



**Onondaga**  
Central Schools

**Onondaga Central School District**

# **New UPK Student Registration Packet**

**2025-2026**

**Registration**

**(315) 552-5070**

**[registration@onondagacsd.org](mailto:registration@onondagacsd.org)**

# Onondaga Central School District

## CENTRAL REGISTRAR CHECKLIST

*Proof of Residency is required before a student will be registered. (Post Office Box is not acceptable).*

**Parent/Guardian Form of Identification:** ☐ Driver's License ☐ State or Government Issued ID ☐ Passport

**Proof of Residency: TWO FROM LIST A:** ☐ Lease Agreement ☐ Mortgage Statement ☐ Signed Rent Receipt  
☐ Utility Bill (NYSERDA) ☐ Landline Phone Bill

**OR ONE FROM LIST A + ONE LIST B:** ☐ Recent Paystub ☐ Driver's License ☐ State or Gov't Issued ID  
☐ Passport ☐ Current Income Tax Form ☐ Voter Registration Documents ☐ Documents Issued by federal/state/local agencies ☐ Car/Home/Renter Insurance Documents ☐ Bank/Loan Statements

**OR IF LIST A does not apply (2) LIST B + OTHER:** ☐ Notarized statement by third party establishing physical presence of parent/guardian in the school district (i.e. landlord, owner or tenant leased from or live with).

*Documents must be from the past 30 days*

### Determination of Student Age:

- ☐ Original Birth Certificate ☐ Baptismal Record ☐ Passport ☐ Driver's License (student)
- ☐ State or other government issued ID ☐ Consulate identification Card ☐ Hospital or Health Records
- ☐ Military Dependent Identification Card ☐ Court orders or other court issued documents with DOB
- ☐ Native American Tribal Documents ☐ Records from non-profit international aid agencies and voluntary agencies

### Health Records:

#### To Be Completed by Parent/Guardian

- ☐ o Medical History Form
- ☐ o Health Information Release Form

#### To Be Completed by Health Care Professional

- ☐ o Health Certificate/Appraisal Form
- ☐ o Authorization to Administer Medication (if applicable)\*
- ☐ o Dental Health Certificate
- ☐ o Immunization Records\*\*

*\*\* (Proof of up to date immunizations per NYSED requirements. Temporary enrollment will be considered as needed; parents will be given 14 days upon date of registration to supply school with documents, pending administrative approval.)*

### School Records:

- ☐ • Authorization to Request Release of Records
- ☐ • Report Card/ Transcript \*
- ☐ • Current Schedule (MS/HS)\*
- ☐ • Lab grades for Science Courses (HS)\*

### Other Required Paperwork:

- ☐ • Free and Reduced Lunch Application\*
- ☐ • Student Registration Form
- ☐ • Teacher Data Sheet
- ☐ • Residency Questionnaire
- ☐ • Home Language Questionnaire

### Divorce and/or Custodial / Guardianship/Foster Child Documentation:

*Individual's attempting to enroll a student must be listed on the child's birth certificate as the natural parent or must provide court documentation proving legal custody. When parents reside in different school districts the child must attend the school in the district of the parent with whom the child lives for a majority of the time, unless court order specifies otherwise. If parents split time equally, parents are given school of choice.*

**Custodial paperwork is not required only when both natural parents reside in the same household and are both listed on registration paperwork OR if a natural parent is not listed on the child's original birth certificate.**

- ☐ • Copy of the most recent divorce decree and/or custodial/visitation paperwork issued by the court
- ☐ • Copy of official Guardianship Paperwork or Foster Placement
- ☐ • No Official Custody Agreement (both natural parents are not involved) – Affidavit of custodial parent voluntarily relinquishing the role of non-custodial parent, other parent receives copies of school correspondence but has no input on day-to-day.

### Special Education Services:

- ☐ • Most recent IEP (Individualized Education Program) developed by previous school.
- ☐ • Most recent 504 Education Plan developed by previous school.



**Onondaga**  
Central Schools

**Onondaga Central School District**

# **Forms to Return to School**

**Completed by  
parent/guardian**

**PLEASE LIST ALL CHILDREN LIVING IN PRIMARY HOUSEHOLD UNDER THE AGE OF 21**

Name: _____	Name: _____	Name: _____
DOB: _____ Age: _____	DOB: _____ Age: _____	DOB: _____ Age: _____
Gender: _____	Gender: _____	Gender: _____
Name: _____	Name: _____	Name: _____
DOB: _____ Age: _____	DOB: _____ Age: _____	DOB: _____ Age: _____
Gender: _____	Gender: _____	Gender: _____

In accordance with Chapter 549 of the Education Law of 1986, I am providing the following list of people to whom my child(ren), upon my written authorization, may be released from the Onondaga Central School District. These people may also be contacted in the event of an emergency and I cannot be reached:

Name: _____	Address: _____	City, State, Zip: _____
Relationship: _____	Daytime Phone: _____	Alternate Phone: _____
Name: _____	Address: _____	City, State, Zip: _____
Relationship: _____	Daytime Phone: _____	Alternate Phone: _____

Parent in the Armed Forces: ☐ Yes ☐ No If yes, Parent Name: \_\_\_\_\_

(Please check one) ☐ Active Duty ☐ Reserves ☐ Veteran ☐ Civilian

Technology in the Home: ☐ Desktop Computer ☐ Laptop ☐ Smart Phone ☐ Other

(please check all that apply) Access to the Internet: ☐ None ☐ Wifi ☐ Mobile HotSpot ☐ Cell Phone Only

Physician to be called in an Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital Choice: \_\_\_\_\_

**RELEASE**

If emergency treatment is required and the parents or legal guardian cannot be reached immediately, your signature in the space provided below empowers the school authorities to exercise their own judgment to transport the child to a hospital emergency room. It also allows the school physician to complete physical examinations as required by State Law. Likewise, your signature below is not sufficient for the release of confidential information protected by Federal Law

Parent Statement:

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

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Onondaga Central School District  
TEACHER DATA SHEET**

**Student Information**

**Student's Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Student lives with:**

☐ Mother & Father      ☐ Mother      ☐ Father      ☐ Guardian/Other \_\_\_\_\_

**Academic Information**

**Names & Addresses of Previous Schools Attended (list most recent first):**

Name of School:	Phone #:
Address:	Previous Teacher's Name:
	Month /Year Attended: From _____ To _____
Name of School:	Phone #:
Address:	Previous Teacher's Name:
	Month /Year Attended: From _____ To _____

**Has your child ever been retained:**    ☐ Yes    ☐ No      If yes, what grade? \_\_\_\_\_

**Does your child presently receive Special Education Services?**    ☐ Yes    ☐ No

**Does your child have an IEP or 504 plan?**    ☐ Yes    ☐ No

**Have they in the past?**    ☐ Yes    ☐ No

**Does your child presently receive Academic Intervention Services for:**

☐ Reading    ☐ Math    ☐ Science    ☐ Social Studies

**Does your child presently receive:**

☐ Occupational Therapy    ☐ Physical Therapy    ☐ Speech Therapy

**Have they received these services in the past?**    ☐ Yes    ☐ No

**Comments:**

---

---

---

**Has there been a recent change in your family (parent separation, death, birth, hospitalization)? If so, please explain:**

---

---

---

**Does your child receive counseling services?**    ☐ Yes    ☐ No

**Comments:**

---

---

---

## General Academic Levels

	Advanced	Average	Developing	Comments
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

## Sibling information

Name (first & last)	Sex	DOB	Living in the home?	Grade	School Attending
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian  
(Please Print Name)



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

Elisa Alvarez, Associate 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 Person in Parental Relation:*  
*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.*

<b>STUDENT NAME:</b>		
First	Middle	Last
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
Month	Day	Year
		<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	<input type="checkbox"/> Parent 2	_____ specify
	<input type="checkbox"/> Guardian(s)		_____ specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak _____ specify
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read _____ specify
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write _____ specify

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

<b>SCHOOL DISTRICT INFORMATION:</b>	<b>STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:</b>
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? \_\_\_\_\_

Signature of Parent or of Person in Parental Relation \_\_\_\_\_

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_  
 \_\_\_\_\_  
 Date

Relationship to student: ☐ Parent ☐ 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: \_\_\_\_\_ PROFICIENCY LEVEL ACHIEVED ON NYSITELL:  
 MO. DAY YR.    ☐ ENTERING    ☐ EMERGING    ☐ TRANSITIONING    ☐ EXPANDING    ☐ COMMANDING

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



# Onondaga Central School District

4466 S. Onondaga Road - Nedrow, NY 13120

Registrar: (315)552-5070

## **RESIDENCY QUESTIONNAIRE FORM**

Name of Student: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

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 birth certificates. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Is your current address a temporary living arrangement? ☐ Yes ☐ No

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

### **Where is the student currently living? (Please check one box only)**

- ☐ In a shelter
- ☐ With another family member 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)

**Onondaga Central Schools**  
**TRANSPORTATION ENROLLMENT FORM**

Matthew Dodge – Transportation Supervisor  
4457 South Onondaga Rd.  
Nedrow, New York 13120  
Phone: (315) 552-5090 Fax: (315) 492-9624

Start Date: \_\_\_\_\_

Re-enter: Yes \_\_\_\_\_ No \_\_\_\_\_

**\*\*\*Please remember to notify the Registrar and transportation any time your address and/or phone number(s) change. ALSO, YOUR CHILD MUST BE 4 TO RIDE THE BUS!**

ID# \_\_\_\_\_ Grade \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

School- Jr/Sr High \_\_\_\_\_ Wheeler \_\_\_\_\_ Rockwell \_\_\_\_\_ Other (Name) \_\_\_\_\_

Student's Name (please print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City / Town: \_\_\_\_\_

State / Zip: \_\_\_\_\_

Pickup address if different: \_\_\_\_\_

Drop-off address if different: \_\_\_\_\_

Name of sitter (please print): \_\_\_\_\_ Phone # \_\_\_\_\_

Mother's name (please print): \_\_\_\_\_

Home # \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Father's name (please print): \_\_\_\_\_

Home # \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Guardian's name (please print): \_\_\_\_\_

Home # \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Emergency contact person: \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency days/half-days drop off location: \_\_\_\_\_

\_\_\_\_\_  
(Parent / Guardian Signature)

\_\_\_\_\_  
(Date)

## Onondaga Central School District

### Parental/Guardian consent for student use of district computerized information resources

I am the parent/guardian of: \_\_\_\_\_,

The minor student who has signed the District's agreement for student use of computerized information resources. I have been provided with a copy and I have read the District's policy and regulations concerning use of the DCS.

I also acknowledge receiving notice that, unlike most traditional instructional or library media materials, the DCS will potentially allow my son/daughter student access to external computer networks not controlled by the Onondaga Central School District. I understand that some of the materials available through these external computer networks may be inappropriate and objectionable; however, I acknowledge that it is impossible for the District to screen or review all of the available materials. I accept responsibility to set and convey standards for appropriate and acceptable use to my son/daughter when using the DCS or any other electronic media or communications.

I agree to release the Onondaga Central School District, the Board of Education, its agents and employees from any and all claims of any nature arising from my son/daughter's use of the DCS in any manner whatsoever.

I agree that my son/daughter may have access to the DCS and I agree that this may include remote access from our home.

---

**Parent/Guardian Name (Please print)**

---

**Parent/Guardian Signature**

---

**Date**

# Onondaga Central School District

## Website Release form

Dear Parent/Guardian:

The goal of our School District Website is to publish information celebrating our schools, our students, and our accomplishments. Your child's first name, photograph, and original school work\* will not appear on our Website until and unless we receive this signed form from you.

Please check your preference in each category;

### **Photography (check one)**

- ☐ I give permission for my child's first name and photograph to be used on the School Web Pages during the current school year
- ☐ I do NOT give permission for my child's first name and photograph to be used on the School Web Pages during the current school year.
- ☐ I give one time only permission for my child's first name and photograph to be used on the School Web Pages in the circumstances described here: \_\_\_\_\_

### **Original Work (check one)**

- ☐ I give permission for my child's first name and photograph to be used on the School Web Pages during the current school year
- ☐ I do NOT give permission for my child's first name and photograph to be used on the School Web Pages during the current school year.
- ☐ I give one time only permission for my child's first name and photograph to be used on the School Web Pages in the circumstances described here: \_\_\_\_\_

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher Name: \_\_\_\_\_ School: \_\_\_\_\_

Grade/Subject: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

**\*District may wish to prohibit use of a child's name (whether full name or first name only); or, in the alternative, limit identification to use of initials. Original student work will appear with a copyright notice prohibiting the copying of such work without express written permission. Requests for such permission received by the District will be forwarded to the parents/guardians.**

# Onondaga Central School District

## Rockwell Elementary/ Wheeler Elementary/ Onondaga Junior/Senior High School

Dear Parent/Guardian:

During the school year, we take photographs and/or videos of school activities involving the students to share the school's positive vibe and updates. By which incidentally, some photographs may capture your child's participation, directly or indirectly.

These photos and/or videos may be published through our district website, ParentSquare, and the district newsletter.

With this, we seek your consent in allowing us to publish photos which may involve your child to the said platforms.

Please provide your response by selecting your choice below.

- ☐ I hereby allow the reproduction and publication of my child's photograph(s) and/or videos.
- ☐ I do not allow the reproduction of my child's photograph(s) and/or videos.
- ☐ I hereby allow my child's photograph to ONLY be published in the school yearbook.

Student Name: \_\_\_\_\_

Parent/Guardian Name (please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **NEW ENTERERS HEALTH HISTORY**

TO BE COMPLETED BY PARENT

This form must be completed, signed by parent or guardian, and returned to the school nurse prior to entering school.

Date entering school \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Grade \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_

Date of last Tetanus Shot \_\_\_\_/\_\_\_\_/\_\_\_\_

Medication/food allergies (and reaction) \_\_\_\_\_

Allergy to bee stings? ( ) yes ( ) no If Yes (reaction) \_\_\_\_\_ \*Epi-Pen? ( ) yes ( ) no

Is there a history of: (Indicate **YES** or **NO** and write comments or explanations in the section indicated below for **ALL YES** answers. Use back if needed.)

	YES	NO		YES	NO
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Elevated Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problem/Murmur- Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds/Frequent or Severe	<input type="checkbox"/>	<input type="checkbox"/>
Bladder / Kidney Problem or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Ankle Injury	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Fracture-Dislocation Bones/Joints	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems/Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury	<input type="checkbox"/>	<input type="checkbox"/>
Eye Problems/Vision Loss	<input type="checkbox"/>	<input type="checkbox"/>	Nose Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Injury to the Spleen	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Joint Sprain / Ligament Tear /	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Pull	<input type="checkbox"/>	<input type="checkbox"/>			

Comments on all YES answers above or any other health problems/concerns: \_\_\_\_\_

Does your child wear glasses? ( ) yes ( ) no      Contacts? ( ) yes ( ) no

Date of last eye exam: \_\_\_\_\_

Has your child ever been hospitalized? ( ) yes ( ) no      If yes, what was the reason? \_\_\_\_\_

Is your child on any medications? ( ) yes ( ) no      If yes list all medications: \_\_\_\_\_

Will your child need to take any medication(s) while at school? ( ) yes ( ) no      If yes, please list: \_\_\_\_\_

**\*Reminder:** Medication Administration Form must be completed and on file in health office before your child will be allowed to take any medications while at school (Self-Medication & Attestation forms are also required for student to carry and self-administer their medications; such as their inhaler or Epi-Pen)

Date of last physical examination (will need to have copy on file in health office) \_\_\_\_\_

Has your child had screening or evaluation by any other health professionals (such as speech therapist, neurologist, psychiatrist, etc) ( ) yes ( ) no      If yes please explain: \_\_\_\_\_

Does this student require any special attention due to physical limitations? ( ) yes ( ) no

Comments: \_\_\_\_\_

Student's physician/primary care provider: \_\_\_\_\_

Phone: \_\_\_\_\_

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

April. 2024



**ONONDAGA CENTRAL SCHOOL DISTRICT  
IMPORTANT NOTICE TO PARENTS/PERSONS IN PARENTAL RELATION  
OF STUDENTS WITH  
LIFE-THREATENING HEALTH CONDITIONS**

**Definition of life-threatening health condition:** A condition, including a known allergy, that will put the child in danger of serious illness during the school day if a medication or treatment order is not in place (for example food or substance allergy, insect sting allergy, asthma, diabetes, seizure disorder, etc.)

**If your child has a life-threatening health condition, please contact the School Health Office/ School Office for a “Life-Threatening Health Condition Packet” which includes the following:**

- ☐ Authorization for Administration of Medication in School;
- ☐ Self-Medication Release Form; Attestation Form
- ☐ Permission to Disclose Protected Health Information Form

**The appropriate forms and any additional information you or the licensed health provider would like to share must be completed and returned to the School for review and approval by the School Nurse within 72 hours. An emergency care plan may be generated for your child based on recommendations and medical orders from your child’s physician. If no medical management is required, no care plan will be generated.**

**Reminder:**

- ★ *It is the parent/person in parental relations responsibility to alert other school programs that their child has a health condition and/or care plan in place.*
- ★ *Please report immediately any changes needed in emergency contact information, medication, health status, etc. to the School Health Office.*
- ★ *It is strongly encouraged that your child wears a medic alert bracelet.*

If you have any questions or concerns, please contact the Principal of the School Nurse assigned to your child’s school.

Thank you for your assistance in helping us to provide a safe school experience for your child.

*This form should be given to all parents/persons in parental relation at the time of registration or when school staff is notified that a student has a life-threatening health condition.*

---

I have read the above information regarding Life-Threatening Health Conditions.

- ☐ Yes! My child has a life-threatening health condition and am requesting the “Life-Threatening Health Condition Packet.”
- ☐ No, My child does NOT have a life-threatening health condition.

Child’s Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

---

For health office use only

“Life-Threatening Health Condition Packet” provided: \_\_\_\_\_ Date: \_\_\_\_\_ Return date: \_\_\_\_\_

**ONONDAGA CENTRAL SCHOOL DISTRICT**  
**Authorization for Use or Disclosure of Protected Health Information**

I, \_\_\_\_\_ authorize Onondaga Central School District to display and publish my child's life-threatening health concerns listed below on the school information system (\_\_\_\_\_) I understand that this information will be accessible to all Onondaga Central School District employees.

The Protected Health Information may be used, disclosed or received for the following purpose(s):

- To adhere to emergency plans of care as advised by health care professionals
- To develop care or therapy plans for routine and emergent school management
- To design appropriate educational, school or athletic programs
- To assess the impact of the medical conditions(s) on school programming and/or attendance
- To share school observations/concerns
- To assess a medical basis for modification of transportation and/or home tutoring
- Medication delivery or therapy prescriptions
- Other: \_\_\_\_\_

Student Name: \_\_\_\_\_

Life-Threatening Health Condition(s): \_\_\_\_\_

**\*This authorization is valid for the duration of attendance within the school district\***

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the District Administration Building. I understand the revocation of this authorization is not effective if the District has used the authorization for disclosure of Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal and state law. I understand that Protected Health Information will not be disclosed to entities outside of the Onondaga Central School District. I understand that Protected Health Information will be disclosed to Onondaga Central School district employees who have a need to know. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I give permission for the school representatives to share and disclose information as indicated above with the appropriate school district employees.

\_\_\_\_\_  
Signature of Parent/Guardian or student if over 18

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

**A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE ADULT PATIENT OR PARENT OF THE MINOR CHILD**

# Onondaga Central School District

## Immunization Policy Form

The following is the revised policy for immunization for school attendance as per Public Health Law Section 2164:

1. If a student entering has not been in attendance in a school in New York State, he/she will be admitted and given thirty (30) days in which to secure the required proof of immunization, provided that good faith effort to obtain such proof is made.
2. If a student has attended another school in New York State, he/she will be allowed to enter and be given (14) days for proof to be provided of proper immunization. If such proof is not received within the fourteen (14) days, the student will be automatically suspended until such proof is provided.
3. If proof is not provided in the time period allotted in #1 or #2 above, the student is to be excluded and the principal shall:
  - a. Notify the person in parent/guardian relationship of the responsibility to have the child immunized and of the public resources available for doing so. The Onondaga County Department of Health conducts an immunization clinic on Wednesday's by appointment only: 315-435-2000
  - b. Provide the person in parent/guardian relationship to the child with appropriate vaccine information forms supplied by the New York State Department of Health.
  - c. Notify the local health authority of the name and address of the excluded child and of the immunization or immunizations the child lacks.
  - d. Provide, with the cooperation of the local health authority, for a time and place which the required immunization(s) may be administered.

**Please print:**

Student name: \_\_\_\_\_ Grade \_\_\_\_\_

**Signature:**

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



**Onondaga**  
Central Schools

**Onondaga Central School District**

# **Medical Documents**

**To be  
Completed by  
physician**

## **NEW ENTERERS HEALTH HISTORY**

TO BE COMPLETED BY PARENT

This form must be completed, signed by parent or guardian, and returned to the school nurse prior to entering school.

Date entering school \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Grade \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_

Date of last Tetanus Shot \_\_\_\_/\_\_\_\_/\_\_\_\_

Medication/food allergies (and reaction) \_\_\_\_\_

Allergy to bee stings? ( ) yes ( ) no If Yes (reaction) \_\_\_\_\_ \*Epi-Pen? ( ) yes ( ) no

Is there a history of: (Indicate **YES** or **NO** and write comments or explanations in the section indicated below for **ALL YES** answers. Use back if needed.)

	YES	NO		YES	NO
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Elevated Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problem/Murmur- Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds/Frequent or Severe	<input type="checkbox"/>	<input type="checkbox"/>
Bladder / Kidney Problem or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Ankle Injury	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Fracture-Dislocation Bones/Joints	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems/Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury	<input type="checkbox"/>	<input type="checkbox"/>
Eye Problems/Vision Loss	<input type="checkbox"/>	<input type="checkbox"/>	Nose Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Injury to the Spleen	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Joint Sprain / Ligament Tear /	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Pull	<input type="checkbox"/>	<input type="checkbox"/>			

Comments on all YES answers above or any other health problems/concerns: \_\_\_\_\_

Does your child wear glasses? ( ) yes ( ) no      Contacts? ( ) yes ( ) no

Date of last eye exam: \_\_\_\_\_

Has your child ever been hospitalized? ( ) yes ( ) no      If yes, what was the reason? \_\_\_\_\_

Is your child on any medications? ( ) yes ( ) no      If yes list all medications: \_\_\_\_\_

Will your child need to take any medication(s) while at school? ( ) yes ( ) no      If yes, please list: \_\_\_\_\_

**\*Reminder:** Medication Administration Form must be completed and on file in health office before your child will be allowed to take any medications while at school (Self-Medication & Attestation forms are also required for student to carry and self-administer their medications; such as their inhaler or Epi-Pen)

Date of last physical examination (will need to have copy on file in health office) \_\_\_\_\_

Has your child had screening or evaluation by any other health professionals (such as speech therapist, neurologist, psychiatrist, etc) ( ) yes ( ) no      If yes please explain: \_\_\_\_\_

Does this student require any special attention due to physical limitations? ( ) yes ( ) no

Comments: \_\_\_\_\_

Student's physician/primary care provider: \_\_\_\_\_

Phone: \_\_\_\_\_

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

April. 2024

# REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

## TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

### HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

**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/m<sup>2</sup>

**Percentile (Weight Status Category):** ☐ < 5<sup>th</sup> ☐ 5<sup>th</sup>-49<sup>th</sup> ☐ 50<sup>th</sup>-84<sup>th</sup> ☐ 85<sup>th</sup>-94<sup>th</sup> ☐ 95<sup>th</sup>-98<sup>th</sup> ☐ 99<sup>th</sup> and >

**Hyperlipidemia:** ☐ Yes ☐ Not Done

**Hypertension:** ☐ Yes ☐ Not Done

### PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Lead Level Required for PreK &amp; K</b>
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

☐ System Review Within Normal Limits

☐ Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

<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/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list)

ICD-10 Code\*

☐ Additional Information Attached

\*Required only for students with an IEP receiving Medicaid



Name:		Affirmed Name (if applicable):		DOB:	
<b>SCREENINGS</b>					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
<b>Vision Screening</b>	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail					<input type="checkbox"/>
Notes					
<b>Hearing Screening:</b> Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					<b>Not Done</b>
Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
<b>FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>*Family cardiac history reviewed</b> – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b>					
<b>If Restrictions Apply</b> – Complete the information below					
<input type="checkbox"/> <b>Student is restricted from participation in:</b>					
<input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> <b>Other Restrictions:</b>					
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level.					
<b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> <b>Other Accommodations*:</b> Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):					
<small>*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.</small>					
<b>MEDICATIONS</b>					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
<b>COMMUNICABLE DISEASE</b>			<b>IMMUNIZATIONS</b>		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
<b>HEALTHCARE PROVIDER</b>					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form to Your Child's School Health Office When Completed.</b>					



## Onondaga Central School District Health Services

Education law is very strict in the control of over-the-counter and prescription drugs; therefore, we ask all families involved to follow this outline. Most medications can be given outside of the school hours. Please ask your doctor to schedule as such.

If, however, during the school year it becomes necessary for your child to take medication ordered by a doctor while in school, please adhere to the following rules:

1. Doctors must fill out and sign a written order.
2. Parents must fill out and sign a written request.
3. Medication must be properly labeled from your pharmacy with the patient's name, dose, name of medication and date.
4. Parent is to bring the medication into the nurse. Any medications brought in by the student will not be administered.
5. **NO** student is to have **ANY** medication with them at school without a prescription on file in the nurse's office that states "may carry".

On the reverse side is a medication order/request form to be used should your child need it.

**Thank you for your attention in this matter**

**Patricia Cormier, RN ~ Rockwell Elementary School**  
**Lindsey Yonko-Gardner, RN- Wheeler Elementary School**  
**Kayla Geariety, RN ~ Jr/Sr High School**

# PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

## A. To be completed by the parent or guardian:

I request that my child \_\_\_\_\_ DOB \_\_\_\_\_ receive the medication as prescribed below by our physician. I understand that the medication is to be furnished by me in the properly labeled original container from the pharmacy\*.

Signature (Parent or Guardian): \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Date \_\_\_\_\_

## B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis: \_\_\_\_\_

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

### PLEASE CHECK ONE:

- ☐ Student may carry Benadryl / inhaler / epi-pen with them in school and any sporting event they participate in.
- ☐ Student may not carry Benadryl / inhaler / epi-pen with them in school
- ☐ Student no longer requires \_\_\_\_\_ (Medication)

Physician's Signature \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

\*Students with "may carry" orders must have appropriate meds with them at all times, but only the meds specifically ordered by M.D.

\* Medication must be in the original pharmacy labeled container with specific orders and name of medication.

\*Medication and refills must be brought to school by a parent, guardian or responsible adult.



## Dental Health Certificate- Optional

**Parent/Guardian:** New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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:	/ /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first oral health assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Month Day Year		

School Name:	<b>Mechanicville City School District</b>	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.



**Onondaga**  
Central Schools

**Onondaga Central School District**

**Items  
To  
Keep**



# Onondaga Central School District

4466 S. Onondaga Road, Nedrow, NY 13120

Phone: (315) 552-5000

**PLEASE BE ON THE LOOK OUT FOR PARENTSQUARE!!  
THIS IS OUR MAIN COMMUNICATION LINE TO PARENTS!!**

**Onondaga Central School District will send an invitation email to join ParentSquare, and you will click a link to activate your account.**

What to do:

1. Find the email from your school and click to get started, or.
2. Go to [parentsquare.com/signin](https://parentsquare.com/signin) (or install the ParentSquare app) and follow the prompts to sign up.
3. Use Google sign-on, your email, or your phone number to set up your account. *Your email/phone number must match contact details in the school's database for this to work!*
4. **If your contact details aren't recognized, contact your school administrator to get them added.** *After they update your information in their database, the new contact details will appear in ParentSquare after the next daily sync, and you will be able to create an account.*

Note: After you are added to ParentSquare by your school, you will receive school communications even **if** you have not registered your account. However, you will need to register your account in order to participate in two-way communications and to access any confidential student-specific documents or forms.



## **ANNUAL NOTIFICATIONS**

### **Asbestos Management Plan**

In accordance with the Asbestos Hazard Emergency Response Act (AHERA) of 1987, Onondaga Central School District's facilities have been inspected and response actions are planned to ensure a continued safe environment for our students and employees. The district conducts re-inspections every three years. The Onondaga-Cortland-Madison BOCES Health and Safety Department was contracted to complete triennial inspection of all facilities and update the asbestos management plan, which is available for your review in the district office.

### **Body mass index reporting policy**

New York State requires schools to track each student's Body Mass Index (BMI) and weight status category as part of school health examinations. Every year, the NYS Department of Health will survey some schools for the number of pupils in each of six possible weight status categories. If Onondaga Central Schools is surveyed by the state, the district will share summary group data only, not individual names or information. Parents who wish to exclude their child's data from such group calculations must contact the child's school building nurse.

### **Child Nutritional Program**

Children need healthy meals to learn. Onondaga Central Schools offer healthy meals every school day. Breakfast costs \$2.25; lunch costs \$3.25 at the elementary level, and \$3.25 at the secondary level. Your children may qualify for free meals. Additional information may be obtained by contacting Emily Cullen, School Lunch Director at [ecullen@westgeneseee.org](mailto:ecullen@westgeneseee.org).

### **Code of Conduct**

The Onondaga Central Board of Education is committed to providing a safe and orderly learning environment in which students may receive – and Onondaga Central schools personnel may deliver – quality educational services without disruption or interference. Responsible behavior by students, teachers, other Onondaga Central School District personnel, parents and other visitors is essential to achieving this goal.

To this end, the Board of Education has adopted a district Code of Conduct. The Code applies to all students, school personnel, parents and other visitors when on Onondaga Central School District property or attending an Onondaga Central Schools' function. Additional expectations in support of the Code of Conduct can be found in each school's handbook.

Copies of the Code of Conduct are available in the district office and online at [www.ocs.cnyric.org](http://www.ocs.cnyric.org)

### **FERPA: Access to Student Records**

The Family Educational Rights and Privacy Act (FERPA) gives students over 18 years of age and parents the right to review certain educational records. Pursuant to law, the following records are available for review:

- the guidance folder, which contains standardized test scores, biographical data and elementary progress reports;
- academic records for grades seven through 12;
- cumulative health records;
- attendance records;
- student disciplinary records reflecting superintendent's hearings in which the student has been found guilty and letters and/or records of school suspension lasting five days or less;

- school medical records maintained at the school nurse's office that contain the student's medical history;
- pupil service records that include psychological reports maintained by school personnel.

These records are confidential and cannot be released without the prior written consent of the parent or guardian. The law does provide for limited exceptions to the prior consent requirement, e.g., certain school employees or state or federal officials have a legitimate purpose for needing access to information contained in the students' records.

The Board of Education has established a policy for maintaining the confidentiality of student education records, and for providing access to such records for parental review. Copies of this policy are available in the district office. Applications for access to student records also are available in the district office. Please direct any questions about the right to review student records to the respective building principal.

### **Fire inspection report policy**

Notice is hereby given that the annual inspection for 2023 of the Onondaga Central School Buildings for fire hazards which might endanger the lives of students, teachers, employees therein, has been completed and the report thereof is available at the office of the Onondaga Central School District for inspection by all interested Persons.

Structures inspected include: Rockwell Elementary, Junior-Senior High School, Walter Wheeler School, industrial Arts Building, Garage/Storage Building, District Office, Bus Garage, Pumphouse @ High School, Press Box, and Maintenance Office/Grounds Center. The report is available for review by all interested persons at the district office.

### **Health information privacy**

Under the Health Insurance Portability and Accountability Act (HIPPA), some districts or schools may be a "covered entity." If a district or school (or person within that school, i.e. the school nurse) is included in the "covered entity" category, then the district must provide notice of its privacy practices with regard to protected health information.

### **Homeless students policy**

As required by No Child Left Behind, all districts have responsibilities to homeless students in the district. In order to serve these students, each district must appoint a liaison for homeless children that are currently residing within a district. The liaison must first identify these students and, to aid in doing so, post notifications regarding educational services and contact information at places where the parents of homeless students will see it. These locations can include, but are not limited to, homeless shelters, medical clinics, post offices and local Social Service offices. School Social Worker, Amy Stanton, is the liaison for Onondaga Central School District.

### **Non-discrimination policy**

The Onondaga Central School District does not discriminate on the basis of race, color, national origin, sex, disability, or age in its programs, activities, employment, and admissions; and provides equal access to the Boy Scouts and other designated youth groups.

The following person has been designated to handle inquiries regarding the nondiscrimination policies: Joseph Sterbank, compliance officer/coordinator, at [jsterbank@onondagacsd.org](mailto:jsterbank@onondagacsd.org), 315-552-5001, 4466 S. Onondaga Road, Nedrow, NY 13120. Inquiries concerning the application of the Onondaga Central School District

nondiscrimination policies may also be referred to the U.S. Department of Education, Office for Civil Rights (OCR), Lyndon Baines Johnson Department of Education Bldg. 400 Maryland Avenue SW, Washington, DC 20202, telephone (800) 421-3481 or email [ocr@ed.gov](mailto:ocr@ed.gov).

Any parent who believes his or her child has been denied the benefits of an appropriate education as a result of discrimination based on disability should contact the Superintendent of Schools. Moreover, any person who believes his or her rights have been violated should contact the Superintendent of Schools.

## **Pest Management**

Onondaga Central School District practices Integrated Pest Management to keep pests a safe distance away from students, staff and property, while limiting the use of pesticides.

New York State Education Law requires school districts to notify parents/guardians, faculty and staff about the potential use of pesticides periodically throughout the school year. Further, the state requires us to maintain a list of those who wish to receive 48-hour prior written notification of certain pesticide applications. The following applications are not subject to prior notification requirement:

- a school remains unoccupied for a continuous 72 hours following an application;
- anti-microbial products;
- non-volatile rodenticides in tamper-resistant bait stations in areas inaccessible to children;
- non-volatile insecticidal baits in tamper-resistant bait stations in areas inaccessible to children;
- silica gels and other non-volatile, ready-to-use pastes, foams or gels in areas inaccessible to children;
- boric acid and octaborate tetrahydrate;
- the application of EPA designated biopesticides;
- the application of EPA-designated exempt materials under 40CFR152.25;
- the use of aerosol products with a directed spray in containers of 18 fluid ounces or less when used to protect individuals from an imminent threat from stinging and biting insects, including venomous spiders, bees, wasps and hornets;

In the event of an emergency application necessary to protect against an imminent threat to human health, a good faith effort will be made to supply written notification to those on the 48-hour prior notification list.

To receive 48-hour prior notification of pesticide applications scheduled to occur in a school, please contact the Maintenance Department at 315-552-5090.

## **Release of Student Information to Military Recruiters**

Pursuant to the federal No Child Left Behind Act, the Onondaga Central School District upon request will disclose students' names, addresses and telephone listings to military recruiters. Parents and students can request the district not release such information without prior written parental consent.

## **Staff Qualifications: Parents' Right to Know**

In accordance with the federal No Child Left Behind Act, parents/guardians are entitled to information about the professional qualifications of their children's classroom teachers. This includes whether the teacher has state certification for the classes being taught; the teacher's bachelor's degree major and any other certifications or degrees by field or discipline; and whether the child is provided services by instructional aides or similar paraprofessionals and, if so, their qualifications. To obtain this information, call the district office at 315-552-5000.

## **Student Directory Information**

From time to time, student directory information (e.g., name, grade, photo, awards) depicting activities in the schools is released for use in district publications, on the district website or given to the media. Parents who object to the release of their child's directory information and/or photograph should notify both the superintendent and their child's building principal in writing by September 15.

### **Student privacy policy**

The Protection of Pupil Rights Amendment (PPRA) to the federal Family Educational Rights and Privacy Act (FERPA) affords parents certain rights regarding district surveys, collection and use of information for marketing purposes, and certain physical exams. Parents may exercise their right to excuse their child from participating in any survey created by a third party (before it is distributed to students) and questionnaires intended to collect personal information from students for marketing purposes.

### **Notice to Students, Parents and Staff Regarding the Use of Camera Surveillance on School Property**

For the safety of our students, staff and visitors, the School District employs camera surveillance equipment for security purposes. This equipment may or may not be monitored at any time.

Surveillance cameras will generally be utilized only in public areas where there is no "reasonable expectation of privacy." Public areas may include school buses; building entrances; hallways; parking lots; front offices where students, employees and parents come and go; gymnasiums during public activities; cafeterias; and supply rooms. However, it is not possible for surveillance cameras to cover all public areas of District buildings or all District activities.

District surveillance cameras will not be installed in "private" areas such as restrooms, locker rooms, changing areas, private offices (unless consent by the office owner is given), or classrooms.

# ROCKWELL ELEMENTARY

## IMPORTANT PHONE NUMBERS AND INFORMATION



### CONTACTS

#### MAIN OFFICE

rwoffice@onondagacsd.org  
(315) 552-5070 / (315) 552-5076 fax

#### NURSE

(315) 552-5072

#### BUS GARAGE/ TRANSPORTATION

(315) 552-5090

#### SPECIAL EDUCATION

(315) 552-5075

#### VISITORS

Anyone entering the school **MUST** provide photo I.D. no exceptions.

### SCHOOL HOURS

School begins at 8:30AM - arrival after 8:40AM is considered tardy.

Dismissal begins at 2:50PM

### BUS PASSES

Per the Board of Education Policy- All students should be picked up and dropped off at a consistent location every day. These locations should be established in September and unless an emergency situation arises should be permanent.

#### THIS MEANS THAT

- Each family can establish a secondary stop at the beginning of the school year (ex. grandparent, daycare, split custody). Change can be made and bus passes can be written only to the secondary stop. Secondary stops will change only under reasonable, consistent circumstances (change of daycare provider, a move, etc.).
- Bus passes will not be written for students to go home with other students NOT listed as their secondary stop. Parents must arrange to pick up and transport the student if they need to go to a location not listed.
- Exceptions will be made **ONLY** in the case of an emergency. Emergency bus passes must be approved by the principal.

### ATTENDANCE

#### ABSENT / DISMISSAL

If your student will be absent, picked up at dismissal, needs a bus pass, or will be leaving early --> please be sure to email: rwoffice@onondagacsd.org

Please note- THERE ARE NO CHANGES TO THE DISMISSAL LISTS AFTER 2:30PM. In an emergency we will make an exception but please note that to keep the dismissal process running smoothly we ask that all changes be done as early as possible.