Rhinebeck Central School District

POST OFFICE BOX 351
RHINEBECK, NEW YORK 12572
(845) 871-5570 x-5560
(845) 876-4963 (fax)

Date: ___________________________________

Welcome to the Rhinebeck Central School District.

Parents/guardians should begin the registration process by calling (845) 871-5570 x5560. The District will mail the registration packet to you in advance to minimize your appointment time or you may visit the District's website at www.rhinebeckcsd.org (under the Departments tab) to obtain the required forms.

The school district is required by NYS Education Law to verify the prospective student's eligibility for enrollment based on age and residency within the district's boundaries.

In order to verify your child's eligibility to attend the schools of our district, you must submit the following documents, records, or information to my office **immediately**, if available, but not later than the close of the next regular business day.

- A residential lease, mortgage, or deed
- A statement from a landlord concerning your tenancy
- A statement from a third party that establishes your presence in the Rhinebeck Central School District
- Additionally, you must complete and submit the attached affidavit(s), if applicable.

You may also submit any other relevant evidence you wish to, including but not limited to the following types of documentation:

a) pay stub;
b) income tax form;
c) utility or other bills;
d) membership documents (e.g., library cards) based upon residency;
e) voter registration document(s);
f) official driver's license, learner's permit or non-driver identification;
g) state or other government issued identification;
h) documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement); or
i) evidence of custody of the child in question, including but not limited to judicial custody or order or guardianship documentation.

Finally, if available, you must submit the following: an original or certified transcription of your child's birth certificate, or an original or certified transcription of your child's certificate of baptism, if available. If you are unable to provide the District with either of these types of documents, please provide your child's passport, regardless of the issuing nation. In the absence of any of the aforementioned, you may provide any other documentation that has been in existence for over two years that could be used to establish your child's age.

For example:

a) official driver's license;
b) state or other government issued identification;
c) school photo identification with date of birth;
d) consulate identification cards;
e) hospital or health records;
f) documents issued by federal, state or local agencies (e.g., local service agency, federal Office of Refugee Resettlement);
g) court orders or other court-issued documents;
h) Native American tribal document; or
i) records from non-profit international aid agencies and voluntary agencies.

In order to make a timely decision regarding a student's right to continued enrollment in the District, the aforementioned information and documentation should be delivered to the Registrar located at 48 Knollwood Road, Rhinebeck, NY **by tomorrow** (or the next regular business day if tomorrow is a weekend or holiday). If you have any questions, please contact the Registrar at (845) 871-5570 x5560.

Thank you,

Joseph Phelan
Superintendent of Schools
Residency Officer

RHINEBECK CENTRAL SCHOOL DISTRICT
EMILY DAVISON
OFFICE OF SPECIAL PROGRAMS
P.O. BOX 351
RHINEBECK, NEW YORK 12572
(845) 871-5570 x5551

Parental Rights to Referral and Evaluation for Special Education Services or Programs

The Rhinebeck Central School District offers supports for students attending Chancellor Livingston Elementary School, Bulkeley Middle School or Rhinebeck High School in general education such as related services, curriculum and instructional modifications and Academic Intervention Services (AIS). The Response to Intervention (RtI) team in your child's school may make a referral to the Committee on Special Education (CSE) if interventions have not been successful. Contact your child's teacher for more information.

If you think your child has a disability which adversely affects his/her educational performance and may require special education, you may initiate a referral by writing to the Committee on Special Education ("CSE") in this school district or where the nonpublic school is located.

A referral is a written statement asking that the school district evaluate your child to determine if he or she needs special education services. This written statement should be addressed to:

Emily Davison
Director of Special Education
Rhinebeck Central School District
PO Box 351
Rhinebeck, NY 12572

Additional information is available in English and Spanish in a document called, *A Parent's Guide to Special Education* at www.nysed.gov.

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STUDENT REGISTRATION FORM

STUDENT INFORMATION

Name: ____ **Gender:** ☐ Male ☐ Female **Age:** ________
(Last) *(First)* *(Middle)*

Address: ____

Phone number (_____) ________________________ **Unlisted:** ☐ Yes ☐ No **Date of Birth:** _____/_____/_____

Entering Grade:________________________ **Date of entry in Grade 9:** _____/_____/_____

Note: Official grade level to be determined by Principal of assigned school.

Has the student attended Rhinebeck Schools before? ☐ Yes ☐ No If Yes, when? _____/_____/_____ Grade(s):________

Academic Needs: Reading Assistance ☐ Yes ☐ No Prior enrollment in any Special Programs? ☐ Yes ☐ No

If Yes, list: ____

Are there any special concerns that the teacher/nurse/counselor should be aware of? ☐ Yes ☐ No

If Yes, list: ____

____

Immunization date of first Polio vaccination: _____/_____/_____

Health: Glasses, allergies, etc.:____

ACADEMIC HISTORY

Name of last school attended: ____ **Phone:** (_____) _________________

Address: ____

Reason for leaving school: ____ **Counselor Name:** ____________________

Enrollment dates: ____

Names of any prior schools/academic programs attended:

1. ____
2. ____

FAMILY HISTORY

MOTHER: Name:	**FATHER:** Name:
Address: *(include street address if PO Box)*	**Address:** *(include street address if PO Box)*
Phone:	**Phone:**
Employer/job title:	**Employer/job title:**
Business Phone:	**Business Phone:**
Email:	**Email:**

OTHER CHILDREN IN THE FAMILY

Name	Date of Birth	Address (other than home)	School	Grade

SINGLE / SEPARATED /DIVORCED / FOSTER PARENT, OR GUARDIAN

- **If you are a single parent, please complete the following and submit any legal documents:**

  Custody is with:____

  Official Document on file:______________________________________

  Are there any court orders of protection or restricted visitation papers? □ Yes □ No

  If Yes, legal documentation must be submitted to Registrar within three (3) days from enrollment.

- **If you are the Legal Guardian, and not the Parent, please complete the following and submit any legal documents:**

  Legal documentation must be submitted to Registrar within three (3) days from enrollment.

  Name: ____

  Relationship to child: __________________________________

- **If you are a Foster parent, please complete the following:**

  Name of Foster Parent(s):_______________________________

  Name of Agency:______________________________________

  Social Worker name and phone number:_____________________

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REQUEST FOR RECORDS

Student Name: ____

Date of Birth: ____

Previous School Attended:

School Name: ____

Street Address: ____

City: ____

State: ______________________________Zip: ____________________

Phone: _____________________________ Fax: ____________________

Kindly fax or mail to:

☐ **Chancellor Livingston Elementary School**
PO Box 351, Knollwood Road
Rhinebeck, NY 12572
Attn: Main Office
(845) 871-5570 ext. 5571
(845) 876-4174 (fax)
rranalli@rhinebeckcsd.org

☐ **Bulkeley Middle School**
PO Box 351, North Road
Rhinebeck, NY 12572
Attn: Carmela Fountain, Guidance Office
(845) 871-5500 ext. 5552
(845) 871-5553 (fax)
cfountain@rhinebeckcsd.org
ckeegan@rhinebeckcsd.org

☐ **Rhinebeck High School**
PO Box 351, North Road
Rhinebeck, NY 12572
Attn: Guidance Office
(845) 871-5500 ext. 5505
(845) 871-5562 (fax)
smulkins@rhinebeckcsd.org

Please provide any and all records as follows:

1. Academic records including grades/transcripts, discipline, attendance, testing/assessments
2. Medical records including immunization records
3. Psychological, psychiatric and neurological evaluations
4. Individualized Education Plan or 504 Plan, if applicable.

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STUDENT TRANSPORTATION INFORMATION

Date: ________________________________

Student ID: ____________________________

Last Name: _________________________________ First Name: ______________________________

House #___________ Street: _____________________________ City: _________________Zip:______

Date of Birth: _____/_____/_____ Male ☐ Female ☐ Age: _________ Grade: ________

Emergency Contact: ____

Home Phone:_______________________________ Work Phone: _______________________________

Physician's Name: ___________________________ Physician's Phone: __________________________

Known allergies: ____
(be specific)
____

BUS PICK-UP

Bus pick-up @ address/location ____
(circle days of week) (M) (T) (W) (Th) (F)

Alternate pick-up @ address/location ____
(circle days of week) (M) (T) (W) (Th) (F)

BUS DROP-OFF

Bus drop-off @ address/location ____
(circle days of week) (M) (T) (W) (Th) (F)

Alternate drop-off @ address/location ____
(circle days of week) (M) (T) (W) (Th) (F)

Father's Name: _____________________________ Mother's Name: ____________________________

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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.

Please write clearly when completing this section.

STUDENT NAME:			
First	*Middle*	*Last*	
DATE OF BIRTH:			**GENDER:**
Month	*Day*	*Year*	❑ Male ❑ Female
PARENT/PERSON IN PARENTAL RELATION INFO:			
Last Name	*First Name*	*Relation to Student*	

HOME LANGUAGE CODE ______

Language Background

(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other ______ *specify*	
2. What was the first language 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:**
Rhinebeck CSD	PO Box 351, Rhinebeck, NY 12572	
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:

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STUDENT INFORMATION

1. INFORMATION

Child's Name	
Custodial Parent	

Information collected below is required by the NYS Education Department for data collection purposes only. This information shall not be used to deny resident students enrollment in the school district.

2. CITIZENSHIP

Immigrant	☐ Yes ☐ No *(If answer is No, skip rest of question 2)*		
City & Country of Origin			
First Date of Entry to US		Date Entered US Schools	

3. ETHNICITY/RACE*

Ethnicity*	Is the Student Hispanic, Latino, or of Spanish origin? ☐ Yes ☐ No
Race* (Please circle all that apply)	**I B A W P**
Ethnicity*	
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.	
Race*	
I - American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.	
B - Black or African-American: A person having origins in any of the Black racial groups of Africa	
A - 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.	
W - White: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.	
P - Native Hawaiian Or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	

4. STUDENT SCREENING

All students new to entering the New York State public school system are mandated to be screened in the areas of cognitive, academic, language, and motor development for the possibility of being gifted, the possibility of having or the suspicion of having a disability, and the possibility of being limited English proficient. The results of the screening will be mailed home to parents/guardians and may be shared with the student's teacher/s to better their educational instruction. Please sign below in acknowledgement of this.

____
Parent/guardian signature

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RESIDENCY QUESTIONNAIRE

Name of LEA: Rhinebeck Central School District

Name of School: ______________________________

Name of Student: ______________________________
Last First Middle

Gender:
- ☐ Male
- ☐ Female

Date of Birth: ______ /_____ /_____ (*Month Day Year*)
Grade: _________ (*preschool-12*)
ID#: ______________ (*optional*)

Address: ____________________________________ Phone: ______________________

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or proof of age. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (*Please 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

____
Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

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

____
Date

Rhinebeck Central School District

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CUESTIONARIO DE RESIDENCIA

Nombre del Distrito Escolar: Rhinebeck Central School District

Nombre de la Escuela: ____________________

Nombre del Estudiante: ____________________
Apellido Primer Nombre Segundo Nombre

Género: ☐ Hombre
☐ Mujer

Fecha de Nacimiento: _____ / _____ / ______
Mes *Día* *Año*

Grado:______ *(jardín de infantes – 12)*

ID#: _______ *(opciónal)*

Dirección: ____________________ Teléfono: ____________________

Su respuesta abajo permitirá al distrito escolar definir los servicios que puede aprovechar su hijo/hija según el Acto de McKinney-Vento. Los estudiantes elegibles tienen derecho a la inscripción inmediata en la escuela, aun si ellos no tienen los documentos necesarios tales como: prueba de residencia, documentos escolares, documentos de inmunización, o partida de nacimiento. Los estudiantes elegibles según el Acto de McKinney-Vento tienen además derecho al transporte gratuito y otros servicios que ofrece el distrito escolar.

¿Donde está el estudiante viviendo actualmente? (*Por favor marque **una** caja.*)

- ☐ En un refugio
- ☐ Con otra familia o otra persona debido a la pérdida del hogar o a dificultades económicas
- ☐ En un hotel/motel
- ☐ En un carro, parque, autobús, tren, o camping
- ☐ Otra vivienda temporal (Por favor describa):
  ____
- ☐ En un hogar permanente

____
Nombre de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

____
Firma de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

____
Fecha

Rhinebeck Central School District

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Dear Parent or Guardian:

The New York State Education Law requires that every child in ***grades K, 2, 4, 7, and 10, and*** any ***new entrants*** to the school district, must have a health examination given by either their family physician or the school doctor. Your family physician has a more complete understanding of your child, can interpret his findings directly to you, and assist you, in carrying out any recommendations which may be indicated.

We respectfully urge, therefore, that you take your child to your family physician and have the **ANNUAL HEALTH APPRAISAL FORM** on the other side of this sheet filled out and returned when the child enters school. This exam should be done **within twelve months** of your child's current school year in order to be accepted.

We are asking that all statements from the private physician be turned in to the Health Office (**NO LATER THAN OCTOBER 1st**). If, by that time, we do not have the record of examination, (or a known appointment date), it will be necessary to have the examination done by the school physician, in order to have the record of the child's physical condition on hand for reference.

The New York State Department of Health has revised the regulations regarding immunization requirements for school attendance *EFFECTIVE August 2015*. The new dosing requirements are based on the Advisory Committee on Immunization Practice (ACIP).

THE FOLLOWING VACCINATIONS ARE REQUIRED AND MANDATORY before a child enters or transfers to our school:

Vaccines	Grades K-1	Grades 2 - 5	Grade 6-7	Grades 8 - 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (*DTaP/DPT/Tdap*)	4 – 5 doses	4 – 5 doses	3 doses	3 doses
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (*Tdap*) (*Required only for students enrolling in grades 6-12 who have not previously received a Tdap at 7 years of age or older)*	Not applicable	Not applicable	1 dose	1 dose
Polio vaccine (*IPV/OPV*)	3 – 4 doses	3 – 4 doses	3 – 4 doses	3 doses
Measles, Mumps, and Rubella vaccine (*MMR*)	2 doses	2 doses	2 doses	2 doses
Hepatitis B vaccine	3 doses	3 doses	3 doses	3 doses
Varicella (chicken pox) vaccine	2 doses	1 dose	2 doses	1 dose

***EFFECTIVE September 2016-Meningococcal Vaccine -1 dose-REQUIRED for grades 7 and 12**

Sincerely,
Mary Skeen, RN
Teresa Costakis, RN
School Nurses

12/17/2015

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH CERTIFICATE / APPRAISAL FORM

Name: ______________________ **Date of Birth:** ______________________

School: ______________________ **Gender:** ❑ M ❑ F **Grade:** ______________________

IMMUNIZATIONS / HEALTH HISTORY

❒ Immunization record attached
❒ No immunizations given today
❒ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ❒ Positive ❒Negative ❒ Not done Date: ________
PPD: ❒ Positive ❒Negative ❒ Not done Date: ________
Elevated Lead: ❒ Yes ❒ No ❒ Not done Date: ________
Dental Referral ❒ Yes ❒ No ❒ Not done Date: ________

____

Significant Medical/Surgical History: ❒ See attached ______________________

____

Allergies: ❒ **LIFE THREATENING** ❒ Food: ________ ❒ Insect: ________ ❒ Other: ________

❒ Seasonal ❒ Medication: ______________________ ________

PHYSICAL EXAM

Height: ________ Weight: ________ Blood Pressure: ________ Date of Exam: ________

Body Mass Index: ____ ____ . ____					
Weight Status Category (BMI Percentile):					*Referral*
❑ less than 5th	❑ 5th through 49th	❑ 50th through 84th			
❑ 85th through 94th	❑ 95th through 98th	❑ 99th and higher			

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ❑ Pass 20 db sc both ears or:	R	L	

❒ **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: ________

OPTIONAL INFORMATION, if known

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

Provider's Signature: ______________________ Phone: ________ (Stamp below)

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. 2/08*

Rhinebeck Central School

HEALTH RECORD

Child's Name ____ Male ____ Female ____

Address ____Place of Birth ___________

Date of Birth ___________________________________ Home Phone # _______________
Month Day Year

Mother's Name _________________________________ Bus. Phone # ________________

Father's Name _________________________________ Bus. Phone # ________________

Local Physician ______________________________ Phone # ______________________

Siblings ______________________________________ Birth Date ____________________

______________________________________ Birth Date ______________________

Have you ever suspected that your child may have problems with his eyesight? If so, has he/she ever been seen by an optometrist or an eye specialist ? ____________

____

If so, what was the result of the examination and recommendations, if any ?

____

Have you ever suspected that your child may have hearing problems ?

____

If so, has your child been tested? Yes/No Date_____________________

If so what was the result of the examination and recommendations, if any?

____

Has your child had any other screening or evaluations? Yes/No Date ___________

If yes, what were the results ? ____

____

Has your child been hospitalized since birth? Yes/No Date ______________________

If so what was the reason ? ____

____

Does your child take any medications at home? Yes/No

Please list:____

Any other serious illnesses or injuries? ____________________________

Has your child seen a dentist? Yes/No Date ________________

If so, for what reason? ___________________________________

Does your child have allergies? Yes/No

Please list: ____

Has your child ever had any of the following? If so, give dates below:

Chicken Pox ________	Scarlet Fever ________	Ear Conditions ________
Diptheria ________	Whooping Cough ________	Frequent Colds ________
German Measles ________	Diabetes ________	Sore Throats ________
Measles ________	Epilepsy ________	Operations ________
Mumps ________	Heart Disease ________	________________
Pneumonia ________	Tuberculosis ________	________________
Poliomyelitis ________	Contact w/TB ________	________________
Rheumatic Fever________	Asthma or Allergies ________________	

Serious Injuries ________________ Other ________________

____

Health Record Consent

*This information will be kept confidential unless an emergency arises, or the nurse determines that the school team, or primary care provider have a need to know because of a specific health concern regarding your child.

I give consent to share this information with the school team, and primary care provider if an emergency occurs or if the nurse determines that there is a need to know to ensure the health, safety, and well-being of your child. I understand that it's my (parent's/guardian's) responsibility to inform teacher(s), and school staff, including extracurricular coaches and club advisors, of my child's health condition(s).

Parent/Guardian Signature:________________________ Date:__________

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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 oral health assessment? ☐ 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/ Dental Hygienist

I. The dental health condition of ________________________________ _______ on__________ (date of assessment) The date of the assessment 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/ Dental Hygienist's name and address (please print or stamp)	**Dentist's/Dental Hygienist'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):____

II. 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.

Rhinebeck Central School District

POST OFFICE BOX 351
RHINEBECK, NEW YORK 12572
(845) 871-5570 x-5560
(845) 876-4963 (fax)

AFFIDAVIT OF LEGAL RESPONSIBILITY
(TO BE USED BY CUSTODIAL PARENTS)

STATE OF NEW YORK)
) SS.:
COUNTY OF ____________)

I (We), __________________________________, a resident(s) of the Rhinebeck Central School District, being duly sworn, say:

1. I(We) reside at:____

_____________________________________ Telephone No.:_________________

2. ____________________________ is my___________________________________
(Full Name of Child) (Relationship to Child)

and he/she has been living with me(us) since_________________________________.
(Date)

3. I(We) expect the duration of this living arrangement to be:

____

____

4. The reason(s) that the above-named child lives with me(us) is:

____

____

____

5. Does the above-named child live at any other location?_____________________
If so, please indicate the length of time the child is at the other address and provide an explanation. If the child does not live at any other address, so indicate:

____

____

6. Please indicate who provides the support for the above-named child (e.g., room, food, clothing, health and dental insurance, other insurance, other necessities):

____

____

7. Please provide any other relevant facts and attach any relevant documents:

____

____

____

I(We) hereby affirm that I(we) accept and assume full parental rights and responsibilities (care, custody and control) for the above-named child, including but not limited to full responsibility for all matters relating to the child's education (parent conferences, discipline, truancy, vandalism) and medical care.

I(We) will be financially responsible for damage, defacement and/or destruction of school buildings and property and any other legal matters that may arise pertaining to this child.

I(We) affirm that the information provided on this form is true and correct and that the statements made herein are being made under the penalties of perjury. I(We) understand that the District may investigate any allegation contained in this form and may ask for written proof of any statement.

I(We) further understand that in the event the information contained in this affidavit is determined to be inaccurate or false, in whole or in part, the District may commence legal proceedings against me to collect tuition and/or seek to seek criminal action against me for filing a false legal document.

____
(Signature of Custodian)

____
(Signature of Custodian)

Subscribed and sworn to before me
this ___ day of _____________, 20___

____
NOTARY PUBLIC

Rhinebeck Central School District

POST OFFICE BOX 351
RHINEBECK, NEW YORK 12572
(845) 871-5570 x-5560
(845) 876-4963 (fax)

AFFIDAVIT OF LEGAL RESPONSIBILITY
(TO BE USED BY PARENTS WHO ARE HAVE SURRENDERED LEGAL CUSTODY)

STATE OF NEW YORK)
) SS.:
COUNTY OF ____________)

I (We), __________________________________, being duly sworn, say:

1. I (We) are the natural parent(s) or legal guardian(s) of______________________.
(Name of Student)
(If the legal guardian, please attach documents which prove legal guardianship.)

2. I(We) reside at:____

____

Telephone No.________________________

3. The reason why _______________________ is not living with me (us) is:
(Name of Student)

____

____

____

4. I(We) hereby relinquish all parental rights and responsibilities for my(our) child,

__________________________ to____,
(Name of Child) (Name of Individual[s])

including but not limited to the right to make decisions pertaining to the health, welfare and education of my(our) child. This individual(s) resides at:

____

_____________________________________ Telephone No._____________________

5. The reason(s) for relinquishing all parental rights and responsibilities for my(our) child is(are) as follows:

____

____

____

____

____

6. My(Our) child's current address and living arrangement is:

____

____

7. Please explain the initial duration of this living arrangement, as well as expected duration:

____

____

____

8. Please describe any other location(s) where your child lives, including the length of time the child is at the other address and provide an explanation. If the child does not live at any other address, so indicate:

____

____

____

9. I(We) provide and will continue to provide the following support for the above-named child:

_____	Medical	_____	Automobile Insurance
_____	Dental	_____	Food
_____	Life Insurance	_____	Clothing
_____	Health Insurance	_____	Other (specify)___________

10. Please provide any other relevant facts:

____

____

____

I(We) affirm that we will remove the above-named child from my(our) federal and state income tax, which is subject to confirmation by the District.

I(We) understand that the responsibility for parent conferences, discipline, truancy, money owed, emergency medical treatment and other legal matters is being given to the District resident accepting custody.

I(We) affirm that the information provided on this form is true and correct and that the statements made herein are being made under the penalties of perjury so that my child(ren) may be admitted to the Schools of the [INSERT NAME OF SCHOOL DISTRICT]. I(We) understand that the District may investigate any allegation contained in this form and may ask for written proof of any statement.

I(We) further understand that in the event the information contained in this affidavit is determined to be inaccurate or false, in whole or in part, the District may commence legal proceedings against me to collect tuition and/or seek to seek criminal action against me for filing a false legal document.

____
(Signature of Parent/Legal Guardian)

____
(Signature of Parent/Legal Guardian)

Subscribed and sworn to before me
this ___ day of ____________, 20____

____
NOTARY PUBLIC

Rhinebeck Central School District

POST OFFICE BOX 351
RHINEBECK, NEW YORK 12572
(845) 871-5570 x-5560
(845) 876-4963 (fax)

AFFIDAVIT OF EMANCIPATION
(STUDENT)

STATE OF NEW YORK)
) SS.:
COUNTY OF DUTCHESS)

I, ________________________________, being duly sworn, say:
(Name of Student)

1. I was born on ____________________ and am over the age of sixteen.
(Date of Birth)
(Please attach a copy of your birth certificate or other proof of age, if a new enrollee.)

2. I currently reside at:____

_________________________________ Telephone No.________________

(Please attach a rent stub or statement from person with whom you are living.)

3. I am not currently living with my parent(s)/legal guardian(s) because:

____

____

____

4. Name, Address and Telephone Number of parent(s)/legal guardian(s):

____

____

5. Please describe your current relationship with you parent(s)/legal guardian(s), e.g., when last seen, contacted, knowledge of whereabouts, etc.):

____

____

____

6. My means of support is:

____

____

(Please attach a copy of your pay stub or other proof of means of support.)

7. I am receiving the following financial assistance from my parent(s)/legal guardian(s) (e.g., health insurance, dental insurance, car insurance, monthly checks, clothes, food, etc.):

____

____

____

8. Please provide any other relevant facts regarding your status as an emancipated minor:

____

____

____

I affirm that the information provided on this form is true and correct and that the statements made herein are being made under the penalties of perjury. I understand that the District may investigate any allegation contained in this form and may ask for written proof of any statement.

I(We) further understand that in the event the information contained in this affidavit is determined to be inaccurate or false, in whole or in part, the District may commence legal proceedings against me to collect tuition and/or seek to seek criminal action against me for filing a false legal document.

____

(Signature of Student)

Subscribed and sworn to before me
this ___ day of _____________, 20___

____

NOTARY PUBLIC