Niagara Falls City School District
Niagara Falls, New York

Prekindergarten Program Information and Overview

The Niagara Falls City School District will offer a free program for all 3 and 4 year old children living in the City of Niagara Falls in September 2021. Classes will be offered at; Cataract Elementary, Hyde Park Elementary, Kalfas Magnet, Maple Avenue Elementary, G.J. Mann Elementary, Niagara Street Elementary, and 79th Street Schools.

Important Facts About the Pre-K Program
TRANSPORTATION IS NOT PROVIDED

- Children who have turned **3 or 4 years of age, on or before December 1, 2021** are strongly encouraged to attend.
- A lottery will be conducted when there are more applications than seats at a particular school.
- Children will receive breakfast, lunch, and a fruit snack daily.
- Classes meet Monday, Wednesday, Thursday and Friday 8:45 a.m. to 3:00 p.m. Tuesday's schedule is 8:45 a.m. – 2:00 p.m.
- The program will include family events and informational parent workshops.

Application Process

- Parents wishing to have their child attend this valuable program must complete and return the full registration packet to:

Niagara Falls Board of Education
Pre-K Program
630 66th Street
Niagara Falls, New York 14304

- Applications must be received by **June 11, 2021.**
- Placement letters are mailed in **July 2021.**

Pre-Kindergarten Registration Process

The following steps are required of all families wishing to enroll their child in a Pre-K 3 OR a Pre-K 4 classroom. The same steps are followed for new students in both Pre-K 3 and Pre-K 4.

Children who have completed the District's Pre-K 3 program will automatically be registered into the District's Pre-K 4 program.

1. New families must complete and return the full Pre-K Registration Packet. Registration packets are available at the following locations:

- All District schools including Prep and High School levels
- The Niagara Falls City School District Administration Building - 630 66th Street - Door 2 - Registration Office
- The District's website
- Niagara Falls Public Library

The Pre-K registration packet must include the documents listed below. Please note that all required medical records are mandated by New York State Education Laws, as well as Public Health Laws.

- The District Pre-Kindergarten Application
- A current copy of the child's Immunization Record (a list of the required immunizations is included in the packet)
- A current copy of the child's Physical Exam
- Social History of the child
- Health History of the child
- Parent Photo Identification
- Home Language Questionnaire
- Copy of the child's Birth Certificate
- Proof of residency (a copy of a utility bill with the parents name/address on it, social services information, lease/deed)

2. Once all documents have been completed in their entirety, the full Pre-K registration packet must be returned to the District Registration Office - 630 66th Street - Door 2.

3. All paperwork will be processed and sent to the child's school.

4. Families will receive detailed information regarding start dates, screening dates and orientation opportunities from the school Principal or child's Teacher.

Please Note children will not be registered until the full, completed packet has been returned to the Registration Office.

Niagara Falls City School District
Universal Prekindergarten Application
2021 – 2022

IF YOUR CHILD CURRENTLY ATTENDS THE DISTRICT'S PRE K-3 PROGRAM, YOU DO NOT NEED TO COMPLETE THIS APPLICATION.

Child's Name: _____

Program Level (circle one) Pre-K 3 – All Students Pre-K 4 New to District Students Only

Parent's Name: _____

Address: _____ Niagara Falls, NY Zip _____

Cell Phone Mother: _____ Cell Phone Father: _____

Child's Date of Birth: _____ Child's Gender: Male / Female (Circle One)

Language Spoken at Home: _____

Ethic Origin (circle one): Hispanic/Latino NOT Hispanic/Latino

Race (circle all that apply): Asian Black or African-American White
American Indian or Alaskan Native Hawaiian or Other Pacific Islander

Does Child receive Special Education services? _____

****NEW SCHOOL SELECTION PROCESS FOR 2021-2022****

As of September 2020, all families wishing to enroll their child in the District's Pre-K program will be required to participate in the District's Pre-K lottery when all seats have been filled at their desired school.. The lottery process is as follows:

1. Complete and return the full Pre-K Registration Packet no later than **June 11, 2021.**
2. Select your school(s) of choice in order of preference using "1" as the first choice. **Remember,** transportation is not provided for Pre-K students, it is imperative that you consider how your child will get to and from school, and where your other children currently attend school.
3. If all seats are filled at the 1st school of choice, the application will be moved to the 2nd choice etc.

TRANSPORTATION IS NOT PROVIDED

Please select your school(s) of choice in order of preference using "1" as your first choice:

_____ Cataract Elementary School, 6040 Lindbergh Avenue
_____ Hyde Park Elementary School, 1620 Hyde Park Blvd.
_____ Henry J. Kalfas Elementary School, 1800 Beech Avenue
_____ Geraldine J. Mann Elementary School, 1330 – 95th Street
_____ Maple Avenue Elementary School, 952 Maple Avenue
_____ Niagara Street Elementary School, 2513 Niagara Street
_____ 79th Street Elementary School, 551 – 79th Street

*****For Office Use Only*****

Received by _____ *Dated Received* _____

NIAGARA FALLS CITY SCHOOL DISTRICT
STUDENT REGISTRATION FORM

Rev. 9/29/10

FOR OFFICE USE ONLY Roll Call/Homeroom # _____

Date of Entry _____ Student ID Number _____ Teacher _____

Child's
Legal Name _____
Last Name *First Name* *Middle Name*

Home Address _____ Apt. # _____ Zip _____

☐ Female ☐ Male Date of Birth _____ Grade _____

Year started 9th grade _____

Special Education _____ Yes _____ No 504 Plan _____ Yes _____ No
(If Yes, refer to PSA)

U.S. Citizen _____ Yes _____ No (If no, citizen of what country?) _____

ESL: _____ Yes _____ No (If yes, what is Native Language: _____)

Parent E-Mail address for school contact _____

Ethnicity (Check One)	Race (Check one or more, regardless of Ethnicity)
☐ Hispanic/Latino	☐ American Indian or Alaska Native ☐ White
☐ Non-Hispanic/Latino	☐ Black or African American ☐ Asian
	☐ Native Hawaiian or Other Pacific Islander

Previously registered in the Niagara Falls School System? ☐ Yes ☐ No

Last School Attended _____ Date Left _____ Grade(s) Repeated _____

Address of Last School _____
(If NOT in Niagara Falls) Street City/State Zip

Phone Number of Last School _____ Fax Number _____

Student resides with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other Legal/Custody Papers? Yes ___ No ___

If Other: Name and Relationship _____

Mother's Name (if applicable) _____ Home Phone _____

Address (if different from student) _____ Cell Phone _____

Place of employment _____ Work Phone _____

Father's Name (if applicable) _____ Home Phone _____

Address (if different from student) _____ Cell Phone _____

Place of employment _____ Work Phone _____

Student's Guardian's Name _____ Home Phone _____

Guardian's Address _____ Cell Phone _____

Place of Employment _____ Work Phone _____

(OVER)

Niagara Falls City School District Student Residency Questionnaire

Name of LEA: School District of the City of Niagara Falls, New York

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____ (Month Day Year) Grade: ____ (preschool-12) ID#: _____ (optional)

Address: _____ Phone: _____

Where is the student currently living? (*Please check one box.*)

- ☐ In permanent housing
- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____

_____ _____

Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

Date _____

NOTE: The answer you give will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services. After the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

Please send a copy of this form to Eileen Burkett at Central Office (Fax Number 286-4123)

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

Lissette Colón-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:

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

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Cuestionario de Idioma del Hogar ("HLQ" por sus siglas en inglés)

Estimados padres o tutores:
Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura, escritura y comprensión en el inglés, así como conocer su educación previa e historial personal. Por favor, llene con su información las secciones "Conocimientos de idiomas" e "Historial educativo". Apreciamos mucho su colaboración respondiendo a estas preguntas.
Gracias.

Por favor escriba con claridad al completar esta sección.

NOMBRE DEL ESTUDIANTE:

Nombre *Segundo nombre* *Apellido*

FECHA DE NACIMIENTO:

Mes *Día* *Año*

GÉNERO:
❑ Masculino
❑ Femenino

INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL

Apellido *Primer Nombre* *Relación con el estudiante*

CÓDIGO DEL IDIOMA DEL HOGAR

Conocimientos de idiomas
(Por favor, marque todas las opciones que sean aplicables)

1. ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante?	❑ Inglés	❑ Otro _____ *especifique*	
2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?	❑ Inglés	❑ Otro _____ *especifique*	
3. ¿Cuál es el idioma primario de cada padre / tutor?	❑ Madre _____ *especifique*	❑ Padre _____ *especifique*	❑ Tutor(es) _____ *especifique*
4. ¿Qué idioma o idiomas entiende su hijo(a)?	❑ Inglés	❑ Otro _____ *especifique*	
5. ¿Qué idioma o idiomas habla su hijo(a)?	❑ Inglés	❑ Otro _____ *especifique*	❑ No sabe hablar
6. ¿Qué idioma o idiomas lee su hijo(a)?	❑ Inglés	❑ Otro _____ *especifique*	❑ No sabe leer
7. ¿Qué idioma o idiomas escribe su hijo(a)?	❑ Inglés	❑ Otro _____ *especifique*	❑ No sabe escribir

TO BE COMPLETED BY THE DISTRICT IN WHICH THE STUDENT IS REGISTERED

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

PARA LLENAR POR EL DISTRITO EN EL QUE EL ESTUDIANTE SE HA INSCRITO

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

Angelica Infante-Green, 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
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Home Language Questionnaire (HLQ) گھریلو زبان کے بارے میں سوالنامہ (ایچ ایل کیو)

عزیزی والدین یا سرپرست
آپ کے لڑکے/ لڑکی کو ممکنہ بہترین تعلیم دینے کے لیے ہمیں یہ تعین کرنے کی ضرورت ہے کہ وہ کتنی اچھی طرح سے انگلش سمجھتا / سمجھتی ، بولتا/ بولتی اور لکھتا /لکھتی ہے اور پہلی سکول بسٹری کیا ہے۔ مہربانی کر کے نیچے کی سیکشن زبان کا پس منظر اورتعلیمی بسٹری کو مکمل کریں۔ ان سوالات کے جوابات دینے میں آپ کی مدد قابلِ ستائش ہے۔
آپ کا شکریہ

آپ جب یہ حصہ مکمل کررہے ہوں تو مہربانی فرما کر صاف صاف لکھیں

طالب علم کا نام

نام کا آخری حصہ | نام کا درمیان والا حصہ | نام کا پہلا حصہ

جنس | تاریخ پیدائش
☐ مرد
☐ عورت
سال | دن | ماہ

والدین / والدین جیسے رشتہ دار کے بارے میں معلومات

نام کا آخری حصہ | نام کا پہلا حصہ | طالب علم کے ساتھ تعلق

گھریلو زبان کا کوڈ

زبان کا پس منظر
(ہر ایک کے ہر متعلقہ سوال کا جواب دیں)

1. طالب علم کے گھر / رہائش میں کون سی زبان / زبانیں بولی جاتی ہیں؟ ☐ انگلش ☐ دوسری _____ وضاحت کریں
2. وہ پہلی زبان کونسی تھی جو آپ کے بچے نے سیکھی تھی؟ ☐ دوسری ☐ دوسری _____ وضاحت کریں
3. دونوں والد اور والدہ کی گھریلو زبان کون سی ہے؟ ☐ باپ _____ وضاحت کریں ☐ ماں _____ وضاحت کریں ☐ سرپرست _____ وضاحت کریں
4. آپ کا بچہ کونسی زبان / زبانیں سمجھتا ہے؟ ☐ دوسری ☐ دوسری _____ وضاحت کریں
5. آپ کو بچہ کون سی زبان / زبانیں بولتا ہے؟ ☐ دوسری ☐ دوسری _____ وضاحت کریں ☐ نہیں بولتا
6. آپ کا بچہ کون سی زبان / زبانیں پڑھتا ہے ؟ ☐ دوسری ☐ دوسری _____ وضاحت کریں ☐ نہیں پڑھتا
7. آپ کا بچہ کون سی زبان / زبانیں لکھتا ہے؟ ☐ دوسری ☐ دوسری _____ وضاحت کریں ☐ نہیں لکھتا

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*	

City School District Of the City Of Niagara Falls
Consolidated Permission Form for Releasing Information to the US Military,
Using District Computer Systems, Online Art Gallery and Media Release and Publication on-line.

Put your initials in the appropriate box, Yes I give my permission or No I do not give my permission.

Student Name _____ Student ID Number _____

School _____ Class/Homeroom Teacher _____

☐ Yes ☐ No

Release of Information to the US Military (Grades 11 and 12 only)
The No Child Left Behind Law of 2002 requires high schools to release the name, address, and phone number of any 11th or 12th grade student to the United States Military. In order to receive federal funding, the City School District Of the City Of Niagara Falls must comply with this mandate unless parents provide written notification via this form that they do not want this information released.

☐ Yes ☐ No

Computer Acceptable Use (all grades)
Parents and guardians can obtain a copy of the District's Acceptable Use Policy by visiting any school or www.nfschools.net. All student computer use must comply with this policy. Internet Safety is part of the State curriculum and learning to use technology responsibly is an important part of education. Unless a parent provides written notification via this form, students will have access to the District's computer system in accordance with the Districts AUP.

☐ Yes ☐ No

Online Art Gallery (all grades)
I give permission to the City School District Of the City Of Niagara Falls to share my child's artwork along with his/her first name on the Online Art Gallery on the School District's Website, www.nfschools.net

☐ Yes ☐ No

Photographs ,Videos, Interviews District Website Release (all grades)
I give my permission to City School District Of the City Of Niagara Falls that photographs, and/or video tapes and/or interviews of my child may be taken and used by the District only for public relations, educational, or other purposes consistent with the purposes and mission of the District, including use of any photograph and/or image and/or interview on the District Website or other District electronic resources such as social media. I understand that my permission allows the District to use my child's first and last name for public relations and educational purposes. I further agree that said materials will become the property of the District and I hereby release and discharge the District and it representatives from any
and all claims that may result by reason of taking of such photographs and/or videotapes and/or interviews.

Niagara Falls City School District
Department of Health Services

Pre-Kindergarten Packet

Dear Parent or Guardians:

You have filled out an application for your child to attend a Pre-kindergarten in September. We would like your child to have a positive, successful and exciting school experience. In order for this to happen without difficulty for your child, certain regulations of New York State Education Laws and Public Health Laws must be fulfilled. **You must supply us with the following information when you register your child for school.**

1. **Immunization Record** for your child – Vaccine updates are necessary for Kindergarten attendance/entrance. See School Nurse for ***Immunization requirements for school Entrance/attendance. (I-1a).*** **Failure to satisfy these requirements may result in exclusion from school.**

2. **Physical Examination (if your child is a new entrant) (F-16a)** - this must be completed and signed by a licensed health care provider. Any physical completed within the last 12 months will be valid. If your child enters kindergarten after the school year has begun, check with the school nurse for acceptable dates for the physical examination.

3. **Pre-Kindergarten Social History (F-12a) and Health History Form for Students (F-8)** – completed and signed by parents/guardians in order to help us understand your child and provide the safest education plan.

4. **Dental Health Certificates** – a report of a comprehensive dental examination, signed by a licensed dentist, will be requested for all public-school students entering for the first time and students in grades 2, 4, 7 & 10. This law became effective September 1, 2008.

IMPORTANT THINGS TO REMEMBER

1. The Niagara County Health Department provides immunizations by appointment only. Call **278-1903** for an appointment.

2. In order for your child to attend a kindergarten program in New York State he or she must be three or four years old on or before December 1.

If you have any questions, please contact your school nurse.

_____ _____ _____

School School Nurse Telephone

Sincerely,
School Health Services

Blue F – 11 K 4/17

4455 Porter Road, Niagara Falls, NY 14305

Niagara Falls City School District
Department of Health Services

PRE-K & K SOCIAL HISTORY

Child's Name_____ Date of Birth_____
School Entering_____ Today's Date_____
Brothers/Sisters_____ Date of Birth_____
_____ Date of Birth_____
_____ Date of Birth_____
(USE BACK IF NECESSARY)

PLEASE ANSWER **YES OR NO** TO ALL QUESTIONS. THIS WILL HELP US BETTER UNDERSTAND THE HEALTH NEEDS OF YOUR CHILD.

Birth Information	Yes	No
Did you have:		
Premature birth	___	___
Cesarean delivery___	___	
Any newborn problems	___	___
Any problems the First year	___	___
Normal pregnancy	___	___
Full term pregnancy	___	___
Normal delivery	___	___
Birth Weight _____		
Breast fed	___	___
How long?_____		
Comments:_____		
_____		
_____		

Growth and Development/Skills		
Any problems with:		
Feeding	___	___
Crawling	___	___
Walking	___	___
Talking	___	___
Hopping	___	___
Counting numbers	___	___
Naming colors	___	___
Dressing self	___	___
Eating	___	___
Muscle coordination	___	___
Speech	___	___
Did your child attend		
Preschool	___	___
Head start	___	___
Day Care	___	___
Name_____		
Comments_____		
_____		

Behavior Development	Yes	No
Would you say your child:		
is friendly		___ ___
is secure	___	___
is talkative		___ ___
is shy	___	___
is helpful		___ ___
is cooperative		___ ___
listens well		___ ___
follows directions well		___ ___
adjusts well to new situations		___ ___
has stayed overnight away from mother		___ ___
is eager to start school		___ ___
separates easily from family		___ ___
plays well with other children		___ ___
plays well alone		___ ___
relates well to other adults	___	___
has temper tantrums	___	___
is disobedient		___ ___
talks back		___ ___
is destructive		___ ___
has nightmares	___	___
has fears	___	___
is jealous		___ ___
sucks thumb		___ ___
has uncontrolled bowel movements		___ ___
constipation		___ ___
wetting		___ ___
wets the bed		___ ___
has had any unusual or unexpected stresses		___ ___
does your child have any habits that concern you	___	___

Do you have any concerns as a parent?_____
Comments_____
_____

_____
Signature

F-12a 1/00

4455 Porter Road, Niagara Falls, NY 14305
Phone (716) 286-0787 Fax (716) 286-0788

NIAGARA FALLS CITY SCHOOL DISTRICT
HEALTH SERVICES

Health and Dental Examination Requirements

Dear Parents/Guardians, Date:

New York State law requires a health examination for all students **entering the school district for the first time and when entering Pre-K or K, 1st, 3rd, 5th, 7th, 9th and 11th grade.** Any physical examination completed on or after September 7, 2019, will be accepted if signed by a New York State licensed physician, physician assistant or nurse practitioner, and on the approved NYSED Student Health Examination form attached. **New York State Education Law, Section 903, was amended to read "Each Health Certificate shall also state student's body mass index (BMI) and weight status category... each school and school district shall participate in surveys directed by the commissioner of health pursuant to the public health law..." The Niagara Falls School District may be selected to report student weight status category information. PARENTS OR GUARDIANS MAY NOTIFY THE SCHOOL NURSE IN YOUR CHILD'S SCHOOL IF YOU WISH TO HAVE YOUR CHILD'S BMI AND WEIGHT STATUS CATEGORY EXCLUDED IN THIS ANONYMOUS SURVEY.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time. The school will provide you with a list of dentists and registered dental hygienists who offer dental services on a free or reduced cost basis if you ask for it.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts Pre-K or K, 1st ,3rd, 5th, 7th, 9th & 11th grades. If a copy is not given to the school within 30 days, the school will contact you.
- If you are unable to obtain a physical exam from your child's health care provider (HCP) a health appraisal will be completed at school, by the District Medical Director/Nurse Practitioner. In order for the physical appraisal to be thorough and of real value to the student, it will be necessary for the student to remove some clothing. Modesty will be maintained. You may also be present at the examination by notifying your child's school nurse or the district medical directors office at 286-0787.
- If your child has an appointment for an exam during this school year with their HCP that is after the first 30 days of school, please fill out the attached form to notify the School Nurse.
- For your convenience, a physical exam form and dental certificate for your health care providers is enclosed.
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing the attached consent form for the school at the time of your child's appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office. Forms may also be faxed to your child's school nurse.

Sincerely,

Dr. Jo Silvaroli DNP, FNP
School Medical Director/Nurse Practitioner

NIAGARA FALLS CITY SCHOOL DISTRICT

HEALTH SERVICES

Parent Notification/Request for Mandated Health Appraisal

Dear Parent(s) or Guardian(s):

New York State law requires that each child in a school district have a health examination including body mass index before entering school for the first time, and again in grades 1, 3, 5, 7, 9, 11. Students wishing to play interscholastic sports or requesting work permits must have an annual health exam. A dental exam form is also requested but not required at these same times.

Your own health care provider is always the best choice for these exams especially for Pre-K and Kindergarten. We encourage you to call early as it may take several weeks to schedule exams during the busy summer and fall months.

We have included a form for your health care provider to complete. We can accept any exam form dated before *September 2020.* You or your provider may return the completed form to the school health office.

If you do not provide an exam form by *November 2021,* an exam will be scheduled with our school medical director. While most parents choose not to attend, you may do so if you wish. Please let your child know they will be examined at school. In order that the physical examinations completed by the District Medical Director/Nurse Practitioner be thorough and of real value to the student, it will be necessary for the student to remove some clothing. Modesty will be maintained

Upon completion of in-school exams, you will be informed of any important findings and need to follow up with your health care provider.

Please Complete and Return the Bottom Portion to Your Building Health Office Today

✂

Student's Name _____ **Grade** _____

Student's School _____

☐ My child had a health exam on _____. I will return the completed form by the date above.

☐ My child has an appointment to have a physical with his/her health care provider on _____. My child's MD/NP/PA or I will return the form by the date above.

☐ I need information on obtaining health insurance or finding a health care provider.

☐ Schedule the district physician/nurse practitioner to complete the exam for my child.

Parent Name _____ Date _____

Parent's Signature _____

Parent Phone Contact ( ) _____

This document is available on the NYS Center for School Health Website @ www.schoolhealthny.com

(1/10/20)

NIAGARA FALLS SCHOOL DISTRICT STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	☐	☐	
Been tested positive, had Symptoms or Diagnosed with COVID 19	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	See back section to give details
Had an operation	☐	☐	See back section to give details
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Dental Injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
- ☐ Scoliosis
- ☐ Single Organ (☐kidney, ☐testicle)
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Urinary Condition

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?
☐ No ☐ Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

_____

Niagara Falls City School District

Health Services

To Be Completed by Parent/Guardian

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your healthcare provider will require this release of information form to share Protected Medical Information with the school district. Please sign and give the form to your healthcare provider and/or your school nurse to avoid delays.

I _____ hereby grant permission for the medical staff of the Niagara Falls City School District to obtain medical information from my child _____ health care providers listed below, pertaining to the health and wellbeing of my child for the _____ School Year. 1. _____ HCP
2. _____ Specialist 3. _____ Specialist.

_____ _____ _____

Parent/Guardian Signature Parent/guardian printed name Date

The healthcare provider may disclose the following protected health information.

☐ Immunizations
☐ Health Appraisals (Physical Exam)
☐ Past/Current Medical conditions that may affect Attendance, School Programming, and/or PT, OT, ST needs
☐ Other_____

The Protected Health Information may be used, disclosed or received for the following purpose(s).

☐ To develop care or therapy plans for routine and emergent school management
☐ To design appropriate educational programs
☐ To assess the impact of the medical condition(s) on school programming and/or attendance
☐ To share school observations/concerns surrounding behavior
☐ To assess a medical basis for modification of transportation and/or home tutoring
☐ Medication delivery and/or therapy prescriptions for PT, OT, ST
☐ At patient's request with no specified purpose
☐ Other _____

Please select one:

☐ This authorization is valid for the entire academic school year 20___ - 20___
☐ This authorization shall expire on ___/___/___ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building.

I understand that the revocation of this authorization is not valid if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice.

I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that my child's treatment is not dependent on my agreement to release or withhold information.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A signed copy of this authorization must be given to the adult patient or parent of the minor child.

NIAGARA FALLS CITY SCHOOL DISTRICT

HEALTH SERVICES

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER
NYSED REQUIRES A PHYSICAL EXAM FOR NEW ENTRANTS AND STUDENTS IN GRADES Pre-K or K, 1, 3, 5, 7, 9 & 11, AND AS REQUIRED FOR THE COMMITTEE ON SPECIAL EDUCATION

STUDENT INFORMATION

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

***PROVIDER IF AN AREA IS NOT ASSESSED INDICATE NOT DONE * PLEASE COMPLETE THE FORM TO ITS ENTIRETY**

HX OF POSITIVE COVID 19 DIAGNOSIS ☐NO ☐YES DATE OF DX _____

Allergies ☐ **No** ☐ **Yes, indicate type**	**Type:** ☐ **Medication/Treatment Order Attached** ☐ **Anaphylaxis Care Plan Attached**
Asthma ☐ **No** ☐ **Yes, indicate type**	☐ **Intermittent** ☐ **Persistent** ☐ **Other:** ☐ **Medication/Treatment Order Attached** ☐ **Asthma Care Plan Attached**
Seizure ☐ **No** ☐ **YES**	**Type:** _____ **Date of last seizure** _____ ☐**MEDICATION/TREATMENT ORDER ATTATCHED**
Diabetes ☐ **No** ☐ **Yes, indicate type**	**Type:** ☐ **1** ☐ **2** ☐ **Diabetes Medical Mgmt. Plan Attached** ☐**MEDICATION/TREATMENT ORDER ATTATCHED**

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:** ☐ **<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**
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL			

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **System Review and Abnormal Findings Listed Below**

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

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list) ICD-10 Code*

*Only for students with an IEP and receiving Medicaid

NIAGARA FALLS CITY SCHOOL DISTRICT

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: Name

Grade

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

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature _____ Date

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

I. The dental health condition of _____ on_____(date of assessment) The date of the assessment 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/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

II. 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.

(3/2018)