Student Number ____________

STUDENT NAME: ______________________________ EXPECTED ENROLLMENT DATE: ___________

GRADE LEVEL: ______________________________ DATE OF BIRTH: ______________________

Residential Address: ____
House # Street Apt #

____
City State Zip

Mailing Address: (if different from above) ____

____

Household Phone Number – To be designated for emergency school notifications (i.e. school closings): ____________________________

Is English the only language spoken at home? Yes ________No ___________

If no, what other language does your family speak? ______________________Is your child bilingual? Yes _______No ________

Student Racial and Ethnic Identification as specified by the NYS Dept. of Education

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

Select one or more races from the following five racial groups:

O AMERICAN INDIAN or ALASKA NATIVE: A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition.(e.g. Cherokee, Mohawk, Inuit.)

O 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.

O NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

O BLACK: A person having origins in any of the black racial groups of Africa

O WHITE: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Child's Place of Birth: City: ________________________________ State: ____

Was your child born **outside the United States?** No ______________ Yes ______________ **If Yes, please answer questions below:**

What country was your child born in? ______________________ Date of entry into the United States: ________________

Date child first entered U.S. schools: ______________________ Date child first entered NY schools: ________________

Did your child previously attend the BKW Central School? Yes __ No ___ Date Left _____

ALL CHILDREN LIVING IN PRIMARY HOUSEHOLD UNDER THE AGE OF 21

Last Name	First Name	Middle	SEX M/F	Date of Birth	Grade	Birth Cert. Received	Student ID# Office Use Only

PRIMARY HOUSEHOLD PARENT / GUARDIAN INFORMATION

(Only list those adults currently living in the household)

Father / Male Guardian / Other Adult Male: ______________________________

Living in the household with the child listed above — *Last Name* *First Name* *Middle Name*

Relationship to child(ren) ______________________________

Work Number:______________ Cell Phone Number: ______________ Other Number: ______________

Email Address:______________________ Occupation: ______________________

Mother / Female Guardian / Other Adult Female: ______________________________

Living in the household with the child listed above — *Last Name* *First Name* *Middle Name*

Relationship to child(ren) ______________________________

Work Number:______________ Cell Phone Number: ______________ Pager Number: ______________

Email Address:______________________ Occupation: ______________________

NON-HOUSEHOLD PARENT: If dad or mom is not residing in the primary household, please list their information below.

____

Last Name *First Name* *Middle Name*

Relationship to child(ren) listed above ______________________________

Home Address: ______________________________

Work Number:______________ Cell Phone Number: ______________ Other Number: ______________

Email Address:______________________ Occupation: ______________________

Any legal custodial restrictions? No______________ Yes______________ **If yes, please attach court documents.**

Important Note Regarding Release of Students from School: *The school district shall presume that either parent of a student has authority to obtain the child's release from school. However, a student shall not be released to a non-custodial parent if the district has been provided with a certified copy of a legally binding instrument, such as a court order or decree of divorce, separation or custody, that indicates the non-custodial parent does not have the right to obtain such release.*

Is **BKW CSD** __currently__ transporting your child to private school? No ____________ Yes ____________

If **Yes**, please cancel my application for non-public transportation as of________________(date):

Parent Signature: ____ Date: ______________

Special Education Needs:

Is your child **__CURRENTLY__ receiving special education services?** No ____________ Yes ____________

If Yes, please place a checkmark next to each service he/she is receiving.

____________ Speech / Language Therapy	____________ Occupational Therapy	____________ Physical Therapy
____________ Consultant Teacher	____________ Self-Contained Classroom	____________ Resource Room
____________ BOCES	____________ 504 Plan	____________ Declassified
____________ 1:1 Aide	____________ Classroom Aide	____________ Extended Test Taking Time

Other Special Education Needs:

____

Has your child ever received special education services **__IN THE PAST__?** **No** ____________ **Yes** ____________

Services Received: ____

Date Services Ended: ______________

Names, addresses and phone numbers of two people with whom you have made arrangements to take responsibility for your child in the event you cannot be reached.

Emergency Contact #1	____________________	Emergency Contact #2	____________________
Gender	____________________	Gender	____________________
Relationship to Student	____________________	Relationship to Student	____________________
Street Address	____________________	Street Address	____________________
City, State, Zip	____________________	City, State, Zip	____________________
Home Phone	____________________	Home Phone	____________________
Work Phone	____________________	Work Phone	____________________
Cell Phone	____________________	Cell Phone	____________________

Parent Statement:

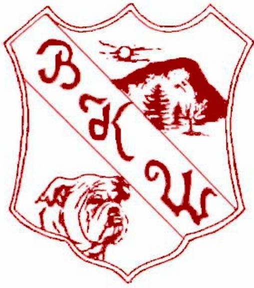
I certify that the above information is true and correct. Any misinformation regarding residency may result in being billed to cover the cost of instruction and/or exclusion from attending the Berne-Knox-Westerlo Central School District.

Parent
Signature: ______________________________ Date: ______________

The student information we enter and maintain in BKW's electronic Student Information System is used for many purposes. Please be aware that when an adult who is not a parent or legal guardian resides with a student's family, and is included in the student's permanent record, it is assumed we have the parent's permission to discuss academic, disciplinary and other student matters with that adult. In addition, "other adult in household" may be contacted in emergencies. Therefore non-parent/legal guardian adults should not be included on the registration form unless you agree with the above and sign the statement below.
Our schools maintain separate Emergency Contact information and you may indicate any adult of your choosing to be contacted should an emergency occur and you cannot be reached.
When/if any of the information you are providing changes, please inform your child's school in order to ensure we have the most up-to-date information on file.
By signing below, you are agreeing that the non-parent/legal guardian may be contacted regarding your child.

Parent
Signature: ______________________________ Date: ______________

Print Name Here: ______________________________ Relationship to Student: ______________



Berne-Knox-Westerlo Central School District
1738 HELDERBERG TRAIL · BERNE, NEW YORK 12023

Dr. Timothy Mundell, Superintendent (518) 872-1293
http://www.bkwschools.org

District Office · (518) 872-0909 · Fax: (518) 872-0341
Secondary School Office · (518) 872-1482 · Fax: (518) 872-2083
Elementary Office · (518) 872-2030 · Fax: (518) 872-2031
Special Education Office · (518) 872-0945 · Fax: (518) 872-5128

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RELEASE OF STUDENT RECORDS

____
Date

_____________________________________ ____________________
Name of School Student Last Attended Telephone/Fax

Please send all health information, academic records, attendance records, discipline records, IEP (Individual Education Plan), and psychological reports if applicable, for the following student(s) who have enrolled in Berne-Knox-Westerlo Central School District.

Grades K – 6 email or fax records to Mrs. Dibble ddibble@bkwschools.org or (518) 872-2031
Grades 7 – 12 email or fax records to Mrs. Walbridge lwalbridge@bkwschools.org or (518) 872-5277

Student	Grade
_________________________________	____
_________________________________	____
_________________________________	____

I hereby give my permission to release my child's records to Berne-Knox-Westerlo CSD.

____ __________________________________
Signature of Parent/Guardian Date

Berne-Knox-Westerlo Central School District

Student Residency Questionnaire

Name of School: ______________________________ Grade: ______________

Name of Student: ______________________________ Sex: _____ Male
Last First Middle _____ Female

Birth Date: ___/___/___ Age: ________ Student ID # ________________
Month / Day / Year

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? _____ Yes _____ No

2. Is this temporary living arrangement due to loss of housing or economic hardship? _____ Yes _____ No

If you answered YES to the above questions, please complete the remainder of this form.
If you answered NO, you may stop here.

Where is the student presently living? (Check one)

_____ In a motel
_____ In a shelter
_____ With more than one family in a house or apartment
_____ Moving from place to place
_____ In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite

Name of Parent(s)/Legal Guardians(s) ______________________________

Address______________________________ Zip __________ Phone(s) ______________________

** Is transportation (bus) required: _______ Yes _______ No
** If "Yes," What date would you like transportation to start ? ____________________
(We will make every effort to accommodate your request).

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002(3)(d).

Signature of Parent/Legal Guardian ______________________________ Date______________
Signature of School Official ______________________________ Date______________

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

Date __________ ***McKinney-Vento Liaison Signature*** ______________________________

HEALTH FORM
BERNE-KNOX-WESTERLO CENTRAL SCHOOL
(to be completed by parent)

Date______________________

Name____ Sex ____________

Date and Place of Birth____ Grade ___________

Parent/s or Guardian (resides with)____

Address____

Father's Name____ Home Phone ____________

Mother's Name____ Home Phone ____________

Father's Place of Business____ Phone____________

Mother's Place of Business____ Phone____________

Family Physician____ Phone____________

Has your child ever had any of the following? If so, indicate the date.

Chicken Pox_____________ Pneumonia____________ Diabetes______________

Diphtheria_______________ Poliomyelitis______________ Seizures______________

German Measles____________ Rheumatic Fever____________ Heart Disease____________

Mumps_____________ Scarlet Fever_______________ Tuberculosis______________

Measles________________ Whooping Cough____________ Contact with TB__________

CHECK IF HISTORY AND DESCRIBE **Please list dates, type and medications.**

Asthma

Frequent colds & sore throat

Bee Sting Allergy

Ear condition

Allergies

Frequent Headaches

Operations

Serious injuries

Under treatment at this time for any other condition?____________________

Revised 1/13/06

IMMUNIZATIONS
(Please attach physician's record or physician may complete this form)

IPV ________ ________ ________ ________

DTaP ________ ________ ________ ________ ________ Tdap ________

HIB ________ ________ ________ ________

Hep B ________ ________ ________

Prevnar ________ ________ ________ ________

MMR ________ ________

Varivax ________ ________

Hep A ________ ________

Menactra ________

Gardasil ________ ________ ________

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.

Berne-Knox-Westerlo CSD

STUDENT HEALTH EXAMINATION FORM (To be completed 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, 2, 4, 7 & 10, interscholastic sports and working papers.

Name: ______________________ DOB: __________ Gender: ☐M ☐F

School: Grade: ☐No Grade Exam Date:

IMMUNIZATIONS

☐ Immunization record attached
☐ Immunizations reported on NYSIIS
☐ No immunizations received today

☐Immunizations received today:

☐Will return on: to receive:

HEALTH HISTORY

☐**Asthma:** ☐Intermittent ☐Persistent ☐Asthma Action Plan Attached

☐**Diabetes:** ☐Type I ☐ Type 2 ☐Hyperlipidemia ☐Hypertension ☐Diabetes Medical Mgmt Plan Attached

☐**Seizures** Type: __________ Last Occurrence: ______ ☐Emergency Care Plan Attached

☐**Allergies:** ☐Non Life-Threatening ☐Life-Threatening ☐Emergency Care Plan Attached

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Allergen(s):

☐Hx of Anaphylaxis: Last occurrence: ______ Previous symptoms: ______

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

Significant Medical/Surgical Information:	Diagnostic Tests	Positive	Negative	Not Done	Date
	Sickle Cell Screen	☐	☐	☐	
	PPD	☐	☐	☐	
	Elevated Lead:	☐	☐	☐	

☐Vision one eye only ☐One functioning kidney ☐One testicle ☐Concussion - Last occurrence:

PHYSICAL EXAMINATION

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

Scoliosis: ☐Negative ☐Positive

Degree of deviation: __________

Angle of trunk rotation via scoliometer:

Weight Status Category (BMI Percentile):

☐ <5th ☐ 85th - 94th
☐ 5th - 49th ☐ 95th - 98th
☐ 50th - 84th ☐ 99th & higher

Vision	**Right**	**Left**	***Referral***
Distance acuity			☐Yes ☐No
Distance acuity with lenses			☐Yes ☐No
Vision - near vision			☐Yes ☐No
Vision - color perception	☐ Pass	☐ Fail	☐Yes ☐No
Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes ☐No

Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders): **Tanner:** ☐I ☐II ☐III ☐IV ☐V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ Additional information attached

Specify any abnormalities:

Name: ______________________ DOB: ______________

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

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

☐ **Restrictions/Adaptations.** Please base restrictions/modifications on the following Interscholastic Sports Categories.

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

Accommodations / Protective Equipment:	☐Athletic Cup	☐Insulin Pump/Insulin Sensor	☐Pacemaker
	☐Brace/Orthotic	☐Medical /Prosthetic Device	☐Sports Safety Goggles
	☐Hearing Aides	☐Other:	

MEDICATION HISTORY (optional)

Please list names of prescribed or OTC medications used on a routine basis at home

______________________ ______________________

______________________ ______________________

PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS - VALID 1 YEAR

Independent Carry and Use Option: NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine autoinjector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option in schools.

☐ **Required Independent Carry and Use Attestation documentation is attached.**

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

Parent/Guardian Permission: I request the school nurse give the medications listed on this plan; or after the nurse determines my child can take their own medications, trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff caring for my child

Parent/Guardian Signature:

HEALTH CARE PROVIDER

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: ______________________ Date: ______________

Provider Name: (please print) ______________________ Phone #: ( )

Provider Address: ______________________ Fax #: ( )

Return to:

School Nurse: Katie Johnson School: B-K-W

Phone #: (518) 872-2030 Fax: (518) 872-2031 Date: