AUBURN ENLARGED CITY SCHOOL DISTRICT

Universal Pre-Kindergarten (3PK /UPK) and Kindergarten Programs for the 2025-26 School Year

TO BE ELIGIBLE YOUR CHILD MUST:

A. Be a RESIDENT of the Auburn Enlarged City School District (AECSD)

Meet the **AGE REQUIREMENT.** On or before **December 1st** my child will be

- **3 years of age** for participation in our 3PK program
- **4 years of age** for participation in our UPK program
- **5 years of age** for enrollment in Kindergarten

B. We **CANNOT ACCEPT** your child's completed application without this supporting documentation:

1. ___ **Proof of Residence** in the AECSD - must submit **one** of the following:
   - * **Lease** or **Deed** – dated and signed
   - * **Mortgage Statement** or **Tax Bill**
   - * **Utility** or **Cable Bill**
   - * **NYS Driver's License, Learner's Permit** or **Non-Driver Identification**
   - * **Furniture Rental Receipt**
   - * **Pay Stub** dated within the last two weeks showing address
   - * **Auto Insurance Card** with address
   - * **Social Security Statement, DSS Documentation or other documents issued by Federal, State or Local Government Agencies**
   - * **Court Orders or Court Issued Documents**
   - * **Notarized Landlord Statement**
2. ___ Copy of child's **Birth Certificate**
3. ___ **Custody papers**, if applicable
4. ___ **Special Education records**, if applicable

C. Must complete the **Medical Packet** and provide:

5. ___ **Immunization Record** (signed by a physician/clinical staff *or* NYSIS print out). Baby books are not acceptable proof!
6. ___ **Physical Exam** (dated within one year of scheduled school start date)
7. ___ Proof of **Lead Screening**
8. ___ Proof of **Dental Screening**

D. Parents/guardians can **register their child online** and upload the supporting documentation to the appropriate link which can be found on the district website:

AECSD.education *under* Student Registration

OR complete the **Enrollment, Registration and Health forms** and then submit these forms along with the **required supporting documentation** to the AECSD by:

Mail or **Drop off** to Mary White, Registrar, AECSD, 78 Thornton Avenue, Auburn, N.Y. 13021

Fax to Mary White, Registrar at (315) 282-2830 or **E-mail** marywhite@aecsd.education

SELECTION CRITERIA: This program is open to all children who turn three years old (3PK) or four years old (UPK) on or before **December 1st,** and who live in the Auburn School District. If we receive more applications than we have slots available prior to the application cutoff date, children will be randomly selected. Site placement will be determined on the basis of daycare, financial income, and parental choice.

INELIGIBILITY: A child is ineligible for this program if he/she is enrolled in another pre-kindergarten program that is supported by public funds, such as a preschool special education program. Students who are unable to attend Pre-Kindergarten 5 days per week, 2 ½ hours per day (half-day program) or 5 hours per day (full-day program), for the entire school year are also ineligible.

The Pre-Kindergarten program will be held at the locations listed below. Due to limited space, AECSD **CANNOT Guarantee your choice**, but will make every effort to accommodate families' preferences. In the event that the district receives more applications than available spots, students will be randomly placed where there are openings. Students currently enrolled in a program will be allowed to continue at their current site, if desired.

Please indicate two site preferences. You will be notified of placement **via email** on or around June 15th.

3-YEAR-OLD Program

Full-Day Options

___ Cayuga Community College
___ Cayuga-Onondaga BOCES
___ Cayuga-Seneca Community Action Agency (CSCAA)
___ Early Childhood Center
___ E. John Gavras Center
___ Montessori School of the Finger Lakes
___ YMCA

4-YEAR-OLD Program

Full-Day Options

___ Cayuga Community College
___ Cayuga-Onondaga BOCES
___ Cayuga-Seneca Community Action Agency (CSCAA)
___ Early Childhood Center
___ E. John Gavras Center
___ Montessori School of the Finger Lakes
___ YMCA

Applications are accepted starting February 1st, spots are limited. No applications will be accepted without the required documentation. Please contact MaryWhite 315-255-8825 or Michelle Kolceski 315-255-8613 with any questions.

For Office Use Only

Student Last Name: _____

Student First Name: _____

3PK UPK

AUBURN ENLARGED CITY SCHOOL DISTRICT

Universal Pre-Kindergarten and Kindergarten Enrollment Form

Form 1 of 2

CHILD MUST BE A PERMANENT RESIDENT OF THE AUBURN ENLARGED CITY SCHOOL DISTRICT

For Office Use Only

I. STUDENT INFORMATION (For Student Being Enrolled)

Grade (circle one): 3 PK 4 UPK K

Last Name: _____ First Name: _____ Middle Name: _____ Suffix: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Proof of Birth submitted with application: _____

Address (must be street address): _____ Apt, Bldg., Other: _____

City, State, Zip Code: _____ Telephone No. _____

In which elementary school attendance area does this child reside?

☐ Casey Park ☐ Genesee ☐ Herman ☐ Owasco ☐ Seward

II. FAMILY INFORMATION

PARENT/LEGAL GUARDIAN

Name: _____
First Middle Last

Relationship (to child): _____

Address (must be street address):

_____

Apt., Bldg., Other: _____

City: _____ State: _____ Zip: _____

Home Phone:( ) _____ Cell:( ) _____

Employer: _____

Work Phone: ( ) _____

Email Address: _____

Authorized to Pick Up: ☐ Yes ☐ No

PARENT/LEGAL GUARDIAN

Name: _____
First Middle Last

Relationship (to child): _____

Address (must be street address):

_____

Apt., Bldg., Other: _____

City: _____ State: _____ Zip: _____

Home Phone:( ) _____ Cell:( ) _____

Employer: _____

Work Phone: ( ) _____

Email Address: _____

Authorized to Pick Up: ☐ Yes ☐ No

EMERGENCY CONTACT 1

(List a person who will assume temporary care if parent/legal guardian is not reachable)

Name: _____
First Middle Last

Relationship (to child): _____

Address (must be street address):

_____

Apt., Bldg., Other: _____

City: _____ State: _____ Zip: _____

Home Phone:( ) _____ Cell:( ) _____

Employer: _____

Work Phone: ( ) _____

Email Address: _____

Authorized to Pick Up: ☐ Yes ☐ No

EMERGENCY CONTACT 2

(List a person who will assume temporary care if parent/legal guardian is not reachable)

Name: _____
First Middle Last

Relationship (to child): _____

Address (must be street address):

_____

Apt., Bldg., Other: _____

City: _____ State: _____ Zip: _____

Home Phone:( ) _____ Cell:( ) _____

Employer: _____

Work Phone: ( ) _____

Email Address: _____

Authorized to Pick Up: ☐ Yes ☐ No

PLEASE NOTIFY THE SCHOOL DISTRICT OF ANY CHANGES AS THEY OCCUR. THANK YOU!

III. OTHER FAMILY INFORMATION

LIST ALL FAMILY MEMBERS LIVING IN THE CHILD'S HOME, INCLUDING ANY CHILDREN NOT YET OLD ENOUGH TO ATTEND SCHOOL:

Name	M/F	DOB	AGE	Relationship to Child

HOUSEHOLD TYPE: (Please check the choice that best describes the household situation)

☐ Single Parent/Female (F) ☐ Single Parent/Male (M) ☐ Two Parent Household (T)
☐ Foster Parent (E) ☐ Teen Parent (17 years old or younger) (TP)
☐ Other, please specify: _____

IV. GENERAL PERMISSIONS

☐ Yes ☐ No My son/daughter is permitted to attend all field trips, provided I am informed about them in advance.
☐ Yes ☐ No My son/daughter may be pictured in the school newsletter, school brochures, newspaper articles, videos, web etc

V. ADDITIONAL ENROLLMENT INFORMATION

Do you suspect your child has an educational disability or learning problem? ☐ Yes ☐ No
If yes please explain _____ *or*
Has a Committee of Special Education (CSE) identified the student with an educational disability? ☐ Yes ☐ No
If yes, please explain _____
Does the student have a 504 Plan? ☐ Yes ☐ No
If yes, please explain _____
Is your child enrolled in the Dolly Parton Imagination Library? ☐ Yes ☐ No
If yes, please circle years enrolled: 1 2 3 4

VI. ACADEMIC HISTORY

The questions below also refer to Pre-School experience. Please include Pre-School and childcare programs.

Has the child ever attended an Auburn School? ☐ Yes ☐ No
If yes, which school(s) and in what grade(s)? School: _____ Grade: _____
Date(s) attended: _____
Name of last school child attended: _____ Name of School District: _____
School Address and Telephone: _____
Date(s) last attended: _____ Present Grade: _____
Note: It is no longer necessary to obtain written consent from parents/guardians to request records from other schools.

★ **I attest that the information completed by me on pages 1 – 2 of this enrollment form is current, true and accurate.**

_____ _____
Signature of Parent/Guardian **Date**

CONFIDENTIALITY PROCEDURES AND REGULATIONS – *This form will be filed in the student's permanent record as confidential information. The information which has been provided on this form is protected by the Confidentiality Regulations cited below: "The family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number."*

AUBURN ENLARGED CITY SCHOOL DISTRICT

Universal Pre-Kindergarten and Kindergarten Registration Form

Form 2 of 2

For office use only

CHILD MUST BE A PERMANENT RESIDENT OF THE AUBURN ENLARGED CITY SCHOOL DISTRICT

I. STUDENT INFORMATION (For Student Being Registered)

Last Name: _____ First Name: _____ Middle Name: _____ Suffix: _____

Sex: ☐ Male ☐ Female Date of Birth: _____

II. STUDENT RACIAL AND ETHNIC IDENTIFICATION

Directions for Parent/Guardian:

The Auburn Enlarged City School District has adopted a procedure, which requires the collection and recording of the ethnic identity of students in the district in accordance with the Federal categories, and definitions the information will be used to:

- Report information to the State and Federal Education Departments
- Plan educational programs and make sure that they are readily available to all students
- Analyze differences in academic performance, attendance, and completion of school

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions listed below. Put a check in the box for the category, or categories, which best describe your child. We understand the sensitive nature of this information and wish to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

Directions for Parent/Guardian: Please answer questions (1) and (2). Please read them before you respond. For question (1), check the box that best describes your child.

(1) Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

☐ YES, Hispanic ☐ NO, not Hispanic

(2) Select one or more races from the following five racial groups. For question (2) check all groups that apply to your child; check at least one box.

☐ **American Indian or Alaskan Native**: A person having origins in any of the original peoples of North or South America (including Central America), and who maintain 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, the Philippine Islands, Thailand and Vietnam).

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

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

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

_____ _____ _____

Parent/Guardian Signature Relationship (to registering child) Date

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

III. STUDENT FOSTER CARE INFORMATION

Is the student in a foster care placement? ☐ Yes ☐ No

If yes, continue below. If no, move on to section IV.

Foster Care

(Copy of DSS 2999 Form must be supplied at registration)

Case Worker (Name & Contact Information) _____ County _____

Date of Placement _____ School District of Residence at Time of Foster Care Placement _____

IV. STUDENT HOMELESS INFORMATION

The answer you give below will help the district determine what services 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 certificates. Students who are protected under the **McKinney-Vento Act** may also be entitled to free transportation and other services.

☐ 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 shelter ☐ In a car, park, bus, train, or campsite

☐ In a motel/hotel

☐ Temporary living situation (please describe): _____

☐ In permanent housing

Print name of Parent/Guardian, or _____ Signature of Parent/Guardian, or _____

Student (for unaccompanied homeless youth) Student (for unaccompanied homeless youth)

PLEASE NOTE: If ANY box other than "In Permanent Housing" is checked, then the student/family should be immediately referred to the MV Liaison. In such cases, proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. 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.

V. HOME LANGUAGE QUESTIONNAIRE

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 English. Your assistance in answering these questions is greatly appreciated.

1. What language(s) is spoken in the student's home or residence? _____
2. What language(s) are spoken in most the time to the student in the home? _____
3. What language(s) does the student understand? _____
4. What language(s) does the student speak? _____
5. What language(s) does the student read? _____
6. What language(s) does the student write? _____
7. In your opinion, how well does the student: understand, speak, read and write English?

Understands English:	Very well _____	Only a little _____	Not at all _____	
Speaks English:	Very well _____	Only a little _____	Not at all _____	
Reads English:	Very well _____	Only a little _____	Not at all _____	UPK Student _____
Writes English:	Very well _____	Only a little _____	Not at all _____	UPK Student _____

★ **I attest that the information completed by me on pages 1 – 2 of this registration form is current, true and accurate.**

_____ _____

Signature of Parent/Guardian **Date**

***CONFIDENTIALITY PROCEDURES AND REGULATIONS** - This form will be filed in the student's permanent record as confidential information. The information which has been provided on this form is protected by the Confidentiality Regulations cited below: "The family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number."*

AUBURN ENLARGED CITY SCHOOL DISTRICT
Universal Pre-Kindergarten and Kindergarten MEDICAL PACKET

This packet contains the following forms:

For your information . . . .

* Letter to Parents/Guardians from AECSD Nursing Supervisor
* District Medication Policy

To be completed by Parent/Guardian . . . .

* Pre-Kindergarten and Kindergarten Registration Health Form
* Health Insurance Coverage Form
* HIPPA Form

To be completed by Physician and Dentist and submitted by Parent/Guardian . . .

* Health Appraisal Form (Physical Form)
* Dental Health Certificate

IF YOUR CHILD IS REGISTERING FOR **UNIVERSAL PRE-KINDERGARTEN (3PK / UPK)**

Please complete the forms referred to above, and along with the items listed below, return to the District with your completed Enrollment and Registration Forms or at least ***prior to the first day of classes***:

Physical Exam
Proof of Lead Screening
Proof of Dental Screening

IF YOUR CHILD IS REGISTERING FOR **KINDERGARTEN**

Upon receipt of your completed Enrollment and Registration Forms, you will be supplied with information regarding the next step of the registration process, which involves a visit to your child's new school. ***You must present your completed Medical Packet to Health Services staff for review at that visit.***

The Medical Packet includes: the forms referred to above, along with the items listed below:

Physical Exam
Proof of Lead Screening
Proof of Dental Screening

Auburn
Enlarged City School District

Harriet Tubman
Administration Building

Office of Health Services

Dear Parents/Guardians of Pre-Kindergarten and Kindergarten Students:

Welcome to the beginning of an exciting adventure – the start of your child's formal education! New York State Public Health Law, Section 2164 mandates that schools shall not permit a child to be admitted to school, unless the parent provides the school with a certificate of immunization or proof from a physician that their child has been immunized. Immunizations must be documented and signed by a health care provider or health department. Baby books are no longer accepted as proof of vaccination. All documentation must specify the exact date each immunization was administered. Your child will not be permitted to attend school without the necessary verification of immunizations.

Most Pre-Kindergarten students will require additional vaccinations prior to the start of Kindergarten. Please contact your health care provider to make these arrangements.

In addition to vaccinations, New York State Law also requires the parent/guardian of any child entering a Pre-Kindergarten/Kindergarten program to provide the school district with a report of a medical examination, signed by a licensed health care provider and submitted using the enclosed physical exam form (no other format will be accepted). This exam must be current and not done more than twelve months prior to the commencement of the school year. Proof of lead testing and a dental health certificate containing a report of a comprehensive dental examination are also required.

Thank you for your attention in this matter. Have a wonderful school year!

Sincerely,

Caren Radell, RN
Supervisor of Nursing and Health Services

Updated: 12/19/2018

78 Thornton Avenue • Auburn, New York 13021 • Telephone: (315) 255-8829 • Fax: (315) 255-8855

AUBURN ENLARGED CITY SCHOOL DISTRICT
School Health Services

To: Parent/Guardian

From: School Health Services

Re: Administration of Medication in School

The policy for students receiving medication in school is as follows:

1. **NO MEDICATION WILL BE GIVEN IN SCHOOL WITHOUT A WRITTEN PHYSICIAN'S ORDER.** This order must include the student's name, name of medication, dosage, time and dates to be given. The label on the medicine bottle is not sufficient.

2. **A WRITTEN REQUEST FROM THE PARENT FOR THE SCHOOL HEALTH OFFICE TO ADMINISTER THE MEDICATION MUST BE PROVIDED.**

3. Medicine arriving in school in unmarked containers, baggies, etc., will not be given. The medication must be in its original container.

4. The medication should be delivered to the school by the parent/guardian.

5. Do not send aspirin or other single dose medication to school with your child. These medications will not be administered without fulfillment of the requirements stated above. **This also includes cough drops.**

6. The medication will be kept in the school health office throughout the time it is to be administered.

7. Parents will be contacted to make arrangements to pick up discontinued or unused medication.

8. Medications must be picked up at the end of the year or they will be discarded.

9. New physician orders for medication administration are required for each school year.

If, at any time, you have questions or concerns regarding the administration of medication, or this procedure, please contact your school health office.

Thank you for your cooperation.

Updated 10/2009

AUBURN ENLARGED CITY SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
Pre-Kindergarten and Kindergarten Registration Health Form

Student Last Name: _____ **Student First Name:** _____

Date of Birth: _____ **Place of Birth:** _____

Sex: M____ F____ **Grade:** *(circle one)* **3PK UPK K** **School:** _____

Student Address: _____

In case of accident or illness, it is mandatory that you provide the following information for emergency calls:

Name	Last	First	Address	Home/Cell Phone	Work Name	Work Phone
Mother						
Father						
Step Parent						
Step Parent						

List TWO persons (relatives/babysitter/neighbor) who will assume temporary care of your child if you cannot be reached:

Name	Relationship	Address	Home/Cell Phone	Work Name	Work Phone

Physician Name: _____ **Dentist Name:** _____

MEDICAL HISTORY

Has child, or any immediate family member (Parents/Grandparents) had a history of:

Diabetes _____
Heart Disease _____
Seizures _____
Sickle Cell Trait _____
Sudden Cardiac Death _____

Has child had: (Provide dates)

RSV _____ Scarlet Fever _____
Chicken Pox _____ Rheumatic Fever _____
Pneumonia _____ Pertussis _____

Surgery _____ Serious Injury _____
Broken Bones _____ Head Injury _____
Loss of Consciousness _____

Does child have any problem with:

Constipation _____ Diarrhea _____ Bedwetting _____
Frequent Urination _____ Is your child potty trained _____

Does child contract frequent: (More than 4-5 per year)

Sore Throats/Strep Infections _____

Earaches/Ear Infections _____ Under care of Dr. _____

Tubes in ears _____ Date of insertion _____

Skin Rashes/Eczema _____

Headaches _____ Stomachaches _____

Does child have:

Asthma/Wheezing _____

Under care of Dr. _____ Medication _____

Allergies: *(circle all that apply)* Food Insect bites Medications Other

Describe allergens/reactions: _____

Has child ever been stung by a bee? Yes ____ No ____

If yes, describe reaction: _____

Heart Murmur _____ Under care of Dr. _____

Seizure Disorder _____ Under care of Dr. _____

Medication _____ Date of last seizure _____

Vision Problems _____

Under care of Dr. _____ Glasses: Yes ____ No ____

Last appointment _____

Hearing Problems _____

Under care of Dr. _____ Hearing aids: Yes ____ No ____

Last appointment _____

Are there any other medical problems or concerns that the school should be aware of: _____

_____

_____

Does child take any medication on a regular basis? _____

_____

In case I cannot be reached, I authorize the Auburn School District to render such treatment as may be necessary in an emergency for the health of my child. I give my permission to the school official in charge to obtain the services of the nearest ambulance, rescue service, family physician on record, or other physician if my own is not available, to provide immediate and necessary care. This form will be utilized for the current school year. The information will be shared with appropriate instructional staff, the transportation department, and Health Services. It will also be available on field trips and in the event of an emergency will be given to emergency personnel.

Date: _____ **Signature of Parent/Guardian X** _____

* If any of the above information changes during the course of the school year, please notify the School Nurse, as soon as possible. ***NYS Education Law requires school districts to have on file signed instructions for emergencies from parents/guardians.***

For Office Use Only

If Kindergarten Registrant, did parent/guardian provide:

Physical Exam ____ Date of Exam: _____

Dental Certificate ____ Date of Exam: _____

Immunizations ____ Up to date: _____

Reviewed by: (Nurse) _____

Date of Interview/Form Completion: _____

____ Release of Information signed

____ Renewed/Received Emergency Action Plan (date: ____)

____ Reviewed and Received Medication Policy and Order Sheet

____ Reviewed Immunizations, Physical and Dental requirements

Revised: 01/24/2017

RELEASE OF INFORMATION FORM TO ASSIST PARENTS IN OBTAINING HEALTH AND DENTAL INSURANCE COVERAGE FOR THEIR CHILDREN ATTENDING AUBURN ENLARGED CITY SCHOOL DISTRICT

The purpose of this release is to allow the Cayuga County Health and Human Services (CCHHS) Department, Auburn Enlarged City School District (AECSD), and the Booker T. Washington Center (BTW) to better assist you and your children to get and maintain health and dental coverage through the Public Insurance Program (Medicaid).

By signing this release you will be allowing CCHHS, AECSD, and BTW to share the confidential information listed below. This information may be further disclosed to the Cayuga County Health and Human Services Department and the local facilitated enrollers at BTW so they can also assist in ensuring your child(ren)'s uninterrupted coverage. A facilitated enroller is someone who can assist you to enroll in a health insurance plan or dental insurance coverage. **The information will only be shared to the extent that it is necessary or helpful to achieve this goal.**

The information disclosed will be limited to:

- My name and names of persons living in the household
- Dates of birth
- Address
- Phone number
- Gender
- Last four digits of Social Security Number for those applying for, or in receipt of Medicaid coverage
- Eligibility Status for Health and Dental Insurance, Temporary Assistance, Food Stamps, Day Care, HEAP Medicaid, including eligibility periods
- Status of School enrollment

Child's name: _____ SS# * _____ DOB _____ School _____
(last four digits)

Child's name: _____ SS# * _____ DOB _____ School _____
(last four digits)

Child's name: _____ SS# * _____ DOB _____ School _____
(last four digits)

My child(ren) currently has ***health*** insurance with _____
(name of insurance company)

My child(ren) currently has ***dental*** insurance with _____
(name of insurance company)

☐ My child(ren) have NO ***health*** insurance at this time. ☐ My child(ren) have NO ***dental*** insurance at this time.

RELEASE

I hereby give CCHHS, AECSD, and BTW permission to share the above information between themselves on my behalf. I also give permission for AECSD to share this information to CCHHS and BTW, only to the extent of helping me get or maintain health and dental coverage. I understand that any information released on my behalf may not be further disclosed without my express written permission.

I may revoke (cancel) this release at any time by writing to AECSD, Caren Radell, Nurse Supervisor, 78 Thornton Ave., Auburn, NY 13021. Such revocation will not affect any previous actions already taken.

_____ _____
(Signature of Parent/Guardian or Student over 18) *(Date)*

_____ _____
(printed name) *(relationship to student)*

_____ _____
(address) *(phone number)*

☐ I do not wish to participate in this insurance program.

*optional

New York State Department of Health
AIDS Institute

Authorization for Release of Health Information and Confidential HIV-Related Information*

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; or by special court order. Under New York State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of health and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, health information and/or HIV-related information can be given to the people listed on page two (and on additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your health information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☒ My non-HIV health information
- ☐ Both (non-HIV health and HIV-related information)

PLEASE FILL OUT THE HIGHLIGHTED FIELDS ON BOTH PAGES

Name and address of facility/person disclosing HIV-related information: (Doctor/Facility) _____

_____

Name of person whose information will be released: (Student) _____

Name and address of person signing this form (if other than above): (Parent/Guardian) _____

_____

Relationship to person whose information will be released: _____

Describe information to be released: Medical _____

Reason for release of information: School accommodations _____

Time Period During Which Release of Information is Authorized: From: _____ To: _____

Exceptions to the right to revoke consent, if any: _____

_____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences): _____

_____

Please sign below **only** if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.

Signature _____ Date _____

* This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.

Complete information for each facility/person to be given general information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general health and/or HIV-related information:

Auburn Enlarged City School District

78 Thornton Avenue, Auburn, New York 13021

Reason for release, if other than stated on page 1:

N/A

If information to be disclosed to this facility/person is limited, please specify:

N/A

Name and address of facility/person to be given general health and/or HIV-related information:

N/A

Reason for release, if other than stated on page 1:

N/A

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York City Commission on Human Rights at (212) 306-7500 or the NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release health and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

If legal representative, indicate relationship to subject:

Print Name _____

Client/Patient Number _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

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

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

BMI_____kg/m2

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

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

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

☐ **System Review Within Normal Limits**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list) ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	With Correction ☐Yes ☐ No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.

Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	**Not Done** ☐

Notes

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

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

☐ ***Family cardiac history reviewed** – required for Dominick Murray Sudden Cardiac Arrest Prevention Act

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

If Restrictions Apply – Complete the information below

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

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

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

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

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

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

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	IMMUNIZATIONS
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone:	Fax:

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

Auburn Enlarged City School District

ADMINISTRATIVE OFFICES
78 Thornton Avenue, Auburn, N.Y. 13021-4698

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

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

Child's Name: 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

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

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

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

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

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) Dentist's Signature

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

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

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

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least 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): _____

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.