

Student Number _____

STUDENT NAME: _____ EXPECTED ENROLLMENT DATE: _____

GRADE LEVEL: _____ DATE OF BIRTH: _____

Residential Address: _____

House # _____ Street _____ Apt # _____

City _____ State _____ Zip _____

Mailing Address: (if different from above) _____

Household Phone Number – To be designated for emergency school notifications (i.e. school closings): _____

Is English the only language spoken at home? Yes _____ No _____

If no, what other language does your family speak? _____ Is your child bilingual? Yes _____ No _____

Student Racial and Ethnic Identification as specified by the NYS Dept. of Education

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

Select one or more races from the following five racial groups:

AMERICAN INDIAN or ALASKA 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. (c.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.

PRIMARY HOUSEHOLD PARENT / GUARDIAN INFORMATION

(Only list those adults currently living in the household)

Father / Male Guardian / Other Adult Male:

Living in the household with the child listed above

Relationship to child(ren) _____

Last Name

First Name

Middle Name

Work Number: _____ Cell Phone Number: _____ Other Number: _____

Email Address: _____ Occupation: _____

Mother / Female Guardian / Other Adult Female:

Living in the household with the child listed above

Relationship to child(ren) _____

Last Name

First Name

Middle Name

Work Number: _____ Cell Phone Number: _____ Pager Number: _____

Email Address: _____ Occupation: _____

NON-HOUSEHOLD PARENT: If dad or mom is not residing in the primary household, please list their information below.

Last Name

Relationship to child(ren) listed above _____

First Name

Middle Name

Home Address: _____

Work Number: _____ Cell Phone Number: _____ Other Number: _____

Email Address: _____ Occupation: _____

Any legal custodial restrictions? No _____ Yes _____

If yes, please attach court documents.

Important Note Regarding Release of Students from School: The school district shall presume that either parent of a student has authority to obtain the child's release from school. However, a student shall not be released to a non-custodial parent if the district has been provided with a certified copy of a legally binding instrument, such as a court order or decree of divorce, separation or custody, that indicates the non-custodial parent does not have the right to obtain such release.

Is **BKW CSD** currently transporting your child to private school? No _____ Yes _____

If Yes, please cancel my application for non-public transportation as of _____ (date):

Parent Signature: _____ Date: _____

Special Education Needs:

Is your child **CURRENTLY** receiving special education services? No _____ Yes _____

If Yes, please place a checkmark next to each service he/she is receiving.

- _____ Speech / Language Therapy _____ Occupational Therapy _____ Physical Therapy
- _____ Consultant Teacher _____ Self-Contained Classroom _____ Resource Room
- _____ BOCES _____ 504 Plan _____ Declassified
- _____ 1:1 Aide _____ Classroom Aide _____ Extended Test Taking Time

Other Special Education Needs:

Has your child ever received special education services **IN THE PAST?** No _____ Yes _____

Services Received: _____
Date Services Ended: _____

Names, addresses and phone numbers of two people with whom you have made arrangements to take responsibility for your child in the event you cannot be reached.

Emergency Contact #1	_____	Emergency Contact #2	_____
Gender	_____	Gender	_____
Relationship to Student	_____	Relationship to Student	_____
Street Address	_____	Street Address	_____
City, State, Zip	_____	City, State, Zip	_____
Home Phone	_____	Home Phone	_____
Work Phone	_____	Work Phone	_____
Cell Phone	_____	Cell Phone	_____

Parent Statement:

I certify that the above information is true and correct. Any misinformation regarding residency may result in being billed to cover the cost of instruction and/or exclusion from attending the Berne-Knox-Westerlo Central School District.

Parent
Signature: _____ Date: _____

The student information we enter and maintain in BKW's electronic Student Information System is used for many purposes. Please be aware that when an adult who is not a parent or legal guardian resides with a student's family, and is included in the student's permanent record, it is assumed we have the parent's permission to discuss academic, disciplinary and other student matters with that adult. In addition, "other adult in household" may be contacted in emergencies. Therefore non-parent/legal guardian adults should not be included on the registration form unless you agree with the above and sign the statement below.

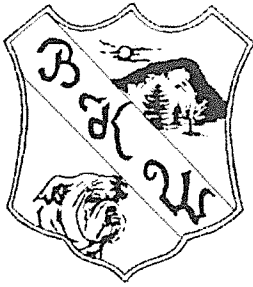
Our schools maintain separate Emergency Contact information and you may indicate any adult of your choosing to be contacted should an emergency occur and you cannot be reached.

When/if any of the information you are providing changes, please inform your child's school in order to ensure we have the most up-to-date information on file.

By signing below, you are agreeing that the non-parent/legal guardian may be contacted regarding your child.

Parent
Signature: _____ Date: _____

Print Name Here: _____ Relationship to Student: _____



Berne-Knox-Westerlo Central School District
1738 HELDERBERG TRAIL · BERNE, NEW YORK 12023

Dr. Timothy Mundell, Superintendent (518) 872-1293
<http://www.bkwschools.org>

Business Office · (518) 872-0909 · Fax: (518) 872-0341
Secondary School Office · (518) 872-1482 · Fax: (518) 872-2083
Elementary Office · (518) 872-2030 · Fax: (518) 872-2031
Special Education Office · (518) 872-0945 · Fax: (518) 872-5128

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Vice President

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RELEASE OF STUDENT RECORDS

Date

Name of School Student Last Attended

Telephone/Fax

Please send all health information, academic records, attendance records, discipline records, IEP (Individual Education Plan), and psychological reports if applicable, for the following student(s) who have enrolled in Berne-Knox-Westerlo Central School District.

Grades K – 6 email or fax records to Mrs. Dibble ddibble@bkwschools.org or (518) 872-2031

Grades 7 – 12 email or fax records to Mrs. Walbridge lwalbridge@bkwschools.org or (518) 872-5277

<u>Student</u>	<u>Grade</u>
_____	_____
_____	_____
_____	_____

I hereby give my permission to release my child's records to Berne-Knox-Westerlo CSD.

Signature of Parent/Guardian

Date

District Mission Statement:

The B-K-W CSD will provide an environment that fosters the creative, emotional, intellectual, and physical well-being of each student in order to enable a mastery of the curriculum and a life-long learning capability to meet the challenges of the future.

Berne-Knox-Westerlo Central School District

Student Residency Questionnaire

Name of School: _____ Grade: _____

Name of Student: _____ Sex: _____ Male
Last First Middle _____ Female

Birth Date: ____ / ____ / ____ Age: _____ Student ID # _____
Month / Day / Year

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? _____ Yes _____ No

2. Is this temporary living arrangement due to loss of housing or economic hardship?
_____ Yes _____ No

**If you answered YES to the above questions, please complete the remainder of this form.
If you answered NO, you may stop here.**

Where is the student presently living? (Check one)

- _____ In a motel
- _____ In a shelter
- _____ With more than one family in a house or apartment
- _____ Moving from place to place
- _____ In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite

Name of Parent(s)/Legal Guardians(s) _____

Address _____ Zip _____ Phone(s) _____

** Is transportation (bus) required: _____ Yes _____ No

** If "Yes," What date would you like transportation to start ? _____

(We will make every effort to accommodate your request).

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002(3)(d).

Signature of Parent/Legal Guardian _____ Date _____

Signature of School Official _____ Date _____

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

Date _____ McKinney-Vento Liaison Signature _____

HEALTH FORM
BERNE-KNOX-WESTERLO CENTRAL SCHOOL
(to be completed by parent)

Date _____

Name _____ Sex _____

Date and Place of Birth _____ Grade _____

Parent/s or Guardian (resides with) _____

Address _____

Father's Name _____ Home Phone _____

Mother's Name _____ Home Phone _____

Father's Place of Business _____ Phone _____

Mother's Place of Business _____ Phone _____

Family Physician _____ Phone _____

Has your child ever had any of the following? If so, indicate the date.

Chicken Pox _____ Pneumonia _____ Diabetes _____

Diphtheria _____ Poliomyelitis _____ Seizures _____

German Measles _____ Rheumatic Fever _____ Heart Disease _____

Mumps _____ Scarlet Fever _____ Tuberculosis _____

Measles _____ Whooping Cough _____ Contact with TB _____

CHECK IF HISTORY AND DESCRIBE Please list dates, type and medications.

Asthma _____ Frequent colds & sore throat _____

Bee Sting Allergy _____ Ear condition _____

Allergies _____ Frequent Headaches _____

Operations _____ Serious injuries _____

Under treatment at this time for any other condition? _____

IMMUNIZATIONS

(Please attach physician's record or physician may complete this form).

IPV	_____	_____	_____	_____	
DTaP	_____	_____	_____	_____	Tdap _____
HIB	_____	_____	_____	_____	
Hep B	_____	_____	_____	_____	
Pevnar	_____	_____	_____	_____	
MMR	_____	_____	_____	_____	
Varivax	_____	_____	_____	_____	
Hep A	_____	_____	_____	_____	
Menactra	_____	_____	_____	_____	
Gardasil	_____	_____	_____	_____	

Dental Health Certificate-

Parent/Guardian: New York State law (Chapter 284) 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 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, 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: _____			<small>Last</small>	<small>First</small>	<small>Middle</small>
Birth Date: / /	Sex: <input type="checkbox"/> Male	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<small>Month</small>	<small>Day</small>	<small>Year</small>			
School: <small>Name</small> _____			Grade _____		
Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? <input type="checkbox"/> Yes <input type="checkbox"/> 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

I. 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. 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 name and 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 1/2 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.

Berne-Knox-Westerlo CSD

STUDENT HEALTH EXAMINATION FORM (To be completed 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, 2, 4, 7 & 10, interscholastic sports and working papers.

Name: _____ DOB: _____ Gender: M F
 School: _____ Grade: No Grade Exam Date: _____

IMMUNIZATIONS

Immunization record attached
 Immunizations reported on NYSIIS
 No immunizations received today

Immunizations received today:
 Will return on: _____ to receive: _____

HEALTH HISTORY

Asthma: Intermittent Persistent Asthma Action Plan Attached
 Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension Diabetes Medical Mgmt Plan Attached
 Seizures Type: _____ Last Occurrence: _____ Emergency Care Plan Attached
 Allergies: Non Life-Threatening Life-Threatening Emergency Care Plan Attached
 Type: Food Insect Latex Medication Seasonal/Environmental Other:
 Allergen(s): _____
 Hx of Anaphylaxis: Last occurrence: _____ Previous symptoms: _____
 Treatment prescribed: None Antihistimine Epinephrine Autoinjector

Significant Medical/Surgical Information:	Diagnostic Tests	Positive	Negative	Not Done	Date
	Sickle Cell Screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	PPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Elevated Lead:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Vision one eye only One functioning kidney One testicle Concussion - Last occurrence: _____

PHYSICAL EXAMINATION

Height:	Weight:	BP:	Pulse:	Respirations:			
Scoliosis: <input type="checkbox"/> Negative <input type="checkbox"/> Positive				Vision	Right	Left	Referral
Degree of deviation: _____				Distance acuity			<input type="checkbox"/> Yes <input type="checkbox"/> No
Angle of trunk rotation via scoliometer: _____				Distance acuity with lenses			<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Status Category (BMI Percentile): <input type="checkbox"/> <5 th <input type="checkbox"/> 85 th - 94 th <input type="checkbox"/> 5 th - 49 th <input type="checkbox"/> 95 th - 98 th <input type="checkbox"/> 50 th - 84 th <input type="checkbox"/> 99 th & higher				Vision - near vision			<input type="checkbox"/> Yes <input type="checkbox"/> No
				Vision - color perception	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Hearing	Right	Left	Referral
				<input type="checkbox"/> 20 db sweep screen both ears or			<input type="checkbox"/> Yes <input type="checkbox"/> No

Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders): Tanner: I II III IV V

SYSTEM REVIEW AND EXAM ENTIRELY NORMAL Additional information attached
 Specify any abnormalities: _____

Name: _____

DOB: _____

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

Full Activity without restrictions including Physical Education and Athletics.

Restrictions/Adaptations. Please base restrictions/modifications on the following Interscholastic Sports Categories.

No Contact Sports includes: basketball, baseball, field hockey, ice hockey, lacrosse, soccer, football, softball, volleyball, competitive cheerleading and wrestling

No Non-Contact Sports includes: archery, bowling, cross-country, golf, gymnastics, rifle, swimming and diving, skiing, tennis, track & field, fencing, badminton

Other Specific Restrictions:

Accommodations / Protective Equipment:	<input type="checkbox"/> Athletic Cup	<input type="checkbox"/> Insulin Pump/Insulin Sensor	<input type="checkbox"/> Pacemaker
	<input type="checkbox"/> Brace/Orthotic	<input type="checkbox"/> Medical /Prosthetic Device	<input type="checkbox"/> Sports Safety Goggles
	<input type="checkbox"/> Hearing Aides	<input type="checkbox"/> Other:	

MEDICATION HISTORY (optional)

Please list names of prescribed or OTC medications used on a routine basis at home

_____	_____
_____	_____

PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS - VALID 1 YEAR

Independent Carry and Use Option: NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine autoinjector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option in schools.

Required Independent Carry and Use Attestation documentation is attached.

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

Parent/Guardian Permission: I request the school nurse give the medications listed on this plan; or after the nurse determines my child can take their own medications, trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff caring for my child

Parent/Guardian Signature: _____

HEALTH CARE PROVIDER

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: _____ Date: _____

Provider Name: (please print) _____ Phone #: () _____

Provider Address: _____ Fax #: () _____

Return to:

School Nurse: Katie Johnson School: B-K-W

Phone #: (518) 872-2030 Fax: (518) 872-2031 Date: _____