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# FORT PLAIN CENTRAL SCHOOL DISTRICT

25 HIGH STREET \* FORT PLAIN, NEW YORK 13339-1365

"OUR AIM IS EXCELLENCE"

TELEPHONE 518-993-4000

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Dear Parent/Guardian,

Welcome to the Fort Plain Central School District! To complete your child's enrollment, we will need the following documentation:

- A copy of your child's **Birth Certificate or Baptismal Certificate**
- **Custody Documentation** (if applicable)
- **Proof of your residency** within the Fort Plain School District (**deed, lease, utility bill**)
- The attached **Enrollment** forms completed

Prompt submission of the above documents to the Main Office will allow us to begin the process of your child's enrollment. Our Superintendent and Principals review the documents you submit.

Once a decision by our administration is made as to whether or not your child's enrollment has been approved, we will contact you.

If you have any questions, please feel free to call our office.



## Student Registration Form

(Please Print Clearly)

This form must be completed for each child in the household that is enrolling.

### OFFICE USE ONLY

School \_\_\_\_\_  
Date Enrolled \_\_\_\_\_ Grade \_\_\_\_\_  
Student ID \_\_\_\_\_  
Homeroom \_\_\_\_\_  
Bus # \_\_\_\_\_

### SECTION 1: Student Information

Student's Legal Name \_\_\_\_\_ Gender: \_\_\_ M \_\_\_ F

(First Middle Last)  
Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Physical Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone Number \_\_\_\_\_ Text message number \_\_\_\_\_

This can be landline or cell, but a number where automated messages/attendance calls can be left.)

Previous School Attended \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Has student ever attended Fort Plain CSD before? ☐ Yes ☐ No

What kind of pre-school did the student attend (Pre-K): \_\_\_ Home \_\_\_ Private Day Care \_\_\_ Pre-K Program

Name of Facility: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Country of Birth \_\_\_\_\_ Date first entered U.S. School, if born outside U.S. \_\_\_\_\_

Primary Language Spoken in Household: \_\_\_\_\_

If registering for grades 9-12, date student completed 8th grade \_\_\_\_\_

### SECTION 2: Special Programs (Please initial in one of the spaces below)

\_\_\_\_\_ Initial here if student is CURRENTLY participating in any special program listed below

\_\_\_\_\_ Initial here if student PREVIOUSLY participated in any special program listed below

\_\_\_\_\_ Initial here if student HAS NEVER participated in any special program listed below

**Please indicate which Special Programs student is/has been in:**

\_\_\_ IEP \_\_\_ Speech \_\_\_ RTI \_\_\_ 504 Plan \_\_\_ AIS Math \_\_\_ AIS Reading \_\_\_ Counseling \_\_\_ Other

Is there anything you wish to tell us regarding your child, please explain:

Has your student ever been retained? ☐ Yes ☐ No If so, what grade? \_\_\_\_\_

If your child currently receives services, would you like them to continue to receive these services? \_\_\_ Yes \_\_\_ No

### SECTION 3: Ethnicity/Race

Is student of Hispanic/Latino Ethnicity?

\_\_\_ Yes \_\_\_ No



\*Race (Check all that apply): **You MUST check AT LEAST one option**

\_\_\_ American \_\_\_ Indian or Alaska Native \_\_\_ Black or African-American  
\_\_\_ Asian \_\_\_ Native Hawaiian or Other Pacific Islander \_\_\_ White

#### SECTION 4: Medical Information

List any medical conditions of the student \_\_\_\_\_

Does this student have any life-threatening food, nut, or insect allergies? \_\_\_\_\_

Does this student have any medically documented restrictions that would prevent participating in PE?

\_\_\_\_\_ Yes (must provide a doctor's statement) \_\_\_\_\_ No

#### Emergency Medical Authorization:

\_\_\_\_\_ I, the parent/guardian give permission for emergency medical treatment of my child for illness or accident if a parent/guardian cannot first be contacted or if an ambulance needs to be called.

Doctor's Name: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

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

#### SECTION 5: Custody and Parent/Guardian Information

Student lives with . . .

\_\_\_\_ Both Parents \_\_\_\_ Father \_\_\_\_ Mother \_\_\_\_ Grandparent(s) \_\_\_\_ Guardian(s) \_\_\_\_ Foster Parent(s)

\_\_\_\_ Alone \_\_\_\_ Other Relative(s) \_\_\_\_ Other, please explain \_\_\_\_\_

Enrolling Parent/Guardian is: \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Separated \_\_\_\_ Widowed \_\_\_\_ Single

**Is there a custody issue** \_\_\_\_ Yes \_\_\_\_ No

**Does an order of protection exist?** \_\_\_\_ Yes \_\_\_\_ No

*(Copy of court order or other legal documents may be required.)*

#### Primary Household Parent/Guardian 1:

Name \_\_\_\_\_ Cell Phone \_\_\_\_\_  
(First Middle Last)

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Preferred Email Address \_\_\_\_\_ Landline Phone \_\_\_\_\_

Active member of military: \_\_\_\_ Yes \_\_\_\_ No **OR** Member of military reserves: \_\_\_\_ Yes \_\_\_\_ No

#### Primary Household Parent/Guardian 2:

Name \_\_\_\_\_ Cell Phone \_\_\_\_\_  
(First Middle Last)

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Preferred Email Address \_\_\_\_\_ Landline Phone \_\_\_\_\_

Active member of military: \_\_\_\_ Yes \_\_\_\_ No **OR** Member of military reserves: \_\_\_\_ Yes \_\_\_\_ No

**Is mailing address different than physical address?** \_\_\_\_ Yes \_\_\_\_ No

Street or P.O. Box \_\_\_\_\_

City \_\_\_\_\_

Zip \_\_\_\_\_

Secondary Household Information, if applicable (**Applies to parent(s) not living at the same residence as students**)

**Secondary Household Parent/Guardian 1**

Name \_\_\_\_\_ Landline Phone \_\_\_\_\_  
 (First Middle Last)  
 Employer \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Preferred Email Address \_\_\_\_\_ Work Phone \_\_\_\_\_

This person is allowed to pick up student from school and can be contacted in the event of an emergency: \_\_\_\_ Yes \_\_\_\_ No  
 Active member of military: \_\_\_\_ Yes \_\_\_\_ No **OR** Member of military reserves: \_\_\_\_ Yes \_\_\_\_ No

**Secondary Household Parent/Guardian 2:**

Name \_\_\_\_\_ Landline Phone \_\_\_\_\_  
 (First Middle Last)  
 Employer \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Preferred Email Address \_\_\_\_\_ Work Phone \_\_\_\_\_

This person is allowed to pick up student from school and can be contacted in the event of an emergency: \_\_\_\_ Yes \_\_\_\_ No  
 Active member of military: \_\_\_\_ Yes \_\_\_\_ No **OR** Member of military reserves: \_\_\_\_ Yes \_\_\_\_ No

**Is a double mailing required? If so, please complete the following.**

Street Address \_\_\_\_\_ Apartment # \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_  
 Mailing Address (if different) \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Primary Telephone Number \_\_\_\_\_ (If only cell phones are used, please provide primary number at which to be contacted)

**SECTION 6: Student Information (Include new students enrolling and currently enrolled students)**

Please provide the names of all students residing in the primary household, along with the date of birth and relationship to each Parent/Guardian (that is, son, daughter, stepson, stepdaughter, grandchild, sister, brother, etc.).

| First Name | Middle Name | Last Name | Date of Birth | Relationship to Primary Household Parent/Guardian 1 | Relationship to Primary Household Parent/Guardian 2 | Relationship to Secondary Household Parent/Guardian 1 | Relationship to Secondary Household Parent/Guardian 2 |
|------------|-------------|-----------|---------------|-----------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------|
|            |             |           |               |                                                     |                                                     |                                                       |                                                       |
|            |             |           |               |                                                     |                                                     |                                                       |                                                       |
|            |             |           |               |                                                     |                                                     |                                                       |                                                       |

If there are custody issues that prevent any of the previously indicated heads of household from having access to the students listed above, please provide details. If such restrictions apply to a natural parent or legal parent/guardian, court documentation must be provided.

\_\_\_\_\_  
 \_\_\_\_\_

**SECTION 7: Additional Household Members (Please list any other adults living in the Primary Household)**

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**SECTION 8: Emergency Contacts**

The following people have permission to pick up my child from school without further contact from me and in the event of an emergency when the Parent/Guardian cannot be reached.

|                   | CONTACT ONE | CONTACT TWO | CONTACT THREE |
|-------------------|-------------|-------------|---------------|
| Name              |             |             |               |
| Relationship      |             |             |               |
| Cell Phone        |             |             |               |
| Work/Landline     |             |             |               |
| Town of Residence |             |             |               |

**SECTION 9: Housing Questionnaire**

*Where is the student currently living?*

- ☐ In permanent housing  
☐ In a hotel/motel  
☐ In a car, park, bus, train, or campsite  
☐ In a shelter  
☐ With another family or person due to loss of housing or as a result of economic hardship  
☐ Other temporary living situation: \_\_\_\_\_

***The answer you gave above will help the district determine what service 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, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.***

**SECTION 10: Parent/Guardian Signature**

*My relationship to the student is:*

- ☐ Parent ☐ Person having lawful Court Order (copy required)  
☐ Grandparent ☐ Other (Non-Parental Affidavit required)  
☐ Legal Guardian (documentation needed) ☐ Self/ Student (must be 18 years or older)

***I hereby certify that I am either a full-time resident of the Fort Plain school district or am an employee of FPCSD and affirm that all the information contained in this form is true and accurate to the best of my knowledge.***

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

### SECTION 11: Transportation

My student will: \_\_\_\_ Walk \_\_\_\_ Will be picked up \_\_\_\_ Will ride the bus

If your child will be riding the bus:

AM Pick-Up: \_\_\_\_\_

PM Drop-Off: \_\_\_\_\_

#### Enrollment Documents Received:

- \_\_\_\_ Birth Certificate
- \_\_\_\_ Records Release
- \_\_\_\_ Custody Documentation
- \_\_\_\_ Health Records
- \_\_\_\_ Report Card
- \_\_\_\_ SPED Records

#### FOR SCHOOL USE ONLY

##### Residency Proof:

- \_\_\_\_ Lease or Mortgage Statement
- \_\_\_\_ Utility Bill
- \_\_\_\_ Other: \_\_\_\_\_
- \_\_\_\_ Parent is FPCSD Employee
- \_\_\_\_ Homeless Statement
- \_\_\_\_ From Parent

- \_\_\_\_ IT student account
- \_\_\_\_ Status Codes
- \_\_\_\_ Parent Notification
- \_\_\_\_ Email teachers

Approved: \_\_\_\_\_ (Principal) Date: \_\_\_\_\_

Approved: \_\_\_\_\_ (Superintendent) Date: \_\_\_\_\_

# New York State Housing Questionnaire

Identifying and serving students in temporary housing under the McKinney-Vento Act and NYS Ed Law §3209

This form is to be completed when a student first enrolls, and any time a change in housing status occurs. There are no wrong answers. This form may be filled out independently, or the McKinney-Vento Liaison can assist. To access a list of McKinney-Vento Liaisons, please visit <https://www.nysteachs.org/liaisons>

|                 |             |
|-----------------|-------------|
| District or LEA | School Name |
|-----------------|-------------|

**About this form and your rights**

Schools are required by federal and state law to identify students living in temporary housing and ensure they can enroll, attend, and succeed in school. The **McKinney-Vento Homeless Assistance Act**, together with **New York State Education Law Section §3209**, protects students and families who no longer have a permanent, stable place to live; families who have lost housing; are staying with others temporarily; or are living somewhere that was never meant to be a home.

**Eligible students have the right to:**

- ✓ Stay in the school they attended when last permanently housed (called the school of origin), for as long as they are in temporary housing.
- ✓ Immediately enroll in the local school where they are temporarily staying (the school of current location).
- ✓ Enroll and start school right away, even without a birth certificate, proof of residency, immunization records, or school records.
- ✓ Receive free transportation to and from the school of attendance, as well as after-school activities (If within 50 miles).
- ✓ Receive free school meals without income paperwork as well as access to other school services including McKinney-Vento Grant resources, if available.

This information is confidential and will be shared only with school staff who have a legitimate educational need to support student access to McKinney-Vento rights and services. Providing this information is voluntary and will be used only to determine eligibility for services under the McKinney-Vento Act and NYS Education Law §3209. Providing it will not affect your immigration status or your eligibility for enrollment or other services.

## STUDENT INFORMATION:

|                                                                                                                |                                        |
|----------------------------------------------------------------------------------------------------------------|----------------------------------------|
| Student Name (Last, First)                                                                                     | Student Grade Level (Preschool-12)     |
| Student Gender<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X = Nonbinary | Student Date of Birth (Month/Day/Year) |
| Parent/Legal Guardian Name                                                                                     |                                        |
| Phone Number                                                                                                   | E-Mail Address                         |
| Address where the student is currently living                                                                  |                                        |

### Where is the student residing right now?

Under the McKinney-Vento Act, students are protected when their nighttime residence is not **fixed, regular, and adequate**. Check every box that describes where **the student** is residing right now.

- ☐ Permanent housing: you own or rent a fixed, regular, and adequate home
- ☐ Doubled up: staying with another family or person due to a loss of housing, economic hardship, eviction, or other similar reason
- ☐ In an emergency, transitional, or domestic violence shelter. Shelter or program name: \_\_\_\_\_
- ☐ In a hotel or motel because there is no other alternative, adequate place to stay
- ☐ In a car, park, campsite, bus or train station, abandoned building, or another place not meant for stable habitation or established dwelling.
- ☐ In a place with no heat, running water, or electricity, or that is otherwise structurally unsafe or inadequate to reside in
- ☐ Displaced by a fire, flood, natural disaster, or other emergency
- ☐ Another temporary situation not listed here: \_\_\_\_\_

Is there anything else you would like us to know about your situation? (optional)

\_\_\_\_\_

### Is the student an Unaccompanied Homeless Youth (UHY)?

The McKinney-Vento Act identifies students who are not living with a parent or legal guardian, and are not residing in permanent housing, as **Unaccompanied Homeless Youth (UHY)**. UHYs have the right to enroll in school and to complete and sign this form independently, without a parent or adult present. The McKinney-Vento Liaison can assist UHYs with this process.

☐ Please check the box if you believe the student identified above may meet the McKinney-Vento eligibility criteria described above.

### Additional Children within the Household?

To help us identify and support all eligible children and youth, please list every child who is currently living with you, regardless of age or school enrollment status. This includes infants, preschool-aged children, and school-aged children.

| Student Name<br>(Last, First) | Date of Birth | Grade | Current or Recent School | Last School Attended Before Current or Recent |
|-------------------------------|---------------|-------|--------------------------|-----------------------------------------------|
|                               |               |       |                          |                                               |
|                               |               |       |                          |                                               |
|                               |               |       |                          |                                               |

| Student Name<br>(Last, First) | Date of<br>Birth | Grade | Current or Recent<br>School | Last School Attended<br>Before Current or Recent |
|-------------------------------|------------------|-------|-----------------------------|--------------------------------------------------|
|                               |                  |       |                             |                                                  |
|                               |                  |       |                             |                                                  |

### Accuracy of Information and Signature

The person completing this form certifies that the information provided above is correct and accurate to the best of their ability.

Name (print): \_\_\_\_\_

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

*An unaccompanied homeless youth may sign on their own behalf.*

**Need help?** Contact the McKinney-Vento Liaison listed at the top of this form or call the NYS-TEACHS Helpline at 800-388-2014. Visit [nysteachs.org](http://nysteachs.org) for more information.

### OFFICIAL USE ONLY (School Staff)

Date received: \_\_\_\_\_ Received by: \_\_\_\_\_ Eligibility: ☐ Eligible ☐ Not Eligible ☐ Pending

**Homeless Primary Nighttime Residence Code (SIRS):**

☐ D = Doubled up ☐ S = Shelter ☐ H = Hotel/Motel ☐ U = Unsheltered ☐ T = Transitional Housing

Unaccompanied Homeless Youth (UHY): ☐ Yes ☐ No

Designation Form: ☐ Yes ☐ N/A ☐ Coded in Student Information System (SIS)

Liaison notified (initials): \_\_\_\_\_ Date: \_\_\_\_\_ ☐ Family declined to provide information

**Notes:**

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# FORT PLAIN CENTRAL SCHOOL DISTRICT

25 HIGH STREET \* FORT PLAIN, NEW YORK 13339-1365

"OUR AIM IS EXCELLENCE"

TELEPHONE 518-993-4000

Dear Parents and Guardians of Fort Plain Students,

On July 1, 2015 an amendment was made to New York State Education Law, pursuant to Chapter 434 of the Laws of 2014, regarding special education parental notification requirements upon a student's entry into school. Section 4402 of the Education Law is an amendment that requires school districts to notify every parent or person in parental relation of their rights regarding the referral and evaluation of their child for the purposes of special education services or programs. This notification is provided to parents of all students in the Fort Plain Central School District, with or without disabilities.

This information may be obtained in either of two ways:

1) Follow the link below to *A Parent's Guide to Special Education* on the New York State Education Department's web site,

<http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm>

2) Obtain a copy of *A Parent's Guide to Special Education* from the main office at Harry Hoag Elementary School or the Junior/Senior High School.

If there are any questions regarding special education and/or the referral process, please contact Fort Plain Central School District's Special Education office. Contact information is as follows:

Brenna Kirkpatrick  
Director of Special Education  
(518)993-4000 Ext. 3080  
[brenna.kirkpatrick@fortplain.org](mailto:brenna.kirkpatrick@fortplain.org)

Sincerely,

Brenna Kirkpatrick

Brenna Kirkpatrick  
Director of Special Education

Fort Plain Central School District

25 High Street

Fort Plain, NY 13339

Harry Hoag Elementary School

Mrs. Bartholomew, Principal

Fort Plain Jr. /Sr. High School

Mrs. Canallatos, Principal

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

Prior School District: \_\_\_\_\_

Fax \_\_\_\_\_ Phone \_\_\_\_\_

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

Does your child currently receive Special Education Services    Y        N    (Please circle)

The above student has registered at Fort Plain Central School. This is to request and authorize the release of the following records and information.

----Current transcript with exiting grades

----IEP / 504 / Remediation / Support Services

---- Standardized Test Scores

----Academic Records

----Health and Immunization Records

----Birth Certificate

----Attendance Records

----Psychological Evaluation

----Custody/Guardianship/Court Orders

----Social History

Date of entry at Fort Plain CSD: \_\_\_\_\_

**Please Email or Fax records to:**

**PK-6**

**7-12**

**Jennifer Ruskowski**

**Karen Shibley**

**[jennifer.ruskowski@fortplain.org](mailto:jennifer.ruskowski@fortplain.org)**

**[karen.shibley@fortplain.org](mailto:karen.shibley@fortplain.org)**

**Phone: (518) 993-4000 x 3059**

**Phone: (518) 993- 4000 x 2124**

**Fax: (518) 993-4501**

**Fax: (518) 993-2897**

| Fort Plain Central School                                                                                                                  |                                                                       |  |
|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--|
| Student Name:                                                                                                                              | DOB:                                                                  |  |
| School Name:                                                                                                                               | Age:                                                                  |  |
| Grade (check): PK K 1 2 3 4 5 6 7 8 9 10 11 12                                                                                             | Limitations: <input type="checkbox"/> NO <input type="checkbox"/> YES |  |
| Sport                                                                                                                                      | Date of last Health Exam:                                             |  |
| Sport Level: <input type="checkbox"/> Modified <input type="checkbox"/> Fresh <input type="checkbox"/> JV <input type="checkbox"/> Varsity | Date form completed:                                                  |  |
| <b>MUST be completed and signed by Parent/Guardian - Give details to any YES answers on last page</b>                                      |                                                                       |  |

| DOES OR HAS YOUR CHILD                                                                                                                                                                                 |                          |                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| GENERAL HEALTH                                                                                                                                                                                         | No                       | Yes                      |
| Ever been restricted by a health care provider from sports participation for any reason?                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had surgery?                                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever spent the night in a hospital?                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Been diagnosed with mononucleosis within the last month?                                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Have only one functioning kidney?                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Have a bleeding disorder?                                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Have any problems with hearing or have congenital deafness?                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Have any problems with vision or only have vision in one eye?                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Have an ongoing medical condition?                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, check all that apply:                                                                                                                                                                          |                          |                          |
| <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes<br><input type="checkbox"/> Seizures <input type="checkbox"/> Sickle cell trait or disease<br><input type="checkbox"/> Other:        |                          |                          |
| Have Allergies?                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, check all that apply                                                                                                                                                                           |                          |                          |
| <input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine<br><input type="checkbox"/> Pollen <input type="checkbox"/> Other: |                          |                          |
| Ever had anaphylaxis?                                                                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Carry an epinephrine auto-injector?                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| BRAIN/HEAD INJURY HISTORY                                                                                                                                                                              | No                       | Yes                      |
| Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Receive treatment for a seizure disorder or epilepsy?                                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had headaches with exercise?                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had migraines?                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |

| DOES OR HAS YOUR CHILD                                                                                              |                          |                          |
|---------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| BREATHING                                                                                                           | No                       | Yes                      |
| Ever complained of getting extremely tired or short of breath during exercise?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Use or carry an inhaler or nebulizer?                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheeze or cough frequently during or after exercise?                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever been told by a health care provider they have asthma or exercise-induced asthma?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| DEVICES / ACCOMMODATIONS                                                                                            | No                       | Yes                      |
| Use a brace, orthotic, or another device?                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Wear protective eyewear, such as goggles or a face shield?                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Wear a hearing aid or cochlear implant?                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Let the coach/school nurse know of any device used.</b><br><b>Not required for contact lenses or eyeglasses.</b> |                          |                          |
| DIGESTIVE (GI) HEALTH                                                                                               | No                       | Yes                      |
| Have stomach or other GI problems?                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had an eating disorder?                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Have a special diet or need to avoid certain foods?                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Are there any concerns about your child's weight?                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| INJURY HISTORY                                                                                                      | No                       | Yes                      |
| Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?      | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Have a bone, muscle, or joint that bothers them?                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Have joints that become painful, swollen, warm, or red with use?                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever been diagnosed with a stress fracture?                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |

| DOES OR HAS YOUR CHILD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| <b>HEART HEALTH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          |                          |
| Ever complained of:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | No                       | Yes                      |
| Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Lightheadedness, dizziness, during or after exercise?                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain, tightness, or pressure during or after exercise?                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Fluttering in the chest, skipped heartbeats, heart racing?                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever been told by a health care provider they have or had a heart or blood vessel problem?                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, check all that apply:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                          |                          |
| <input type="checkbox"/> Chest Tightness or Pain <input type="checkbox"/> Heart infection<br><input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> High Cholesterol <input type="checkbox"/> Low Blood Pressure<br><input type="checkbox"/> New fast or slow heart rate <input type="checkbox"/> Kawasaki Disease<br><input type="checkbox"/> Has implanted cardiac defibrillator (ICD)<br><input type="checkbox"/> Has a pacemaker<br><input type="checkbox"/> Other: |                          |                          |

| DOES OR HAS YOUR CHILD                                                                           |                          |                          |
|--------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| <b>FEMALES ONLY</b>                                                                              | No                       | Yes                      |
| Have regular periods?                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>MALES ONLY</b>                                                                                | No                       | Yes                      |
| Have only one testicle?                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Have groin pain or a bulge, or a hernia?                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>SKIN HEALTH</b>                                                                               | No                       | Yes                      |
| Currently have any rashes, pressure sores, or other skin problems?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had a herpes or MRSA skin infection?                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>COVID-19 INFORMATION</b>                                                                      |                          |                          |
| Has your child ever tested positive for COVID-19?                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| If <b>NO, STOP.</b> Go to Family Heart Health History.<br>If <b>YES,</b> answer questions below: |                          |                          |
| Date of positive COVID test:                                                                     | No                       | Yes                      |
| Was your child symptomatic?                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Did your child see a health care provider for their COVID-19 symptoms?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Was your child hospitalized for COVID?                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?                          | <input type="checkbox"/> | <input type="checkbox"/> |

| FAMILY HEART HEALTH HISTORY                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| A relative has/had any of the following:                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                |
| Check all that apply:                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy<br><input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy?<br><input type="checkbox"/> Heart rhythm problems, long or short QT interval?                              | <input type="checkbox"/> Brugada Syndrome?<br><input type="checkbox"/> Catecholaminergic Ventricular Tachycardia?<br><input type="checkbox"/> Marfan Syndrome (aortic rupture)?<br><input type="checkbox"/> Heart attack at age 50 or younger?<br><input type="checkbox"/> Pacemaker or implanted cardiac defibrillator (ICD)? |
| A family history of:                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Known heart abnormalities or sudden death before age 50? <input type="checkbox"/> Structural heart abnormality, repaired or unrepaired?<br><input type="checkbox"/> Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50? |                                                                                                                                                                                                                                                                                                                                |
| If you answered <b>Yes</b> to any Questions, please give details:                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                |

|                            |  |
|----------------------------|--|
| Parent/Guardian Signature: |  |
| Date:                      |  |

If you answered **YES** to any questions give details. Sign and date below.

[illegible]

Parent/Guardian  
Signature:

Date:

**Parent and Prescriber's Authorization for Administration of Medication in School**

A. To be completed by parent/guardian:

I request that my child \_\_\_\_\_, grade \_\_\_\_\_  
receive the medication as prescribed below by our licensed health care Prescriber. The  
medication is to be furnished by me in the properly labeled original container from the pharmacy. I  
understand that the school nurse, trained staff (per supervised student), or whom I have  
designated, will administer the medication.

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

Address \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Date \_\_\_\_\_

B. To be completed by the licensed health care prescriber:

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

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Name of Medications: \_\_\_\_\_

Prescribed Dosage, Frequency and Route of Administration: \_\_\_\_\_

Time to be taken during the school hours: \_\_\_\_\_

Duration of Treatment: \_\_\_\_\_

Possible side effects and adverse reaction (if any): \_\_\_\_\_

Other recommendations: \_\_\_\_\_

Please check all that apply:

\_\_\_\_\_ Supervised Student – can be assisted by trained staff (Student able to identify medication,  
knows when, how much, and why they take the medication. They know what happens if  
they don't take it and knows when to refuse the medication).

\_\_\_\_\_ Nurse Dependent Student

\_\_\_\_\_ Independent Student – can take (self-administer) their own medication without  
assistance.

\_\_\_\_\_ Student takes medication independently in health office (after being handed the  
medication container by school staff).

\_\_\_\_\_ Student is permitted to carry and use medication with the required documentation at  
school and sporting events.

Name of Licensed Prescriber and Title (Please Print) \_\_\_\_\_

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

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**  
**TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**  
**IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

**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"/> <b>Allergies</b> | Type:<br><input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached                                                                                                |
| <input type="checkbox"/> <b>Asthma</b>    | <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other:<br><input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached |
| <input type="checkbox"/> <b>Seizures</b>  | Type: _____ Date of last seizure: _____<br><input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached                                                                  |
| <input type="checkbox"/> <b>Diabetes</b>  | Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2<br><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</b><br>Required for PreK & K                                                          |
| 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  |

|                                                                          |                                                                           |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations: | Diagnoses/Problems (list) <span style="float: right;">ICD-10 Code*</span> |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------|

☐ 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</b>                                                                                                                                                                                                                                                     | <b>With Correction</b> <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Right</b>                                                            | <b>Left</b>                                                                          | <b>Referral</b>              | <b>Not Done</b>          |
| Distance Acuity                                                                                                                                                                                                                                                   |                                                                                 | 20/                                                                     | 20/                                                                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> |
| Near Vision Acuity                                                                                                                                                                                                                                                |                                                                                 | 20/                                                                     | 20/                                                                                  |                              | <input type="checkbox"/> |
| Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail                                                                                                                                                                            |                                                                                 |                                                                         |                                                                                      |                              | <input type="checkbox"/> |
| Notes                                                                                                                                                                                                                                                             |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>Hearing</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                                                                                                                                                                                                                                               | <b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail        | <b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail | <b>Referral</b> <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 Dominic 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> (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.                                                                                            |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <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>                                                                                                                                                                               |                                                                                 |                                                                         |                                                                                      |                              |                          |

# 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:

/ /  
Month Day Year

Sex: ☐ Male

☐ Female

Will this be your child's first oral health assessment?

☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature

Date

## Section 2. To be completed by the Dentist/ Dental Hygienist

**I. The dental health condition of \_\_\_\_\_ on \_\_\_\_\_ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:**

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means, that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

**Dentist's/ Dental Hygienist's name and address**

(please print or stamp)

**Dentist's/Dental Hygienist's Signature**

**Optional Sections - If you agree to release this information to your child's school, please initial here.**

### II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify): \_\_\_\_\_

### II. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.



**FORT PLAIN  
HILLTOPPERS**

### **School Bus Behavior Contract**

## **RIDE WITH PRIDE**

Please read carefully, then sign and return this agreement to your school office within 3 days after receiving the contract.

#### **General Information**

- Bus drivers, students, parents, teachers, and school administrators share the responsibility for bus safety, following all bus rules, and behaving in a responsible manner.

☐ **I agree to ride the bus safely.**

Stay seated  
Keep aisles free of backpacks  
At stops, remain at designated area until bus comes to complete stop

DO NOT put any part of my body outside the window  
DO NOT push or shove others  
DO NOT leave seat while bus is in motion

☐ **I agree to follow all bus rules and be responsible.**

Keep hands and feet to myself  
No eating on the bus  
Respect bus property  
Sit in assigned seats

DO NOT possess weapons including laser pens  
DO NOT possess alcohol, tobacco, or illegal drugs  
DO NOT tamper with emergency door or equipment

☐ **I agree to treat the bus, the driver, and all passengers with respect.**

Obey directions from my bus driver  
Talk and act kindly to others

DO NOT leave trash, food, etc. on the bus  
DO NOT throw, spit, kick or hit  
DO NOT use foul language, tease, threaten others, or use inappropriate gestures.

**If I choose not to follow this contract, I understand the following consequences may occur, or in the event of a serious offense I may be suspended from the bus immediately:**

- #1 My parent(s)/guardian will be notified by an administrator at my school district and I will be warned about the consequences of not following the school bus rules. I understand that other disciplinary measures may include a change in seat assignment, loss of privileges, parent/student conference with district administration, or other actions that are relevant to the offense.
- #2 My parent(s)/guardian will be notified by an administrator and I may lose all bus privileges. If a student loses bus privileges, it is your responsibility to arrange transportation to school to ensure continuity in the student's education.
- #3 Severe Clause: Students may be suspended immediately from the bus for severe infractions for a period of time to be determined by the school administrator. A serious infraction, such as a weapon, drug or physical violence, may result in bus privileges being suspended immediately and further disciplinary actions may occur.

**NOTE: If bus privileges are suspended, I must arrange my own transportation to and from school.**

**Please print legibly. Signatures indicate that you have discussed, understand, and agree to the above statements. Thank you.**

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

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

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

Student's Signature \_\_\_\_\_

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

# FORT PLAIN CENTRAL SCHOOL DISTRICT

25 HIGH STREET \* FORT PLAIN, NEW YORK 13339-1365

"OUR AIM IS EXCELLENCE"

TELEPHONE 518-993-4000

New York State requires school districts to collect information regarding student access to technology. Please complete and return to the main office.

Student's Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Student's Grade \_\_\_\_\_

1. Did the school district issue your child a dedicated school or district-owned device for their use during the school year?    ☐ Yes    ☐ No
2. What is the device your child uses most often to complete learning activities away from school? (This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.)
  - A. Desktop
  - B. Laptop
  - C. Tablet
  - D. Chromebook
  - E. Smartphone
  - F. Other
3. Who is the provider of the primary learning device identified in question 2? (This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.)
  - A. Personal
  - B. School
  - C. No Device
4. Is the primary learning device (identified in question 2) shared with anyone else in the household?
  - A. No Device
  - B. Shared
  - C. Not Shared
5. Is the primary learning device (identified in question 2) sufficient for your child to fully participate in all learning activities away from school?    ☐ Yes    ☐ No
6. Is your child able to access the internet in their primary place of residence?    ☐ Yes    ☐ No
7. What is the primary type of internet service used in your child's primary place of residence?
  - A. Residential Broadband
  - B. Cellular
  - C. Mobile Hotspot
  - D. Community WIFI
  - E. Satellite
  - F. Dialup
  - G. DSL
  - H. Other
  - I. None
8. In their primary residence, can your child complete the full range of learning activities, including video streaming and assignment upload, without interruptions caused by slow or poor internet performance?    ☐ Yes    ☐ No
9. What, if any, is the primary barrier to having sufficient and reliable internet access in your child's primary place of residence?
  - A. Availability
  - B. Cost
  - C. Other
  - D. None



## **Student Technology Sign-Out Agreement**

### **CORE PRACTICE:**

- Technology is to be used for research and school related activities.
- Devices will be carried in protective cases, with care and used responsibly.
- Food and liquids will be kept away from devices.
- Students will ensure their device is charged when not in use.
- Websites and apps used will be relevant to the given assignment topic, and appropriate for school.
- Students will take care of the device as if it were their own.

### **OUT OF BOUNDS BEHAVIOR:**

- Deliberate damage or physical changes to the device.
- Carelessness that may result in accidental damage to the device.
- Cyberbullying.
- Food and drinks near or on the devices.
- Inappropriate videos, sites or content that violate the Fort Plain Central School District Code of Conduct.
- Using the device for activities not related to school work.

### **LOSS OR DAMAGE:**

- If the device or charger is damaged, lost, or stolen, the student and parent are responsible for the cost of the repair or replacement deductible, up to \$100.00.
- Any damage, loss or theft of the property must be reported to the District as soon as possible, and no later than the next school day following the occurrence.
- The District may pursue legal action against any student who willfully, maliciously or unlawfully damages, destroys or steals a District-own device.



## Student Technology Sign-Out Agreement

By signing below, I acknowledge the following:

- I have read the expectations listed above, and the official Fort Plain School District Acceptable Use Policy: Student Use of Computerized Information Resources, Policy #7314.
- I have read the limited directory information disclosure provided in the official Fort Plain Central School District Student Directory Information Policy, # 7242.
- I understand that technology access is designed for educational purposes. The Fort Plain School District has taken reasonable steps to control access to the Internet, but cannot guarantee that all controversial information will be inaccessible to students.
- I agree that I will not hold the Fort Plain School District responsible for materials acquired on the device or network. I accept full responsibility for supervision when my child's use is not in a school setting.
- I understand that any violation of the regulations defined in these aforementioned guidelines and policies is unethical, and that violations may constitute the following actions: My child and I may be responsible for the cost of repair or replacement up to \$100.00. My child's privileges may be revoked. School disciplinary action against my child may be taken. Appropriate legal action may be initiated against my child or me.
- I understand that my agreement to these terms will be binding for the remainder of my child's schooling at the Fort Plain Central School District, or until a revised agreement is released and signed.

Name of Child(ren) \_\_\_\_\_

Grade Level of Child(ren) \_\_\_\_\_

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

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

Date of Signature \_\_\_\_\_

## Emergency School Closing Plan

Student's Name: \_\_\_\_\_

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

Should there be an actual school emergency, there would not be time to call parents. This means that a specific plan **MUST** be in place for your child or children.

Please remember- If someone usually meets your child at the end of the school day, this person may not be aware that an emergency has arisen and therefore, would not be outside to meet your child. It is important that you have an alternate plan should this type of situation arise.

### **Please Choose One:**

\_\_\_\_\_ Dismiss my child to ride the regular bus.

\_\_\_\_\_ Dismiss my child to ride the bus to an alternate location:

\_\_\_\_\_  
*(Name/Location/Phone Number)*

\_\_\_\_\_ Dismiss my child to walk home as usual.

\_\_\_\_\_ Dismiss my child to the following alternate location:

\_\_\_\_\_  
*(Name/Location/Phone Number)*

\_\_\_\_\_ Other dismissal arrangement not shown above:

Please also remember to discuss these alternate plans with the appropriate people involved.

Parent Name and Daytime Phone Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date



**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>                |
|                                                 |            | <input type="checkbox"/> Male |
| Month                                           | Day        | Year                          |
| <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 | _____                                         |
|                                                                        | <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:

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT  
INFORMATION SYSTEM:

District Name (Number) & School:

Address:

## Home Language Questionnaire (HLQ)—Page Two

### Educational History

8. Indicate the total number of years that your child has been enrolled in school \_\_\_\_\_

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes\*    No    Not sure

☐
☐
☐

\*If yes, please explain: \_\_\_\_\_

How severe do you think these difficulties are?    ☐ Minor    ☐ Somewhat severe    ☐ Very severe

10a. Has your child ever been referred for a special education evaluation in the past?    ☐ No    ☐ Yes\* \*Please complete 10b below

10b. \*If referred for an evaluation, has your child ever received any special education services in the past?

☐
☐

No    Yes – Type of services received: \_\_\_\_\_

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

☐

Birth to 3 years (Early Intervention)

☐

3 to 5 years (Special Education)

☐

6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)?    ☐ No    ☐ Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

12. In what language(s) would you like to receive information from the school? \_\_\_\_\_

Month:    Day:    Year:

Signature of Parent or of Person in Parental Relation

Date

Relationship to student:    ☐ 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:

MO.

DAY

YR.

PROFICIENCY LEVEL  
ACHIEVED ON  
NYSITELL:

☐ ENTERING

☐ EMERGING

☐ TRANSITIONING

☐ EXPANDING

☐ COMMANDING

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

STAC ID

The University of the State of New York  
THE STATE EDUCATION DEPARTMENT  
STAC/Medicaid Unit  
Room EB 25, Education Building  
Albany, NY 12234

STAC-202

HOMELESS DESIGNATION

Rev. 11/2022

## Designation of School District of Attendance for a Homeless Child

Submitted by: ☐ Local Dept of Social Services (DSS)☐ Designated School District of Attendance (PSD)

## PLEASE READ THE INSTRUCTIONS ON THE REVERSE BEFORE COMPLETING THIS FORM

1. NAME OF CHILD

LAST NAME

FIRST NAME

2. DATE OF BIRTH

MO / DAY / YR

M.I.

3. GENDER

☐ FEMALE☐ MALE☐ NON-BINARY

5. Racial/Ethnic Category of Child (See definitions on reverse side of last page.)

American Ind or Alaskan Native ☐ Asian or Pacific Isl. ☐ Black ☐ Hispanic ☐ White ☐

7. COMPLETE ADDRESS BEFORE CHILD/FAMILY BECAME HOMELESS

8. COMPLETE ADDRESS OF CURRENT LOCATION

DATE CHILD/FAMILY  
PLACED IN TEMPORARY  
HOUSING

MONTH DAY YEAR

9. DATE DISTRICT OF ATTENDANCE CHOSEN

MONTH DAY YEAR

10. DATE PLACED IN PERMANENT HOUSING

MONTH DAY YEAR

6. GRADE LEVEL FOR WHICH  
PLACEMENT IS SOUGHT

7A. NYS SCHOOL DISTRICT OF ATTENDANCE BEFORE BECOMING HOMELESS

7B. NYS SCHOOL DISTRICT WHERE LAST ENROLLED

8A. NYS SCHOOL DISTRICT OF CURRENT LOCATION

9A. NYS DESIGNATED DISTRICT OF ATTENDANCE

One of four school districts may be chosen to provide the education component: the school district of attendance before becoming homeless, the school district where last enrolled, the school district of current location or a school district participating in a Regional Placement Plan. This designation may be changed either prior to the end of the first semester of attendance or within 60 days of making this designation, whichever occurs later.

11. Check the appropriate box if the designated school district of attendance (9A) is different from the district of attendance before becoming homeless (7A) and from the district of current location (8A).

☐ District participating in a Regional Placement Plan OR ☐ District where last enrolled (7B) if it is different from the district where last permanently housed (7A) and the district of current location (8A).

12. NAME OF PARENT OR PERSON IN PARENTAL RELATIONSHIP

AREA CODE

TELEPHONE NUMBER

13. SIGNATURE OF PERSON IN PARENTAL RELATIONSHIP TO CHILD

DATE

IT HAS BEEN REPORTED TO ME THAT THIS CHILD IS UNDER THE AGE OF 21 YEARS AND IS THEREFORE ELIGIBLE FOR EDUCATIONAL SERVICES. THE CHILD HAS BEEN ADVISED OF HIS/HER RIGHT TO DESIGNATE THE SCHOOL DISTRICT OF ATTENDANCE.

14. PRINT NAME OF LOCAL DSS OR SCHOOL DISTRICT REPRESENTATIVE

TITLE

15. SIGNATURE OF LOCAL DSS OR SCHOOL DISTRICT REPRESENTATIVE

DATE

16. PLACEMENT COUNTY

Local DSS use only

AREA CODE

TELEPHONE NUMBER

**INSTRUCTIONS FOR COMPLETING THE STAC-202 FORM**  
**Designation of School District of Attendance for a Homeless Child**

*Education of homeless children means 1) a child or youth who lacks a fixed, regular, and adequate night-time residence, including a child or youth who is (i) sharing the housing of other persons due to a loss of housing, economic hardship or a similar reason; (ii) living in motels, hotels, trailer parks or camping grounds due to the lack of alternative adequate accommodations; (iii) abandoned in hospitals, (iv) awaiting foster care placement; or (v) a migratory child, as defined in § 1309(2) of the Elementary and Secondary Education Act of 1965, as amended, who qualifies as homeless under any of the provisions of clauses (i) through (iv) of this subparagraph or subparagraph two of this paragraph; or 2) a child or youth who has a primary nighttime location that is (i) a supervised publicly or privately operated shelter designed to provide temporary living accommodations including, but not limited to, shelters operated or approved by the state or local department of social services, and residential programs for runaway and homeless youth established pursuant to article nineteen-H of the executive law; or (ii) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, including a child or youth who is living in a car, park, public space, abandoned building, substandard housing, bus or train stations or similar setting.*

1. Enter the youth's complete last name and first name.
2. Enter the youth's date of birth.
3. Place a check in the box which identifies the gender of the youth.
4. Item reserved for future use.
5. Place a check in the box which identifies, to the best of your knowledge, the racial/ethnic category with which the youth most closely identifies.

**Racial/Ethnic Categories:**

**American Indian or Alaskan Native** - A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

**Asian or Pacific Islander** – A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.

**Black** – A person having origins in any of the black racial groups of Africa.

**Hispanic** – A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

**White** – A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

6. Enter the grade level for which placement is being sought.
7. Enter the complete last permanent address prior to becoming homeless.
- 7A. Enter the name of the school district that served the area where the child resided prior to becoming homeless.
- 7B. Enter the name of the school district where the student was last enrolled. This will be different from 7A if the student was previously temporarily housed in a different district and enrolled in that district as a non-resident homeless student.
8. Enter the complete address of current temporary housing including the name of the shelter if applicable and the date the student moved to the current location. If the location is confidential (for example, if the student is living in a domestic violence shelter), the name and address of the location do not need to be provided.
- 8A. Enter the name of the school district of current location.
9. Enter the date of designation.
- 9A. Enter the name of the designated school district of attendance. One of four districts may be designated to provide the educational component:
  - District of attendance before becoming homeless,
  - District where last enrolled,
  - District of current location of temporary housing, or
  - District participating in a Regional Placement Plan (RPP).
10. Enter, if applicable, the date the child moved to permanent housing and is no longer eligible as a homeless student.
11. If the student attends school in a district participating in a Regional Placement Plan or the district where last enrolled (7B), and that district is different from both the district of attendance before becoming homeless (7A) and the district of current location (8A), check the corresponding box where the student attends school (either the District participating in a Regional Placement Plan or the District where last enrolled).
12. Print the name and telephone number of the designator. The designator can be the parent, person in parental relation, the unaccompanied youth (a youth who meets the definition of homeless and is not in the physical custody of a parent or guardian), or the director of a residential program for runaway and homeless youth if the student is living in such a program.
13. The signature of the designator and current date.
14. Print the name of the local Department of Social Services or School District representative and title.
15. The signature of the local Department of Social Services or School District representative is required attesting that this child has moved to temporary housing. A telephone number is required in case the STAC & Special Aids Unit has questions relating to the information provided.
16. The name of the local Department of Social Services that has placed the child in temporary housing, if applicable.

NOTE: Copies should be distributed to the following:

1. State Education Department, only if designated district of attendance is entitled to reimbursement for educational services pursuant to N.Y. Educ. Law § 3209(3);
2. Designated School District of Attendance;
3. District of Attendance before becoming homeless;
4. District where last enrolled;
5. Parent/Guardian/Unaccompanied youth/director of a residential program for runaway and homeless youth; and
6. Local Department of Social Services, only if placed in temporary housing by DSS.

## ParentSquare Tips for Parents

### 1 Activate Account

Click the link in your invitation email/text or sign up on ParentSquare.com or via the ParentSquare app.

### 2 Download App

It's easy to stay in the loop with the ParentSquare app. Download it now from the App store or Google Play.

### 3 Set Preferences

Click your name in the top right to visit your account page and set your notification and language preferences.

### 4 Get Photos & Files

Click 'Photos & Files' in sidebar to easily access pictures, forms and documents that have been shared with you.

### 5 Appreciate Posts

Click 'Appreciate' in your email/ app or website to thank a teacher or staff for a post. Teachers love the appreciation.

### 6 Comment or Reply

Click 'Comment' in app or website to privately ask a question about the post that your teacher or school sent.

### 7 Participate

Click 'Sign Ups & RSVPs' in the sidebar to see available opportunities. Click bell on top to check your commitments.

### 8 Join a Group

Click 'Groups' in the sidebar to join a group or committee at your school to participate or to stay up-to-date.

### 9 Find People

Click 'Directory' in the sidebar to find contact information for teachers and parents (not available at all schools).

### 10 Get in Touch

Click 'Messages' in the sidebar to privately get in touch with staff, teachers and parent leaders.



## Fort Plain Central School PTA Membership Enrollment



**Please support the Fort Plain PTA today by joining! The cost for a membership is \$5 per year. These dues support programs for the students, teacher appreciation, and much, much more!**

Your membership alone will give us a BIGGER voice in our school and the community! Budget, programs, school events, and volunteer opportunities will be discussed at monthly PTA meetings (attendance is not mandatory but is encouraged).

We would love for you to join us at our next meeting and see all the awesome things that the Fort Plain PTA has to offer!!

Keep in mind that anyone can join the PTA – parents, grandparents, aunts, uncles, close friends, high schoolers, neighbors, church members, etc. are all welcome!

Anyone that has an interest in making your child's potential a reality can join the PTA and help make it possible!



**YES, I would like to join the Fort Plain PTA!**

Number of memberships: \_\_\_\_\_ Total: \$\_\_\_\_\_

**Please return this form to school with your student, OR JOIN ONLINE at:**

<https://fphilltoppers.memberhub.store/>

Name(s): \_\_\_\_\_

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

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

E-mail: \_\_\_\_\_

E-mail addresses are important, as this is how you will get your membership card sent to you. If you do not have an e-mail address, you can still be a member! Please provide an address if possible.

Once your membership is processed, you will have access to the Fort Plain PTA MemberHub, which will allow for easy communication, via the website or convenient mobile app (iPhone or Android apps are available!

