OTSELIC VALLEY CENTRAL SCHOOL DISTRICT
PreK-12 Enrollment Checklist

The following forms and/or documents are required for enrollment:

1. Enrollment Application
2. Residency Questionnaire
3. Health Certificate/Appraisal form
   (To be filled out by a physician and completed prior to staring school)
4. Dental Health Certificate
   (To be filled out by dentist and completed prior to starting school)
5. Copy of Birth Certificate
6. Copy of Social Security Card
7. Copy of Immunization Record
   Complete immunization of school age children includes:

VACCINE	#OF SHOTS (As of 2014)
DPT	4 - 5 Shots
Polio	3 - 4
MMR	1 *(2 doses required by age 7)
Hepatitis B	3
Hib	3
Varicella	2

8. Copy of **Legal Custody Agreements**, if any
9. Copy of CSE Information, if any, (IEP, etc…)

(Also included is the Health Office Policies to keep at home)

Otselic Valley Central School District
PreK-12 Enrollment Application

Date _____ Grade your child will be in: _____

Child's Full Name _____ Gender _____

Birth Date _____ Birth Place _____

Child's name that you wish him/her to be called in school _____

Ethnicity-(please check all that apply):
Hispanic/Latino _____ Asian _____ Native Hawaiian/Other Pacific Islander _____
Caucasian _____ American Indian or Alaskan Native _____ African American _____ Other _____

Contact Information

Primary Contact-Student residence/Parent(s) contact information:

Name: _____ Relationship to child _____

Mailing Address (physical residence address, PO Box (if you have one):

_____

_____

_____

Home Phone _____ E-Mail _____

Cell/Work Phone _____ Cell/Work Phone _____

Are there any custody issues? No_____ Yes _____ If yes, please provide court documentation.

Names of people living in the home:

Name (first & last)	Relationship to child	Parent Occupation	Age & Date of Birth

Secondary Contact Person (example: parent not living in home):

Name: _____ Relationship to child _____

Physical & Mailing Address:

_____

_____

_____

Home Phone _____ Cell or Work Phone _____

PreK-12 Enrollment Application

Does your child have an Individualized Education Plan (IEP)? Yes _____ No_____
OR Does your child receive any special education or remedial services? Please explain:

_____

_____

_____

School child last attended (if outside NYS, please provide city, and state where school is located):

_____

_____

Phone # _____

Summary of Medical History (include allergies, major illnesses, operations and any current medications)

Physician's Name _____ Phone _____

Dentist Name _____ Phone _____

Allergies to foods, medications, etc. : No _____ Yes _____ (please list below)

_____

_____

Special Medical Problems: No _____ Yes _____ (please list below)

_____

_____

Additional information pertaining to your child's medical history:

_____

_____

My Child:

Is used to playing _____Alone _____With a few children _____With many children
Is often frightened _____Yes _____No
Likes to play with children who are _____Younger _____Same age _____Older

Comments: _____

Seems to have a lot of accidents or gets hurt often _____Yes _____No

Comments: _____

Notes to My Child's Teacher (please tell us anything that you feel would be helpful in planning your child's program:

_____

_____

_____

OTSELIC VALLEY CENTRAL SCHOOL DISTRICT

ENROLLMENT FORM – RESIDENCY QUESTIONNAIRE

Please check one:
Name of School: Otselic Valley Central School: Elementary ____ High School ____

Name of Student: _____
Last First Middle

Gender: Male_____ Female_____ Date of Birth: _____/____/____ Month Day Year Grade: _____ (K-12) ID# _____ (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**.)

_____ 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

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 ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

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

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

Diabetes ☐ No ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type ☐ 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.

Otselic Valley Central School
Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination 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 & take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school year, ask your dentist 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 visit to a dentist? ____ 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/Guardian's Signature _____ Date _____

Section 2. To be completed by the Dentist

1. The Dental Health condition of _____ on _____(date of exam)
The date of the exam needs to be within 12 months of the start of the school year in which it is requested.

____ 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 name & address (please print or stamp) Dentist'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): _____

III. 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.

Otselic Valley Central School
Health Office Policies

These policies are intended to serve as a resource for you throughout the year. You may find it helpful to keep this packet for future reference.

Medication During School Hours

When your child's licensed healthcare provider feels that medication is necessary during the school day, you are asked to follow certain procedures. New York State law requires that the school nurse must have on file a written order from a licensed healthcare provider stating the name, dosage and time the prescribed medication or over-the-counter (OTC) medication is to be given. School Nurses cannot administer medication to students without a written order from a licensed healthcare provider. Therefore, you are requested to:

* Complete the Authorization of Administration of Medication form for each medication ordered. See attached. This is to be signed by the parent and the licensed healthcare provider.
* Obtain a new licensed healthcare provider's order for each new medication or any change in medication dosage, time of administration, etc.
* Send in a new order at the beginning of each school year as needed.
* The parent must bring the medication to the school in the original prescription bottle, or original packaging of an over the counter medicine. Medication will not be accepted from a student.

Students are not allowed to carry medication of any kind on their person, or to take medication without written directive from a licensed healthcare provider or parent. The only exception to this is a child with asthma. Students with asthma may carry and use a prescribed inhaler during the day with the written permission from their licensed healthcare provider and parent. Please contact the school nurse for the Self Administration Authorization form.

Emergency Medications

In the event of a sudden and life threatening reaction to an allergen (insect bites, food allergy, or severe asthma attack), an epinephrine injection may be given by the nurse. Ambulance and emergency personnel will be contacted any time this medication is given. Epinephrine is only given when the reaction becomes life threatening. New York State mandates school districts to have such emergency polices to protect students.

Illness during School Hours

If your child becomes ill at school, you or the person designated on you emergency form will be notified. No child will be sent home unless there is someone to receive him or her. ***NOTE***: Please notify the office of any changes in telephone number and/or of the name of the person to be notified.

Communicable Diseases/Extended Illness

All communicable diseases are to be reported to the school nurse as soon as the parent knows the diagnosis. For other illnesses or conditions, please notify the nurse if your child will be out more than two days.

Regarding Head Lice

This is a topic that can be very alarming to parents and faculty members. 8-12 million students are affected by head lice each year in this country. Here are some facts and tips for you.

* Head lice **DO NOT** hop, jump or fly.
* Head lice prefer clean hair.
* Head to head contact is the way to contact lice. Live louse may crawl onto carpet or clothing and can survive long enough to crawl onto hair that comes in contact with it.
* An adult louse has a life span of 30 days and can produce 300 eggs, known as nits.
* Nits hatch in 10 days and need a warm, humid environment. They require human blood to survive. They cannot survive on plastic, smooth, or hard surfaces.
* Adult lice are the size of a sesame seed. They are brown and move very quickly through hair.
* Nits are white and stick very tightly to individual hair strands.

TREATMENT WITH AN APPROVED HEAD LICE PRODUCT AND MANUAL REMOVAL OF ALL NITS IS THE ONLY WAY TO BREAK THE LICE CYCLE.

If your child does get head lice, try not to panic. Ask your doctor or pharmacist for a recommended treatment product. Follow instructions carefully. Call the school nurse or your doctor if the instructions seem confusing. Remember to retreat in 10 days as indicated by the product instructions.

1. Check all family members….including parents.
2. Disinfect combs and brushes.
3. Wash and dry bedding on high heat setting.
4. Vacuum carpets, furniture, mattresses and vehicles.
5. Stuffed animals can be put into a plastic garbage bag and sealed for 14 days.
6. There is no need to spray or bomb your house. These products are toxic and are not proven to help prevent lice.
7. Children and pregnant women should not use products containing Lindane (kwell). This product is toxic.

If you need more help or would like to learn more about lice you can call the National Pediculosis Association 1-800-446-4672.

The school nurse will perform head checks throughout the year. The management of head lice can be effective if we all work together. Children who are found to have head lice during routine checks will NOT be identified in front of their classmates. The child will

be called down to the nurse's office in a discreet manner. Parents will be contacted to pick up their child. Your child will need to report to the school nurse for re-check after you have successfully treated and removed all nits. If there are no less than 3 nits that can easily be removed during the re-check, your child may remain in school. If there are more than 3 nits, you will be asked to take your child home for the continued removal of nits. Our NO NITS practice puts you, the parent, in control of head lice and decreases the risk of reoccurrence.

General Guidelines for Parents

If your child complains of or shows the following symptoms at home, please follow these guidelines:

* ***RED EYES***: Any child with an itchy eye that is red, puffy and draining colored fluid will be sent home and asked to see their healthcare provider.
* ***RASH***: Any child with an unexplained rash or eye inflammation should be kept at home until the conditions is diagnosed by a physician.
* ***FEVER***: If a fever is present during an illness, a child should be kept home until the temperature is normal for a least 24 hours, and until all symptoms are gone. Children with temperatures of 100.5 or higher will be sent home . Children with temperatures below 100.5 will be assessed and may be sent home depending on their complaints.
* ***COLD***: A child with acute early symptoms of a cold should stay at home to prevent serious developments and to protect classmates from exposure to infection. If this practice is followed, fewer absences due to respiratory illness will occur. Some symptoms are a runny nose, persistent cough, swollen glands, sore throat and headache.
* ***STOMACH PROBLEMS***: An upset stomach, diarrhea and stomach pains are also reasons your child should stay home. If your child has diarrhea, please wait 24 hours before returning your child to school.
* ***HEADACHES***: Many times headaches are from not eating or drinking properly. Please encourage your child to eat breakfast either at home or make arrangements for your child to eat breakfast at school.
* ***VOMITING***: Any child that has an episode of vomiting will be sent home from school. Please do not send your child to school if they have vomited in the last 24 hours.

Excuses

Please send in excuses for absences as soon as possible. The following are acceptable excuses for absences as outlined by the State Education Department: sickness, sickness or death in the family, impassable roads, religious observance or required court appearance.

Physical Examinations and Health Screening

New York State Education law requires that all new students and students in PK, kindergarten, grades 1, 3, 5, 7, 9 and 11 have physical examinations. Ideally, the child's primary health care provider should perform the physical examination. Students in grades PK through 12 are checked for height, weight, hearing and vision as per New York State recommendations. Scoliosis screenings are performed on children in grades 5 through 9. All students are checked for visual color perception, near visual acuity and hyperopia at one point during their elementary years.

Finally……..

If you have any other questions or concerns, please call the K-12 School Nurse at 315-653-7418 ext. 4006.

Stacie Morse, RN
PreK-12 School Nurse