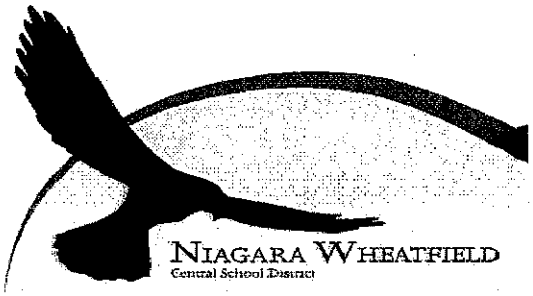


5700 West Street
Sanborn, NY 14132

Mr. Daniel G. Ljiljanich
SUPERINTENDENT
www.nwcsd.k12.ny.us

Dear Parent/Guardian,

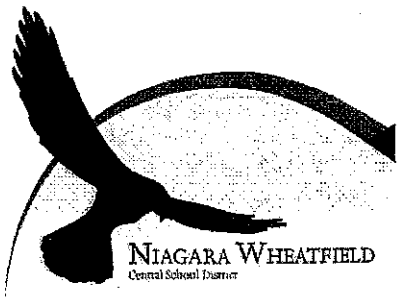
Welcome to the **Niagara Wheatfield Central School District**. The enclosed checklist provides you with a list of items that you must bring with you in order to register your child(ren) for school, unless you have a McKinney-Vento Exemption. You will need to complete a separate packet for each child that you are registering. If you have any questions regarding the registration process, please feel free to contact the District Administration Building at 215-3000. Student Registrations are accepted between **8:30am - 3:00pm**.

The items listed on the enclosed pages will provide the district with the information that is needed to properly register your child(ren). All items are essential to the registration process. It is the responsibility of the parent/guardian to obtain and provide all required information. Registration cannot be completed if any of these items are missing. Partial packets will not be accepted.

The entire process of registration for your child(ren) may take up to three days. Once you complete Central Registration, your child's school will be notified. If you would like to make an appointment to visit the school or discuss your child's schedule for Middle School or High School, please contact the school counseling office at the number located on the reverse side of this letter to arrange a time. Thank You!

We wish your child(ren) a happy and successful school year!

Important district phone numbers are listed on the back for your reference



5700 West Street
Sanborn, NY 14132
(716) 215-3000

Superintendent –Daniel G. Ljiljanich
Phone: (716) 215-3003 Fax: (716) 215-3039

Director of Special Programs – Jessica O'Hern
Phone: (716) 215-3012 Fax: (716) 215-3032

Niagara Wheatfield Senior High School
2292 Saunders Settlement Road
Sanborn, NY 14132
215-3100
Principal - Michael Mann

Edward Town Middle School
2292 Saunders Settlement Road
Sanborn, NY 14132
215-3150
Principal – Jordan Schmidt

Colonial Village Elementary School
1456 Saunders Settlement Rd.
Niagara Falls, NY 14305
215-3270
Principal - Marissa Vuich

Errick Road Elementary School
6839 Errick Rd.
North Tonawanda, NY 14120
215-3240
Principal - Nora O'Bryan

West Street Elementary School
5700 West Street
Sanborn, NY 14132
215-3200
Principal - Theron Mong

Tuscarora Elementary School
2015 Mt. Hope Rd.
Lewiston, NY 14092
215-3670
Principal - Elizabeth Corieri

Niagara Wheatfield Transportation Dept.
2260 Saunders Settlement Road
Sanborn, NY 14132
215-3300
Transportation Supervisor - Leslie Buczkowski

Niagara Wheatfield Buildings & Grounds
2260 Saunders Settlement Road
Sanborn, NY 14132
215-3221
Director - Cono Sammarco, Jr.

NIAGARA WHEATFIELD CENTRAL SCHOOL DISTRICT
STUDENT RESIDENCY QUESTIONNAIRE

Name of School: _____ Grade:_____ for school year: _____

Student Name:_____
Last First Middle

Date of Birth: _____ Age: _____ Gender: _____ male _____ female

Address: _____

Parent/ Guardian: _____

Phone: (H)_____ (W)_____ (CELL)_____

Phone: (H)_____ (W)_____ (CELL)_____

Where is the student currently living? (for temporary living arrangements, please see next section)

___ In permanent housing ___ Voluntary shared living arrangement -share expenses

If you checked one of the above, **STOP HERE.** Fill in the following statement then print and sign name:
I am the **(circle one)** parent/ legal guardian/ head of household of _____ (student)
who is seeking admission to the Niagara Wheatfield Central School District.

_____
Print name of parent/ guardian

_____ _____
Signature of parent/ guardian **Date**

The answers given below will help the district determine what services you/ your child may be able to receive under the McKinney-Vento Act. Students protected under the McKinney-Vento Act are entitled to immediate enrollment even if they don't readily have the documents normally needed and may also be entitled to other services.

If your living arrangement fits any of the following: COMPLETE AND SIGN THIS PAGE AND BACK PAGE

___ In a shelter
___ With another family/ person (doubled-up) due to loss of housing or as a result of economic hardship
___ In a hotel/ motel
___ In a car, park, bus, train, or campsite
___ Other temporary living situation/ Please describe_____

_____

Our family has been living under the above-mentioned temporary living arrangement since_____(date)
___ We anticipate moving into a permanent residency by_____(date)
___ We do not yet know when we will obtain permanent residency.

I declare under penalty of perjury under the laws of New York State that the information provided here is true and correct. I have been provided information regarding my rights under the McKinney-Vento Act and contact information for the district liaison.

_____
Print name of parent/ guardian/ unaccompanied youth

_____ _____
Signature Date

BACK PAGE INSTRUCTIONS: Complete Areas **1-9 ONLY.** Print name & phone contact **(#12).**
SIGNATURE and DATE should be included on THIS PAGE AND ON BACK PAGE (#13).

STAC CHILD ID

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
STAC & Special Aids Unit
Room 514, Education Building
Albany, NY 12234

STAC-202
HOMELESS DESIGNATION

Designation of School District of Attendance for a Homeless Child

Submitted by: ☐ Local Dept of Social Services (DSS) ☐ Designated School District of Attendance (PSD)

PLEASE READ THE INSTRUCTIONS ON THE REVERSE BEFORE COMPLETING THIS FORM

1. NAME OF CHILD _____ LAST NAME _____ FIRST NAME _____ M.I.
2. DATE OF BIRTH _____ MO / DAY / YR
3. GENDER _____ M F
4. SOCIAL SECURITY NUMBER _____

5. Racial/Ethnic Category of Child

American Ind or Alaskan Native ☐ Asian or Pacific Isl. ☐ Black ☐ Hispanic ☐ White ☐

6. GRADE LEVEL FOR WHICH PLACEMENT IS SOUGHT _____

7. COMPLETE ADDRESS BEFORE CHILD/FAMILY BECAME HOMELESS

8. COMPLETE ADDRESS OF CURRENT LOCATION

DATE CHILD/FAMILY PLACED IN TEMPORARY HOUSING _____ MONTH DAY YEAR

9. DATE DISTRICT OF ATTENDANCE CHOSEN _____ MONTH DAY YEAR

10. DATE PLACED IN PERMANENT HOUSING _____ MONTH DAY YEAR

7A. NYS SCHOOL DISTRICT OF ATTENDANCE BEFORE BECOMING HOMELESS

7B. NYS SCHOOL DISTRICT WHERE LAST ENROLLED

8A. NYS SCHOOL DISTRICT OF CURRENT LOCATION

9A. NYS DESIGNATED DISTRICT OF ATTENDANCE

One of four school districts may be chosen to provide the education component: the school district of attendance before becoming homeless, the school district where last enrolled, the school district of current location or a school district participating in a Regional Placement Plan. This designation may be changed either prior to the end of the first semester of attendance or within 60 days of making this designation, whichever occurs later.

11. Check the appropriate box if the designated school district of attendance (9A) is different from the district of attendance before becoming homeless (7A) and from the district of current location (8A).

☐ District participating in a Regional Placement Plan OR ☐ District where last enrolled (7B) if it is different from the district where last permanently housed (7A) and the district of current location (8A).

12. _____ NAME OF PARENT OR PERSON IN PARENTAL RELATIONSHIP _____ AREA CODE _____ TELEPHONE NUMBER

13. _____ SIGNATURE OF PERSON IN PARENTAL RELATIONSHIP TO CHILD _____ DATE

IT HAS BEEN REPORTED TO ME THAT THIS CHILD IS UNDER THE AGE OF 21 YEARS AND IS THEREFORE ELIGIBLE FOR EDUCATIONAL SERVICES. THE CHILD HAS BEEN ADVISED OF HIS/HER RIGHT TO DESIGNATE THE SCHOOL DISTRICT OF ATTENDANCE.

14. _____ PRINT NAME OF LOCAL DSS OR SCHOOL DISTRICT REPRESENTATIVE _____ TITLE

15. _____ SIGNATURE OF LOCAL DSS OR SCHOOL DISTRICT REPRESENTATIVE _____ DATE

16. PLACEMENT COUNTY _____ Local DSS use only _____ AREA CODE _____ TELEPHONE NUMBER

REGISTRATION PARENT CHECKLIST

Student Name: _____

Date of Registration: _____

Expected Start Date: _____

- ❑ Registration Form
- ❑ Residency Questionnaire
- ❑ Birth Certificate or Baptismal Certificate
- ❑ If not a US Citizen, passport, and/or VISA to verify length of stay
- ❑ Photo Identification of registering parent/guardian
- ❑ Proof of Residency (*see next page*)
- ❑ Proof of Rental Residency (*must be completed only if applicable*)
- ❑ Immunization Record (*requirements attached*)
- ❑ Proof of Custody (*if not living with both biological parents*)
- ❑ Release of Records (*completed and signed*)
- ❑ Home Language Questionnaire
- ❑ Health Physical Exam Form – from your health care provider within the last 12 months
- ❑ New Enrollment Health History
- ❑ Dental Health Letter and Form
- ❑ Free & Reduced Lunch Application
- ❑ DSS 2999 Form (*if child is in foster care*)
- ❑ Copy of current I.E.P. (*Individual Education Program – if applicable*)
- ❑ Copy of Recent Card or Transcript

New York State Immunization Requirements for School Entry
2019 – 2020
School Year

SCHOOL RECORDS ARE NOT ACCEPTABLE

1. **DTaP** (diphtheria, tetanus, pertussis)
   - 4 to 5 doses for students enrolling in Kindergarten

Tdap
   - 1 dose for students enrolling in grades 6th – 12th grade, who have not previously received Tdap at 7 years or older

---

2. **Polio**
   - 3-4 doses (OPV or IPV)

---

3. **MMR**
   - 2 doses

---

4. **Hepatitis B**
   - Pre-K through 12th grade: 3 doses
   - Students enrolled in grades 7th-12th: 2 or 3 dose series

---

5. **Varicella** (Chicken Pox)
   - 2 doses for students enrolling in K, 1st, 6th and 7th grades

   OR

   - Medical documentation of chicken pox disease, parent statement is not acceptable

---

6. **HIB Vaccine** – *Pre-K only*
   - 1 dose if administered on or after 15 months of age, 3 doses if administered less than 15 months of age

---

7. **Meningococcal**
   - 1 dose for students entering 7th and 12th grades

ACCEPTABLE PROOF OF IMMUNIZATION RECORDS INCLUDE: (per NYSDOH)

- Physician Record, which should include physician stamp
- Department of Health medical record
- Physician documentation of disease

******SCHOOL IMMUNIZATION RECORDS ARE NOT ACCEPTABLE******

2/18

NIAGARA WHEATFIELD CENTRAL SCHOOL DISTRICT
Proof of Residency List

It will be necessary for you to provide ***one*** form of **Primary Proof** and at least ***one*** form of **Secondary Proof**.

All forms of proof must be dated within three months of presentation.

Acceptable Primary Forms of Proof:

1. Residential tax bill for improved residential real property within the District, in the name of a parent or Legal Guardian.

2. Lease Agreement and rental receipt in the name of a parent or Legal Guardian, for improved residential real property within the District, with name, address and telephone number of landlord for verification purposes.

3. Residential mortgage instrument or deed, duly recorded in the Niagara County Clerk's Office in the name of a parent or Legal Guardian, which describes real property with a residential address within the District.

Acceptable Secondary Forms of Proof:

4. Utility bill (electricity, telephone, water/sewer or natural gas or propane) for service at a residential address within the District being billed in the name of a parent or Legal Guardian.

5. Utility company (electricity, telephone, water/sewer or natural gas or propane) letter indicating service to begin within thirty (30) days at a residential address within the District being billed in the name of a parent or Legal Guardian.

6. Bank statement in the name of a parent or Legal Guardian, addressed to a residential address within the District.

7. Social Security correspondence or statement addressed in the name of a parent or Legal Guardian, addressed to a residential address within the District.

8. U.S. Postal Service verification of change of address to a residential address within the District, in the name of a parent or legal guardian.

9. Federal or NYS income tax documentation with preprinted name and address, addressed in the name of a parent or legal guardian, addressed to a residential address within the District, such as a W-2 Form, preprinted label from government, or income tax return with preprinted label.

10. A certificate of occupancy for residential real estate for real property within the District addressed and/or issue in the name of a parent or Legal Guardian.

11. A Policy binder of homeowners or residential renters insurance for residential real property within the District addressed and/or issued in the name of a parent or Legal Guardian.

12. Other proof acceptable to a District administrator.

Niagara-Wheatfield Central School District Student Registration

Student Information (Please Print. Complete all the information requested and place a check in the appropriate spaces.)

Student's Legal Name: Last: First: Middle:

Student's Nickname: Gender: ☐ Male ☐ Female

Birth Date: / / (* Must be 5 years old on or before Dec. 1st to start Kindergarten) Birthplace:

Date of Arrival in US (If applicable) / / Primary Language Spoken at Home:

Student Racial and Ethnic Identification (2 part question is required for reporting to State and Federal Education departments)

Ethnicity - Check One: ☐ Yes ☐ No Is the student Hispanic Latino, or of Spanish origin? (Cuban, Mexican, Puerto Rican, Central or South American, other Spanish culture or origin, regardless of race.)

Race – Select one or more races from the following five racial groups that best describe the student. At least ONE box must be checked:

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

☐ 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, Philippine Islands, Thailand, and Vietnam.

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

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

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

Registration Information

Last School Attended: Phone: ( )

Address: City: State: Zip:

Grade Entering: If Applicable, Grade(s) Repeated:

Has the student ever attended Niagara Wheatfield Central Schools before? ☐ Yes ☐ No

If "Yes", please provide the Year(s), Grade(s) and School:

Is the student receiving Special Education services? (Does the student have an Individualized Education Plan (IEP)?) ☐ Yes ☐ No

Is the Free/Reduced Meal app. completed for this school year? ☐ Yes ☐ No Did the student previously qualify for Free /Reduced Meal? ☐ Yes ☐ No

Medical/Health Needs and/or Speech Services? ☐ Yes ☐ No If "Yes", please specify:

Registering School: ☐ Colonial Village ES ☐ Errick Road ES ☐ West Street ES ☐ Tuscarora ES ☐ Edward Town Middle ☐ Senior High

Student Residence

Home Phone Number: ( )

Residence Address: Street: City: State: Zip:

Mailing (if Different):

Office Use Only

Student Number: _____

Date Received: ____/____/____

Registration Date: ____/____/____

Entrance Date: ____/____/____

Proj. Grad Year

---------- / ---------- / ----------

Foster Child:

☐ Yes ☐ No

District of Origin (If app): _____

☐ **Birth Certificate***

☐ **Immunization Records***

☐ **Parent/Guardian ID***

☐ **2 Proofs of Residency***

☐ Records Release (If app)

☐ Report Card (If app)

☐ Custody Papers (If app)

☐ Free/Reduced Meal App.

☐ Approved by:

Initials:

Custodial Parent/Guardian Information

Parent/ Guardian Contact #1	Last Name:	Lives with Student? ☐ Yes ☐ No Receive Mailings? ☐ Yes ☐ No
	First Name: Middle:	Email Address:
	Gender ☐ Female ☐ Male US Citizen? ☐ Yes ☐ No Parent on Active Duty in Armed Forces? ☐ Yes ☐ No	Complete Address:
	Relationship to Student: ☐ Mother ☐ Father ☐ Guardian	City: State: Zip:
	☐ Stepmother ☐ Stepfather ☐ Other:	Home Phone (_____) _____ - _____ Call this # : ☐ 1st ☐ 2nd ☐ 3rd
Calling Order:	Contact this person: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th	Cell Phone (_____) _____ - _____ Call this # : ☐ 1st ☐ 2nd ☐ 3rd Work Phone (_____) _____ - _____ Ext_____ Call this # : ☐ 1st ☐ 2nd ☐ 3rd
Parent/ Guardian Contact #2	Last Name:	Lives with Student? ☐ Yes ☐ No Receive Mailings? ☐ Yes ☐ No
	First Name: Middle:	Email Address:
	Gender ☐ Female ☐ Male US Citizen? ☐ Yes ☐ No Parent on Active Duty in Armed Forces? ☐ Yes ☐ No	Complete Address:
	Relationship to Student: ☐ Mother ☐ Father ☐ Guardian	City: State: Zip:
	☐ Stepmother ☐ Stepfather ☐Other:	Home Phone (_____) _____ - _____ Call this # : ☐ 1st ☐ 2nd ☐ 3rd
Calling Order:	Contact this person: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th	Cell Phone (_____) _____ - _____ Call this # : ☐ 1st ☐ 2nd ☐ 3rd Work Phone (_____) _____ - _____ Ext_____ Call this # : ☐ 1st ☐ 2nd ☐ 3rd

Legal Custody: ☐ Both Parents ☐ Father ☐ Mother ☐ Other If "Other", please list relationship:

(If Applicable) Legal Documentation of Custody? ☐ Yes-copies attached. ☐ No – Explain:

Are one or both parents deceased? ☐ Yes ☐ No If "Yes", which parent?

Please List Other Children Living in the Household (Birth through Grade 12)

Last Name	First Name	Middle Name	Birth Date	Gender	School (If Applicable)	Grade (If Applicable)	Relationship to Student
				Female Male			
				Female Male			
				Female Male			

Please List Other Children Living in the Household (Birth through Grade 12)							
				Female Male			
				Female Male			
				Female Male			

Emergency Contact Information Please list two (2) local emergency contacts (other than those listed on page 2) who are available during schools hours.

Contact #3	Last Name:	Gender ☐ Female ☐ Male Lives with Student? ☐ Yes ☐ No
	First Name: Middle:	Allowed to Pick Up Student? ☐ Yes ☐ No
	Relationship to Student: ☐ Stepmother ☐ Stepfather	Address: City: Zip:
	☐ Grandmother ☐ Grandfather ☐ Other:	Home Phone (_____) _____ – _____ Call this # : ☐ 1st ☐ 2nd ☐ 3rd
Calling Order:	Contact this person: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th	Cell Phone (_____) _____ – _____ Call this # : ☐ 1st ☐ 2nd ☐ 3rd
		Work Phone (_____) _____ – _____ Ext_____ Call this # : ☐ 1st ☐ 2nd ☐ 3rd
Contact #4	Last Name:	Gender ☐ Female ☐ Male Lives with Student? ☐ Yes ☐ No
	First Name: Middle:	Allowed to Pick Up Student? ☐ Yes ☐ No
	Relationship to Student: ☐ Stepmother ☐ Stepfather	Address: City: Zip:
	☐ Grandmother ☐ Grandfather ☐ Other:	Home Phone (_____) _____ – _____ Call this # : ☐ 1st ☐ 2nd ☐ 3rd
Calling Order:	Contact this person: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th	Cell Phone (_____) _____ – _____ Call this # : ☐ 1st ☐ 2nd ☐ 3rd
		Work Phone (_____) _____ – _____ Ext_____ Call this # : ☐ 1st ☐ 2nd ☐ 3rd

Parent/Guardian Signature_____ Date_____

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

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

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

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

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH: *Month* *Day* *Year*

GENDER: ❑ Male ❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other	*specify*	
2. What was the first language your child learned?	❑ English	❑ Other	*specify*	
3. What is the Home Language of each parent/guardian?	❑ Mother *specify*	❑ Father *specify*	❑ Guardian(s) *specify*	
4. What language(s) does your child understand?	❑ English	❑ Other	*specify*	
5. What language(s) does your child speak?	❑ English	❑ Other *specify*	❑ Does not speak	
6. What language(s) does your child read?	❑ English	❑ Other *specify*	❑ Does not read	
7. What language(s) does your child write?	❑ English	❑ Other *specify*	❑ Does not write	

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** *No* *Not sure*
❑ ❑ ❑ ***If yes,** please explain:_____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ **No** ❑ **Yes*** **Please complete 10b below*

10b. *If referred for an evaluation,* has your child ever *received* any special education services in the past?
❑ **No** ❑ **Yes – Type of services received:**_____

Age at which services received *(Please check all that apply):*
❑ **Birth to 3 years (Early Intervention)** ❑ **3 to 5 years (Special Education)** ❑ **6 years or older (Special Education)**

10c. Does your child have an Individualized Education Program (IEP)? ❑ **No** ❑ **Yes**

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ **Mother** ❑ **Father** ❑ **Other:**_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

DATE OF INDIVIDUAL INTERVIEW: _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

NIAGARA WHEATFIELD CENTRAL SCHOOL DISTRICT

HEALTH HISTORY FORM FOR STUDENTS

Student Name:_____ Date of Birth: _____ Grade: _____

Please check YES or NO for questions below so that our school health services may best serve your child. For YES answers, please provide dates in the space provided. **Thank You.**

Has Your Child Ever Had:

	YES	NO	DATE
SKIN			
Eczema			
Psoriasis			
Dry Skin			
Hives			
EYE			
Vision loss	RT LT		
Amblyopia	RT LT		
Glasses			
Contact lenses			
EAR			
Hearing loss	RT LT		
Ear tubes	RT LT		
Freq.infections			
NOSE			
Freq. nose bleeds			
Nose frac/surgery			
THROAT			
Tonsillitis			
Strep throat			
Tonsils/adenoids removed			
Scarlet Fever			
DENTAL			
Capped Teeth			
Braces			
Bridge/Lost Teeth			
CARDIOVASCULAR			
High bld. pressure			
Heart murmur			
Rheumatic fever			
GASTROINTESTINAL			
Freq. abdom. pain			
Ulcers			
Constipation			
Recurrent diarrhea			
Encopresis			
GENITOURINARY			
Bladder/kidney prob.			
Infections			
Hernia			
Freq. Urination			

	YES	NO	DATE
MUSCULOSKELETAL			
Arthritis			
Joint Pain			
Limb/Back Deformaties			
Fractures/Dislocations			
Chronic/recurrent sprains			
Scoliosis			
NEUROLOGICAL			
Freq. headaches			
Head injury/concussion			
*Seizures/Epilepsy (if yes, see back #10)			
Dizziness/Fainting			
Paralysis/Numbness			
Hyperactivity			
RESPIRATORY			
*Asthma (if yes, see back #11)			
Allergies/Hayfever			
Sinusitis			
Recurrent colds			
Chronic cough			
Pnuemonia			
Bronchitis			
Tuberculosis			
Shortness of breath			
HEMATOLOGY			
Anemia			
Bleeding disorders			
ENDOCRINE			
*Diabetes (if yes, see back #12)			
Hypoglycemia			
Thyroid conditions			
Delayed puberty			
COMMUNICABLE ILLNESS			
Measles			
Chicken Pox			
OTHER			
Recent weight loss/gain			
Sleeps poorly			
Male: Testicular inj./surg.			
Female: Date 1st menses			

Student Name: _____ Date of Birth: _____ Grade: ____

Has your son/daughter:

1.) Ever been a patient in a hospital? Please explain: _____

_____

2.) Had any operations? Please explain: _____

_____

3.) Had any accidents? Please explain: _____

_____

4.) Is your son/daughter currently under a physicians care? Please explain: _____

_____

5.) Is your son/daughter taking any medications? Please list: _____

_____

6.) Does your son/daughter have any allergies to medications, insects/bees, foods?

Please be specific and indicate reaction and treatments. _____

_____

_____

7.) Does your child ever seem anxious, nervous, depressed? Please explain: _____

_____

8.) Has your son/daughter ever been excused from physical education class? _____

_____

9.) Does your son/daughter have any physical limitations? _____

_____

*10.) Seizures – Please describe: _____

_____

* 11.) Asthma – Please indicate severity, triggers and medications: _____

_____

*12.) Diabetes – Please indicate signs of low blood sugar and treatment: _____

_____

Parent Signature: _____ Date: _____

PLEASE NOTE: HEALTH INFORMATION WILL BE SHARED WITH APPROPRIATE STAFF, INCLUDING BUS DRIVERS, ON A NEED TO KNOW BASIS.

Student Name: _____ **Date of Birth:** _____ **Grade:** _____

HEALTH CONDITIONS: Please list recent illness or injury, recent immunizations or other health conditions, not already listed, that may require special care (if none: indicate none).

Recent illness or injury: _____
Recent immunizations: _____
Other health conditions: _____
Blood Type (if known): _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: Please initial authorization to release medical information.

Please read both & check ONLY one:

_____ I do hereby give permission for health information about my child to be shared with staff on a need to know basis. This release authorization is valid while above named child is a student in the Niagara Wheatfield school district, unless revoked in writing, and will authorize health office staff to contact my child's medical doctor(s) or other sources, and will authorize the release of any medical information from said doctor(s) or other sources, pursuant to Federal Law.

OR (please check ONLY one)

_____ I DO NOT give permission for any health information to be released to staff.

EMERGENCY SITUATIONS: In an emergency, the school is authorized to contact any of the following. For emergency medical care, I authorize sending my child to the nearest hospital by ambulance for treatment. I realize that the school district cannot assume responsibility for expenses incurred.

PHYSICIAN: _____ PHONE: _____

DENTIST: _____ PHONE: _____

HOSPITAL PREFERENCE: _____
In case of emergency, students will be transported to the nearest hospital.

MANDATED PHYSICAL:

If you do NOT want the school to complete a mandated physical (New students, K, 2, 4, 7, 10) or scoliosis screening), please initial here _____. Your initials indicate it is your responsibility and you hereby agree to provide this information within 30 days after entry into the school.

_____ _____
Signature of Parent/Guardian Date

Rev. 11/05, 3/08, 2/09

NIAGARA WHEATFIELD CENTRAL SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

Dear Parent/Guardian,

New York State Education Law requires that all new students and students in Pre-Kindergarten or Kindergarten and Grades 1, 3, 5, 7, 9 and 11 provide proof of a physical exam upon entry to school. Effective September 1, 2008, schools are also required to request a dental certificate in addition to a physical exam. Attached you will find both a physical exam form and a dental certificate for Niagara Wheatfield. Please have these forms completed by your family health care provider and dentist, respectively, and return to your child's school health office within 30 days of school entry. Physical exams and dental exams are acceptable if completed after September 4, 2018. If you have any questions, please contact your child's school health office or district health services at the numbers below.

Thank you for your cooperation. We want to assure that your child has a safe and healthy school year.

Best Regards,
Health Office Staff
Niagara Wheatfield School District

Niagara Wheatfield Senior High
Nichole Horton, RN
Kathryn Lanigan, RN
215-3115

Edward Town Middle School
Tammy Szarejko, RN
Linda Destino, LPN
215-3163

Colonial Village Elementary School
Christina Mueller, RN
215-3274

Errick Road Elementary School
Janine Muscarella, RN
215-3246

West Street Elementary School
Ashley Richardson, RN
215-3208

Tuscarora Indian School
Marilyn Schlehr, RN
215-3672

12/18

NIAGARA WHEATFIELD-CENTRAL SCHOOL DISTRICT
DENTAL HEALTH CERTIFICATE

Student Name: _____ DOB: _____

School: _____ Grade: _____

A comprehensive dental examination was performed on the above named student.

Date of Exam: _____

Dental Work Completed: _____

_____

Further Treatment Necessary: _____ YES Comments: _____

_____

_____ NO

Dentist Signature: _____ Date: _____

Dentist Printed Name: _____

Dentist Address & Phone or Stamp: _____

_____

_____

Please return to your child's school health office

dmcgranor@nwcsd.org

NIAGARA WHEATFIELD CENTRAL SCHOOL DISTRICT PHYSICAL EXAM FORM

SCHOOL_____

Name: _____ ☐ M ☐ F Date of Birth: _____ Grade_____

Immunizations & Screening

**Required for NYS school entry, varies by age and grade*

☐ None given today ☐ Given since last exam ☐ Record attached

	1st	2nd	3rd	4th	5th
DtaP	*	*	*	*	*
Polio ☐IPV ☐OPV	*	*	*		
HIB					
Tdap		Tetanus	(Td)		
Hepatitis B	*	*	*		
MMR	*	*			
Varivax	*		☐ Disease / /		
Pneumococcal	*	*	*	*	

*4 IPV only

Screening Must Be Completed

Vision: Distance ☐ Unaided	R	L
Vision: Distance ☐ glasses ☐ contact lenses	R	L
Vision: Near Point ☐ Unaided	R	L
Vision: Near Point ☐ glasses ☐ contact lenses	R	L
Hearing: ☐Pass 20dB both ears or as indicated ☐ Screening ☐ Audiogram	R	L

Medical History

1) Significant medical/surgical history: _____

2) Allergies: _____

3) Medications taken: ☐ No ☐ Yes List: _____

***If medication *is required for school and/or sports*, a SCHOOL MEDICATION AUTHORIZATION form must be on file in the school health office**

Physical Examination

Date of Exam___/___/____

Height: _____ Weight: _____ BP: _____/_____ Resting Pulse: _____ Fe LMP: _____

	Normal	Abnormal
General Appearance		
Nutrition		
Skin		
Head		
Eyes		
Ears		
Nose/Throat		
Teeth		
Neck: Nodes/Thyroid		
Lungs		
Heart/Murmur		
Pulses		
Abdomen		
Genitalia		
Neurological		
Musculoskeletal		
Scoliosis	☐ Negative	☐ Positive

COMPLETE PER NYSED LAW, SECTION 903

Body Mass Index: _____

Weight Status Category (BMI Percentile):

☐ Less than 5th ☐ 5th through 49th

☐ 50th through 84th ☐ 85th through 94th

☐ 95th through 98th ☐ 99th and higher

*Tanner Stage: ☐ I. ☐ II. ☐ III. ☐ IV. ☐ V.

☐ Comments/Restrictions _____

Referred for: ☐ BP ☐ Scoliosis ☐ Weight ☐ Murmur ☐ Other _____

☐ **Physically qualified for participation in sports**, full playground, and school activities, or as indicated below (☑ or circle):

☐ Contact/Collision: Field Hockey, Football, Ice Hockey, Soccer, Wrestling, Lacrosse.

☐ Limited (Contact/Impact): Baseball, Basketball, Diving, Gymnastics, Skiing, Softball, Volleyball.

☐ Strenuous/Non-contact: Cross Country, Track & Field, Swimming, Tennis, Cheerleading.

☐ Non-strenuous/Non-Contact: Bowling, Golf

☐ **Physically qualified for employment** ☐ Known or suspected disability: _____

☐ Restrictions: _____

Provider Name (please print): _____

Provider Signature: _____

Phone Number: _____ Date: ___/___/____

Physician Stamp

Rev. 5/11

Physical Exam (Part B)

Health History (Part A) on back should be completed by parent / guardian

NIAGARA WHEATFIELD CENTRAL SCHOOL DISTRICT
Health History: 20____ - 20____ School Year

Name: _____ ▫ M ▫ F Date of Birth: _____ Grade_____

HEALTH HISTORY SHOULD BE COMPLETED FOR ALL STUDENTS PRIOR TO PHYSICAL

HEALTH HISTORY To be completed by parent /guardian.
Has your child ever had, or currently has, any of the following: (please check) ***Fill in below if Yes

		YES	NO	Date
1.	Does student have an ongoing medical condition (i.e. diabetes/hypoglycemia, asthma)?			
2.	Elevated blood pressure/heart problems/murmur/chest pains			
3.	Has physician ever said student has allergies/hay fever asthma?			
4.	Insect sting allergy (type) _____			
5.	Has student ever passed out or nearly passed out during or after exercise?			
6.	Does student cough, wheeze, or have difficulty breathing during or after exercise?			
7.	Has student ever used inhaler or taken asthma medication?			
8.	Does anyone in the family have a heart problem?			
9.	Has student complained of heart skipping beats or racing during exercise?			
10.	When exercising in the heat, has student had severe muscle cramps, or become ill?			
11.	Has student ever had a head injury or concussion? How many?_____			
12.	Loss of consciousness due to injury?			
13.	Headaches/dizzy			
14.	Ever had a seizure/convulsion			
15.	Neck injury			
16.	Injury to spleen			
17.	Kidney disease or injury			
18.	Joint sprains/ligament tear, muscle			
19.	Back problem			
20.	Knee problem			
21.	Ankle problem			
22.	Hernia			

Please circle:

23.	Does your child wear dental bridges, plates/braces, special pads/protective equipment			
24.	Does your child wear glasses/contacts			

Does your child take any medication? Please list:

25. _____

FOR WOMEN:

26. At what age did you experience your first menstrual period?_____
27. How often does your period occur? _____ When was your last period? _____

***PLEASE PROVIDE AN EXPLANATION FOR ALL YES ANSWERS:

_____
_____
_____
_____
_____
_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

SIGNATURE OF PARENT_____ **Date** _____

PLEASE COMPLETE THE FOLLOWING:

- I authorize the Health Office to share this information with school personnel as needed.
- I authorize the information contained in this physical exam to be released to _____Health Office. I also give permission for the information to be faxed to the above health office at 215-_____.

_____ _____
Parent Name (Print) Parent Signature

Date:_____

Part A- Health History form must be completed.