BOQUET VALLEY
CENTRAL SCHOOL DISTRICT

Lake View Campus
25 Sisco Street
Westport, NY 12993

Ph: (518) 962-8244

Board of Education
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SHARLENE PETRO-DURGAN, DISTRICT TREASURER

Joshua R. Meyer Superintendent of Schools

Dear Families,

We hope this letter finds you in good health and high spirits. As we gear up for the upcoming school year, we are thrilled to extend a warm welcome to all the new Pre-Kindergarten parents joining our community.

Starting school is a significant milestone for both parents and their little ones, and we want to assure you that we are here to make this transition as smooth and enjoyable as possible. Our commitment to providing a nurturing and enriching environment for your child is at the forefront of everything we do.

Enclosed you will find documents and information necessary to complete the Early Bridges registration process. Please complete these enclosed forms and return to the Lake View Campus Main Office by May 1st, 2024. The successful completion of these forms will allow us to effectively prepare for your child's Pre-K screening. We will complete a DIAL assessment with your child. The DIAL is a screening tool used to assess a child's motor, speech, and academic baseline to determine potential needs. This assessment will be completed by PK staff and related service providers and the results will be shared with your family.

We are enthusiastic about the upcoming school year and look forward to building a positive and collaborative relationship with you and your child. Together, we can create an educational journey filled with curiosity, discovery, and growth.

If you have any immediate questions or concerns, please do not hesitate to contact our school office. Once again, welcome to the Adirondack Community Action Programs, Inc. and Boquet Valley Central School District family!

Warm regards,

Mallory Finnegan Head Start
Head Start/Early Head Start Director
Adirondack Community Action Programs, Inc.

Lee Kyler
Principal, Lake View Campus
Boquet Valley Central School District

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Early Bridges Registration

The **Early Bridges** program is a collaborative partnership between the Boquet Valley Central School and Adirondack Community Action Program, Inc.'s Head Start. This partnership created a Pre-Kindergarten program that is led by certified teachers and supported by Head Start staff. The program follows the school calendar and runs 8:10 AM to 3:10 PM. **Please note that completing this Registration packet for your child, does not necessarily mean that your child will be selected to participate in the Early Bridges program.**

Who: Any child who will be three or four years of age on or before December 1, 2024 that lives within the Boquet Valley School District will be eligible. Any child who resides outside the district may apply, but would be required to pay tuition.

Items needed:

- Child's Birth Certificate or Baptismal Certificate
- Immunization records
- Income verification
- Proof of residency

Items required before officially entering into Early Bridges:

- Completed physical form
- Dental Health Certificate

If you have any questions, please contact Jolene Sayward,
Early Bridges Family Worker at (518) 225-5162.

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Worker at (518) 225-5162.

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Pre-Kindergarten Registration - Required Paperwork Checklist

Please use this checklist to help you prepare for Pre-Kindergarten screening. The following documents MUST be completed and on file with Boquet Valley Central School District in order for your child to begin school.

Emergency Information

☐ Student Emergency form

Basic Registration Information (Required)

☐ Allergy Information Form (*If Applicable*)

☐ Birth Certificate

☐ Health History Examination form

☐ Home Language Questionnaire

☐ Income Verification

☐ Pre-Kindergarten Registration form

From the Doctor's Office

☐ Authorization of Administration of Medication (*If Applicable*)

☐ Dental Health Certification

☐ Student Health Examination form

☐ Vaccination Records (Copy)

Thank you for your cooperation!

If you have any questions, please do not hesitate to contact us at (518) 962-8244.

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

Elisa Alvarez, Associate 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 Person in Parental Relation:
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.

STUDENT NAME:		
First	*Middle*	*Last*
DATE OF BIRTH:		GENDER:
Month	*Day*	*Year*
		☐ Male ☐ Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to*

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?	◯ Parent 1 *specify*	◯ Parent 2 *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:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School: *Address:*	

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 ○ **Parent** ○ **Other:** _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF 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 ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

BOQUET VALLEY CENTRAL SCHOOL DISTRICT

Joshua R. Meyer Superintendent of Schools

District Office
@ Mountain View Campus
P.O. Box 158
Elizabethtown, NY 12932
Ph: (518) 873-6371

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Student Residency Questionnaire

Name of Student: _____ Sex: _____

Birth Date: ____/_____/_____ Age:_____ Social Security #:_____

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
3.

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 box*)

- ☐ 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 ordinarysleeping accommodations such as a car, park, or campsite

Name of Parent(s)/Legal Guardian(s)_____
Address _____Zip_____Phone_____

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:_____
Please send a copy to _____ at the Central Office.
Fax:_____

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)

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Joshua R. Meyer Superintendent of Schools

Pre-Kindergarten Registration Form

Child's Name: _____

Parents Name: _____

Name of Pediatrician: _____ Contact Number: _____

Pediatrician Address: _____

Do you have any health concerns regarding your child's development (*circle one*): ☐ ☐

Household Income(s): Number in Household: _____

☐ $0 - $11,770	☐ $24,250 $24,809	☐ $ 40,890 - $40,45-049
☐ $11,771 - $15,930	☐ $24,810 - $32,569	☐ $ 45,050 - $49,203
☐ $15,931 - $20,089	☐ $32,570 - 36,729	☐ $ 49,204 - or more
☐ $20,090 - $24,249	☐ $36,730 - $40,889	

Household Members:

Name	D.O.B.	Sex: M/F	Relationship to Applicant

Social Services Received (check all that apply): ☐ TANF ☐ SNAP ☐ Supplemental Security Income

Please state who receives Supplemental Security Income, if applicable. _____

Is the child in foster care? ☐ Yes ☐ No

Did your child participate in a Preschool or Head Start program? ☐ Yes ☐ No

If yes, which program? _____ Name of School: _____

If no, did your child participate in daycare? ☐ Yes ☐ No If yes, who? _____

Was the daycare registered? ☐ Yes ☐ No

Does your child have an IEP through CPSE or early education services? ☐ Yes ☐ No

Does your child have any special needs, including special education? (If So, Please explain)

_____

_____

_____

Have there been any changes or additions in the family in the past year?

For example: Health issues, changes in marital status, changes in occupation, new siblings.

_____

_____

_____

BOQUET VALLEY CENTRAL SCHOOL DISTRICT

STUDENT EMERGENCY FORM

Please supply all information requested below and return this form to the school. This form will be kept on file in the office for the school year. If more than one form is needed per family, please contact the office for additional forms.

Student Information

Student Name: _____ Date of Birth: _____
Mailing Address: _____
Physical Address: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____

Parent/Guardian Information:

To serve your child in case of an accident, sudden illness, emergency closing and/or other occurrence requiring immediate parental notification; it is necessary that you furnish the following information for emergency calls.

Mother's Name: _____
Business Address: _____
Business Phone: _____ Cell Phone: _____
Email Address: _____

Father's Name: _____
Business Address: _____
Business Phone: _____ Cell Phone: _____
Email Address: _____

Emergency Contacts:

Please designate two emergency contacts who will assume temporary care of your child, if you cannot be reached in the event of an accident, sudden illness, emergency closing and/or other occurrence requiring immediate parental notification.

Contact #1: _____ Relationship to Student: _____
Address: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Contact #2: _____ Relationship to Student: _____
Address: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Medical Information:

Physician (Full Name): _____
Address: _____ Phone: _____
Hospital/Dr. Office: _____

I, the undersigned, do here authorize officials of the Boquet Valley Central School District to contact directly the persons named on this form and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this card or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment.

I will NOT hold the school district financially responsible for the emergency care and/or transportation of the child.

Parent/Guardian Signature: _____ Date: _____

Early Bridges Annual General Consent Form

I hereby give permission for my child _____ to participate in the following:

Health Screenings:	**YES**	**NO**	**N/A**
Hearing/Vision	☐	☐	☐
Height/Weight/BMI	☐	☐	☐
Blood Pressure	☐	☐	☐
Dental Examination	☐	☐	☐
Developmental Screenings	☐	☐	☐
Social Emotional Screening	☐	☐	☐

Pictures & Videos used in slideshows, ACAP and or BVCS website, newspaper, newsletters, brochures, public relations articles, etc. (Childs last name will not be used)

	☐	☐	☐

Other:

Local library	☐	☐	☐
Field Trips	☐	☐	☐
Transportation to/from site	☐	☐	☐
Application of sunscreen	☐	☐	☐
HS Counselor's Group observation (2x/year)	☐	☐	☐
Join a therapist during a session	☐	☐	☐
Transition information to School/Early Bridges	☐	☐	☐

Which may include: Transitional observation, Health Records, Family contact information, Observation by local school personnel, Child assessment summary or Special service record.

I understand that the Early Bridges Program deems these services necessary, advisable and are typical elements of the preschool experience. The purpose and nature of any examinations, screenings, and/or observations, have been explained to me. Any and all results may be shared. This permission is valid for one program year after the signature.

Parent/Guardian Signature _____ Date _____

Staff _____ Date _____

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A MESSAGE FROM THE SCHOOL NURSE

Requirements for the administration of medication:

The School Nurse must have on file, a written request from a physician that indicates the frequency and dosage of the prescribed medication. The nurse must also know the condition being treated, the regime of treatment, and the frequency of treatment.

Sending a child home from school:

It is necessary, at times, to send a child home from school due to illness or injury. Except in a severe emergency when immediate transportation is needed, it is the responsibility of the parent/guardian to pick up the child or make arrangements. In which case the parent/guardian should notify the nurse as to the person that will be picking the child up.

Keeping a child home:

If your child is NOT well, please keep them home, for both their well-being and for the protection of others in the school. If a child is not sent to school, please be sure to contact the School Nurse to notify them of your child's absence. It is important that we can account for every child and know that they are safe!

If you have any questions regarding the above information, please call the School Nurse, Carol Schwoebel at (518) 962-8244.

BOQUET VALLEY
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Student Medical Information

www.boquetvalleycsd.org

Student Name: _____ _____
Last First M. Date of Birth

Parent/Guardian Information: _____ ☐ Male / ☐ Female

Mailing Address: _____

911 Address: _____

Employer:: _____

Employer Address: _____

Cell Phone: _____ Work Phone: _____ Home Phone _____

Parent/Guardian Information: _____ ☐ Male / ☐ Female

Mailing Address: _____

911 Address: _____

Employer:: _____

Employer Address: _____

Cell Phone: _____ Work Phone: _____ Home Phone _____

Student's Health Care Provider: _____ Phone: _____

Address of Health Care Provider: _____

Does your child wear glasses/contact lenses? ☐ Yes ☐ No

Does your child wear a hearing device? ☐ Yes ☐ No

Does your child wear a dental appliance? ☐ Yes ☐ No

Does your child take any medication daily? ☐ Yes ☐ No

If yes, please list _____

_____

Does your child take medication as needed? ☐ Yes ☐ No

If yes, please list _____

_____

Please indicate if any of the following applies your child's medical history by checking **Yes or No** below. If you checked Yes, please provide a brief description.

Yes	No	
☐	☐	Allergies (Please describe) Food, Medication? _____

Other _____

_____ Epi-Pen ☐ Y ☐ N

☐	☐	Asthma (Seasonal, chronic)_____
☐	☐	Blood Disorder _____
☐	☐	Diabetes _____
☐	☐	Ear Conditions_____
☐	☐	Frequent Colds _____
☐	☐	Head Injury _____
☐	☐	Heart Disease _____
☐	☐	Kidney Issues (Renal) _____
☐	☐	Muscular/Skeletal Condition _____
☐	☐	Pneumonia _____
☐	☐	Seizure Disorder (Epilepsy) _____
☐	☐	Operations (Please explain & provide dates) _____
☐	☐	Serious Injuries (Please explain)_____
		_____
☐	☐	Other medical issues, not listed above? _____
		_____

Is this child covered by Health Insurance? ☐ Yes ☐ No Type:_____

_____ _____

Parent/Guardian Signature Date

BOQUET VALLEY
CENTRAL SCHOOL DISTRICT

HEALTH HISTORY FORM

Student Name: _____

Date of Birth: _____

(Please circle if applicable)

Accidents:

- ☐ Serious Head Injury
- ☐ Loss of consciousness
- ☐ Other (Specify)

Eye Difficulty:

- ☐ "Lazy Eye"
- ☐ Glasses or contact lenses
- ☐ Other (please specify)

Ear Problems:

- ☐ Ear Infections
- ☐ Tubes
- ☐ Hearing Loss
- ☐ Throat Infections
- ☐ Others (Specify)

Heart Problems:

- ☐ Heart Murmurs
- ☐ Congenital Heart Disease
- ☐ Rapid Heartbeat/palpitations
- ☐ Other (specify)

Respiratory Difficulties:

- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Cystic Fibrosis
- ☐ Other (Specify)

Kidney/Bladder Difficulties:

- ☐ Kidney Disease
- ☐ Bladder infections
- ☐ Enuresis (Bedwetting)
- ☐ Encopresis (Fecal Soiling)
- ☐ Other (Specify)

Aliments:

- ☐ Constipation
- ☐ Hernia
- ☐ Undescended or one testicle

Musculoskeletal/Orthopedic Problems:

- ☐ Joint pain or swelling
- ☐ Limited movement
- ☐ Fractures
- ☐ Braces/adaptive equipment
- ☐ Other (Specify)

Poor Condition (Please Specify):

_____

Birth Defects (Please Specify):

_____

Hospitalizations (Please Specify):

_____

Operations (Specific):

_____

Allergies:

_____

Currently taking any Medication? Reason?

_____

Syndromes: _____

Skin Conditions: _____

Chicken Pox: _____

Mono: _____

Tuberculosis TB Contact: _____

Diabetes: _____

Hepatitis: _____

Thyroid Disease: _____

Speech Defects: _____

Emotional Problems: _____

Any Special Educational Needs?

_____

_____

Have there been any changes or additions in the family in the past year? For example: Health Issues, changes in marital status, changes in occupation, new siblings.

_____

_____

_____

If you have any questions or concerns, please contact the School Nurse at (518) 962-8244.

_____ _____

Parent/Guardian Signature **Date**

Dental Health Certificate - Optional

Parent/Guardian: Please complete Section 1 and take the form to your dentist/dental hygienist for an assessment. Request your dentist/dental hygienist to fill out Section 2. Return the completed form to your child's teacher 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

Section 2. To be completed by the Dentist/Dental Hygienist

I. 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**

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

II. Treatment Needs (check all that apply)

☐ **No need for Treatment**

☐ **Urgent Treatment –** abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** – amalgams, composites, crowns, etc.

☐ **Preventive Care** – sealants, fluoride treatment, prophylaxis, mouthguard etc.

☐ **Other** – periodontal, orthodontic treatments

Please note

The Dental Health condition of _____ on _____ (date of exam) Check one:

☐ **Yes, The student listed above *is* in fit condition of dental health to permit him/her attendance at the public schools.**

☐ **No, The student listed above *is not* in fit condition of dental health to permit him/her attendance at the public schools.**

Dentist's Name and Address (Please Print or Stamp):

Dentist/Dental Hygienist Signature:

Date of Exam: / /

* The dental health condition of the student when the exam is made and the date of exam shall not be more than 12 months prior to the commencement of the school year in which the exam is requested.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

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

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

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

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

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

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

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

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

☐ **System Review and Exam Entirely Normal**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

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

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

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

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

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

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

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

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

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

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

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

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

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

HEALTH CARE PROVIDER

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

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

BOQUET VALLEY
CENTRAL SCHOOL DISTRICT

Food Allergy and Sensitivity Notification

Dear Parent/Guardian:

Please inform the Health Office on the note below if your child is allergic to any food items. Please note food allergies and sensitivities are different from food likes and dislikes. A food allergy is when an anaphylactic incident will occur if your child is exposed to a particular food item. **Anaphylaxis is a serious life-threatening incident; please provide BVCSD with an Epi-Pen for your child's allergies.**

If you have any questions or concerns please contact the Health Office at 518-962-8244.

Student's Name: _____ Grade: _____

☐ My child has no allergies or sensitivities that I am aware of at this time.

Food Allergy: _____

Food Sensitivity: _____

(e.g. lactose intolerance, foods that cause gastric upset, etc.)

_____ _____

Parent/Guardian Signature Date

BOQUET VALLEY
CENTRAL SCHOOL DISTRICT

Joshua R. Meyer Superintendent of Schools

District Office
@ Mountain View Campus
P.O. Box 158
Elizabethtown, NY 12932
Ph: (518) 873-6371

Board of Education
HEATHER REYNOLDS, PRESIDENT
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MICAH STEWART
JANA ATWELL, DISTRICT CLERK
SHARLENE PETRO-DURGAN, DISTRICT TREASURER

BEE STING ALLERGY FORM

Student Name: _____ Date: _____

- My child is allergic to stings by (Please check those that are applicable)
  - ☐ Bees
  - ☐ Yellow Jackets
  - ☐ Hornets/Wasps

- My child is allergic but has a local reaction ONLY (at the site of a sting) and requires treatment as follows:

  _____

  _____

- My child is SEVERELY allergic to stings and requires treatment as follows:

  _____

  _____

_____ _____

Parent/Guardian Signature Date

PLEASE NOTE: If your child requires medication of any kind, the School Nurse must have:

1. Written parental permission to administer specified medication
2. Doctor's written authorization to give specified medication.
3. Medication in its ORIGINAL bottle or package with the prescription attached.

BOQUET VALLEY
CENTRAL SCHOOL DISTRICT

PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL & SCHOOL ACTIVITIES

A. To be completed by the Parent or Guardian:

I request that my child _____ (date of birth_____) receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of an absence, will administer the medication.

Signature (Parents/Guardian): _____Date:_____

Telephone: Home:_____Work:_____Cell:_____

B. To be completed by the Private Healthcare Provider:

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ D.O.B_____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible side effects and adverse reactions (if any): _____

Healthcare Providers Signature: _____Date: _____

Address: _____Phone: _____

**Medications must be in the original pharmacy labeled container with specific orders and name of medication.*

**Medication and refills must be brought to school by parent or guardian.*

This medication order is valid through the school year and summer school if necessary.