DOLGEVILLE CENTRAL SCHOOL DISTRICT
PRE-K-12 ENROLLMENT FORM

NEW STUDENT ENROLLMENT – RECORD REQUEST AUTHORIZATION
Parent/Guardian Signature Authorization

Student Name	**Date of Birth**	**Grade**

Previous School Information:

School Name	Phone Number	Fax Number

School Address

By signing below:

- I give permission for Dolgeville Central School to request all transfer records and pertinent information from my child's former school.
- I certify that the student has had polio, diphtheria (DPT), MMR, and varicella vaccines.
- I certify that the information contained in this enrollment form is true and current to the best of my knowledge.

Parent/Guardian Signature	**Date**

DOLGEVILLE CENTRAL SCHOOL DISTRICT
PRE-K-12 ENROLLMENT FORM

NEW STUDENT REGISTRATION

District Registrar use only **Student ID:** _____ **Enter Date:** _____

Placement: ❑ **Prekindergarten** ❑ **Dolgeville Elementary K-6** ❑ **James A. Green High School**
❑ **Other:** _____

Grade: _____ **Homeroom Teacher (PK-6 only):** _____

Documentation:

❑ Proof of Age/Birth Certificate	❑ Proof of Residency	❑ New Student	❑ Returning Student
❑ School Records Received	❑ Foster Care	❑ CSE	❑ CSE Records Received
❑ Immunization Records	❑ Physician Physical	❑ Guardianship/custody paperwork (if applicable)	

STUDENT INFORMATION

Last (legal name only) _____ First _____ Middle _____

Gender
❑ Not Specified
❑ Female
❑ Male
❑ Non-Binary

Date of Birth _____ Place of Birth _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1 ❑ Primary Residence

Name _____ Relationship to Student _____

Address _____

Mailing Address (if different) _____

Phone: ❑ Home ❑ Cell _____
❑ Work ❑ Cell _____

Email _____

Place of Employment _____

Education/Highest grade completed _____

Parent/Guardian #2 ❑ Primary Residence

Name _____ Relationship to Student _____

Address _____

Mailing Address (if different) _____

Phone: ❑ Home ❑ Cell _____
❑ Work ❑ Cell _____

Email _____

Place of Employment _____

Education/Highest grade completed _____

EMERGENCY CONTACTS

Person or relative who we can contact if you are not reachable by phone.

Name	Relationship to Student
Address	Phone
Name	Relationship to Student
Address	Phone
Name	Relationship to Student
Address	Phone
Name	Relationship to Student
Address	Phone

DOLGEVILLE CENTRAL SCHOOL DISTRICT
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STUDENT RESIDENCY QUESTIONNAIRE

Note: The questions in this section are used to help identify students in homeless situations as required by the McKinney-Vento Homeless Assistance Improvements Act, 42U.S.C. 11453. Answers to this residency information help determine the services the student may be eligible to receive.

Is your current address a temporary living arrangement? ❑ No ❑ Yes

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

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
❑ In a hotel/motel
❑ In a car, park, bus, train, or campsite
❑ Another living situation (please explain): _____
❑ In permanent housing

PRINT Name of Parent, Guardian, or Unaccompanied Homeless Youth

Signature of Parent, Guardian, or Unaccompanied Homeless Youth

SIBLINGS (Be sure to include any future Blue Devils that are not currently enrolled!)

Name	* Gender	Date of Birth	Grade	Residence
				❑ Home ❑ Other
				❑ Home ❑ Other
				❑ Home ❑ Other
				❑ Home ❑ Other
				❑ Home ❑ Other
				❑ Home ❑ Other
				❑ Home ❑ Other

* Gender: Not Specified, Female, Male, Non-Binary

OTHERS IN HOUSEHOLD

Name	Date of Birth	Relationship to Student

Continued on next page

FOSTER CARE PLACEMENT – Please complete this section **only** if the student is in foster care.

Foster Parent Name

Relationship to Student

Address

Mailing Address (if different)

Phone: ❑ Home ❑ Cell

❑ Work ❑ Cell

Email

Student's District of Origin

Agency placing student

School Last Attended

Caseworker Name

Date student was placed

Phone

DOLGEVILLE CENTRAL SCHOOL DISTRICT
PRE-K-12 ENROLLMENT FORM

EDUCATION/SCHOOL BACKGROUND

Previous School Attended _____ Address _____

Entry Date: _____ Grade: _____ Left Date: _____ Grade: _____

Previous School Attended _____ Address _____

Entry Date: _____ Grade: _____ Left Date: _____ Grade: _____

Previous School Attended _____ Address _____

Entry Date: _____ Grade: _____ Left Date: _____ Grade: _____

Previous School Attended _____ Address _____

Entry Date: _____ Grade: _____ Left Date: _____ Grade: _____

Did your child attend preschool or pre-kindergarten? ❑ **No** ❑ **Yes** ❑ **Enrolling this school year**

Has your child ever been retained? ❑ **No** ❑ **Yes** Grade: _____ Year: _____

Does your child have a IEP or 504 Plan? ❑ **No** ❑ **Yes, please explain** _____

CHAPTER 53, EDUCATION LAW of 1980 - SCREENING

According to Chapter 53, Education Law of 1980, all new entrants to public schools in New York State must be screened for possible handicapping conditions (such as learning disabilities, sensory deficits, physical impairments, etc.) or for giftedness (students who are capable of high academic aptitude, leadership, or special talent in one of more of the arts). Your child will be screened in areas of physical development, speech and language, motor abilities and cognitive development.

_____ _____

Parent/Guardian Signature **Date**

RELEASE OF STUDENT ACCOMPLISHMENTS

The Dolgeville Central School District is pleased to celebrate the accomplishments of our children. As a result, student artwork, writing, photographs, videos, and/or audio clips and quotes may be used in the Dolgeville Central School's printed and electronic publications or by the media. Please select one option below regarding the sharing of your child's accomplishments:

- ❑ I give permission to use my child's photos, works, and words in promotional publications for the Dolgeville Central School District (district website, Facebook page, ParentSquare, etc.).
- ❑ I do not want the district to share my child's photos, works, or words published in any form.

_____ _____

Parent/Guardian Signature **Date**

DOLGEVILLE CENTRAL SCHOOL DISTRICT
PRE-K-12 ENROLLMENT FORM

MEDICAL INFORMATION

- To Be Completed By Parent/Guardian

Last (legal name only) _____ First _____ Middle _____

Gender
❑ Not Specified
❑ Female
❑ Male
❑ Non-Binary

Grade _____ Date of Birth _____ Place of Birth _____

Student Address: _____ Phone: ❑ Home ❑ Cell _____

Parent/Guardian #1 Name _____ Parent/Guardian #2 Name _____

Physician Name _____ Address _____ Phone _____

Dentist Name _____ Address _____ Phone _____

Emergency Contact Name #1 _____ Phone _____ Relationship _____

Emergency Contact Name #2 _____ Phone _____ Relationship _____

Immunizations: Please attach a copy of your child's most recent immunization records from their physician.

HEALTH HISTORY

Please complete the following as accurately as possible.

Allergies (food, drugs, bees, animals, environmental)	❑ No ❑ Yes	Type of Allergy:	Medication Taken:

		If yes, indicate dates and explain:
Hay fever, asthma, wheezing	❑ No ❑ Yes	
Eczema or frequent skin rashes	❑ No ❑ Yes	
Convulsions or seizures	❑ No ❑ Yes	
Heart trouble or murmurs	❑ No ❑ Yes	
Diabetes	❑ No ❑ Yes	

		If yes, indicate dates and explain:
Tuberculosis	❑ No ❑ Yes	
Kidney Disease	❑ No ❑ Yes	
Pneumonia	❑ No ❑ Yes	
Frequent colds, sore throat, or ear aches	❑ No ❑ Yes	
Rheumatic fever / scarlet fever	❑ No ❑ Yes	
Mononucleosis	❑ No ❑ Yes	
Chicken Pox	❑ No ❑ Yes	
Measles/Mumps/Rubella	❑ No ❑ Yes	
Meningitis	❑ No ❑ Yes	
Strep Infections	❑ No ❑ Yes	
Speech problems	❑ No ❑ Yes	
Bowel or urinary problems	❑ No ❑ Yes	
Nutrition or weight problems	❑ No ❑ Yes	
Behavior, developmental or maturity problems	❑ No ❑ Yes	
Social adjustment problems	❑ No ❑ Yes	
Severe accidents or injuries	❑ No ❑ Yes	
Hospitalizations	❑ No ❑ Yes	
Surgeries	❑ No ❑ Yes	
Known vision problems	❑ No ❑ Yes	
Known hearing problems	❑ No ❑ Yes	
Pain in legs, arms, back or joints	❑ No ❑ Yes	
Limp or unusual walk	❑ No ❑ Yes	
Balance issues or unexplained sudden movements	❑ No ❑ Yes	
Other:	❑ No ❑ Yes	

Medications

Is your child taking any medications? (If a child needs medication administered in school, a medication request form must be completed and signed by a physician before medication can be given at school). ❑ No ❑ Yes

Name of medication and dosage _____ Reason for medication _____

Prenatal History

Child's birth weight _____ Duration of pregnancy _____ Prenatal difficulties _____

Did the child have difficulties at birth? ❑ No ❑ Yes, please explain _____

Physical Activity

Does your child have any physical difficulty that would prevent them from participating in the normal physical education class or other activities? (If your child is unable to participate in physical education class, then a physician's certificate is required.)

❑ No ❑ Yes, please explain _____

Annual Physical Examinations

The New York State Education Law requires a physical examination before entrance to school and routinely at grades Pre-K, K, 2, 4, 7, and 10. All athletes, and those with physical disabilities, are examined yearly.

Student to be examined:
❑ In school
❑ By family physician

Parent/Guardian Signature _____ **Date** _____

DOLGEVILLE CENTRAL SCHOOL DISTRICT
PRE-K-12 ENROLLMENT FORM

DENTAL HEALTH CERTIFICATE

- Optional

New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, and 10. 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 school, ask your dentist to complete Section 2. The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Return the form to the school nurse as soon as possible.

SECTION 1. TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name	First	Middle	Grade

Gender: ❑ Not Specified ❑ Female ❑ Male ❑ Non-Binary

Date of Birth

Will this be your child's first dental visit? ❑ No ❑ Yes

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak, or focus on school activities? ❑ No ❑ Yes, please explain

SECTION 2. TO BE COMPLETED BY THE DENTIST

The Dental Health condition of _____ on _____ (date of exam – should be within 12 months of the start of the school year).

❑ Is in fit condition of dental health to permit his/her attendance at public school.
❑ Is not in fit condition of dental health to permit his/her attendance at public school.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with the students 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 Signature

Date

DOLGEVILLE CENTRAL SCHOOL DISTRICT

REQUIRED NYS SCHOOL 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, 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

Child's Last Name _____ First _____ Middle _____ Date of Birth _____

Gender: ❑ Not Specified ❑ Female ❑ Male ❑ Non-Binary

Date of Exam _____

❑ Prekindergarten ❑ Dolgeville Elementary K-6 ❑ James A. Green High School

Grade _____

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

❑ Allergies	Type: ❑ Medication/Treatment Order Attached ❑ Anaphylaxis Care Plan Attached
❑ Asthma	❑ Intermittent ❑ Persistent ❑ Other: ❑ Medication/Treatment Order Attached ❑ Asthma Care Plan Attached
❑ Seizures	Type: Date of last seizure: ❑ Medication/Treatment Order Attached ❑ Seizure Care Plan Attached
❑ Diabetes	Type: ❑ 1 ❑ 2 ❑ Medication/Treatment Order Attached ❑ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI _____ kg/m2

Percentile (Weight Status Category): ❑ <5th ❑ 5th-49th ❑ 50th-84th ❑ 85th-94th ❑ 95th-98th ❑ 99th and >

Hyperlipidemia: ❑ No ❑ Yes ❑ Not Done **Hypertension:** ❑ No ❑ Yes ❑ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	❑	❑		❑ Test Done ❑ Lead Elevated > 5 µg/dL	
Sickle Cell Screen-PRN	❑	❑			

❑ **System Review Within Normal Limits**

❑ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

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

❑ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
❑ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Continued on next page

Child's Last Name	First	Middle	Date of Birth

SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision Screening	**With Correction** ❑ Yes ❑ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	❑ Yes	❑
Near Vision Acuity		20/	20/	❑ Yes	❑
Color Perception Screening ❑ Pass ❑ Fail					❑
Notes:					

Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ❑ Pass ❑ Fail	**Left** ❑ Pass ❑ Fail	**Referral** ❑ Yes	❑
Notes:				

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	❑	❑	❑ Yes	❑
Notes:				

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

❑ ***Family cardiac history reviewed** - required for Dominick Murray Sudden Cardiac Arrest Prevention Act

❑ **Student may participate in all activities without restrictions.**

<u>If Restrictions Apply</u> - Complete the information below

❑ **Student is restricted from participation in:**

- ❑ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ❑ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ❑ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ❑ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ❑ I ❑ II ❑ III ❑ IV ❑ V

❑ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

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

MEDICATIONS	
❑ Order Form for medication(s) needed at school attached	
COMMUNICABLE DISEASE	**IMMUNIZATIONS**
❑ Confirmed free of communicable disease during exam	❑ Record Attached ❑ Reported in NYSIIS

HEALTHCARE PROVIDER	
Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

DOLGEVILLE CENTRAL SCHOOL DISTRICT
PRE-K-12 ENROLLMENT FORM

ELIGIBILITY SCREEN FOR MIGRANT EDUCATION SERVICE

Migrant Education Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed.

Has your family moved to a different school district in the last three years? ❑ No ❑ Yes

In the last three years, has the parent or guardian of the child enrolling done farm work as a paid job? (Did they work on a dairy farm planting, picking/harvesting vegetables or fruits, food processing or packaging, logging or tree farming?) ❑ No ❑ Yes

If yes, what farm did you work on? _____

Where? _____

Dates of Work: _____

If you can answer <u>YES to BOTH of the above questions</u>, your family MAY qualify for Migrant Education services. To be contacted by a staff member regarding possible services, please complete the information for your children below:

Name of Child(ren)	* Gender	Date of Birth	Grade

* Gender: Not Specified, Female, Male, Non-Binary

PARENTS/GUARDIANS INFORMATION

Parent/Guardian #1

_____
Name

_____
Address

_____
Mailing Address (if different)

Phone: ❑ Home ❑ Cell _____
❑ Work ❑ Cell _____

Parent/Guardian #2

_____
Name

_____
Address

_____
Mailing Address (if different)

Phone: ❑ Home ❑ Cell _____
❑ Work ❑ Cell _____

Migrant Education services are offered through Herkimer-Fulton-Hamilton-Otsego BOCES,
352 Gros Boulevard, Herkimer, NY 13350.