Ms. Erin E. Woods
Superintendent of Schools
(315)562-8130
Fax: (315)562-2477

Mrs. Amy Sykes
7-12 Principal
(315)562-8131
Fax: (315)562-2477

Ms. Lura Hughes
PK-6 Principal
(315)562-8132
Fax: (315)562-2477

EDWARDS-KNOX CENTRAL SCHOOL DISTRICT
2512 COUNTY ROUTE 24
HERMON, NEW YORK 13652

BUS GARAGE: (315) 562-8133
MAIN OFFICE FAX: (315) 562-2477
www.ekcsk12.org

February 2024

Dear Parent/Guardian:

Thank you for expressing interest for your son/daughter to attend our full-day Universal Prekindergarten program. Enclosed you will find a Prekindergarten Registration Form for the 2024-2025 school year and an information sheet regarding our Universal Prekindergarten program.

We ask that you return the registration packet to us **by Monday, March 18, 2024**. Applications will be accepted after that date, but there is a possibility that the 36 slots will be filled and you may jeopardize securing a spot for your child. **APPLICATIONS ARE FILLED ON A FIRST COME FIRST SERVED BASIS ON WHEN WE RECEIVE THE COMPLETED APPLICATION, CHILD BIRTH CERTIFICATE AND IMMUNIZATION RECORD, AND THE REQUIRED PARENTAL DOCUMENTATION (PHOTO I.D. AND PROOF OF RESIDENCY IN THE E-K SCHOOL DISTRICT).**

In mid-summer, families of registered Prekindergarten students will receive mailed notification of your child's classroom teacher. Any additional information that we have at that time will be shared as well. Prior to the start of school in September, there will be an opportunity for a Prekindergarten meet and greet.

Please do not hesitate to call our office or to contact Amanda Hamilton or Shannon Saxton at (315) 562-8132 if you have further questions.

Sincerely,

Lura K Hughes

Lura K. Hughes
Elementary Principal

LKH/rn

Enclosures

UNIVERSAL PREKINDERGARTEN
2024-2025 School Year

Any child in the Edwards-Knox Central School District who is or will be four years old on or before December 1, 2024, is eligible to attend the Edwards-Knox Universal Prekindergarten program.

The program consists of a full-day session running from 7:55 a.m. to 2:55 p.m. daily.

Children will be involved in basic readiness skills such as cutting and pasting; recognizing colors, numbers, shapes, and letters; printing names; fine motor skills; large motor skills; and personal care skills such as zipping, tying, and taking care of personal belongings, as well as a social-emotional program (Second Step).

If you have a child who is eligible and who wishes to attend the Prekindergarten program, please call Rachel Newvine in the Elementary Office at (315) 562-8132, Ext. 25533, to request an application be sent to you.

If you have any questions, you may call (315) 562-8132, Ext. 25533, and speak with Rachel Newvine in the Elementary Office; or ask for Amanda Hamilton or Shannon Saxton.

2024-2025 SCHOOL YEAR
PREKINDERGARTEN REGISTRATION FORM

ITEMS REQUIRED TO BE SUBMITTED WITH THIS REGISTRATION PACKET:

***A COPY OF PARENT/GUARDIAN PHOTO I.D.**

***PROOF OF RESIDENCY IN THE E-K SCHOOL DISTRICT (I.E. A PIECE OF MAIL, COPY OF LEASE OR RENTAL AGREEMENT)**

***CHILD'S BIRTH CERTIFICATE**

***CHILD'S IMMUNIZATION**

IT IS ALSO RECOMMENDED THAT A DENTAL CERTIFICATE BE PROVIDED IF ONE IS AVAILABLE.

Student Name _____

Date of Birth _____/_____/_____ M_____ F_____

Mother's Name _____

911 Address _____ Town _____Zip _____

Mailing Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Father's Name _____

911 Address _____ Town _____Zip _____

Mailing Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Student lives with: _____both, _____ mother, _____ father, _____other

****

PLEASE COMPLETE ALL OF THE FOLLOWING:

1. Please list other pre-school children in your family.
   (1) child's name_____ Date of Birth___/___/_____
   (2) child's name_____ Date of Birth___/___/_____
   (3) child's name_____ Date of Birth___/___/_____

2. Does your child have any special needs or supports in the area of toileting?
   _____ Yes _____ No
   If yes, please list: _____
   _____

3. Is child taking any medication: _____ Yes _____ No If yes, please list: _____

_____

4. Have you suspected your child may have defective eyesight? _____

If yes, has he/she ever been seen by an optometrist or an eye specialist? _____
If yes, what was the date, results of the examination, and recommendation, if any: _____

_____

_____

5. Have you ever suspected that he/she may have defective hearing? _____

If yes, has he/she ever been examined? _____
If yes, what were the results of the examination, and recommendations, if any: _____

_____

6. Has your child had any other screenings or evaluations?

_____ Yes _____ Date _____ No

If yes, what were the results: _____

_____

7. Has your child been hospitalized at all since birth? _____ Yes _____ No

If yes, what was the reason? _____

8. Any other illnesses or injuries? _____

9. Has your child ever seen a dentist? _____ Yes _____ No

10. Does your child have any allergies? _____ Yes _____ No If yes, please list: _____

_____

11. Can he/she remember a short message or a telephone number? _____ Yes _____ No

Additional Comments: _____

_____

_____

12. Are there any medical/emotional needs or issues that should be shared with your child's teacher(s)?

_____

_____

_____

Are you interested in volunteering in the Prekindergarten program?

_____ Yes _____ No

I understand that all reports and testing results will be treated confidentially.

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Fax: (315) 562-8137 (7-12)

FOR OFFICE USE ONLY:
Student ID#: _____
Grade: _____
Teacher/Homeroom: _____

EMERGENCY INFORMATION SHEET – 2024-2025

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

Gender: □M □F Date of Birth: _____ Bus #/Driver: _____

Resident *911* Address: _____

Resident *Mailing* Address: _____

Language Spoken at Home: □ English □ Other (specify): _____

Is there a current custody arrangement? □ **Yes** □ **No** *If yes, paperwork must be provided. If changes occur at ANY time during the school year, updated documentation is required.*

Father: _____ Legal Guardian: □ Yes □ No Receives Mail: □ Yes □ No
Lives in household: □ Yes □ No If no, address: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____

Mother: _____ Legal Guardian: □ Yes □ No Receives Mail: □ Yes □ No
Lives in household: □ Yes □ No If no, address: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____

Other Legal Guardian IF NOT FATHER/MOTHER: _____
Relationship: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____

Sibling(s) living in same household:
Name: _____ Grade: _____ Name: _____ Grade: _____
Name: _____ Grade: _____ Name: _____ Grade: _____

Emergency Contact Information (people to contact if parent not available AND to whom we may release your child to):
Name: _____ Relationship to Student: _____ Phone No: _____
Name: _____ Relationship to Student: _____ Phone No: _____
Name: _____ Relationship to Student: _____ Phone No: _____
Name: _____ Relationship to Student: _____ Phone No: _____

If there is an **early dismissal**, child should be sent to: _____
Address: _____

Medication and/or special medical needs to share with staff: _____
_____

Permission to (please check): □ Provide Treatment □ Call Ambulance □ Call Doctor

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

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HOUSING QUESTIONNAIRE

Student Name: _____ Gender: □M □F Date of Birth: _____ Grade: _____

Address: _____ Phone: _____

During the time the student resides at the current location, who is responsible for:

(a) Receiving and responding to academic and other reports concerning the student?

_____

(b) Making decisions regarding the student's education?

_____

(c) Releasing records for the student?

_____

(d) Providing other necessary consents for the student?

_____

The answers you give below will assist the district in determining what services you or your child may be able to receive under the McKinney-Vento Act 42 U.S.C. 11435. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they do not have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

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

□ In permanent housing

Answer question 2 if not in permanent housing:

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

2. Last permanently housed location: _____

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).

I certify that all the information I provided is true and accurate. I understand that:

***if I provide false information to the Edwards-Knox Central School District, I may be committing the crime of Perjury in the Third Degree (a Class A Misdemeanor);**

***if I provide false information to the Edwards-Knox Central School District with the intent to defraud the Edwards-Knox Central School District, I may be committing the crime of Perjury in the Second Degree (a Class E Felony); and**

***I may be prosecuted on criminal charges for such false information.**

_____ _____

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

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

_____

Date

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STUDENT RACIAL AND ETHNIC IDENTIFICATION LETTER

To Parents/Guardians:

In accordance with federal categories and definitions, the Edwards-Knox Central School District is required to collect and record ethnic identity of students in the district. 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.
- Study the movement of students in different ethnic groups as they move from school to school.
- 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. Put a check (√) in the box for the category or categories which best describe your child. The Edwards-Knox Central School District understands the sensitive nature of this information and wishes 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.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff: this form will be filed in the student's permanent record as confidential information.

To the Parent/Guardian: the information which you have provided on this form is confidential. It 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.

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STUDENT RACIAL AND ETHNIC IDENTIFICATION LETTER

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: _____ Date of Birth: _____ Grade: _____

PLEASE ANSWER *BOTH* QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND.

1. Is your child 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.) **Check (√) the one box that best describes your child:**

□ YES: Hispanic.

□ NO: Not Hispanic.

2. Select one or more races from the following five racial groups. Check (√) at least one box but choose all groups that apply to your child:

□ **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 (i.e. Cherokee, Mohawk, Inuit).

□ **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:** 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.

_____ _____
Signature of Parent/Guardian/Other Date

Relationship to Student (please check one): □ Mother □ Father □ Guardian □ Other: _____

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TECHNOLOGY GUIDELINES FOR ACCEPTABLE STUDENT USE GRADES PRE-KINDERGARTEN-12 USER AGREEMENT AND PARENT PERMISSION FORM - 2024-2025

As a user of the Edwards-Knox Central School computer network, I hereby agree to comply with the stated rules on the reverse side- communicating over the network in a reliable fashion while honoring all relevant laws and restrictions.

Student Name (please print) _____

Grade _____ **Birth Date** _____

Student Signature _____

As the parent or legal guardian of the student signing above, I grant permission for my son or daughter to use networked computer services at Edwards-Knox Central School as outlined in this document. I understand that my son or daughter will be held liable for the aforementioned violations.

Parent Name (please print) _____

Street Address _____

Town _____

Home Telephone _____

Parents' Signature _____

Date _____

This form is required in order for your child to have a network account to use with student devices.

****

PHOTO RELEASE

Please submit in writing to the Superintendent if you do not wish for your child to have his/her photo taken at school for publication in local newspapers and on the school website at any time during the school year.

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TECHNOLOGY GUIDELINES FOR ACCEPTABLE STUDENT USE

We are pleased to offer the students of Edwards-Knox Central School access to the district computer network for Internet access. To gain independent access (the use of the Internet during a student's free time) all students must obtain parental permission and must sign and return this form to the school.

Access to the Internet will enable students to explore thousands of libraries, databases, and bulletin boards throughout the world. Families should be warned that some material accessible via the Internet may contain items that are illegal, defamatory, and inaccurate or potentially offensive to some people. While our intent is to make Internet access available to further educational goals and objectives, students may find ways to access other materials as well. We believe that the benefits to students from access to the Internet, in the form of information resources and opportunities for collaboration, exceed any disadvantages. Edwards-Knox Central School teachers who utilize the Internet for instruction will review the guidelines for its use. Parents and guardians should help set and convey the standards that their children should follow when using media and information sources. To that end, Edwards-Knox Central School supports and respects each family's rights to decide whether or not to apply for independent access. However, by not approving Internet access a student's ability to research information will be limited.

Guidelines for Acceptable Use - Users are expected to follow these rules of network etiquette:

1. Users are to be polite and use appropriate language. Abusive and/or vulgar messages are not allowed.
2. Users are not to engage in illegal activities including sexually explicit material, gambling, and hate websites.
3. Users are not to reveal anyone else's address, phone number or personal information out over the Internet.
4. Users cannot hold the district responsible for materials that he/she acquires on the network.
5. Users files are NOT private. The District has access to all files and can monitor computer activity at all times.
   - Any messages relating to or in support of illegal activities may be reported to the authorities.
6. Users are not to use the network in any way that will be disruptive to other users.
7. Users are not to access, alter, or destroy any files.
8. Users may access the network ONLY for educational intent.
9. Users are not to investigate, download or play Internet games that are not approved by a teacher, use chat rooms (ICRs) or use Multi-Dimensions (MUDS).
10. Users are not to download or install any software to the computers.
11. Users are not to give out their username and password to anyone, nor are they to use another person's username and password to access the network.
12. Users will credit all materials in their work in keeping with copyright laws.
13. Users are not to employ the network for commercial purposes.
14. Users are to report any misuse of the system according to these rules to the administration.
15. Users are to treat the equipment with care and not abuse it.
16. Users are to follow printing guidelines and ARE NOT allowed to print in color unless given permission by an EK staff member and should only be done for academic purposes.
17. Users are not to use Proxy servers to access the Internet.
18. Users in grades 7-12 will have access to a school provided e-mail account and are expected to use this account within the intent of these guidelines. Grades K-6 will not have permission to access or use any e-mail accounts.
19. If you have any questions about using a computer not consistent with these guidelines, please ask a staff member.

The following are possible consequences depending on the severity of the offense and the impact it may have on others:

* Loss of privileges for 30 days.
* Loss of privileges for remainder of semester or 60 days.
* Loss of privileges for remainder of the year or 90 days.
* Students may be removed from the Network by the Network Administrator for inappropriate use of the network/Internet.
* A discipline referral needs to be filled out by faculty/staff to report violations.

Additional disciplinary action may be determined at the building level for infractions that may violate existing practices (i.e. inappropriate language.) When applicable, law enforcement agencies may be involved.

NEW YORK STATE MIGRANT EDUCATION PROGRAM

IDENTIFICATION & RECRUITMENT OFFICE

PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take few minutes to complete this questionnaire.

Has anyone in your family worked, or looked for work at the following occupations during the past 3 years?

- ☐ 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, packing fruits or vegetables, etc.)

If you answer YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____

Telephone number: (____)_____-_____Best time to be reached:_____AM/PM

Previous Address: _____

Student name: _____ Age_____Grade_____

Student name: _____ Age_____Grade_____

To submit this referral please fax to 607-436-3606, or by mail to NYS Migrant Education Program-Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.

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

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH: *Month* *Day* *Year*

GENDER: ❑ Male ❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other _____ *specify*	
2. What was the first language your child learned?	❑ English	❑ Other _____ *specify*	
3. What is the Home Language of each parent/guardian?	❑ Mother _____ *specify*	❑ Father _____ *specify*	❑ Guardian(s) _____ *specify*
4. What language(s) does your child understand?	❑ English	❑ Other _____ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other _____ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other _____ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other _____ *specify*	❑ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
Edwards-Knox Central School 2512 CR 24, Hermon, NY 13652	
District Name (Number) & School *Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

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:** _____

Age at which services received *(Please check all that apply):*
❑ **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 ***Date***

Relationship to student: ❑ **Mother** ❑ **Father** ❑ **Other:** _____

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:** _____ (MO DAY YR)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:** _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL:
❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

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

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

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

HEALTH HISTORY

Allergies ☐ No
☐ Yes, indicate type ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results:_____ Date Drawn: _____

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

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

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:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

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 ☐ Colostomy Appliance* ☐ Hearing Aids

☐ Insulin Pump/Insulin Sensor* ☐ Medical/Prosthetic Device* ☐ Pacemaker/Defibrillator*

☐ Protective Equipment ☐ Sport Safety Goggles ☐ 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 NYSIIS 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.

2022-23 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]	**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses or 2 doses** of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9, 10 and 11: 1 dose**	**2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.

   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.

   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 and 7: 10 years, minimum age for grades 8 through 12: 7 years)

   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.

   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2021-2022, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 and 7; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 8 through 12.

   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)

   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.

   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)

   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

   b. Measles. One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

   c. Mumps. One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

   d. Rubella. At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine

   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).

   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)

   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 and 8: 10 years; minimum age for grades 9 through 12: 6 weeks)

   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.

   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.

   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.

   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.

   d. If dose 1 was received at 15 months or older, only 1 dose is required.

   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)

   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.

   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.

   d. If one dose of vaccine was received at 24 months or older, no further doses are required.

   e. PCV is not required for children 5 years or older.

   f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at www.health.ny.gov/prevention/immunization/schools.

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

Date Withdrew_____ **Attachment Va** F___R____D____

2024-2025 Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and **return it to the address listed below.** Call ***(315) 562-8130,*** if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: **Edwards-Knox Central School**
2512 County Route 24
Hermon, NY 13652

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	Homeless Migrant, Runaway
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. **Skip to Part 4, and sign the application.**

Name: _____ CASE #: _____

3. Report all income for ALL Household Members (Skip this step if you answered 'yes' to step 2)

All Household Members (including yourself and all children that have income).
List all Household members not listed in Step 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any other source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of household member	Earnings from work before deductions ***Amount / How Often***	Child Support, Alimony ***Amount / How Often***	Pensions, Retirement Payments ***Amount / How Often***	Other Income, Social Security ***Amount / How Often***	No Income
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐

Total Household Members (Children and Adults) ☐☐

***Last Four Digits of Social Security Number:** XXX-XX-__ __ __ __ I do not have a SS# ☐

*When completing section 3, an adult household member must provide the last four digits of their Social Security Number (SS#), or mark the "I do not have a SS# box" before the application can be approved.

4. Signature: An adult household member must sign this application before it can be approved.
I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school will get federal funds; the school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.
Signature: _____ **Date:** _____
Email Address: _____
Home Phone: _____ Work Phone: _____ Home Address: _____

5. Ethnicity and Race are optional; responding to this section does not affect your children's eligibility for free or reduced price meals.
Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
Race (Check one or more) : ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Island ☐White

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

☐ SNAP/TANF/Foster
☐ Income Household: Total Household Income/How Often: _____/_____ Household Size: _____
☐ Free Meals ☐ Reduced Price Meals ☐ Denied/Paid
Signature of Reviewing Official **Date Notice Sent:**

APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, complete only one application for your household using the instructions below. Sign the application and return the application to Edwards-Knox Central School.
If you have a foster child in your household, you may include them on your application. A separate application is not needed. Call the school if you need help: (315) 562-8130 Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

PART 1 ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE APPLICATION FOR YOUR HOUSEHOLD.

(1) Print the names of the children, including foster children, for whom you are applying on one application.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, or if you believe any child meets the description for homeless, migrant, runaway (a school staff will confirm this eligibility).

PART 2 HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.

(1) List a current SNAP, TANF or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. The case number is provided on your benefit letter.
(2) An adult household member must sign the application in PART 4. SKIP PART 3. Do not list names of household members or income if you list a SNAP case number, TANF or FDPIR number.

PART 3 ALL OTHER HOUSEHOLDS MUST COMPLETE THESE PARTS AND ALL OF PART 4.

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box.** The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.
(3) Enter the total number of household members in the box provided. This number should include all adults and children in the household and should reflect the members listed in PART 1 and PART 3.
(4) The application must include the last four digits only of the social security number of the adult who signs **PART 4** if Part 3 is completed. If the adult does not have a social security number, check the box. **If you listed a SNAP, TANF or FDPIR number, a social security number is not needed.**
(5) An adult household member must sign the application in PART 4.

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). To determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

USE OF INFORMATION STATEMENT

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not submit all needed information, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the primary wage earner or other adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs.
We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

DISCRIMINATION COMPLAINTS

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.