

FILLMORE CENTRAL SCHOOL

April 1, 2024

Dear Parents;

Fillmore Central School will provide a Universal Pre-Kindergarten program for eligible students during the 2024-25 school year. Children born between December 2, 2019 and December 1, 2020, are eligible to participate in the Universal Pre-Kindergarten program.

Universal Pre-Kindergarten is a **voluntary** program for parents who desire a Pre-Kindergarten experience for their children. The program

- is a half day session (8:05-11:15 or 12:15-3:13),
- follows the Fillmore Central School calendar,
- is located in the Fillmore Central School building,
- is no cost to parents,
- has a certified teacher and support staff,
- provides transportation if necessary, and
- provides a developmentally appropriate curriculum focusing on cognitive, social, emotional, and physical skill development.

If you are interested in your child being a member of the 2024-25 Pre-Kindergarten, please complete and return all of the enclosed Pre-Kindergarten entrance forms. In addition, please submit a copy of your child's *immunization records* and *birth certificate*. All paperwork must be submitted before your child may enter the program.

Applications must be received by July 31. The Universal Pre-Kindergarten program is only permitted to service eighteen students in each session. If more than thirty-six student applications are submitted, Fillmore Central will institute a lottery system to fill the preschool openings. *Parents will be contacted the first week in August about their child's program enrollment.*

If you have any questions, please contact me at 567-4432. Thank you for your interest in Universal Pre-Kindergarten, and we look forward to receiving your child's registration information and working with you and your child.

Sincerely,



Mrs. Sarah Petre
Pre-K-12 Assistant Principal

**Fillmore Central School
Universal Pre-Kindergarten
Entrance Checklist**

Child's Name: _____

Date of Birth: _____

- _____ Entrance Form
- _____ Emergency Form
- _____ Developmental and Social History Form
- _____ Health Form
- _____ Physical (completed by a physician)
- _____ Home Language Questionnaire/ Identification of Homeless Students Form.
- _____ Immunization Records
- _____ Dental Health Certificate
- _____ Birth Certificate
- _____ Session request

Please return all forms and the checklist to:

Sarah Petre
PK-12 Assistant Principal
104 Main Street
Fillmore, NY 14735

Office use:

Date Information Received: _____

Preschool applications must be returned before July 31, 2024

Fillmore Central School Entrance Form

Student Number: _____ Grade: _____ Teacher: _____ Bus Number: _____
Date Registered: _____ First Date Attended: _____ SSN: _____

Student Information

DOB: _____ Sex: M F
Last Name First Name MI _____ school-age _____ preschool age child

Place of Birth _____ Circle: New Student Former Student Year(s) Attended: _____

Ethnicity (Check): Is your child Hispanic/Latino or of "Spanish origin" _____ Yes _____ No
Please select one: _____ American Indian or Alaskan American _____ Asian _____ White/ Other
_____ Black or African American _____ Native Hawaiian or Other Pacific Islander

☐ District Resident ☐ Non-Resident ☐ Placed by DSS/ Agency Agency Name: _____

Address: _____ Telephone: _____
_____ Emergency Number: _____

How many schools has this child attended? _____ Previous School: _____
My child receives or is eligible for _____ free lunches _____ reduced price lunches. (if known)
My child participates in a half day vocational program. _____ yes (program: _____) _____ no

Custodial Parent/ Guardian Information

Name: _____ Active Duty _____ Relationship: _____

Name: _____ Active Duty _____ Relationship: _____

Mailing Address _____

(If different from above): _____

The child's parents are: _____ Married _____ Single Parent _____ Divorced (Custody Papers: _____ received _____ needed)
The child is in foster care: _____

Non-Custodial Parent/ Guardian Information (The following people should receive information about the child.)

Name: _____ Active Duty _____ Relationship: _____

Name: _____ Active Duty _____ Relationship: _____

Mailing Address: _____ Telephone: _____

Census Information: Other Children in the Family

Pre-School Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

In School Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

Special Placement Approval

I agree to the temporary continuation of the classification and programs in which my child, _____, was placed in his/her previous school prior to transferring to Fillmore Central School. My child's program included:

_____ CSE (Resource Room/ Consultant Teacher/ Special Class) _____ Remedial Reading _____ Remedial Math

_____ Academic Intervention Service (Area: _____) _____ Gifted and Talented Program _____ Speech

Route to: _____ CSE _____ Psychologist _____ 5-12 Office _____ District Office _____ Guidance Office
_____ Mrs. Barber _____ Cafeteria _____ Attendance _____ Bus _____ Remedial _____ Speech

Identification of Homeless Students

This questionnaire is intended to address the McKinney-Vento Act. Your answers will help the administrator determine residency documents necessary for enrollment of this student.

1. Presently, where is the student living? *Check one box:*

Section A	Section B
<input type="checkbox"/> With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "double-up") <input type="checkbox"/> In a shelter <input type="checkbox"/> In a hotel/motel, car, park, bus, train or campsite (please specify) <input type="checkbox"/> With friends or family members (other than parent/guardian) <input type="checkbox"/> Other temporary living situation (Please Describe) <input type="checkbox"/> Independently <u>CONTINUE:</u> If you checked a box in Section A , complete #2	<input type="checkbox"/> Choices in Section A do not apply <input type="checkbox"/> In permanent housing <input type="checkbox"/> Other (Please specify) _____

2. The student lives with:

- | | |
|--|---|
| <input type="checkbox"/> 1 parent
<input type="checkbox"/> 2 parents
<input type="checkbox"/> 1 parent & another adult | <input type="checkbox"/> a relative, friend(s) or other adult(s)
<input type="checkbox"/> alone with no adults
<input type="checkbox"/> an adult that is not the parent or the legal guardian |
|--|---|

Home Language Questionnaire (HLQ) CR 154 A-14

<p><i>Dear Parent or Guardian:</i></p> <p><i>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 English. Your assistance in answering these questions is greatly appreciated.</i></p> <p><i>Thank You</i></p>	TO BE COMPLETED BY SCHOOL PERSONNEL
	District/ School: Fillmore Central School
	Student Name Grade
	Date of Birth Student Identification Number
	Country of Birth/ Ancestry
	Number of Years enrolled in school outside the US
	Name/ Position of school personnel completing this section
	Determination: <input type="checkbox"/> Possible LEP <input type="checkbox"/> English Proficient

(✓ boxes that apply)

- | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--------------------------|--------------------------|------------|---------------------|--------------------------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|--------------------------|--|
| 1. What language(s) is spoken in the student's home or residence? | <input type="checkbox"/> English <input type="checkbox"/> Other (specify) _____ | | | | | | | | | | | | | | | | | | | | |
| 2. What language(s) is spoken most of the time to the student, in the home or residence? | <input type="checkbox"/> English <input type="checkbox"/> Other (specify) _____ | | | | | | | | | | | | | | | | | | | | |
| 3. What language(s) does the student understand? | <input type="checkbox"/> English <input type="checkbox"/> Other (specify) _____ | | | | | | | | | | | | | | | | | | | | |
| 4. What language(s) does the student speak? | <input type="checkbox"/> English <input type="checkbox"/> Other (specify) _____ | | | | | | | | | | | | | | | | | | | | |
| 5. What language(s) does the student read? | <input type="checkbox"/> English <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Does Not Read | | | | | | | | | | | | | | | | | | | | |
| 6. What language(s) does the student write? | <input type="checkbox"/> English <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Does Not Write | | | | | | | | | | | | | | | | | | | | |
| 7. In your opinion, how well does the student understand, speak, read, and write English? | | | | | | | | | | | | | | | | | | | | | |
| <table style="width: 100%;"> <tr> <td></td> <td style="text-align: center;">Very Well</td> <td style="text-align: center;">Only a little</td> <td style="text-align: center;">Not at all</td> </tr> <tr> <td>Understands English</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Speaks English</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Reads English</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Writes English</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> | | Very Well | Only a little | Not at all | Understands English | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Speaks English | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Reads English | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Writes English | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Very Well | Only a little | Not at all | | | | | | | | | | | | | | | | | | |
| Understands English | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| Speaks English | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| Reads English | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| Writes English | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |

Parent/ Guardian Signature: _____ Date: _____

FILLMORE CENTRAL SCHOOL

Student Contact Information

Student Name: _____ Grade _____

Home Address: _____

Mailing Address: _____

Contact 1: (resides with student)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Contact 2: (resides with student)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Contact 3: (DOES NOT reside with student)

Name: _____ Relationship: _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Has Custody: _____ Receives Mailings: _____

Contact 4: (DOES NOT reside with student)

Name: _____ Relationship: _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Has Custody: _____ Receives Mailings: _____

Contact 5: (DOES NOT reside with student)

Name: _____ Relationship: _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Has Custody: _____ Receives Mailings: _____

Additional/**Emergency** Contact Information

Contact 5:

Name: _____ Relationship _____

Phone: _____

Contact 6:

Name: _____ Relationship _____

Phone: _____

Contact 7:

Name: _____ Relationship _____

Phone: _____

After School Program or Care Provider

Name: _____

Fillmore Central School
UPK
Request for Transportation

I am requesting transportation to facilitate my child's participation in Fillmore Central School's Universal Pre-Kindergarten program. I understand that this transportation will be on Fillmore Central School buses.

Student's Name: _____

Home Address (not mailing): _____

Telephone Number: _____

___ My child will need transportation.

_____ My child will not need transportation.

If your child will need transportation to or from an address that is different from your home address (i.e. babysitter, relative's home, daycare, other location), please list that information below. Give your child's location for both the morning and afternoon session (regardless of request for session) to facilitate the busing schedule.

Morning Session

Street Address for Pick Up (7:30-8:15)

Street Address for Drop Off (11:20-12:00)

Afternoon Session

Street Address for Pick Up (11:40-12:10)

Street Address for Drop Off (3:10-3:45)

EMERGENCY FORM
2024-2025

Student: _____
Last First Grade Teacher

*****Physical Conditions Possibly Needing Special Consideration**

Allergies: _____

Other Conditions: _____

In case of an accident or serious illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician below and to follow his/ her instructions. If it is impossible to contact this physician, the school may make whatever arrangements that seem necessary.

Signature Parent/ Guardian _____ Date _____

Physician Name: _____
Telephone Number: _____
Preferred Hospital: _____

*****Early Dismissal Destination** In the event school closes early, my child will go to the indicated destination.

Name Telephone Relationship
Address _____

*****Court Papers** Please indicate whether any type of court paper impacts this student (a copy of the court papers must be on file to be enforced by the school).
Are there any court papers impacting this child? ____ Yes ____ No
Please identify the type of court papers: _____

Standing Order for Over-The-Counter Medication Permission Form

I give permission for Fillmore Central School to administer the following OTC medication to my child to assist him/her to complete the school day. I understand this is for emergencies only and if my child needs the following medication on a regular basis I will fill out the OTC Medication Permission form and supply the OTC medication for my child.

- ☐ Tylenol/Acetaminophen
☐ Advil/Ibuprofen
☐ Hydrocortisone Cream
☐ Triple Antibiotic Cream
☐ Chloraseptic Throat Spray
☐ Tums
☐ Solarcaine
☐ Sun Screen

Parent/ Guardian Signature _____ Date _____

Consent to Publish Name/ Picture

Fillmore Central School is proud of and enjoys sharing the accomplishments of students of all ages. At the same time, it is important to respect the rights of parents and guardians to not have information shared or publicized about their child. For this reason, the district is collecting parent and guardian consent to publish students' names and/ or pictures across various media.

As the parent/ guardian of _____, I am providing consent to Fillmore Central School to publish my child's picture, name, audio clips, student teaching videos, video clips and other school work in various media sources, including the school newsletter, yearbook, website, newspapers, etc.

____ Yes ____ No
Parent/ Guardian Signature _____ Date _____

P.O Box 177
104 Main Street
Fillmore, NY 14735
Phone: (585) 567-2251
Fax: (585) 567-2541

FILLMORE CENTRAL SCHOOL

Student: _____

DOB: _____

The Universal Pre-Kindergarten program is only permitted to service eighteen students in each session. If more than thirty-six student applications are submitted, Fillmore Central will institute a lottery system to fill the preschool openings.

Please check/choose one session:

- ☐ _____ the morning session (8:05-11:15)
- ☐ _____ the afternoon session (12:15-3:13)
- ☐ _____ either session

Please complete and return this form with your application no later than July 31, 2024.

Pre-Kindergarten _____

Kindergarten _____

Fillmore Central School
Pre-Kindergarten and Kindergarten
Developmental & Social History Form

CHILD NAME: _____ **DOB:** _____

Parents: The questions on this form are intended to provide school staff with information which will help us better understand your child's development, experiences and uniqueness. Please feel free to make additional comments in any area. Thank you.

Have you had concerns about any phase of your child's development?

Yes _____ No _____ Comments: _____

Has your child accomplished developmental milestones at the expected ages?

(Walking, first word, speaking in sentences, toileting, etc.)

Yes _____ No _____ Comments: _____

Has your child had any persistent problems with eating, temper tantrums, sleep habits, bedwetting, wetting or soiling clothes, thumb sucking, fingernail biting?

Yes _____ No _____ Please Explain: _____

Has your child had any persistent fears or worries?

Yes _____ No _____ Please Explain: _____

Describe how your child relates to other children: _____

Which hand does your child prefer to use for eating, coloring, etc.?

Right Hand _____ Left Hand _____ Undecided _____

Has your child been referred for any professional evaluation? (Hearing, vision, psychological, or medical specialist)

Please Explain: _____

At what age did your child first begin to:

Walk: _____

Speak: _____

Crawl: _____

Has your child attended any pre-kindergarten program or out-of-home day care? If so, approximant dates and age of your child. Name and program location:

	When attended/age	Name and location of program
Fillmore Pre-K	_____	_____
Headstart	_____	_____
Nursery School	_____	_____
Day Care	_____	_____
BOCES	_____	_____
Other	_____	_____

Please describe who is living in your home at this time:

____ Mother	____ Brother(s)	Ages: _____
____ Father	____ Sister(s)	Ages: _____
____ Step-Mother	____ Step/half brother(s)	Ages: _____
____ Step-Father	____ Step/half sister(s)	Ages: _____
____ Other Adult(s)	____ Foster Children	Ages: _____
____ Other Relative(s)	____ Other Children	Ages: _____

Non-Custodial parent name: _____

Is this person to receive school notices and communications: Yes ____ No ____

If yes, address: _____

Are there any social/family situations of which we should be aware? (Recent separation, divorce, custody issue, family illness, recent loss) _____

What other things would you like us to know about your child? _____

Pre-Kindergarten _____

Kindergarten _____

Fillmore Central School
Pre K and Kindergarten
Health Form

Name of Child: _____ Date of Birth: _____

Place of Birth: _____

Custodial parents/guardians: _____

Address: _____ Phone: (H) _____

_____ (w-mom) _____

_____ (w-dad) _____

Child's Physical Health History:

1. Did your child have a medically normal pre-natal delivery and newborn history?
Yes _____ No _____ (Explain) _____

2. Has your child experienced any loss of consciousness or seizures?
Yes _____ No _____ (Explain) _____

3. Has your child experienced chicken pox, any serious illness, accident or head injury? Yes _____ No _____ (Explain) _____

4. Has your child been diagnosed with any physical abnormality or condition?
Yes _____ No _____ (Explain) _____

5. Has your child experienced any ear or hearing problems that you have known or suspected? (including frequent ear infections at any age).
Yes _____ No _____ (if yes, please indicate age(s) and if treated medically)

6. Has your child experienced any eye or vision problems that you have known or suspected? Yes _____ No _____ (if yes, please indicate age(s) and if treated medically) _____

7. Does your child wear corrective lenses? Glasses _____ Contact lenses _____

8. Is there anything concerning your child which the school should know in order to provide special care in the classroom or on field trips? _____

9. Has your child had dental care? Yes _____ No _____
Most recent date seen: _____

10. Does your child suffer from any allergies? (e.g. food, medications, insects, sun, cosmetics, etc) Please Explain: _____

Special medication, treatments: (inhalers, bee sting kit, etc.) _____

11. Is your child taking any regular medications? Yes _____ No _____

Medication: _____ Dose if known _____ for condition: _____

Medication: _____ Dose if known _____ for condition: _____

Will the medication need to be administered in school? Yes _____ No _____

Other comments: _____

12. Has your child been screened for Lead levels in his/her blood?

Yes _____ No _____ Results: _____

13. Please list your child's medical professionals and locations/phone numbers.

	Name	Address	Phone
Physician			
Eye Doctor			
Dentist			
Specialist & Specialty			
Specialist & Specialty			

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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Environmental

Asthma <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	

Seizures <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> 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): <input type="checkbox"/> <5 th <input type="checkbox"/> 5 th -49 th <input type="checkbox"/> 50 th -84 th <input type="checkbox"/> 85 th -94 th <input type="checkbox"/> 95 th -98 th <input type="checkbox"/> 99 th and >
-----------------	---

Hyperlipidemia: <input type="checkbox"/> No <input type="checkbox"/> Yes	Hypertension: <input type="checkbox"/> No <input type="checkbox"/> Yes
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PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K		Date		<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g}/\text{dL}$				<input type="checkbox"/> Other: _____

☐ System Review and Exam Entirely Normal

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____
	_____	_____

☐ Additional Information Attached

Name:			DOB:	
SCREENINGS				
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis Required for boys grade 9	Negative	Positive	Referral	
And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:	Trunk Rotation Angle:			
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics.				
<input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications				
<input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling				
<input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field				
<input type="checkbox"/> Other Restrictions:				
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> Accommodations: Use additional space below to explain				
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> Brace*/Orthotic </div> <div style="width: 30%;"> <input type="checkbox"/> Colostomy Appliance* </div> <div style="width: 30%;"> <input type="checkbox"/> Hearing Aids </div> </div>				
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> Insulin Pump/Insulin Sensor* </div> <div style="width: 30%;"> <input type="checkbox"/> Medical/Prosthetic Device* </div> <div style="width: 30%;"> <input type="checkbox"/> Pacemaker/Defibrillator* </div> </div>				
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> Protective Equipment </div> <div style="width: 30%;"> <input type="checkbox"/> Sport Safety Goggles </div> <div style="width: 30%;"> <input type="checkbox"/> Other: </div> </div>				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
MEDICATIONS				
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached				
List medications taken at home:				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIS		Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No
HEALTH CARE PROVIDER				
Medical Provider Signature:				Date:
Provider Name: <i>(please print)</i>				Stamp:
Provider Address:				
Phone:				
Fax:				
Please Return This Form To Your Child's School When Entirely Completed.				

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, 1st, 3rd, 5th, 7th, 9th and 11th grade. 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 year, ask your dentist to fill out section 2. Return the completed form to the school nurse as soon as possible. (Fillmore Central School, Health Office, PO Box 177, Fillmore, NY 14735)

Section 1. To be completed by Parent or Guardian (please print)

Child's Name: _____

Birth Date: / /

Month Day Year

Sex: ☐ Male

☐ Female

Will this be your child's first visit to the dentist? ☐ Yes ☐ No

School: Fillmore Central School Fax# 585-567-2541

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.

Community Eligibility Provision (CEP)/Provision 2 non-base year Household Income Eligibility Form

no charge regardless of household income or completion of this form. This form is to determine eligibility for additional State and federal program benefits that your child(ren) may qualify for. Read the instructions on the back, complete **only one** form for your household, sign your name and return it to the school named above. Call _____ (name/school) is participating in the Community Eligibility Provision (CEP) or Provision 2 in a non-base year. All children in the school will receive meals/milk at _____ (school phone number), if you need help.

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

Student Name	School	Grade/Teacher	Foster Child	No Income
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

2. SNAP/TANF/FDPIR Benefits:

if anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. Then skip to Part 4.

Name: _____ CASE # _____

3. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box. If you have listed a foster child above, you must report their personal income.

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
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>

4. Signature: An adult household member must sign this application.

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 may receive 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

Total Household Income/How Often:

Reduced Eligibility

Denied Eligibility

Household Size:

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

Free Eligibility

Signature of Reviewing Official

CEPI/Provision 2 Non-Base Year Household Income Form INSTRUCTIONS

PART 1

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

- (1) Print the names of the children, including foster children, for whom you are applying on one form.
- (2) List their grade and school.
- (3) Check the box to indicate a foster child living in your household, and check the box for each child with no income.

PART 2

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

- (1) List a current SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families) or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. Do not use the 16-digit number on your benefit card. The case number is provided on your benefit letter.
- (2) An adult household member must sign the form in PART 4. **SKIP PART 3** - Do not list names of household members or income if you list a SNAP, TANF or FDPIR number.

PARTS 3 & 4

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

- (1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living 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.

PRIVACY ACT STATEMENT