GATES CHILI CENTRAL SCHOOL DISTRICT REGISTRATION FORM

Please PRINT all information and complete BOTH sides of this form

Student Name: ____________________________ Male ______ Female______

Address: ____________________________ Apt. # _____ Zip 146

Phone# ____________________________ Listed( ) Unlisted( ) Date of Birth ________ Age: ________

Parent/Guardian

☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. ☐Other

Name: ____________________________

☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. ☐Other

Name: ____________________________

Parent/Guardian

Name: ____________________________

Relationship to Student: ☐Mother ☐Father ☐Step Mother ☐Step Father ☐Foster Parent

☐Group Home Contact ☐Guardian ☐Other

Relationship to Student: ☐Mother ☐Father ☐Step Mother ☐Step Father ☐Foster Parent

☐Group Home Contact ☐Guardian ☐Other

Brothers and Sisters (Birth to Age 21)

<table>
<thead>
<tr>
<th>Name: (Last)</th>
<th>(First)</th>
<th>(MI)</th>
<th>Sex</th>
<th>Birth Date</th>
<th>Grade</th>
<th>Living at Home</th>
</tr>
</thead>
<tbody>
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<td>Yes</td>
</tr>
</tbody>
</table>

Others in Home:

Name: ____________________________ Relationship to Student

Below for Office Use Only

ID# ____________________________ Building ____________________________ Grade ______ Registration Date __________

Records: Date Requested ____________________________ Date Received ____________________________

PLEASE COMPLETE BOTH SIDES
School History

Kindergarten Students Only:
Did your child attend nursery school? (Circle One)  Yes No If yes, for how long? ____________________________
Where? __________________________________________ (Name and address of School)
Has your child ever been tested and/or received services for Occupational Therapy ____ Physical Therapy ____ Speech ____ Other ____

ALL OTHERS:
Name of Last School Attended: ____________________________ Last Grade Attended ______
School Address and Phone # ____________________________
List Other Schools Attended _________________________________________________________________
Has child ever played a sport at another Section V school?  YES ____ NO ____
If yes, what school/sport/level ____________________________ List years ______
Has Student ever repeated a grade? YES ____ NO ____ If yes, which grade? ____________________
What year did your child first enter grade nine? ________________
Has Student ever received special help in:  Reading ____ Math ____ Speech ____ Other __________________
Has student ever been placed in Special Education with an IEP?  YES ____ NO ____ If yes, when? __________________
Does student have a 504 Plan YES ____ NO ____

For more information regarding your rights to special education services, please visit the New York State Education Department's website relating to a parent's guide to special education in New York for children ages three through 21

Emergency Information
If your child stays with a sitter before and/or after school:
Name of person who cares for student ____________________________ Phone ________________
Address ________________________________________________________________
If we are unable to reach parents or sitter in an emergency:
Name of Emergency Contact: ____________________________ Phone __________________
Address __________________________________________ Relationship ________________

IF THESE TELEPHONE NUMBERS OR THOSE ON THE FRONT OF THIS FORM ARE CHANGED
DURING THE YEAR, PLEASE NOTIFY US IMMEDIATELY.

This is to confirm that all of the above information is accurate and that I am a resident of the Gates Chili School District.

Parent/Guardian Signature ____________________________ Date ____________
CUSTODY DISCLOSURE FORM

The Registration Office is responsible for registration, not in determining which parent or guardian may check a child in/out of school, etc. If custodial or guardianship issues exist when you register your child in the Gates Chili Central School District, it is your responsibility to provide custodial documentation to the Registration Office and a copy will be forwarded to your child’s school principal.

Please inform your child’s school of changes in custodial arrangements.

Information on Rights of Parents from the Family Education Rights and Privacy Act (FERPA)
An educational agency or institution shall give full rights under the Act to either parent, unless the agency or institution has been provided with evidence that there is a court order, State statute, or legally binding document relating to such matters as divorce, separation or custody that specifically revokes these rights.

(Authority: 20 U.S.C. 1232g)

Please check the current custody/guardianship arrangement:

☐ 1. Parents/guardians are together residing at the same residence
☐ 2. Single parent (father and mother are listed on the birth certificate)
☐ 3. Single parent (father is not listed on the birth certificate)
☐ 4. Parents/guardians divorced/separated – joint custody
☐ 5. Parents/guardians divorced/separated – sole custody
☐ 6. Parents have never been married and have no legal custody papers
☐ 7. Custody/guardianship is transferred by courts
☐ 8. Restricted pickup (legal documentation must be provided)
☐ 9. Student is emancipated (legal documentation provided if available)

Please check all that apply:

☐ I have disclosed my current custody/guardianship arrangement.
☐ I have attached a copy of those pages of the legal court documents that describe custody arrangements.
☐ No legal documents that describe custody arrangements exist.
☐ I understand that it is my responsibility to update my child’s school principal of changes in custody.

Student Name (please print): _______________________________________________________

____________________________________  __________________________
Signature of Parent/Guardian                     Date
Additional Student Identification

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Student Name: ____________________________

Please answer all questions. Please read them before you respond. (For question (1) check the box that best describes your child. Check only ONE box.

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 Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
   - Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, 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.

3. Is the student considered an Immigrant Child or Youth? The term "immigrant children and youth" refers to individuals who:
   - are ages 3 through 21;
   - have not been attending school in any state for more than three full academic years; and
   - were not born in any state.

   Immigrant Status: Yes ___ No ___ if yes, Date arrived in United States: ____________ Country of Origin: ____________

4. Is the student considered a Migrant Child?
   Has anyone in your family worked, or looked for work at the following occupations during the past 3 years? (Please check all that apply.)
   - Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
   - Work related to logging, harvesting, or initial processing of trees.
   - Work at a food processing plant, (such as meat or poultry processing plants, packaging fruits or vegetables, etc.)

   Migrant Status: Yes ___ No ___

Signature of Parent/Guardian ____________________________ Date ____________
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.

Home Language Questionnaire (HLQ)

Please write clearly when completing this section.

STUDENT NAME:

First  Middle  Last

DATE OF BIRTH:

Month  Day  Year

GENDER:

☐ Male  ☐ Female

PARENT/PERSO 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 you learned?
   ☐ English  ☐ Other
   specify

3. What is the Home Language of each parent/guardian?
   ☐ Mother
   ☐ Father
   ☐ Guardian(s)
   specify
   specify
   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

ENGLISH
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:

   ☐ 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

Relationship to student: ☐ Mother  ☐ Father  ☐ Other: ________________________________

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**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:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Outcome of Individual Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>MO</td>
<td>☐ Administer NYSITELL</td>
</tr>
<tr>
<td>Day</td>
<td>☐ English Proficient</td>
</tr>
<tr>
<td>YR</td>
<td>☐ Refer to Language Proficiency Team</td>
</tr>
</tbody>
</table>

**DATE OF NYSITELL ADMINISTRATION:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Proficiency Level Achieved on NYSITELL:</th>
</tr>
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<tbody>
<tr>
<td>MO</td>
<td>☐ Entering</td>
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<tr>
<td>Day</td>
<td>☐ Emerging</td>
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<td>YR</td>
<td>☐ Transitioning</td>
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<tr>
<td></td>
<td>☐ Expanding</td>
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<tr>
<td></td>
<td>☐ Commanding</td>
</tr>
</tbody>
</table>

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

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ENGLISH
Dear Parent(s)/Guardian(s):

Welcome to the Gates Chili Central School District. The enclosed Registration Packet is the First Step in completing the registration process. Please take the time to read the forms carefully and fill them out completely. When completed please call to make an appointment to register your child(ren).

<table>
<thead>
<tr>
<th>Registration Packet Forms – Please fill out completely prior to appointment</th>
<th>Date Rec’d</th>
<th>Initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proof of Residency Checklist</td>
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<tr>
<td>Custody Disclosure Form</td>
<td></td>
<td></td>
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<tr>
<td>Student Registration Form (Complete both sides)</td>
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<tr>
<td>Student Health History</td>
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<tr>
<td>Health Appraisal Form</td>
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<tr>
<td>Dental Health Certificate</td>
<td>n/a</td>
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<tr>
<td>HIPPA Form</td>
<td>n/a</td>
<td></td>
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<tr>
<td>Student Records Request</td>
<td>n/a</td>
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</tbody>
</table>

For Office Use Only

Bring these documents to your registration appointment

When registering your child you need to present Proof of Residency.
Please provide ONE item from Category 1 and ONE from Category 2. If an item from Category 1 is unavailable please provide at least TWO from Category 2.

**Residency Proof**

**Category 1**
- Mortgage Statement; School or Property Tax Receipt; Lease Agreement; Homeowner’s/Renter’s insurance policy; a statement by a third-party landlord, owner or tenant from whom you lease or with whom you share property within the district; or other statement by a third-party that establishes your physical presence in the District.
- Pay stub
- Income Tax Form
- Membership documents (e.g., library cards) based upon residency
- Official driver’s license, learner’s permit, non-driver identification, vehicle insurance
- State or other government issued identification
- Documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement)
- Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers

**Residency Proof**

**Category 2**
- Voter registration document(s)
- Utility or other bills

**Proof of Age**

Birth or baptismal certificate; if not available, then a Passport

If not available, then one of the following:
- Official driver’s license
- State or other government issued identification
- School photo identification with date of birth
- Consulate identification card
- Hospital or health records
- Military dependent identification card
- Documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement)
- Court orders or other court-issued documents
- Native American tribal document
- Records from non-profit international aid agencies and voluntary agencies

Immunization Record signed by Doctor’s Office

Most recent physical

IEP - Individual Education Plan (if classified) or Declassification Plan or 504 Plan (if applicable)

Custody or Guardianship Papers (if applicable)

If you have any questions, please call between 8:00 a.m. and 3:30 p.m. Registration Office 247-5050 ext. 12224.

We look forward to working with you during this enrollment process.
GATES CHILI CENTRAL SCHOOL DISTRICT
Student Health History

Student Name ___________________________ Sex ________ Date of Birth ____________

Physician’s Name ________________________ Physician Address _______________________

Has your child ever had any of the following? If “yes” please comment,

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
<th>Comment</th>
</tr>
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<tbody>
<tr>
<td>Allergies</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Seizures</td>
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<tr>
<td>Bleeding Tendencies</td>
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<tr>
<td>Heart Disease</td>
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<tr>
<td>Tuberculosis Contact</td>
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<tr>
<td>Rheumatic Fever</td>
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<td>Severe Headaches</td>
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<tr>
<td>Chicken Pox</td>
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<tr>
<td>Cancer</td>
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<td>Leukemia</td>
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<td>Vision Problems</td>
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<td>Hearing Problems</td>
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<td>Speech Problems</td>
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<tr>
<td>Orthopedic Problems</td>
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<tr>
<td>Other</td>
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</table>

Approximate date of the most recent physical examination ________________ Exam

Does your child have any allergies to medicine? Yes/No

If “Yes” – Type of Reaction

Has your child had any operations (including tonsillectomy)? Yes/No When?

Explain __________________________________________

Has your child had any serious accidents or injuries? Yes/No

When?

Explain __________________________________________

Is your child now or has he/she ever been on any regular medications? Yes/No

When?

Explain __________________________________________

Does your child have any special health problems or restrictions? Yes/No

Explain __________________________________________

Does your child have any allergy to foods? Yes/No (if yes what?)

Explain __________________________________________

Does your child have any dietary restrictions? Yes/No (if yes what?)

Explain __________________________________________

I give permission for the above health history information to be shared with appropriate school personnel as necessary to promote the health and education of my child.

_________________________ Date ____________________________ Parent/Guardian Signature
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your health care provider will require the release of information form below to share Protected Medical Information with the school district. Please read and sign below.

I, ____________________________, authorize my child’s health care provider(s) listed below to release the medical records (including immunizations, health appraisals, and past/current medical conditions and their impact on attendance, school programming, and/or PT/OT/ST needs) of my child, ____________________________, date of birth __________ to the school district’s medical officer, physical/occupational/speech therapist, counselor, social worker, psychologist and/or school nurse.

HC Provider ____________________________ Phone __________
HC Provider ____________________________ Phone __________
HC Provider ____________________________ Phone __________
HC Provider ____________________________ Phone __________

The Protected Health Information may be used, disclosed, or received for the purposes of developing care or therapy plans for school management, designing appropriate educational programs, assessing school observations/concerns surrounding behavior and/or student health, assessing a medical basis for modification of transportation and/or tutoring (home or district-based), and medication delivery and/or therapy prescriptions for PT/OT/ST.

This authorization for release of information shall be in force and effect until no longer a student in the Gates Chili School District, at which time this authorization expires.

- I acknowledge that I have the right to revoke this authorization at any time by sending written notification to my health care provider and to the District Administration Building.
- I understand that the revocation of this authorization is not effective if the health care provider or district has used the authorization for the disclosure of Protected Health Information before 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, payment, enrollment or eligibility for benefits is not dependent on my agreement to release or withhold information.

____________________  __________________________  __________________________
Date  Signature of parent or guardian, or student over 18  Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION. If you choose not to give authorization, please initial here ______  Date ______________
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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Sex: □ M □ F</th>
<th>DOB:</th>
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</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Exam Date:</td>
</tr>
</tbody>
</table>

HEALTH HISTORY

<table>
<thead>
<tr>
<th>Allergies □ No</th>
<th>□ Medication/Treatment Order Attached</th>
<th>□ Anaphylaxis Care Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes, indicate type</td>
<td>□ Food □ Insects □ Latex □ Medication □ Environmental</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Asthma □ No</th>
<th>□ Medication/Treatment Order Attached</th>
<th>□ Asthma Care Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes, indicate type</td>
<td>□ Intermittent □ Persistent □ Other: __________________________</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Seizures □ No</th>
<th>□ Medication/Treatment Order Attached</th>
<th>□ Seizure Care Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes, indicate type</td>
<td>□ Type: __________________________</td>
<td>Date of last seizure: __________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diabetes □ No</th>
<th>□ Medication/Treatment Order Attached</th>
<th>□ Diabetes Medical Mgmt. Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes, indicate type</td>
<td>□ Type 1 □ Type 2 □ HbA1c results: __________ Date Drawn: __________</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
<th>BP:</th>
<th>Pulse:</th>
<th>Respirations:</th>
<th>Other Pertinent Medical Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>TESTS</td>
<td>Positive</td>
<td>Negative</td>
<td>Date</td>
<td>One Functioning: □ Eye □ Kidney □ Testicle</td>
<td></td>
</tr>
<tr>
<td>PPD/ PRN</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Screen/PRN</td>
<td>□</td>
<td>□</td>
<td>□ Concussion - Last Occurrence: __________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Level Required Grades Pre-K &amp; K</td>
<td>Date</td>
<td>□ Mental Health: __________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Test Done</td>
<td>□ Lead Elevated &gt;10 μg/dl.</td>
<td></td>
<td>□ Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ System Review and Exam Entirely Normal</td>
<td></td>
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</tr>
</tbody>
</table>

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: Diagnoses/Problems (list) ICD-10 Code

□ Additional Information Attached

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**SCREENINGS**

<table>
<thead>
<tr>
<th>Vision</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
<td>20/</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Distance Acuity With Lenses</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision – Near Vision</td>
<td>20/</td>
<td>20/</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Vision – Color</td>
<td></td>
<td></td>
<td>□ Pass</td>
<td>□ Fail</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hearing</th>
<th>Right dB</th>
<th>Left dB</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pure Tone Screening</td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scoliosis</th>
<th>Required for boys grade 9</th>
<th>Negative</th>
<th>Positive</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>And girls grades 5 &amp; 7</td>
<td></td>
<td></td>
<td>□</td>
<td>□ Yes</td>
</tr>
</tbody>
</table>

Deviation Degree: Trunk Rotation Angle:

**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
- □ Insulin Pump/Insulin Sensor*
- □ Protective Equipment
- □ Colostomy Appliance*
- □ Medical/Prosthetic Device*
- □ Pacemaker/Defibrillator*
- □ Sport Safety Goggles
- □ Hearing Aids
- □ 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 NYISIS 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.

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Gates Chili Central School District
Residency Checklist

Student(s)' Name: ____________________________________________________________

In-District Address: __________________________________________________________

Date Registered: ____________________________________________________________

House #                Street Name                Apt. #

These questions are intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help to 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

If you answered YES to the above questions, where is the student presently living? (Check one box)

☐ 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): ____________________________________________
☐ In permanent housing

NOTE: If the student is not living in permanent housing, proof of residency and other documents normally needed for enrollment are not required. Families who are homeless are not required to complete the remaining forms.

Residency Proofs for each family registering students are required by the Gates Chili School District.

Check the box that represents your Residency Status and provide Residency Proofs as listed below.

☐ Homeowner — Please provide ONE item from Category 1 and ONE from Category 2. If an item from Category 1 is unavailable please provide at least TWO from Category 2.
   Category 1: Mortgage Statement; School or Property Tax Receipt; Homeowner’s insurance policy. (If building new home, Copy of Builder Sales Contract indicating purchaser name, address and tentative completion date.)
   Category 2:  
   • Pay stub
   • Income Tax Form
   • Membership documents(e.g., library cards) based upon residency
   • Official driver’s license, learner’s permit, non-driver identification, or vehicle insurance
   • State or other government issued identification
   • Documents issued by federal, state or local agencies(e.g., local social service agency, federal Office of Refugee Resettlement)
   • Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers

☐ Renter — Please provide ONE item from Category 1 and ONE from Category 2. If an item from Category 1 is unavailable please provide at least TWO from Category 2.
   Category 1: Lease Agreement; Renter’s insurance policy, statement from landlord or other third-party that establishes physical address in the District.
   Category 2:  
   • Pay stub
   • Income Tax Form
   • Membership documents(e.g., library cards) based upon residency
   • Official driver’s license, learner’s permit, non-driver identification or vehicle insurance
   • State or other government issued identification
   • Documents issued by federal, state or local agencies(e.g., local social service agency, federal Office of Refugee Resettlement)
   • Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers

☐ Shared Housing: Sharing Single Family Home or Apartment with Another Family. *(This section will be completed when the shared housing is not due to loss of residence because of hardship.)*
   Primary Resident: Person(s) whose name is on the mortgage or lease.
   Individual Residing At or Moving In: Person(s) whose name is not on the mortgage or lease.

BOTH the “Primary Resident” and the “Individual Residing At or Moving In” must provide Residency Proofs as listed on the back of the Shared Housing Certificate and sign the Shared Housing Certificate.