Dear Parent(s)/Guardian(s):

CALL FOR AN APPOINTMENT

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>Initialed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proof of Residency Checklist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Custody Disclosure Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student Registration Form (Complete both sides)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student Health History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Appraisal Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Health Certificate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIPAA Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student Records Request</td>
<td></td>
<td></td>
</tr>
</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.

<table>
<thead>
<tr>
<th>Residency Proof</th>
<th>Category 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residency Proof</th>
<th>Category 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay stub</td>
<td>Voter registration document(s)</td>
</tr>
<tr>
<td>Income Tax Form</td>
<td>Utility or other bills</td>
</tr>
<tr>
<td>Membership documents(e.g., library cards) based upon residency</td>
<td></td>
</tr>
<tr>
<td>Official driver’s license, learner’s permit, non-driver identification, vehicle insurance</td>
<td></td>
</tr>
<tr>
<td>State or other government issued identification</td>
<td></td>
</tr>
<tr>
<td>Documents issued by federal, state or local agencies(e.g., local social service agency, federal Office of Refugee Resettlement)</td>
<td></td>
</tr>
<tr>
<td>Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proof of Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth or baptismal certificate; If not available, then a Passport</td>
</tr>
</tbody>
</table>

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.

Rev. 9/1/2016
Gates Chili Central School District
Residency Checklist

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
• Utility or other bills
• Income Tax Form
• Voter registration document(s)
• 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
• Utility or other bills
• Income Tax Form
• Voter registration document(s)
• 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.
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
**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

**Primary Phone#** ☐ Listed( ) Unlisted( ) Date of Birth ☐ Age: ☐

**Parent/Guardian**

- ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other

**Name:**

- Last ☐ First ☐ Middle ☐ MI

**Address:**

- Street ☐ Apt. ☐ Zip

**Home Phone#:** ☐ Pager#: ☐

**Cell Phone#:** ☐ Work #: ☐

**Email Address:** ☐

**Employer:** ☐

**Occupation:** ☐

**Marital Status:**

- ☐ Single ☐ Married ☐ Divorced ☐ Widowed

**Relationship to Student:**

- ☐ Mother ☐ Father ☐ Step Mother ☐ Step Father ☐ Foster Parent ☐

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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
<th>School:</th>
<th>Gender: □ M □ F</th>
<th>Grade:</th>
</tr>
</thead>
</table>

**IMMUNIZATIONS / HEALTH HISTORY**

- Immunization record attached
- Sickle Cell Screen: □ Positive □ Negative □ Not done Date: ______
- No immunizations given today
- PPD: □ Positive □ Negative □ Not done Date: ______
- Immunizations given since last Health Appraisal:
  - Elevated Lead: □ Yes □ No □ Not done Date: ______
  - Dental Referral □ Yes □ No □ Not done Date: ______

Significant Medical/Surgical History: □ See attached

Specify current diseases: □ Asthma □ Diabetes: □ Type 1 □ Type 2 □ Hyperlipidemia □ Hypertension □ Other:

Allergies: □ LIFE THREATENING □ Food: ______ □ Insect: ______ □ Other: ______ □ Seasonal □ Medication: ______

**PHYSICAL EXAM**

<table>
<thead>
<tr>
<th>Height: _______</th>
<th>Weight: _______</th>
<th>Blood Pressure: _______</th>
<th>Date of Exam: _______</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Mass Index: _______</td>
<td>Vision - without glasses/contact lenses</td>
<td>R</td>
<td>L</td>
<td></td>
</tr>
<tr>
<td>Weight Status Category (BMI Percentile):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ less than 5th □ 5th through 49th □ 50th through 84th</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 85th through 94th □ 95th through 98th □ 99th and higher</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision - with glasses/contact lenses</td>
<td>R</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing □ Pass 20 db sc both ears or:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EXAM ENTIRELY NORMAL

Tanner: I. II. III. IV. V. Scoliosis: □ Negative □ Positive:

Specify any abnormality (use reverse of form if needed):

**MEDICATIONS**

Medications (list all): □ None □ Additional medications listed on reverse of form

Name: ___________________________ Dosage/Time: ___________________________

Name: ___________________________ Dosage/Time: ___________________________

If AM dose is missed at home: ________________________________________________________________________________________________

I assess this student to be self-directed: □ Yes □ No

Student may self carry and self administer medication: □ Yes □ No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

**PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION**

- Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
  - □ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
  - □ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: ___________________________ □ None

Known or suspected disability: ___________________________ □ Please monitor

Restrictions: ___________________________ □ Please monitor

Protective equipment required: □ Athletic Cup □ Sport goggles/impact resistant eyewear □ Other: ___________________________ (Stamp below)

Provider’s Signature: ___________________________ Phone: ___________________________

Provider’s Name/Address: ___________________________ Fax: ___________________________

Parent Signature: ___________________________ Date: ___________________________

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. Rev. 10/3/07
This single form has been designed to help the district maintain compliance with three New York State regulations, as detailed below. Please mail completed form to the respective school health office.

Jackie Dennison, PNP  
Nurse Practitioner Grades K-12

**Education Law, Section 903**
Requires a physical examination of each child entering school for Kindergarten and at these selected grades as well: 2nd, 4th, 7th, and 10th. In addition, any student new to Gates Chili School District at any grade level must have a physical examination. It is recommended that these examinations be done by the family physician as he/she is most familiar with the health needs of your child. The examination should be dated no more than one year prior to the beginning of the school year in which the examination is required.

**Commissioners Regulation 135.4**
Requires all student athletes who will participate in the interscholastic sports program to have a physical examination prior to practicing with any team. Although final approval is the legal responsibility of the school physician, examination by the family physician is recommended. The results of the physical examination will be valid for a period of 12 months before the first day of practice.

**Public Health Law, Section 2164**
Requires all pupils to be immunized against Polio, Diphtheria, Mumps, Rubeola, Rubella, and Hepatitis B. Varicella vaccine or proof of immunity is required. Serologic proof (a blood titer) of immunity to Varicella or a history of Varicella disease as documented by a health care provider are the only acceptable proof of immunity. All students entering 6th grade are required to receive a booster immunization of Tdap (aTetanus booster that contains Pertussis vaccine). The law recognizes certain religious and health exemptions. Required immunizations need to be updated for school records. Please include all recent booster dates.
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)

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Sex:</td>
<td>□ Male</td>
<td>□ Female</td>
<td></td>
</tr>
<tr>
<td>Will this be your child’s first visit to a dentist?</td>
<td>□ Yes</td>
<td>□ No</td>
<td></td>
</tr>
<tr>
<td>School:</td>
<td>Name</td>
<td>Grade</td>
<td></td>
</tr>
<tr>
<td>Have you noticed any problem in the mouth that interferes with your child’s ability to chew, speak or focus on school activities?</td>
<td>□ Yes</td>
<td>□ No</td>
<td></td>
</tr>
</tbody>
</table>

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.
Dear Parent or Guardian

A physical examination, performed by a health care provider in New York State, is required by law for new students entering our district. The examination may be done either by your private physician or by our district nurse practitioner.

Please complete the form below regarding your intentions and it will be forwarded to your child’s school health office. An examination will be scheduled with our district nurse practitioner if this form is not completed at the time of registration.

Thank you for your cooperation.

Very Sincerely Yours,

Jackie Dennison
Nurse Practitioner for the Gates Chili School District

---

NEW STUDENT PHYSICAL

__________________________________________  ______________________

Child's Name  School and Grade

____  I prefer to have my child examined by our private physician. The date of the appointment is ________________________.

____  My child’s examination is dated not more than one year prior to their start date. I will have the physician complete the Health Appraisal form and I will return it to my child’s school Health Office within 30 days.

____  I prefer to have my child examined by the district nurse practitioner.

__________________________________________  ______________________

Date  Parent/Guardian Signature
Gates Chili School District
PUPIL SERVICES DEPARTMENT
3 Spartan Way
Rochester, NY 14624

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 _______________
Request For Records From The Gates Chili Central School District

LAST SCHOOL ATTENDED: ___________________________________________ DATE: __________________________

ADDRESS: ______________________________________________________ PHONE #: _________________________

_________________________________________________________ FAX #: _________________________

PERMISSION TO RELEASE INFORMATION AS INDICATED BELOW ON THE FOLLOWING STUDENT(S):

<table>
<thead>
<tr>
<th>Name of Student</th>
<th>Date of Birth</th>
<th>Grade Attended</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

REQUESTING THE FOLLOWING INFORMATION:

- Permanent Record Information
- Achievement Test Scores
- Health Record Information
- Discipline Record
- Psychological Reports (if applicable)
- Any Other Pertinent Information

Signature of Parent/Guardian ___________________________ Date __________________________

Signature of Employee Requesting Records ___________________________ Date Requested __________________________

PLEASE FAX OR MAIL THE REQUESTED INFORMATION TO THE SCHOOL/OFFICE INDICATED BELOW.

<table>
<thead>
<tr>
<th>SCHOOL/ADDRESS</th>
<th>TEL:</th>
<th>FAX:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEIL ARMSTRONG ELEMENTARY SCHOOL</td>
<td>(585)247-3190</td>
<td>(585)340-5550</td>
</tr>
<tr>
<td>LISA MCGARY, Principal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FLORENCE BRASSER ELEMENTARY SCHOOL</td>
<td>(585)247-1880</td>
<td>(585)340-5577</td>
</tr>
<tr>
<td>TIM YOUNG, Principal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WALT DISNEY ELEMENTARY SCHOOL</td>
<td>(585)247-3151</td>
<td>(585)340-5567</td>
</tr>
<tr>
<td>ELAINE DAMELIO, Principal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAUL ROAD ELEMENTARY SCHOOL</td>
<td>(585)247-2144</td>
<td>(585)340-5571</td>
</tr>
<tr>
<td>PETER HENS, Principal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GATES CHILI MIDDLE SCHOOL</td>
<td>(585)247-5050</td>
<td>(585)340-5555</td>
</tr>
<tr>
<td>LISA BUCKSHAW, Principal</td>
<td>EMAIL:<a href="mailto:deborah_wagner@gateschili.org">deborah_wagner@gateschili.org</a></td>
<td></td>
</tr>
<tr>
<td>GATES CHILI HIGH SCHOOL</td>
<td>(585)247-5050</td>
<td>(585)340-5594</td>
</tr>
<tr>
<td>KENNETH HAMMEL, Principal</td>
<td></td>
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</tr>
<tr>
<td>GATES CHILI STUDENTS WITH DISABILITIES OFFICE</td>
<td>(585)247-5050</td>
<td>(585)247-1072</td>
</tr>
<tr>
<td>JULIE STARK: Pupil Services Coordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention:</td>
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