade level must have a physical within 30 days of entry to the district.
- Screenings for growth (height and weight) annually
- Vision- all PK, K, 1, 3, 5, 7,11 and any new student to the district
- Hearing-all PreK, K, 1,3,5,7,11 and any new student to the district
- Scoliosis- grades 5-9

I understand that I will be informed, in writing, of any abnormal results of examinations and screenings given to my child.

I give permission for the following: (please circle yes or no)

PHYSICAL EXAMS	YES	NO
SCREENINGS	YES	NO

Signature of Parent/Guardian: _____ **Date:** _____

Waverly Central Schools

Dental Health Certificate

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.

For the 2018-19 School Year

Parents:

All kids entering **7th, 8th, 9th** and **12th grades** must have the **meningococcal vaccine.**

Without it, they can't start school.

About the Vaccine:

- It's not a new vaccine. It's been recommended for a decade.
- Most parents already choose to vaccinate their children.
- The meningococcal vaccine has been **required** for school entry since Sept. 1, 2016.

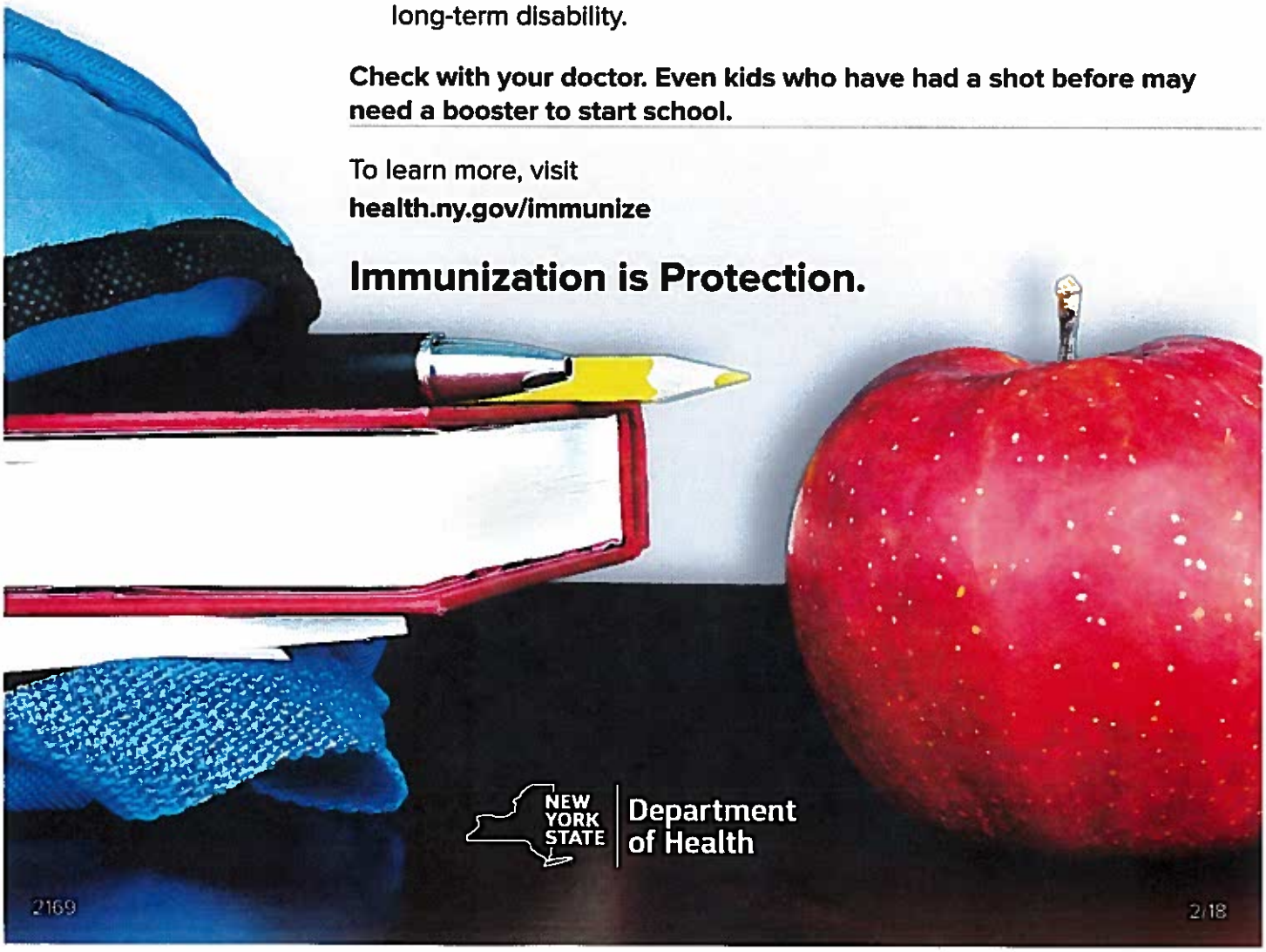
About Meningococcal Disease:

- It causes **bacterial meningitis** and other serious diseases.
- Teens and young adults are at greater risk.
- It comes on quickly and without warning.
- Its symptoms are similar to the flu.
- Every case of this disease can result in death or long-term disability.

Check with your doctor. Even kids who have had a shot before may need a booster to start school.

To learn more, visit
health.ny.gov/immunize

Immunization is Protection.



REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE 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:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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 **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:			DOB:
SCREENINGS			
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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

2018-19 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades pre-k through 10, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: Intervals between doses of polio vaccine DO NOT need to be reviewed for grades 5, 11 and 12.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 11 and 12. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule.

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3 and 4	Grade 5	Grades 6, 7, 8, 9 and 10	Grades 11 and 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older		**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)[3]	**Not applicable**			**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**3 doses**
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**			
Hepatitis B vaccine[6]	**3 doses**	**3 doses or 2 doses** of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years			
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**	**1 dose**	**2 doses**	**1 dose**
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**			**Grades 7, 8 and 9: 1 dose**	**Grade 12: 2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**			
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**			

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday.
   b. If the fourth dose of DTaP was administered at 4 years or older, the fifth (booster) dose of DTaP vaccine is not required.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older. A Tdap vaccine (or incorrectly administered DTaP vaccine) received at 7 years or older will meet the 6th grade Tdap requirement.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap. A dose received at 7 years or older will meet this requirement.
   b. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. Intervals between the doses of polio vaccine do not need to be reviewed for grades 5, 11 and 12 in the 2018-19 school year.
   e. If both OPV and IPV were administered as part of a series, the total number of doses and intervals between doses is the same as that recommended for the U.S. IPV schedule. If only OPV was administered, and all doses were given before age 4 years, 1 dose of IPV should be given at 4 years or older and at least 6 months after the last OPV dose.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten and grades 11 and 12. Two doses are required for grades kindergarten through 10.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks.
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine. (Minimum age: 6 weeks)
   a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7, 8 and 9.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. Unvaccinated children ages 7 through 11 months of age are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

Health Department Information

For families who do not have insurance:

There are no longer open clinics

Both Health Departments require patients

to schedule an appointment!

Chemung County Health Department

103 Washington St.

Elmira, NY 14901

607-737-2028

Tioga County Health Department

1062 State Route 38

Owego, NY 13827

607-687-8576